YOUNG ADULTS FROM BLACK COMMUNITIES EXPERIENCE OF RECEIVING COGNITIVE BEHAVIOURAL THERAPY (CBT) FOR DEPRESSION – A QUALITATIVE ACCOUNT

Krystle Nurse

A thesis submitted in partial fulfilment of the requirements of the
University of East London for the Professional Doctorate
in Clinical Psychology

November 2020
Word count: 26,067

ABSTRACT

CBT is proposed to be one of the most effective treatments for depression. Young adults experience a higher prevalence of mental health difficulties during this stage of life (Gulliver, Griffiths & Christensen, 2010). However, it is well documented that Black communities underutilise talking therapies (Lubian et al., 2016) and face barriers around accessing culturally appropriate services (Arday. 2018). In addition, people from minority ethnic communities have historically been underrepresented in health research (Guiliano et al., 2000). Thus, as a result, there appears to be little systematic research into how young Black adults experience this therapy model.

This study aimed to explore the subjective experience of CBT for depression in young adults aged between 18 – 25 years old that identify as Black. Qualitative semi structured interviews were carried out with nine participants recruited from NHS services. Analysis was conducted using a critical realist epistemology and thematic analysis. The overarching themes identified were 'The Therapy Experience' and 'Navigating Getting Help'. The findings suggest that despite participants reporting a mostly positive therapy experience, there were aspects they found challenging both before getting to therapy and within sessions.

This study raised implications for clinical practice including a greater awareness of the widespread stigma and negative views held in Black communities around mental health. The need for therapists to consider the additional inequalities and vulnerabilities linked to being Black and young in this context. Further research should explore the experiences across different timeframes during treatment. It should also expand on the socio-structural issues that contribute to the conceptualisation of distress and help-seeking within Black communities. Clinical Psychologists should utilise the unique positions they hold within services by further highlighting and evidencing the access, engagement and practical applications of CBT within minority ethnic communities.

TABLES OF CONTENTS

LIST OF APPENDICES

Appendix A: NHS Ethical Approval

Appendix B: UEL Ethical Approval

Appendix C: Participation Information Sheet

Appendix D: Informed Consent Form

Appendix E: Debrief Form

Appendix F: Recruitment Pathways

Appendix G: Screening Tool

Appendix H: Study Poster/Leaflet

Appendix I: Interview Schedule

Appendix J: Parker's Transcription Conventions

Appendix K: Extract from Transcript with Initial Comments

Appendix L: Initial Codes

Appendix M: Coded Extracts across Data Set

Appendix N: Progressing Thematic Maps

Appendix O: Extract taken from Reflective Journal

LIST OF TABLES AND FIGURES

TABLES

FIGURES

LIST OF ABBREVIATIONS

Below is a list of the most commonly used abbreviations in the current study. Relevant citations are provided in the main body.

AMHS: Adult Mental Health Services

BAME: Black, Asian, and Minority Ethnic

BME: Black and Minority Ethnic

CAMHS: Child and Adolescent Mental Health Services

CBT: Cognitive Behavioural Therapy

CYP: Children and Young People

DSM: Diagnostic and Statistical Manual of Mental Disorders (DSM -5*)

EBP: Evidence Based Practice

EST: Evidence Supported Therapies

IAPT: Improving Access to Psychological Therapies

ICD: International Statistical Classification of Diseases and Related Health Problems (ICD -10*)

MHS: Mental Health Services

NHS: National Health Service

NICE: The National Institute for Health and Care Excellence

PBE: Practice Based Evidence

PHQ: The Patient Health Questionnaire

PWP: Psychological Wellbeing Practitioners

RCT: Randomised Control Trial

---

* This number refers to the current version of the text in circulation.

ACKNOWLEDGEMENTS

There are many people I would like to express my deepest thanks and gratitude for making this thesis possible and going through this journey with me.

Firstly, I am incredibly grateful to the participants in this study for sharing their stories with me and being so open about their experiences of therapy. Without them this research would not have been possible.

Secondly, to Jenny Jim my supervisor who has been so patient and thoughtful throughout this process. I have benefited from her knowledge, experience, and mainly her ability to contain the many emotions this project has raised for me. I am truly grateful for her advice and tip to let things "percolate". It was a pleasure to have her beside me during my period as a Trainee Clinical Psychologist.

Finally, to my family and friends, thank you for the unlimited support over the last three years. For listening to my struggles and riding the many waves along the way. In your own unique ways, you have all inspired me to keep going and not give up.

1 INTRODUCTION

1.1 Background

This research focuses on exploring the experiences of receiving Cognitive Behaviour Therapy (CBT) for depression in young adults aged between 18 – 25 years old from Black[1] communitie's. CBT is the most widely available psychological therapy in the U.K and is considered to have a strong evidence base for a wide range of psychological difficulties (Beck, 2016). It is often the first line of treatment offered to those struggling with symptoms of depression. However, it can be argued that the CBT model is based on Western European assumptions (Hall, 2001). Whilst evidence from cross-cultural studies illustrates the effectiveness of CBT, it also highlights that cultural adaptations are important to enhance universal applicability (Chowdhary et al., 2014).

Young adults from all backgrounds are a vulnerable group with higher prevalence rates of mental health issues emerging during this time in life (Gulliver et al., 2010). Research suggests that there are a range of social and contextual factors that are additionally important when considering the experiences of Black adults that present with mental health needs. For instance, Black adults face difficulties around unequal access, coercive treatments, misdiagnosis and inappropriate care (Rai Atkins, 2002).

It is important therefore to gain deeper insight regarding how current services are meeting the needs of this group. A qualitative method has been chosen in this study to discover these experiences. I[2] begin by outlining the theoretical underpinnings of the CBT model, along with the context of mental health within Black communities. Finally, based on the literature review, I will provide a rationale outlining this study's aims and research question.

---

[1]This term will be used to refer to people who self-identify as Black and use this as a descriptor of a part of their personal identity.
[2]I have written this thesis in the first person, as it reflects one interpretation, which is intrinsically influenced by my experiences, rather than a reflection of a reality.

1.2   Literature Review

There are a substantial number of studies showing the effectiveness of CBT as a treatment for the symptoms of depression (Lopez & Basco, 2015). This contrasts with research on client experience of various treatment models, which is limited. The following review will include both qualitative and quantitative research, as well as theoretical and anecdotal literature. The databases searched included: PsychInfo, PsychArticles, CINAHL Plus and Science Direct, with no limits on date or country. Searches were also conducted on Google and Google Scholar search engines.

The following questions guided the literature review:

- How do "young adults"/ "people from diverse populations"/ "Black people" experience therapy?
- How do "young adults"/ "people from diverse populations"/ "Black people" experience CBT therapy?
- How do "young adults"/ "people from diverse populations"/ "Black people" experience CBT for depression?

The search terms used in varied combinations included: "experiences or perceptions or attitudes or views", "therapy or treatment or intervention", "CBT or cognitive behavioural therapy or cognitive behaviour therapy" and "BME or Black minority ethnic or ethnic group". Equally, in a key word searching exercise the terms "Black", "ethnic minority", "ethnic identity", "Black", "race", "Cognitive behavio* therapy", "IAPT", "mental health", "depression treatment" "culturally adapted and responsive CBT". Filters were also used to specify participant's age ranges. I used the category 18 – 29-year-old as this range most closely matched the parameters of this study.

---

* Used to represent additional characters and encompass results based on variations in the ending of the word.

1.3 Cognitive Behavioural Therapy (CBT) Theory and Model

1.3.1 The Development of CBT

Over the years the availability of psychotherapies and talking therapies have expanded, and CBT has become one of the most widely used and evidence-based interventions (Beck, 2016). During the 1950s psychology was dominated by behaviourism. Behaviour Therapy (BT) aimed to remove symptoms by using scientifically based techniques originating from what laboratory psychologists were finding out about the mechanisms of learning and behaviour (Gilbert, 2013). The removal of symptoms was mainly found to be invaluable for the treatment of anxiety disorders. However, despite this success, BT proved inadequate in dealing with the symptoms of depression (Gilbert, 2013).

This gave rise to a theory, which emphasised the importance of cognitive processes. Cognitive Therapy (CT) was a form of psychotherapy based on the principle that certain types of thoughts 'have a major effect on how a person perceives the world' (Gilbert, 2013). It emphasised that a thinking disorder is at the core of all psychiatric syndromes and that client's exhibit a systematic bias in the way they interpret experiences (Beck, 2011). CT proposed that it is not an activating event that causes distress, but instead a person's belief system that causes an emotional reaction and the consequent behaviour (Gilbert, 2013). Thus, greater emphasis was placed on the role of cognitive processes and central to the therapeutic work was modifying underlying dysfunctional beliefs (Beck, 2011).

1.3.2 The Main Assumptions of the CBT Model

The merging of these two therapeutic models led to the development of CBT.

"Modern CBT is derived from the legacy of behaviour therapy with its emphasis on the importance of behaviour change in overcoming mental

health problems, and cognitive therapy with its emphasis on understanding and changing the meaning of events" (Westbrook, Kennerley & Kirk, 2011, p.20).

CBT is an umbrella term, which refers to a group of techniques in which a cognitive approach and set of behavioural procedures are combined (Knapp & Beck, 2008). CBT is a direct, time limited, structured approach aiming to alleviate distress by helping clients to develop more adaptive cognitions and behaviours (Fenn & Byrne, 2013). This approach proposes that the way we think, feel and behave are all intimately linked, and changing the way we think about ourselves, our experiences, and the world around us changes the way we feel and what we are able to do (Gilbert, 2013). It is an educational treatment focusing on specific and structured targeted problems (Corey, 2000; Seligman, 2001). CBT is a well-evidenced therapeutic model with lots of studies demonstrating efficacy and effectiveness in a wide range of psychological disorders (Butler et al., 2006, Hofmann et al., 2012, Beck, 2016).

The approach of CBT is problem-orientated and places an emphasis on the present situation and improvement of the client's current state of mind (Fenn & Byrne, 2013). CBT asserts an assumption of client control and emphasises that it is the client who is the active agent in their treatment (Knapp & Beck, 2008). According to Fenn & Byrne (2013) the key elements of CBT include collaborative empiricism which is based on the establishment of a collaborative therapeutic relationship in which the therapist and client work together as a team to identify maladaptive cognitions and behaviours, test their validity and make revisions if needed. It has been acknowledged that CBT's focus on collaborative empiricism is extremely important with clients of diversity, particularly those whose backgrounds and world-views differ from that of the therapist (Naeem & Kingdon, 2012).

1.3.3 The Treatment Model for CBT for Depression

Beck (1976) argued that the symptoms of depression could be explained as biased interpretations of events attributed to the activation of negative representations of the self, the personal world, and the future. Beck referred to this as the cognitive triad (Knapp & Beck 2008). People who suffer with symptoms of depression are increasingly likely to have frequent and disruptive 'negative automatic thoughts'. Therefore, important components of CBT for depression focuses on helping clients solve problems; increase engagement in activities; and identify, evaluate, and respond to their depressed thinking and negative thoughts (Beck, 2011).

However, these fundamental beliefs about mental health and the treatment implied by this model have origins in Western concepts of emotional well-being and illness (Beck, 2016). For example, a key premise of CBT is that exaggerated or biased cognitions often maintain or exacerbate stressful states such as depression (Leahy, 2003). Cognitions and specifically core beliefs are defined as fundamental, inflexible, absolute, and these influence generalised beliefs that people hold about themselves, others, the world, and/or the future (Beck, 2011). When a core belief is inaccurate, unhelpful, and/or judgmental (e.g., "I am worthless"), it has a profound effect on a person's self-concept, sense of self-efficacy, and continued vulnerability to mood disturbance (Wenzel, 2012).

1.3.4 The Limitations of the CBT Model

CBT is underpinned by cultural values of individualistic cultures such as those of the U.K and the U.S.A (Hays, 2009). It is a model developed in the West and therefore, is underpinned by many beliefs specific to the Western culture (Naeem et al., 2010). The protocol driven interventions are based on cultural assumptions and values (e.g. independence, assertiveness, and individualism) that may not be transportable to other cultures (Ametaj et al., 2018). The CBT model also holds Eurocentric assumptions around

family/societal structures, the expression of symptoms/distress and therapeutic interventions (Williams, Turpin & Hardy, 2006).

There are longstanding concerns around the philosophical basis of CBT when working with people from different cultures, diverse and ethnic backgrounds. People from collectivistic cultures vary from those from individualistic cultures in important ways. For instance, differences have been found in core values, cultural orientation and the attention paid to cognitions versus emotions (Laungani, 2004). Equally, CBT is firmly based on formal analytic reasoning and therefore encourages a client to apply a formal-logic approach, which may not be universal across cultures (Hoffmann, 2014).

Although there is a demand for psychotherapy amongst Black and minority ethnic groups, there is also inappropriate evidence of empirically supported therapies (Hall, 2001). Despite the research suggesting CBT is an effective model for people who experience symptoms of depression; the application of empirically supported CBT within diverse cultures is scarce and ethnic minorities are not usually included within the treatment studies that form the evidence base (Hall, 2001).

Dominant cultural values are embedded in a wide range of psychological theories and a risk is that these values may be different or in opposition to the cultural values held by minority ethnic groups. For instance, the theory and treatment models used in the U.K are primarily based on individual psychology, which raises the following issues:

- Ethnic minority cultures are generally more interdependent and emphases the importance of interpersonal relationships and a group identity.
- Spiritual values are often a component of ethnic minority cultures, which can provide a sense of meaning, unity and include beliefs in a Supreme Being or force that unifies the universe (e.g. a formal religion).

- Racism and discrimination are more common to the experiences of ethnic minority people (Hall, 2001).

The move to focus on adapting the CBT approach has meant that there is currently less attention given to re-thinking the therapeutic framework and practice to incorporate an understanding of diverse ethnic, cultural and religious contexts (Rathod & Kingdon, 2005). The literature around adapted CBT recognises that exporting CBT from one cultural group to another is inadequate without the appreciation (of the above differences) held within diverse cultures. It has been acknowledged that CBT may need modification before it is used in non-Western cultures (Padesky & Greenberger, 1995). Literature emerging from different countries suggests that CBT can be culturally adapted to be effective for clients from different cultures to ethnic groups (Rathod & Kingdon, 2005) and recommends that the adaptation of CBT is both necessary and possible (Deffenbacher, 1988).

1.3.5 Culturally Adapted CBT and Culturally Sensitive CBT

Structured and time limited CBT has been shown by many studies to be a cost-effective therapy and as a result there is a clear motivation to try to adapt CBT to connect more to non-Western clients (Naeem, Swelam & Kingdon, 2012). There are two main approaches to doing this, firstly, via culturally adapted CBT (CA-CBT), and, secondly, culturally sensitive CBT (CS-CBT). Next, I will present in detail both approaches, critique them and give a sense of how they are used in current practice.

1.3.5.1 Culturally Adapted CBT (CA-CBT)

CA-CBT is an approach, which takes an existing therapy, as a starting point and then specifically adapts it for a community (Beck, Brooks & Jankowska, 2019). Culturally adapted versions of CBT tend to focus on incorporating culturally relevant and congruent concepts, metaphors, analogies into the models. The modifications made in collaboration with community

representatives from focus groups, consultants or advisory groups (Jungbluth, Dorsey & Sedlar, 2014). Equally, therapists that typically carry out CA-CBT are also members of that community.

Cultural adaptations of evidence based psychological treatments are important to enhance universal applicability (Chowdhary et al., 2014). CA-CBT ensures that the therapeutic work is done by staff who have an inside knowledge of the language, values and beliefs of that community (Beck et al., 2019). Outlined below are a few studies that demonstrate the use of CA-CBT. The research illustrates CA-CBT within Muslim, Turkish and Pakistani communities and African American clients in the U.S.A.

Mir et al., (2015) studied how adaptations to behavioural interventions such as using metaphors, language, spiritual practices and religious parables can support value led behaviour change for Muslim clients. Acarturk et al., (2019) illustrated how specific adaptations such as normalising symptoms, using Turkish metaphors and religious ideas to teach CBT principles increased the acceptability and positive expectancy of the model for a group of adolescents. Similarly, Ward & Brown (2015) devised a 12 week Culturally Adapted intervention called "Oh Happy Day", which included spirituality, Black identity and Black family issues. However, despite the growing evidence base for CA-CBT, the above studies are often small scale and conducted with very specific groups or communities.

1.3.5.2 Culturally Sensitive CBT (CS-CBT)

CS-CBT or culturally responsive CBT is an approach that allows therapists to recognise and value the diversity of minority groups. It enables therapists to draw support from team members and supervisors to make adaptations to evidence-based therapies, allowing for them to fit with the culture and the context of the client (Beck et al., 2019). Below I outline examples where CS-CBT has been applied individually with a client and within a group context.

Gonzalez-Prendes & Thomas (2009) present a single case study involving

culturally sensitive CBT for the treatment of anger with an African American Women. The case focused on three themes: gender role socialisation, culture bound expectations, and the realities of powerlessness faced because of gender and race. The approach involved empowerment, active involvement and engaging the client to evaluate the validity and functionality of traditional gender and racially based socialisation messages. The treatment aim was to rewrite the script of these messages in a way that promoted a more balanced view of the self (Gonzalez-Prendes & Thomas, 2009). This would ultimately lead to behavioral changes such as "an assertive style of expression" and "socially appropriate communication of anger" (Gonzalez-Prendes & Thomas, 2009).

Hinton & Patel (2018) outlined specific changes made in order to be culturally responsive when working with refugee populations. They designed a CBT model for working with Refugees from a variety of cultures that emphasised the need to consider the context of the person, their particular circumstances, migration history and degree to which they engage with culturally specific spiritual beliefs and practices around their own physical and mental health (Beck et al., 2019).

NICE presents a study where the objective of the Birmingham service was to increase the number of people from BME backgrounds being treated using evidence-based approaches in primary care. This service adapted their practices, developing a culturally sensitive treatment group where clients could feel that their ethnic, cultural and spiritual beliefs were understood (NICE, 2017). They revealed that these changes increased and maintained patient engagement and provided good clinical outcomes (NICE, 2017).

The ROSHNI-2 (meaning light in Urdu and Hindi) study was a multi-centre randomised controlled trial with a culturally adapted group intervention based on the principles of CBT. The central adaptations made to the intervention were: language specific translations, culturally appropriate assignments and homework, folk stories and added consideration given to religious beliefs (Beck et al., 2019). The group has aimed at tackling isolation and the lack of

social support experienced British South Asian populations suffering from symptoms of depression (Beck et al., 2019). They also included an engagement protocol for mothers, fathers and extended family, along with an active focus to address concerns around stigma (Beck et al., 2019).

Although these changes to existing interventions for depression invite ethnic minority involvement in cultural values particular to that ethnic group, Muñoz & Mendelson (2005) further suggest the importance of incorporating spirituality and religion if relevant, taking into account the clients' acculturation level, addressing race, prejudice, and discrimination, and offering strategies to empower the clients if necessary. Equally, the inclusion of community members in the process of sensitively developing a treatment is viewed as an utmost importance to attract and retain participants (Muñoz & Mendelson, 2005).

Although the below table (taken from the IAPT BAME positive practice guide, 2019) highlights clear distinctions between CA-CBT and CS-CBT, these are not always distinguishable in the research literature, and often the different terms (adapted, responsive and sensitive) are used interchangeably.

Table 1: Key Differences between CA-CBT and CS-CBT

	Culturally adapted CBT	Culturally responsive (sensitive) CBT
Developed for a specific population	Yes	No, generalisable
Delivered in community languages	Yes, generally	No, usually in English unless via an interpreter or bilingual therapist
Therapists of the same ethnic background as service users	Yes, generally	No, although they could be
Developed from existing evidence-based therapies	Yes	Yes
Takes values, beliefs and situation of service user into account	Yes	Yes
Flexible around different degrees of cultural identification, religious affiliation and identity	Yes, to some extent	Yes

Despite opportunities there are several challenges with adapting a specific model or sensitively responding to the needs of communities from diverse backgrounds. A key critique of CA-CBT and CS-CBT is ultimately both approaches do not challenge the underlying Western, Eurocentric assumptions and fundamental principles of the therapeutic model (Guo & Hanley, 2015). For instance, this may be detrimental as this intervention has been developed for one group and is then being modified for the application to other groups (Hall et al., 2016). Arguably, using a model like CBT reinforces the particular assumptions and the fundamental principles are further being enforced on those from diverse backgrounds, or which may also have different beliefs and ways of conceptualising distress. Equally, a review of culturally sensitive treatments for depression concludes that many treatments employ an evidence-based bottom up approach, which, at most only involves general and practical adaptations of a model (Kalibatseva & Leong, 2014).

Whilst the CS-CBT approach appears to provide clients with more of a sense of collaborative production, with adjustments being made to the model that appear to fit with the client's world views and experiences, CS-CBT can be criticised if the fidelity of the CBT model is undermined. The benefits for ethnic minority groups only occurs when treatment approaches are evidence based and the when the focus on culture does not overtake the presumed active ingredients of the intervention (Jungbluth, Dorsey & Sedlar, 2014).

However, there is currently insufficient data to show that culturally modified CBT merits evidence supported therapies status (Benuto & O'Donogue, 2015). Culturally sensitive approaches are largely important when working with individuals from minority and traditionally disempowered groups, whose beliefs and behaviours run the risk of being pathologised when taken out of the context of their cultures and measured against the standards of a dominant group (Gonzalez-Prendes & Thomas, 2009).

Therefore, instead of adapted or sensitively responsive CBT, there is some evidence that suggest it may be useful in the U.K to explore and better understand non-Western explanatory models of disease alongside the cultural attitudes of health professionals and the issues in society (Naeem & Kingdon, 2012). Currently Western assumptions and beliefs are aligned within Psychiatry and the individualistic models of care are prioritised (and often viewed as superior) whilst the beliefs of those from non-Western groups are possibly belittled or, even worse. ignored.

A further factor and potential critique of CA-CBT and CS-CBT centres around the cultural competence of therapists and the impact this has on the experience of clients from diverse, ethnic and minority groups. With CS-CBT in a U.K. context, cultural competence may be potentially viewed as necessary, relevant and more applicable. Clinical Psychology, as a profession, lacks representation of therapists from diverse cultural backgrounds. Despite the various attempts over past years to promote diversity in the profession the current number of practicing psychologists in

the U.K. does not reflect the ethnic composition of the communities in which they look to serve (Turpin & Coleman, 2010; Beck et al., 2019). Therefore, it is imperative that there is an appreciation cultural competency, which refers to a sensitivity and appreciation of the importance of different cultural mechanisms (Hall, 2001).

There has been a substantial amount of literature around culturally competent practice. This is the process which ensures therapists are able to address the cultural disparities between themselves and their clients as well as holding an ability to consider the influence of culture throughout every aspect of their work, including the specific components of CBT (Hays, 2009). Despite this and emphasis on culturally competent practices in the mental health field, there still exists disparities in the quality of services delivered to ethnic minority groups (Sue, Zane & Berger, 2009).

To conclude, there are factors that both challenge and facilitate the implementation of CA-CBT or CS-CBT in clinical practice within the U.K context. Whilst it is not ideal to import a model with specific assumptions onto a community or group that potentially holds differing world views, if this approach, is the only option available, the above evidence outlined suggests the need for specific adaptations and responsive changes for communities from BME groups. Although cultural considerations play a vital role when using CBT models (Naeem, 2019) a challenge is that the vast amount of published research is largely conducted in countries outside of the U.K.

The Department of Health regularly publishes guidance on how Improving Access to Psychological Therapies services can be tailored to meet the specific needs of different populations. It produces an IAPT BAME positive practice guide (2019), which draws on knowledge from experts by experience and clinical experts in the field. This guidance provides information that can facilitate the gap in research between cross-cultural research and what is currently implemented in U.K based services. Whilst guidance usefully indicates that CBT models in their current form (without modifications/adaptations) appear to be less applicable or accessible to non-

Western communities it follows it is supplemental and therefore establishing the extent to which this document is effectively translated into current U.K clinical practice is challenging.

1.4 Depression

1.4.1 The Definition

According to the National Institute for Health and Care Excellence (NICE):

> Depression is a broad and heterogeneous diagnosis. Central to it is depressed mood and/or loss of pleasure in most activities. Severity of the disorder is determined by both the number and severity of symptoms, as well as the degree of functional impairment (NICE, 2009).

In Western culture today the theme of 'illness' is consistently used in evaluating certain human problems (Fernando, 2017) and as a result labels such as depression have a functional aspect. The formal diagnosis of depression that is given to an individual is often based on a classification system found within a diagnostic manual such as the Diagnostic and Statistical Manual of Mental Disorders - DSM (American Psychiatric Association, APA, 2013) and the International Statistical Classification of Diseases and Related Health Problems - ICD (World Health Organisation, WHO, 1993). In the U.K. a diagnosis often allows a person to access support, care and treatment. However, such labels are Western constructs that tend to turn 'people with problems' into 'patients with illnesses' (Johnstone, 2014).

A diagnosis in psychiatry is not the same as a diagnosis in the rest of medicine (Boyle, 2002). For instance, in physical illness, physicians can complete objective tests, which allows them to make a diagnosis, however this cannot be done (in the same way) in the field of psychiatry. Unlike the rest

of medicine there has been a longstanding failure in scientific research to reveal any specific biological or psychological marker that identifies a psychiatric diagnosis like depression (Timimi, 2014). Instead, psychiatry evaluates certain types of human problems by identifying a "change" (from a hypothesised norm), giving it a name (a diagnosis), evaluating the causation (aetiology) and making a judgment on interventions/treatments (Fernando, 2017).

Despite the documented difficulties with these classification systems, depression is a condition that has been recorded for several years and was first applied to a mood state in the seventeenth century (Gilbert, 2013). It is a 'mood disorder' and the symptoms of depression can be cognitive, emotional, behavioural and physical (Wilding & Milne, 2010). The functional shift of the construct over time highlights that the concept of depression has gathered status through the natural sciences and has gradually been incorporated into Western cultures (Summerfield, 2006). Timimi (2014) argues that diagnoses serve only as descriptors that do not have the power of explanation, whilst Bentall (2010) suggests that psychiatric diagnoses were invented and arrived at via consensus, rather than the basis of research.

1.4.2   The Statistics

In 2013, it was estimated that there were over 350 million people in the world with a diagnosis of depression (Gilbert, 2013) with approximately 1 in 4 people in the U.K believed to experience a mental health problem each year (Mental Health Foundation, 2016). In England, 1 in 6 people are reported to experience a common mental health problem, anxiety and/or depression (Mental Health Foundation, 2016). Statistics show that in 2014, 19.7% of people in the U.K aged 16 and over, show symptoms of anxiety or depression, which is a 1.5% increase from the previous year, 2013. This percentage is higher among females, 22.5%, than males, 16.8% (Evans, Macrory, & Randall, 2016). This quantitative data is useful in highlighting how common these certain psychological problems are. However, there are

several limitations with these statistics including: issues around over or under reporting, how and who is recording the data, the presentation of data, where data is reported and the intended audience.

1.4.3 Service Structure and IAPT Services

One of the most recent developments within the NHS mental health services has been the formation of IAPT services. The Depression Report (2006) outlined that mental illness in Britain accounts for over a third of the overall burden of illness and mental are a major national problem causing a lot of human suffering. In addition, this report highlighted that diagnoses such as depression and anxiety cost the economy around 4 billion pounds a year in lost productivity and incapacity benefits. The IAPT initiative recommended clinical improvements for all people experiencing depression or anxiety (Layard et al., 2006). NICE guidelines in conjunction set out the care and services suitable for people with specific conditions or needs (NICE, 2020).

The guidance for depression, treatment promotes CBT as the main treatment of choice. This is due to the large evidence-base and research gathered from Randomised Controlled Trials (RCT), to which CBT lends itself well (Kazdin, 2008). CBT research has historically focused almost exclusively on European Americans, with little to no attention given to cultural influences related to ethnicity, religion, sexual orientation, disability or social class (Hays & Iwamasa, 2006). Thus, the research evidence outlined in NICE has played an influential in the roll out of the IAPT programme and a key intention has been to greatly increase the availability of evidence-based psychological therapies (Clark, 2011). IAPT services set out to improve people's employment status as well as symptomology (Clark, 2011). Thus, when evaluating the effects of the treatment model on health, in conjunction with that individual's employment rates, illustrates there is an equally recognisable economic basis for IAPT services.

NICE guidance advocates a stepped care approach in the delivery of treatment for mild to moderate depression. Therapists often deliver and monitor treatments ensuring that the most effective, yet least resource intensive are delivered to clients first (Davison, 2000). Those with moderate to severe depression are not recommended 'low intensity' interventions and instead offered 'high intensity' face-to-face psychological therapy usually in the form of individual sessions CBT (Clark, 2011). The current focus on an individual's recovery rate, and session by session outcome monitoring, has allowed IAPT services to evidence and monitor pre and post treatment data. Various questionnaires are used, with one specific tool, the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer & Williams, 2001) focusing on the reduction of symptoms of depression.

In sum, the development of IAPT services is viewed as one of the largest and radical changes to NHS services. However, although CBT is widely researched producing scientific analysis and quantifiable outcomes (Hays, 2009) the evidence base for which the guidance is developed have not controlled for variables such as race, ethnicity and class (Smith, 2008) and the vast amount of the quantitative outcomes reported in NICE guidelines are based on evidence predominantly conducted in non-minority populations, and therefore does not include different, diverse cultural groups (Miranda et al., 2005). Equally, the majority of CBT studies do not integrate multicultural perspectives into the theory or practice (Hays & Iwamasa, 2006). NICE guidelines and the structure of IAPT services take a "one size fits all" approach and are often considered a "Universalist Service" (Levinson, 2012).

1.5   Black Communities and Mental Health

1.5.1   The terms 'Black', BME' and 'BAME'

What is at issue here is the recognition of the extraordinary diversity of subjective positions, social experiences and cultural identities which compose the category 'Black'; that is, the recognition that 'Black' is

essentially a political and culturally constructed category, which cannot be grounded in a set of fixed trans-cultural or transcendental racial categories and which therefore has no guarantees in nature. What this brings into play is the recognition of the immense diversity and differentiation of the historical and cultural experiences of Black subjects (Hall, 1992, p.254).

For the purposes of this research the term 'Black' is used in the broadest sense and will refer inclusively to the groups defined in the U.K as Black/African/Caribbean/Black British, African, Caribbean and those from any other Black/African/Caribbean background (ONS, 2011). As a Black researcher, I am aware that not every Black person would describe or define themselves as fitting into these predefined categories. Equally, the term 'Black' is commonly used as a descriptive term in the context of referring to the colour of one's skin. However, I acknowledge that in the context of this research I will be using 'Black' as a label that may unwittingly hide a great deal of diversity, be it from country of origin, ways of life or generational beliefs. This study included participants that self-defined as Black, who described originating from a range of countries but shared the common factor of being born in the U.K.

Information about Black communities is often captured within the categorisation of Black and Minority Ethnic (BME) or Black, Asian and Minority Ethnic (BAME). Both of which are widely used social constructs that have become a shorthand used in services and clinical settings to differentiate minority ethnic individuals (Wood & Patel, 2017). Like the construct of depression, the terms BME/BAME have a historical position and therefore contextual meaning. However, both these terms incorporate a broad range of different groups and cultures. Some of the key limitations of using umbrella terms like BME and BAME is that, firstly, they serve to overlook the nuances and differences within the group and secondly, they serve to create "othering" against the majority group of whiteness.

However, in order to avoid the inappropriate homogenisation of minority groups, my research focuses specifically on the experience of people who self-identify as 'Black', rather than those from a BME or BAME background (Buffin Ahmed & Singh, 2009). Nevertheless, as the term BME/BAME is frequently referred to in the literature, I have chosen to refer to it in this report in order to adequately reflect the key findings within the existing research.

1.5.2 Black Mental Health

The inequalities that exist within mental health services particularly for BME communities in the U.K are widely known (Grey et al., 2013). However, understanding the difficulties associated with mental health in Black communities is multi-layered and complex. Firstly, the evidence highlights ethnic variations in the pathways into specialist mental health services in the U.K. Black people are found to have more complex pathways compared to White people; with the former less likely to maintain contact with services and consistently make greater use of inpatient services as well as higher rates of compulsory admissions (Bhui et al., 2003). Secondly, there is a strong interaction between these pathways and the contextual/social barriers that impact specifically on Black communities, including poverty, racism, discrimination, prejudice, fear and stigma.

1.5.3 Help-Seeking Behaviour in Black Communities

There are known differences in the financial and structural barriers and perceived need between different racial groups (Aylon & Young, 2005). Black communities tend to not seek help in the traditional way as that outlined in Western service structures and pathways. Specifically, during a first episode of psychosis, African-Caribbean and Black African patients, are far more likely to come into contact with mental health services via more negative routes (e.g. criminal justice agencies) when compared with White patients (Morgan et al., 2005). Additionally, these patients are less likely to access care

through a General Practitioner (G.P), thus demonstrating a marked ethnic difference in the pathway to care at first presentation (Morgan et al., 2005). In the U.S.A, although African Americans have high prevalence rates of depression, the evidence shows they have low levels of seeking mental health care (Ward & Brown, 2015). Similarly, in the U.K., Black Caribbean women's approach to help-seeking has been shown to be based on a social model of depression constructing symptoms as something requiring attention, a hierarchy of help-seeking - prioritising personal agency, autonomy and self-reliance over seeking help from others and a resistance to psychiatric labeling - perception that their experiences would inevitably be viewed as negative (Edge & MacKian, 2010). Thus, this reference to help-seeking is important and highlights an additional influencing factor for the Black participants in this study.

1.6   Contextual and Social Barriers in Black Communities

There are a several known barriers explaining why minority groups are less likely to seek professional support around mental health difficulties. Often these include varying beliefs around the origins and cause of mental illness, an attitude of cultural mistrust towards professionals, and a stigma associated with mental illness (Saechao et al., 2012). As a result, Black communities often seek help less frequently and in different ways to people from other cultures. Thus, a broader recognition is needed around how different cultural groups have different experiences and levels of distress, which may impact on how they seek help and their engagement with U.K mental health services. Importantly, the strongest evidence around the causes of distress and disordered behaviour comes from the research on social and environmental factors (Mosher & Boyle, 2004).

The idea that people possess problematic attributes that services can 'help' to change remains a fundamental feature of the clinical practice in the U.K. (Boyle, 1997) but is not necessarily the beliefs held across all cultures. There is scepticism around whether the diagnostic driven protocols (and more

broadly service structures that are there to help) have more to do with successful consumer culture marketing than with science (Timimi, 2014). Labels and diagnostic categories (such as depression) are known to influence cultural and political spheres. Categorising people in this way has a significant impact on service provision and public and professional beliefs about mental distress (Timimi, 2014). Some contend that service structures are designed to focus on 'pathological individuals' rather than on 'pathological social structures' (Boyle, 1997).

1.6.1 Poverty

It is known that greater inequality in any society leads to poorer mental health of that society. Wilkinson and Pickett's (2009) The Spirit Level provides compelling evidence which highlights the relationship between income inequalities and health. They demonstrate that areas with the largest income gaps (for example the U.K and U.S) report greater health problems. They illustrate that overall health tends to be worse in more unequal societies.

In the U.K children from BME groups are more likely to be in poverty, with 46% in poverty compared to 26% of children in White British families (Child Poverty, 2019). According to the U.K Poverty (2017) statistics, poverty levels varies across different ethnic groups, however in the past twenty years, working age people in a White ethnic group are reported to have the lowest risk of poverty in contrast to BME groups who have the highest poverty rates. Additionally, U.K employment figures show that unemployment rates are significantly higher for ethnic minorities at 12.9% compared to 6.3% for White people (EHRC, 2016).

1.6.2 Racism, Discrimination and Prejudice

Racism is defined as:

> "A belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race" (Merriam-Webster, 2019).

Research shows that there is a high chance that BME service users will experience racism over their lifetime (Beck, 2019) and the more incidents of racism, the more likely they are to experience mental health difficulties (Wallace, Nazroo, & Becares, 2016). The mental health outcomes amongst Black Americans highlight that discrimination is related to higher levels of psychological distress and is marginally related to the likelihood of developing depression (Brown et al., 2000). Additionally, studies in the U.S.A highlight that racial discrimination is not only linked with adverse mental health outcomes amongst Black Americans but also other racial and ethnic minority groups (Brown et al., 2000).

In the U.K, it has also been shown that cumulative exposure to racial discrimination has incremental negative long-term effects on the mental health of ethnic minority people (Wallace et al., 2016). There are controls that are imposed on Black people in the form of racism and discrimination within all aspects of societies' institutions including that of housing, social services, health services, employment, the legal system, schooling and higher education (Fernando, 2017). Arguably, the oppressive practices within the psychiatric institutions are part and parcel of the overall discrimination faced in the wider society (Fernando, 2017).

Longstanding problems exist when examining the practices of European psychiatry for Black people. Specifically related to race/ethnicity the experiences of Black people in conventional psychiatry appeared to centre on the Black struggle in the U.K and issues of inequality and structural oppression (Francis, David & Johnson, 1989). In the 'Healing a Divided Britain' review into race inequality in Great Britain, the following has been documented:

> "It is indefensible that in 21st century Britain, Black workers with degrees earn 23 per cent less on average than White workers with

degrees; and if you are Black in England you are more than three times more likely to be a victim of murder and four times more likely to be stopped and searched by the police. Fear of crime is also much higher for many ethnic minorities, as is the likelihood of living in poverty with poor housing and experiencing worse health outcomes" (Equality and Human Rights Commission, 2016).

Evidence suggests a large proportion of people from Black communities in the U.K have an increased likelihood of experiencing mental health difficulties. Alongside illustrating the connection between mental health wellbeing and social and economic factors (Timimi, 2014). Increased negative experiences due to the Black people are disproportionately disadvantaged. These disadvantages are often the result of salient factors linked to social rather than biological explanations. Current Western psychiatry and psychological research fails to give enough attention to social situations (Arthur et al., 2010). Equally, the brain, the mind and human emotions cannot be understood in isolation from their social context (Bentall, 2003). Therefore, it is imperative to question whether treatment models (like CBT) effectively acknowledge and address key social influential factors on distress.

1.6.3 Stigma

According to Goffman (1963) and Allport (1958) stigma and prejudice are complex concepts that encompass an individual's experience, interaction between non-marginalised and marginalised groups, alongside broader structural and social phenomena. As there are not much conceptual differences between these terms, in this research I have chosen to use these terms interchangeably.

Stigma and prejudice are believed to adversely impact people's health with higher rates of both amongst ethnic minority groups (Wolff et al., 1996). The multiple forms of stigma experienced is one of the common barriers for BME groups accessing services (Kovandžić et al., 2010). Often stigma manifests in

language, as a disrespect in interpersonal relationships and behaviours, and therefore acts as a barrier to those individuals who need mental health services but are reluctant or refuse to seek help because of the potential discrimination and rejection of others (Gary, 2005).

Stigma is associated with fear, and fear alongside fear influences to varying degrees' Black people's perceptions of diagnostic labels and therapy. A main barrier preventing help-seeking in BME communities is fear of the unknown and treatment process (Castonguay, Filer & Pitts, 2016). It has been found it is the fear of mental illness and people with mental health problems that stops individuals and families from engaging with services (Phelan, Bromet, & Link, 1998). Furthermore, being labelled mentally ill and prescribed mental health medication evokes fear in BME communities because of the long-term impact on people's future (Keating & Robertson, 2002).

Despite the several race related initiatives, Black people have experienced a continued fear towards mental health services (Keating & Robertson, 2004). A study with BME communities in South-East England and explored the barriers to accessing mental health services and concluded that people from BME backgrounds require more practical support to raise awareness, combat the stigma, and improved information about the services and access pathways (Memon et al., 2016). The voluntary sector is often viewed as the most appropriate and least stigmatising source of help for Black patients (Gray, 1999).

A clear relationship exists between the stigma attached to being labelled as mentally ill and the utilisation of mental health services. Consequently, a stronger understanding is needed around the many ways that stigma and prejudice affect those from marginalised communities (Wolff et al., 1996). Increasingly, in recent years, a greater urgency has been placed on understanding the links between people from BME communities, stigma, prejudice, discrimination and health in order to aid the development of effective public health strategies (Stuber, Meyer & Link, 2008).

1.6.4   Double Stigma

Ethnic minority groups and specifically Black communities due to their group affiliation tend to confront prejudice and discrimination. As a result, they may experience "double stigma" because of the group affiliation and the additional burdens of having a mental illness diagnosis (Gary, 2005). Double stigma is the additional burden that confronts ethnic minority groups, which often further impacts on them electing not to seek or adequately participate in treatments (Gary, 2005) and often Western models of care and treatments.

Figure 1: Factors that Produce and Sustain Stigma
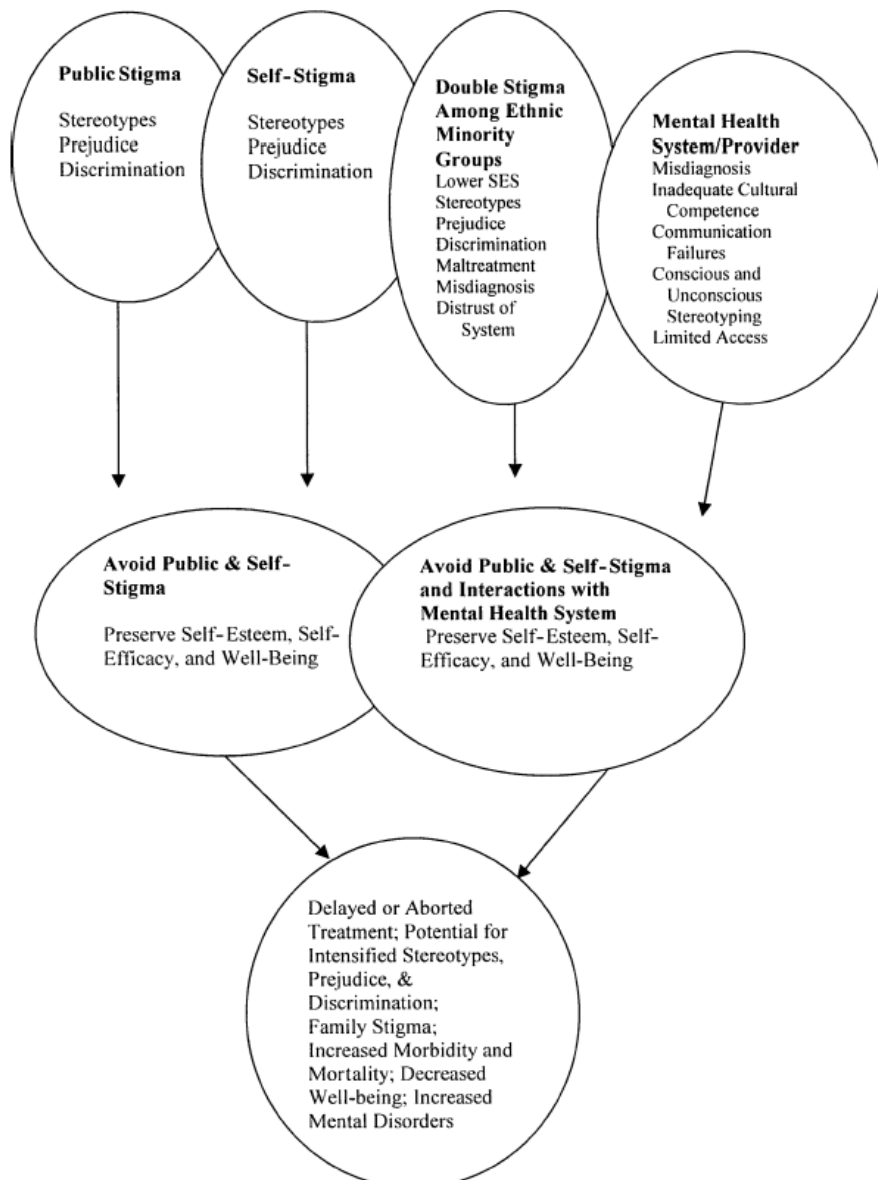
The figure above integrates the numerous factors that interact to produce and sustain stigma related to mental health difficulties in ethnic minority groups. These factors all potentially influence help-seeking behaviours, attendance and completion of treatments (Gary, 2005).

1.7 Inequalities in Mental Health Provisions

1.7.1 Racial Disparities

Black and Asian ethnic minorities, access and utilise treatments prescribed by mental health services differently to White people (Bhui & Bhugra, 2002). BME groups are under-represented in voluntarily accessed services (such as outpatient talking therapies) and contrastingly overrepresented in non-voluntarily services (such as inpatient care under section). Equally, BME clients are generally perceived to have poorer experiences of services in comparison to non BME clients (Raleigh, Iron & Hawe, 2007) and appear to report fewer positive experiences and higher levels of dissatisfaction of services (Joint Commissioning Panel for Mental Health, 2014).

There is often a mistrust and suspicion within Black communities which is compounded by the mistreatment and unfair treatment of Black clients in mental health services especially when compared to White patients (Francis et al., 1989, Ayalon & Young, 2005). In addition, BME communities appear to lack confidence in the mental health services being offered and provided to them. Black and ethnic minority communities tend to experience difficulties around unequal access; coercive treatments, misdiagnosis and inappropriate care (Rai Atkins, 2002).

Table 2: Racial Inequalities in the U.K (Fernando, 2017)

Black/ethnic minorities are more often:
• Diagnosed as schizophrenic
• Sectioned under Mental Health Act
• Admitted as 'offender patients'
• Held by police under MHA for observation
• Transferred to locked wards from open wards
• Not referred for 'talking therapies'

BME groups' access to mental health services has been recognised as problematic for several years. It is well documented that those from BME backgrounds are less likely to receive adequate and timely support for their mental health distress. The release of the national strategy 'Inside Outside – Improving Mental Health Services for Black and Minority Communities in England' (NIMHE, 2003) makes key recommendations for a national approach to reduce and eliminate ethnic inequalities in the health service experience and outcome. This followed the death of David Bennett a 38-year-old African Caribbean patient who died in a medium secure psychiatric unit after being restrained by staff. The Government's response to this incident led to the Delivering Race Equality in Mental Health Care: An action plan for reform (Fountain & Hicks, 2010) which identified three building blocks for change: more appropriate and responsive services, community engagement and better information.

In sum, the needs of minority groups should be recognised and considered important in the planning and delivery of all mental health services (Suresh & Bhui, 2006). Despite much of the above research outlined alludes to secondary care and specialist services, a similar picture can be seen in Black communities' engagement within primary care services.

1.7.2 Age Group Differences

> A 'young adult' (noun) is a person who is in his or her late teenage years or early twenties (Cambridge Dictionary, 2019).

The period of young adulthood is often characterised as a time of significant change in an individual's life (JSNA, 2017). Some describe the phase between 18 – 25 years as 'emerging adulthood' and is associated with a time of increased in distress and instability (Arnett, 2000). It is often a time of frequent changes in occupation, educational status and personal relationships (Arnett, 2000). Individuals also set behaviour patterns during this period and this is where both positive and negative experiences can have a long-lasting effect (JSNA, 2017). This group are also at a stage where they are perceived differently in broader society e.g. 18 years old officially marking 'an adult' in U.K Law.

Young adulthood along with adolescence is seen to be a critical stage for the development of mental health difficulties (Rickwood et al., 2005). The prevalence of mental health problems appears to be at its greatest amongst this age group, and as a result, is viewed as a critical period developmentally in the lifespan of an individual, particularly around mental health and wellbeing (Rickwood et al., 2005). It has also been shown that young people aged 16 - 24 years old are more likely to experience mental health difficulties than any other stage of the lifespan (Gulliver et al., 2010).

The research highlights a growing recognition that services need to be more accessible for this young adult age group. Young adults tend to have greater difficulty booking GP appointments and are twice as likely to attend Accident and Emergency (A&E) or a walk-in centre (GP Champions for Youth Health Project, 2015). Nationally, 16 – 24-year olds are less satisfied than older adults using their GP services (Hagell, Coleman & Brooks, 2015) and it is reported that fewer young adults seek and receive effective care (Nicholas et al., 2018).

Equally, eighteen-year olds are currently "falling through a gap" when transitioning between Children and Adolescent Mental Health Services - CAMHS and Adult Mental Health Services - AMHS (Lavis, 2019). The NHS Long Term Plan outlines a commitment to transforming mental health services for young people and young adults. This document highlights the hope to provide mental health services across 0 – 25-year olds that reach children, young people and adults by the year 2023/2024. This would allow for seamless and accessible children and young people's mental health services and ensure that those individuals that fall into the category of a young adult do not fall off the 'cliff edge' at this vulnerable time in their lives (Lavis, 2019). Equally, further policies like Future in Mind suggest that the age limit of children's' mental health services should extend to 25 years old (NHS England, 2015).

I acknowledge that whilst there are several limitations with the categorisation of emerging adulthood, as a term it highlights a specific and critical stage in an adult's life. With a developing consensus that the current health and social care provisions do not fully understand or meet the needs of 'young adults'/ 'emerging adults' (Care Quality Commission, 2014; Goddard, Wolfson & Wolfson, 2015). It is essential to gather a better understanding of the needs of this cohort in order to inform local commissioning and service design (JSNA, 2017).

The transition from adolescence to adulthood often involves a progressive strengthening in one's sense of identity (Waterman, 1982). Thus, identity development alongside help seeking are additional factors impacting on this age group. Negative attitudes/beliefs, embarrassment and problems recognising symptoms and the fear of stigma are cited as barriers in 18 – 25-year olds to young adults seeking help (Gulliver et al., 2010). This group also shows a high reliance on the self to solve problems and lack of emotional competence (Rickwood, Deane & Wilson, 2007; Rickwood et al., 2005).

In sum, these studies further highlight that this group is particularly vulnerable, and the reason for restricting the age range in this study was to explore these

additional vulnerabilities. Studies indicate that further to the double stigma already faced, Black young adults potentially face triple stigma.

1.8 IAPT, BME groups and Young Adults

As outlined earlier in this chapter, when launched the aim of IAPT service was to deliver effective and appropriate services for the whole community. This was despite early pilot studies recognising that individuals from BME communities were an underrepresented population accessing services (Clark, 2011). The recognition that BME communities are less likely to access IAPT services, has led to a growing focus on understanding the needs of local communities in the U.K. This is an attempt to remove barriers and increase engagement with individuals from different minority communities.

Recent data from the IAPT programme (Baker, 2018) highlights the following key points:

- Compared to people from White backgrounds, people from BAME are less likely to use IAPT services (13% of IAPT referrals are from BAME groups whilst 20% of England's populations are from BAME groups).
- Young adults (as a specific group) are generally less likely to attend therapy.
- Despite referral rates being amongst the highest in those aged 18 – 35, those referred in this younger age group are both less likely to start and finish a course of treatment.
- When they do attend, both younger people and people living in deprived areas are less likely than average to recover from their condition after psychological therapy, with 58% recovery in least deprived compared to 39% in most deprived.

The above statistics highlight that young adults are less likely to seek professional help and attend therapy and recover from their symptoms of depression. People from BME communities due to different help-seeking patterns tend to be underrepresented in primary care services (Arday, 2018).

Given IAPT services depend largely on diagnostic labels, which have the potential to deflect attention away from what minority groups (including Black people) might cite as the basis of their distress, such as poverty, injustice and lack of rights (Summerfield, 2008). As a result, it is important to recognise the key dangers with the medicalisation of everyday life and acknowledge that labels can serve to locate problems within the person and obscure the person's context (including their relationships and social circumstances). Equally, there are embedded assumptions in a diagnosis that function to mask social contexts that are often the key drivers to distress.

1.9   Rationale

The IAPT programme offers the main route into receiving psychological support for individuals experiencing symptoms of depression. The research literature illustrates that Black young adults are particularly vulnerable due to the group affiliation of being Black (associated experiences of poverty, prejudice and discrimination), the Black communities' experience of mental health difficulties (associated stigma and fear) and being a young adult (age, help seeking and identity). Above I have also outlined evidence that Black communities and BME communities in the U.K experience significantly higher amounts of social and contextual difficulties. These factors are all known to cause distress and be associated with mental health difficulties like depression (Rai Atkins, 2002; Beck, 2019; Kovandžić et al., 2010).

Additionally, compared to people from White backgrounds people from BME communities are less likely to use IAPT services (Baker, 2018). Furthermore, although referral rates are amongst the highest in individuals aged 18 - 35, this age group are the least likely to start or finish a course of treatment (Baker, 2018). Young people and specifically those from deprived areas are less likely than average to recover from their condition after psychological therapy (Baker, 2018). This is particularly important with the increased diversity in the populations accessing IAPT services. Although CBT has a

substantial amount of research showing its effectiveness as a treatment for symptoms of depression (Lopez & Basco, 2015), studies often focus on the benefit of the model in successfully reducing symptoms of depression, which has meant that understanding how clients' actually experience this model has been a largely neglected area of research.

As services continue to be widely rolled out in communities across the U.K, ultimately leading CBT being offered widely as the treatment for symptoms of depression, it is important to not only focus on the effectiveness studies but to shed light on understanding the experiences of those clients who attend the sessions. This research will address how CBT, a Western therapeutic model, is experienced in the U.K by young adults from a different cultural background from that for which the model was designed and tested. As little is known about the experiences of therapy within this specific group, this research will be educational in that it will provide insight into how young adults from Black communities' experience CBT for depression with a focus on acceptability and responsiveness rather than symptomology.

1.9.1   Aims and Research Question

This study aims to expand the understanding of young people from Black communities' experience of CBT for depression treatment. It will explore whether participants find CBT acceptable, culturally applicable, and will highlight the useful and less useful aspects of this therapeutic model. The findings will provide insight into how this cohort have made sense of the treatment model and aims to make a novel contribution to the literature through exploring people's experiences of the model.

Figure 2: Venn Diagram of Rationale
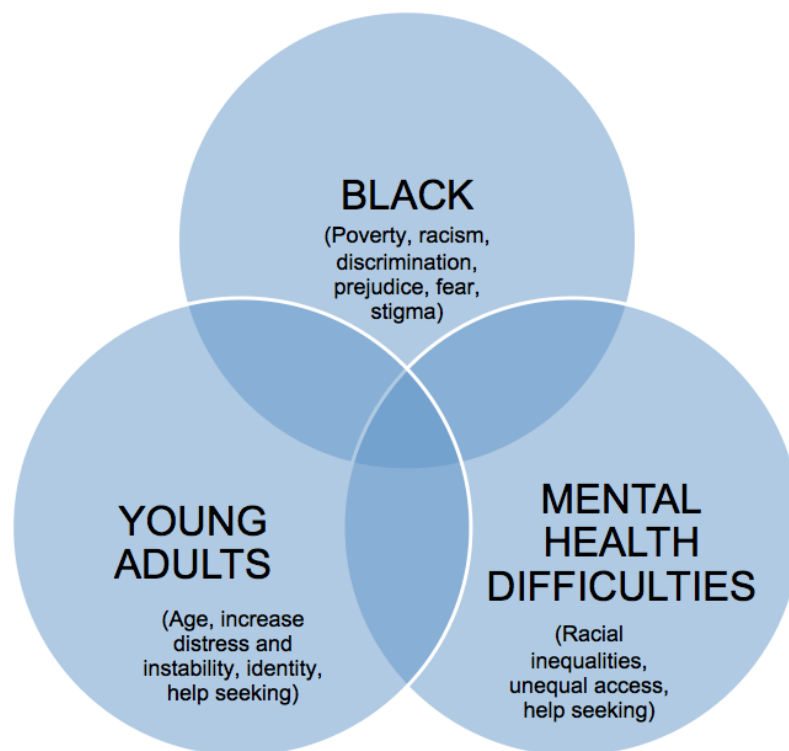
Using semi-structured interviews, participants will be invited to discuss their experiences of therapy. The research question of the proposed study is:

"How do young adults who identify as Black, experience[3] CBT for depression?"

_____

[3]The term 'experience' in this context refers to participant's contact, observation or involvement in CBT therapy.

2 METHODS

2.1 Overview

In this chapter, firstly I will articulate the critical realist position of the study and explain the relationship between my stance, the methodology and the research question proposed. Following this, I will describe the procedures of carrying out this research, including the design and data collection processes. I will then outline my approach to the analysis and offer my reflections.

2.2 Epistemology

"It is because we are implicated in the world that there is implicit content in what we think and say about it" (Bourdieu, 2000).

Epistemology can be defined as the theory of knowledge (Barker, Pistrang & Elliott, 2002). A researcher's epistemological position ultimately influences what kind of knowledge a methodology aims to produce (Willig, 2008) and a researcher should own their perspective and make clear the philosophical framework from which they are working (Ponterotto, 2005). The epistemological assumptions underpinning any research should be made explicit to establish the foundations upon which the knowledge was sought (Willig, 2008). Equally, for qualitative data to be deemed informative it needs to acknowledge the subjective element, the active engagement and position of the researcher (Willig, 2008). This information is imperative as it has a significant implication on the research question, approach, analysis and conclusion.

The research presented in this thesis adopts a *Critical Realist* position, which assumes that the way reality is experienced, is influenced by a range of factors including the socio-political context (Braun & Clarke, 2013). Critical realism acknowledges the beliefs and meanings participants hold and the

broader social context will impact upon the data collected (Braun and Clarke, 2006). I will begin by describing a critical realist position by drawing on Pilgrim & Bentall's (1999) analysis of the concept of depression. I will then relate this to the approach taken in this current research.

2.2.1   Medical Naturalism

Psychopathology is often characterised by two polarised positions (Pilgrim & Bentall, 1999). "Medical naturalism" which assumes a real and invariant external world exists of natural disease entities. This stance is based on the idea that there is a real world out there that is independent of whoever may be observing it (Bhaskar, 1989). Within research, the task of a researcher is to understand as accurately as possible the properties of the real world (Barker et al., 2002). This type of research is commonly held at the top hierarchical position for the evidence across health care.

2.2.2   Social Constructionism

In contrast "social constructionism" that assumes psychopathology is a representation or social construction. It asserts that a real world exists both as a subjective and an objective reality. The role of a researcher is to understand the world of lived experience from the perspective of those who live in it (Andrews, 2012). According to social constructionism the task to search for facts and properties of the real world is flawed, because research findings will always be mediated by its context (Burr, 1995).

2.2.3   Critical Realism

A critical realist approach claims that it is not reality, which is deemed to be socially constructed rather it, is "our theories of reality" and the methods we deploy to investigate it (Pilgrim & Bentall, 1999). This position not only provides an adequate solution to the problems created by the conceptual

incoherence of medical naturalism and social constructionism, but also addresses the perceived limitations of these two polarised positions (Pilgrim & Bentall, 1999). A critical realism perspective proposes that there is a reality "out there" that exists that is separate from a participant's descriptions of it and therefore helps to form an understanding of "how" things come to be the way they are (Stickley, 2006).

This study goes beyond constructing hypotheses, predicting outcomes or viewing how people see the world as if this is "reality". In addition, it states that people's perceptions and experiences are never a direct reflection of environmental conditions. Instead, this study hopes to gain a better understanding of what is "reality" for individuals with the acknowledgement that the data may not provide direct access to this reality (Willig, 2008). I will attempt to bridge the large and growing gap between the current research on effectiveness and outcome studies (e.g. RCT) and what is important to the participants.

> "Experience is not what happens to you. It is what you do with what happens to you" (Huxley, 1932)

In approaching this research from a critical realist stance, as a researcher, I have accepted that while realities such as depression exist, the frameworks through which we understand these realities are influenced by subjective assumptions and often Western biases. These biases are mediated through our language, which in turn shapes an individual's experiences. I would argue that the meaning of depression is idiosyncratic and culturally specific therefore people's experiences of depression are influenced by wider discourses, which ultimately determine the treatments worthy of research and clinical practice.

2.3 Design

2.3.1 Qualitative research

I chose a qualitative design as this approach was primarily concerned with meaning, how people made sense of the world and how they experienced events (Willig, 2008). Qualitative research describes and clarifies the experiences of participants as it is lived and constituted in awareness (Polkinghorne, 2005). It is concerned with the quality and texture of experience, rather than the identification of cause – effect relationships (Willig, 2008). Additionally, a qualitative design aims to be exploratory and is generally best suited for inquiring subjective meanings and their socio-political contexts (Yardley, 2000).

2.3.2   Semi-Structured Interviews

Semi-structured interviews were chosen to enable participants to take a more active role in the research process (Frith & Gleeson, 2012). My intention was to uncover the details of participant's experience that would possibly be undisclosed in structured interviews and other methods such as questionnaires (Allmark, 2009).

Smith's (1995) guidelines on semi-structured interviews were followed:
1. There was an attempt to establish rapport with the participants
2. The ordering of questions was less important
3. The interviewer was freer to probe interesting areas that arose
4. The interview followed the respondents' interests or concerns

Equally, I owned my own interaction with the research topic by sharing my "Black" heritage with potential participants at the recruitment stage. I felt that self-disclosure at this early phase could possibly help with initial rapport building and encourage participants to disclose their genuine reflections. Equally, it was hoped that this could potentially counteract some of the power inequalities between the interviewer/researcher and respondent/participant (Abell et al., 2006). However, I did not assume that being interviewed by someone from the same ethnic background would make it any easier for the

participants in this study to talk about sensitive and personal issues (such as their race, racism and discrimination).

2.4   Ethics

2.4.1   Ethical Approval

Ethical approval was obtained from the London Bridge Research Committee on 07.12.18 (Appendix A) and local approval was granted from the Research and Development departments in four NHS Trusts. Additionally, ethical approval was obtained from the UEL Research Ethics Committee and this was granted on 06.06.18 (Appendix B).

2.4.2   Informed Consent

Verbal and written information was shared with potential participants prior to the interviews (Appendix C). All participants gave written informed consent to take part in this study (Appendix D). Gaining informed consent across the Trusts varied and will be described in more detail in the recruitment and research procedure section. All participants invited to take part in the study were given up to a week to reflect upon the potential risks and benefits of engaging in this project. Participants were reminded of their right to withdraw from the research at any time without any untoward consequences on future psychological care. Participants were aware that should they withdraw after the analysis has begun; their anonymised data might still be used in the study.

2.4.3   Risk to Participant

I was aware that interviews could touch upon upsetting subjects and topics that could be emotionally distressing. Therefore, when designing this research I considered the trade-off between the potential harm caused to participants and the potential gain to humanity from the knowledge being acquired (Barker

et al., 2002). If, during interviews, a participant visibly appeared upset or stated they were distressed they were offered the right to not answer question(s), take a break, continue the interview on another day or terminate the interview.

My intention was to protect participants in the study from harm and maximise the potential benefits of the research process experience. I hoped that interviews would offer participant's self-acknowledgment and validation, whilst giving them a voice and a sense of empowerment from telling their own story (Hutchinson et al., 1994). Most of the participants reported that being involved in the interview was interesting and they were happy they were able help with this research.

2.4.4 Debriefing

All participants were debriefed at the end of the interview. Participants were given the space to ask questions and the opportunity to speak about any issues the research may have raised. They were advised to contact the researcher afterwards should they wish to further discuss any aspects of the research (Appendix E). A contact list was included with relevant services that could offer additional psychological support if needed. The additional information provided to participants depended on whether they were open or closed at the point of the interview. Open cases were advised to contact their respective case managers whilst closed cases were signposted to external organisations or advised to seek further support from their local GP service.

2.4.5 Confidentiality

Confidentiality was upheld to protect anonymity. Names and other identifying information were changed to numbers and pseudonyms. Participant quotes were carefully selected to minimise the possibility that contributions made could be identifiable by readers. Participants were informed that if they were to disclose any risk concerns during data collection the researcher might have

to break confidentiality to ensure safety. All confidential information was stored securely on password protected computers or an encrypted password protected memory stick in accordance with NHS policy. I was the only person who had access to identifiable transcripts and recordings, which will be destroyed five years after the study's completion.

2.4.6   Risk to Researcher

The location of the interviews was decided on a case-to-case basis and where possible held at the chosen location of the participant. Face-to-face interviews were conducted either held at the University of East London (UEL) campus or the participant's local service. To minimise the risks to the researcher interviews were conducted in working hours to ensure other staff members were around, on site or contactable on the phone. Where it proved difficult to arrange an interview at either of these locations, interviews were held over the telephone.

2.5   Recruitment and Research Procedure

A variety of different approaches were initially used to recruit participants into the study. The different recruitment pathways adopted are outlined in Appendix F. As recruitment in both the student population and community organisation did not yield any responses, I decided to solely focus my recruitment across the four NHS sites. Consistent across all recruitment routes was the deliberate choice around the sampling procedure.

2.5.1   Recruitment

The selection of participants concentrated on people with particular characteristics and qualities, namely people who self-identified as Black and were aged between 18 and 25 years old (Etikan, Musa & Alkassim, 2016). Purposive sampling was adopted which allowed me to find people willing to

provide information by virtue of their experiences (Etikan et al., 2016). A screening tool was also used to determine participant eligibility and whether individuals fit the sampling criteria of the study (Appendix G). Participant's were required to self-identify as Black however in order to not assume that being "Black" automatically equated to holding non-Western views, within the screening process participants were asked a question around family migration to establish which generation of their family first moved to the U.K.

2.5.2 Research Procedure

For the purposes of outlining the different recruitment pathways, next I will provide an overview of the different procedures undertaken.

2.5.2.1 *UEL/community organisations*
At UEL, the research project was advertised across the campus using posters/leaflets (Appendix H) and the student online portal (e.g. Moodle). Within the community organisation, a social media platform was used alongside posters placed at regular meeting locations. This allowed those individuals potentially interested in the study to opt into the research project using the contact details.

2.5.2.2 *NHS sites*
The recruitment procedures varied across the NHS sites. For three of the NHS sites, the same processes and patient inclusion criteria were used. This involved the following: information about the study was first circulated to the therapists and then I presented the research project at a team meeting. Therapists were encouraged to review their caseload for potential participants and gain verbal consent for their information to be shared with the researcher. Once verbal consent was obtained, I contacted potential participants providing them with additional information about the study. Alongside this, leaflets were placed in the service waiting areas, allowing participants to choose whether to participate in the project.

For the other site, as clients had made the decision to give their consent to participate in research when they were first accepted into the service, they were contacted directly by the researcher. I shared the inclusion/exclusion criterion with the local collaborator who completed a database search and provided me with the names and contact details of potential participants who had given prior consent for their details to be shared for research purposes. I then individually sent participant's on this list information about the study via email and followed up at a later date with a telephone call to establish if they were interested in my research.

2.5.3 Patient Inclusion Criteria

As outlined earlier, the set inclusion and exclusion criteria of the study was ethically approved by the NHS Research Committee. However, the various Research and Development departments in the Trusts gave additional stipulations around the recruitment of participants from their NHS sites. The following criteria applied across all trusts/sites.

Inclusion:
- Young adults aged between 18 and 25 years old.
- Self-identified as Black. This was in accordance with Patel's (1999) guidelines, which encourages researchers to ask potential participants to provide their own definition of their perceived ethnicity.
- Able to understand written information and verbal explanations given in English (without the need/requirement of an interpreter). From a financial perspective there was no scope to fund interpreters in this study.
- Received six or more individual CBT for depression sessions. It was hoped that by the sixth session participants would have grasped an understanding of their difficulties from a CBT perspective. Equally, they would be sufficiently socialised to the model and have a solid sense of the key tenets of CBT.

- If closed and not currently accessing treatment, the interview would occur within six months of discharge/last session of CBT therapy. It was felt that this time-frame allowed participants to be able to recall and detail accurately their experiences of therapy, which may be forgotten if the therapy had occurred over this timeframe.

Exclusion:
- Adults aged 26 years and older.
- Received CBT for other psychological difficulties e.g. anxiety.
- Received less than 6 individual CBT for depression sessions.
- If closed/not currently accessing treatment and the last session was over six months ago.
- Required secondary care (specialist) mental health services and/or presenting with active suicidal risk or risk to others.
- Presenting with complex needs and would not ordinarily be seen in a primary care setting. This group were excluded as the focus this study was on a specific treatment model offered mainly in U.K primary care services.

The only difference around the inclusion/exclusion criteria across the sites was whether participants were open or closed to the service at the time of being interviewed. This linked to participants being interviewed during treatment (open) or after they had completed treatment (closed). Three trusts requested that participants were only approached after completing their treatment. For the fourth trust, participants were recruited whilst still actively being seen for therapy. For these cases I ensured that participants had completed more than six individual sessions before I interviewed them. I will reflect on the impact this criterion had on data collection in the discussion section.

2.6 Interviews and Transcription

2.6.1 The Interview Schedule

The semi-structured interviews were guided by an interview schedule. My supervisor and I developed this schedule before it was piloted. A pilot interview was completed with one participant in an attempt to test and ensure that the questions were meaningful, made sense and provided different opportunities to explore participant's experiences. The final interview schedule (Appendix I) had open-ended questions aligned with a curious position and included suggested prompts. The interview schedule was not strictly followed but was used flexibly and acted as a loose guide to focus broadly on the following three areas:

1. Background and family heritage
2. Different understandings of distress
3. Experiences of CBT for depression

During all the interviews, in order to facilitate rather than impose I followed the topics and discussion points raised by participants.

Each participant was involved in an interview intended to last approximately 60 minutes. I aimed to recruit 12 participants as this was suggested as an upper limit and enough to reach data saturation (Guest, Bunce & Johnson, 2006). In total, I interviewed nine participants across the four different sites.

2.6.2 Transcriptions

I systematically transcribed all the data from the interviews. The basic conversational, interactional information and non-verbal vocalisations were recorded. I followed the conventions outlined by Parker (2005) in Appendix J. One view is that more detailed transcription conventions would have offered a fuller representation of conversations and made apparent the jointly constructed and socially engaged nature of what was going on in the interviews (Potter & Hepburn, 2005). However, I focused broadly on the words

said rather than how they were said, as this was deemed sufficient for my choice of analysis. Whilst transcribing the interviews I made additional notes of examples where participants spoke about how their background/heritage and age connected with their understandings of their experiences before, during and after therapy (for closed cases) as this information was particularly relevant to my research question.

2.7   Analysis

Data was analysed using thematic analysis, which is an approach that attempts to describe and report patterns across data (Braun & Clarke, 2006). This approach of exploring and interpreting experiences allowed me the opportunity to stay close to the data (Sandelowski, 2000). Thematic analysis provided a good model for summarising the unstructured data into thematic categories. It also had the advantage of providing a group-level analysis, which further protected the anonymity of participants (Harper & Thompson, 2011). I used the following six-stage model outlined by Braun & Clarke (2006) to guide this process:

Table 3: Analyse of the Data (Braun & Clarke, 2006)

Step 1	Familiarising yourself with your data
	After transcribing each interview, I read the transcripts several times to familiarise myself with the data. I made additional notes on anything that particularly struck me from the text. I selected, highlighted and made comments beside the areas of interest (Appendix K). I also re-read my notes, which included my key thoughts and observations taken down during each interview.
Step 2	Generating initial codes
	I then took each interview at a time and began the coding process. This process produced 101 codes across the nine interviews (Appendix L). I ensured that I was careful to acknowledge and challenge my own assumptions whilst coding the text. After coding all the data, I manually organised the data into initial themes.
Step 3	Searching for themes
	The themes identified a pattern in the information that at minimum described and organised the possible observations, and at maximum interpreted aspects of the phenomenon (Boyatzis, 1998). I used separate tables to keep the records of each code and the corresponding quotes across the data (Appendix M).
Step 4	Reviewing themes
	After all the codes had been compiled, I began connecting these codes together. Where there were overlaps with some codes, I was able to collapse the number of codes down to develop intermediate themes. At this step, my supervisor and I reviewed the themes and categories to check they captured what was intended.

Step 5	Defining and naming themes
	I then identified recurring commonalities within the codes and used mind maps to begin to create potential themes and overarching concepts (Appendix N). Once I had gathered the themes, I re-read all the transcripts and considered the coherence of themes and whether they fitted with the data set as a whole. I made revisions as needed. I then worked on defining and writing summaries of each theme/sub theme, finding titles that captured the content.
Step 6	Producing the report
	It was important that I continued to take an analytical approach when writing up my findings. I recognised that the levels of analysis and the chunks of transcript that I would be offering to the reader in the analysis section would represent aspects I deemed important. As Chamberlain (2001) highlighted researchers do not passively receive and present data. Throughout I acknowledge that the interpretations of the data and the claims made regarding this area are not assumed to directly reflect participant's internal worlds and perspectives (Harper, 2012).

2.8   Self-Reflexivity

It was important to reflect on my own standpoint in relation to the phenomenon that I was studying (Willig, 2008). Throughout this research I have recognised that my decisions have been based on and influenced by both my personal and professional experiences. However, to maintain awareness of the above effects, I ensured I kept a research reflective journal throughout, which captured all the information pertaining to the project and reflected the extent to which my beliefs, values, experiences were shaping the research (Appendix O). The following is a summary of aspects of my

biography that seem pertinent to this current research. I hope this will give the reader a sense of situating me (as the researcher) in relation to this study.

- I am a female who self identifies as Black Caribbean.

- As a psychologist, I am particularly influenced by critical, community and social constructionist ideas, which tend to place a larger importance on the impact of social contexts particularly in understanding individual distress.

- I have had the privilege of working in an IAPT service in London as part of my first-year placement. This exposed me to the practicalities of delivering CBT within a diverse client group.

- By participating in this study, I hoped to give participants a space to explore how this model fit with their understandings of their distress.

- My belief was that participants would potentially describe some useful aspects of receiving therapy, however I did not expect CBT for depression to attend to key contextual factors pertinent to the difficulties participants have experienced. For instance, I did not anticipate that participants would be given opportunities to name or even discuss their possible experiences of discrimination and/or racism in therapy.

- I also hoped that hearing directly from a Black population would enable therapists to learn, reflect and further understand the subjective experiences of how this specific treatment model is received in a 'minority group'.

- The focus on 'young adults' (18 -25 year olds) was based on the fact that the adult population (18 – 65 years) incorporates a broad age range and often 'young adults' tend to be overlooked as a group. This is despite this being a period of increased changes, pressures and transitions. I wanted to allow participants to feel heard and hoped that the interviews would give a voice to an often voiceless group (Hutchinson, Wilson & Wilson, 1994).

In the discussion chapter, I will provide a further evaluation of the quality of this present study.

3   ANALYSIS

3.1   Overview

In this chapter I will examine the themes gathered from the data beginning with outlining the context of the study and providing a brief description of the participants involved. Whilst two themes were developed following the stages of analysis, it is important to note that the themes identified are not a representation of all the data collected. Instead, the themes are reflections of a subsection that was relevant to the research question and represents the views of most participants involved in this study.

3.2   Understanding the Context

The interview schedule invited participants to tell their stories and describe their experiences of CBT for depression. Participants were able to explain how they came to understand their distress and the influences their cultural background had in relation to this. There were overlaps in the information gathered at the screening stage and the initial parts of the interviews. This was around participants' background/heritage, the generation of migration and how participants self-identified when asked.

Most participants were either second or third generation immigrants, in that their grandparents or parents were born abroad. When asked to describe their heritage the description of participants varied. Generally, participants identified as having a mixed heritage. The reported heritage of participants included Ghana, Nigeria, Granada, Jamaica, Dominica, Barbados and Antigua. All the participants in this study were born in the U.K. However, during the screening process when asked to describe their backgrounds many of the participants self-identified as "Black British".

3.3 Participant Analysis

Table 4 summarises key demographic information concerning the nine participants involved in the study. All the participants in this study have been given pseudonyms to maintain confidentiality.

Table 4: Participant's Demographic Information

Name	Age	Self-identified as	Gender	Stage in treatment	Interview location
Kiara	23	Black African	Female	Closed	Phone
Jada	23	Black Mixed	Female	Closed	Face to face
Laila	23	Black British	Female	Open	Phone
Latifah	20	Black Caribbean	Female	Closed	Phone
Shanice	18	Black British	Female	Closed	Face to face
Zion	24	Black British	Male	Closed	Face to face
Carmen	21	Black British African	Female	Open	Face to face
Hazel	19	Black British	Female	Closed	Phone
Cherise	24	Black Caribbean	Female	Closed	Phone

The mean age of participants was 22 years old and only one participant recruited identified as male. The majority of participants were no longer in treatment when interviewed, with only two participants still being seen for therapy sessions when recruitment took place. Each interview was either conducted face to face or over the phone and this was decided on an individual basis. The average length of interviews was 62 minutes, with the shortest interview lasting 40 minutes and the longest 86 minutes. The shortest interview conducted was a telephone interview and the longest was face to face. There were notable differences in the conversational processes in

interviews conducted over the phone and face to face, which will be explored further in the discussion section.

3.4 Thematic Map
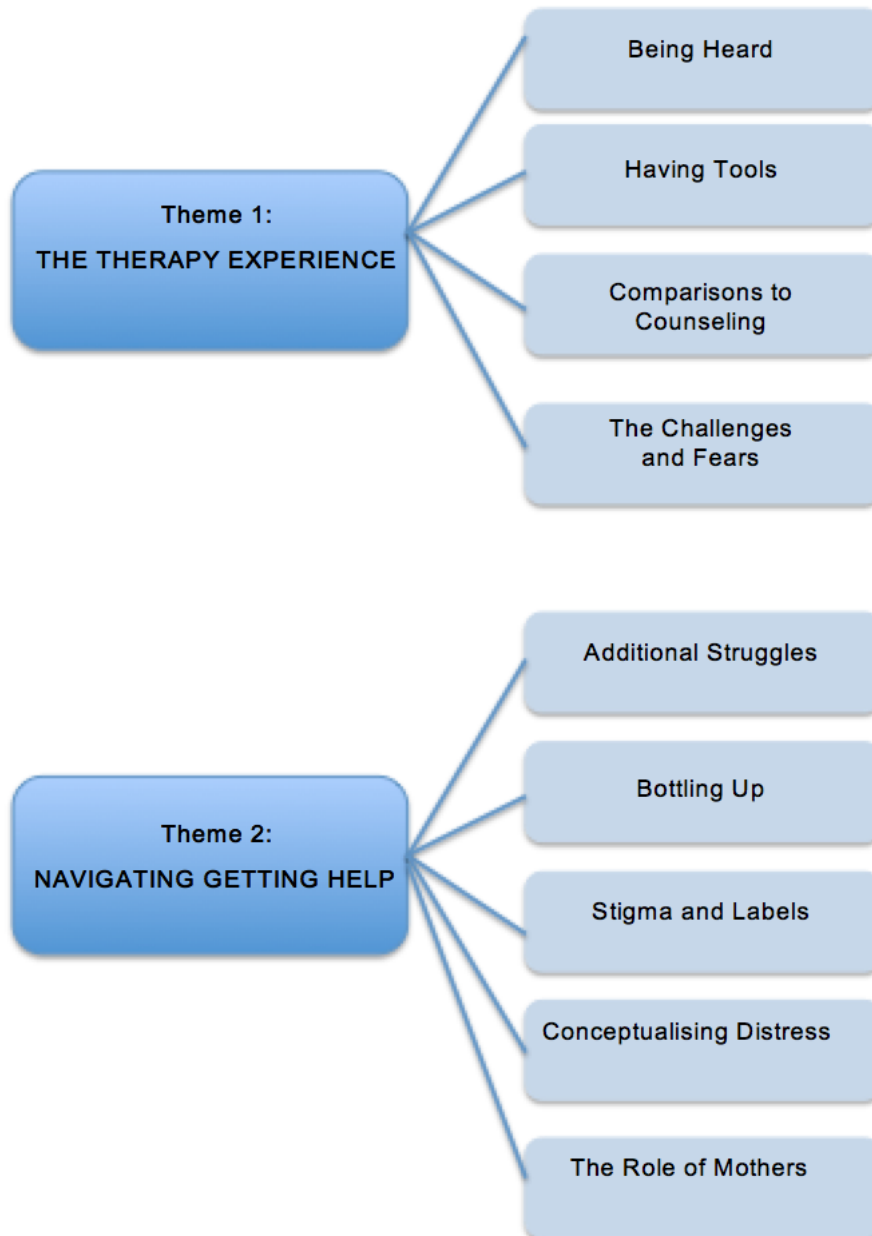
Figure 3: Diagram of Themes.

Although the primary focus of this research was on participant's therapy experience, all the participants spoke about how they got to therapy, their background influences and how they navigated getting therapeutic help.

3.5   Theme 1: THE THERAPY EXPERIENCE

The first theme captures the description of participant's experience of the CBT sessions. Many of the participants expressed mixed feelings about the therapy sessions, however, were mostly positive in their accounts. Participants acknowledged that the space provided an opportunity to open up and be heard. They valued being given strategies to help them with the difficulties they were experiencing and acknowledged that the therapy process required a degree of work in order to make progress. Some participants made a comparison between CBT therapy and prior experiences of other talking therapies such as counselling. However, they also highlighted various factors they were shocked by, had not expected and/or did not work for them; these have been captured in the subtheme 'The Challenges and Fears'.

3.5.1   Subtheme 1: Being Heard

This subtheme refers to participant's descriptions of being able to open up and feel heard by their therapist. Participants valued the reassurance, acknowledgement and validation they received from having a professional to talk to. Similarly, they found it important that their therapist was not judging them and described having a sense of control over what and how much they chose to share in sessions.

> *I just got so comfortable [with my therapist] and I think the most important thing is feeling like you are being listened to and that you're understood and I definitely felt that one hundred per cent (Kiara)*

> *[Therapy] gives you an opportunity to express yourself … it's a good opportunity for you to sort of speak without someone maybe judging or*

looking at you differently and at the same time you can say whatever and they can't really say anything back if you know what I mean (Carmen)

I felt like I had control as to what I wanted to open up, what wounds I wanted to open up and wanted to focus on in the sessions (Hazel)

I found everything quite personalised in the sense it wasn't like this is the model it goes this way, I found that my therapist would maybe put things in a way which I would understand (Jada)

3.5.2   Subtheme 2: Having Tools

I think the most useful [thing] was the fact that I was able to walk away with skills or ways that I could to take myself out those low moods…just being able to console yourself, I have learnt that through this therapy (Kiara)

Participants expressed an importance of being able to "walk away" with skills; solutions or strategies to better manage their emotional distress. Some participants explicitly stated that making progress was important for them.

[Sessions] were mixed, after some sessions I felt lifted and you know good, other sessions I felt really drained and I suppose it would just depend on what we spoke about in the session. In the sessions where I was more lifted, there was more kind of problem solving if that makes sense, I think I began to maybe understand my behaviours or understand why I feel a certain way (Jada)

Breaking down behaviours [and] just really laying out, showing you what you do every day from when you wake up and go to sleep. [Breaking] it down even further and seeing sort of your functions and how you can change those... in CBT you will spot things you are doing

that are unhelpful to your productivity, your mindset, your mental health and that (pause) being that specific is very helpful (Cherise)

There was also an acknowledgment from participants that sessions were not just about talking but that it included them working both inside and outside of the sessions.

I think it's a two-way street, you know, I don't think you can rock up and expect to get better by just being in a room with your therapist, I think you also have to put work in as well (Jada)

She advised me to do like a chart table thing where I write out everything that I have done in a day and then grade it one to five on achievement and pleasure, so like how much I achieved doing that task and then how much pleasure I got out of it and actually [that] did start to help (Hazel)

Everything I learnt I still use now (Laila).

Participant's identified the need to work together with their therapist and specifically referred to this when being introduced to CBT techniques, strategies and homework tasks.

Basically, you are going [to therapy] to work on yourself which, is a positive of course but you are not going there to mope (Cherise)

I said to myself the more I put into this more I am going to get out of it… I made sure that I was cooperative (Laila)

3.5.3   Subtheme 3: Comparisons to Counselling

Some participants compared CBT with their prior experience of counselling. For these participants when answering questions around the CBT for depression sessions they often linked their two therapy experiences.

> *So weirdly I thought CBT was going to be similar [to counselling] I thought someone was going to sort of listen to my problems and maybe interpret them offer me solutions going forward, but it wasn't it was different to that, it was a lot more proactive and it wasn't really focusing on you feeling low (Zion)*

Generally, participants who had the two experiences, found CBT more helpful because it practically orientated and provided them with tools and strategies.

> *CBT, I found way more helpful, a lot more practical (Hazel)*

> *I never found counselling helpful, I have had counselling since I was like fifteen [years old]… and it hasn't ever really helped but when I did CBT, I found that way more helpful, a lot more practical (Hazel)*

> *I did try seeing a counsellor when I was in sixth form…and I did not enjoy that… Errn it was based on school progression so they weren't really focusing on my actual problems (Shanice)*

One participant described how important the explanation about the different types of therapy was in helping her to decide to attend CBT therapy.

> *I spoke to them [and] they explained to me what counselling was and what CBT was, and that in effect cognitive behavioural therapy encourages you to be your own counsellor so that when you suffer this mood again you kinda know what to do…so I was quite keen to do that because I didn't want to just sit and speak and tell somebody my business unnecessarily (Cherise)*

However, another participant was taken aback by the CBT approach because they had an expectation that CBT would be similar to their prior counselling experiences.

> *Well the differences obviously threw me, erm initially it made me think whether CBT was for me and if it's mistake… I thought I should have researched this (referring to CBT) more than I did (Zion)*

3.5.4 Subtheme 4: The Challenges and Fears

Although all participants named the benefits of going to therapy, they also expressed that sessions were not what they expected and that the strategies were not necessarily providing them with the "solutions" to their difficulties.

> *Well my idea of the sessions I thought it would be me just talking and talking, but it wasn't like that, I did speak to her sort of discussing the symptoms and what's going for me. She doesn't like give me solutions to whatever I am talking about but she will try and get me out of the place that I am in, like for example she made me do a diary (Hazel)*

> *I suppose they kind of find ways to give you distractions, to you know not think about [the depression] no more…so it's kind of not like a solution or anything like that they just give you stuff to do it's a distraction (Laila)*

Additionally, participants described feeling a need to withhold certain information from their therapists. Participants identified challenges and fears linked to perceived differences in the belief systems and perspectives they held, in contrast to their therapist. They also described a reluctance to always 'cooperate' in therapy.

I don't think there was anything that wasn't useful but there were things I was bit reluctant to do, in terms of the ways that she wanted me to start thinking (Kiara)

Everything has just been pretty useful but sometimes I feel like I can't tell them (referring to therapist) a lot of things that is on my mind, like I have to hold myself back mainly because I know they won't understand or it's just the fear (Laila)

I assume there would be some people like myself who would think that (pause) a [White] therapist probably couldn't understand our experiences at all really (Zion)

They (referring to therapist) just don't understand the context or history, or upbringing and I don't feel like these things are talked about on a deeper level because the reality is the people that are writing the text books don't understand our history they don't understand our background, so they are teaching it from one perspective (Cherise)

Participants also described a fear that their therapists were unable to understand certain aspects of their Black experience.

I think because of the negative image of Black people in the media, especially Black men, I assume there would be some people like myself who would think that a therapist probably couldn't understand their experiences at all really, I mean [my therapist was] White and female [and] I assume some people would think we wouldn't have experience anything similar so I wouldn't expect [her] to have that nuance of experience, I didn't have that view but I can understand why people who have also experienced discrimination would maybe feel like that wouldn't want to open up to someone who they don't feel have experienced similar things (Zion)

Here one participant wonders if other young Black adults would be able to talk about specific issues in therapy when there are the clear ethnic differences between themselves and their therapist. Participants framed this difference using terms such as therapist and client, Black and White and us and them.

Below, Jada suggests that possibly having a Black therapist and a person to "relate" to may have had an impact on the amount Black client's share with their therapist.

> *I don't have any issue, or feel anyway to talk about anything with my therapist who for the record was a White lady… I didn't have any issue with that, but I don't know, maybe some people would feel they could relate to someone who is from the same ethnic background as them or somebody who they feel has more of an awareness of the things they are going through (Jada)*

In addition, participants referred to specific challenges around discussing race related problems and financial difficulties. Participants described feeling their therapist would not be able to understand them as they were not from a Black background. Cherise's and Laila's examples relate to race whilst Carmen's refers to finance:

> *I feel like when you speak to White people about a race issue, I don't feel like they feel very comfortable, so I just feel like they wouldn't understand it so [instead of] trying to explain myself and then still not being able to explain it I would just rather not have that conversation (Cherise)*

> *Yeh I don't think I brought it (referring to race) up but I probably touched upon it...I just thought maybe they (referring to therapist) wouldn't understand or probably like everyone has different upbringings so different beliefs so I wasn't too sure if they would understand (Laila)*

68

When I do the therapy sessions she (referring to therapist) says what makes you happy and it's like some of the stuff that did make me happy, it involves money so how can I get there if I don't have the money… I didn't obviously say that I need money to do certain things...On my diary she asked what are the things you are going to change, going to the gym [but] again going to the gym I have to pay for that… everything I do involves money, there is nothing that I don't want to do that involves money basically...I think coming up with ideas that are bit more realistic…ones that don't really involve money (Carmen)

Interestingly, participants shared predictions about the aspects they thought got in the way of having specific discussions in therapy. Participants shared that certain topics were difficult (both for them and for their therapist to discuss in therapy). They offered reasons for why they felt unable to openly talk with their therapists which some linked to a belief that you 'do not' or it is 'not right' to discuss personal problems people, least of all a therapist who is a "stranger".

I feel like a lot of people my age don't want to go for counselling … literally just the stranger thing (Latifah)

[I was] definitely withholding information [from my therapist]… I think we (referring to Black people) are just like private people …I have learnt it from my parents (Shanice)

The data also suggests that participants were not overtly asked about factors around race and/or their finance in sessions. Participants expressed that such discussions would have been useful however they feared they would not be understood if they tried to raise these topics with their therapists.

We never had discussions about race, but I think it would be a good idea (Carmen)

I think a lot of things at work I didn't speak about with the therapist, a lot of things I didn't mention that was around issues around racial comments, mainly issues that came down to race, and that's mainly why I put it down to because she (referring to therapist) wasn't Black (Cherise)

3.6 Theme 2: NAVIGATING GETTING HELP

This second theme linked to participant's experience before getting to the therapy room. Participants named struggles associated with having to "bottle up" their emotions and an inability to talk openly to those around them about their feelings of distress. They named a fear around the judgments and the perceptions of others. There was an overall sense that participants had to manage the stigma around mental health held in families, the community and broader society. This was alongside the negative perceptions held around the concept "depression". Participants also described a sense of pressure as Black young adults experiencing distress in this context.

The majority of participants expressed that having emotional distress or mental health difficulties made them "weak" which contrasted with preconceived images and stereotypes of being "strong". The dichotomy of weak and strong came through in several interviews and seemed to influence how and when the participants in this study sought help and professional support. This process of navigating help seemed to involve a process of taking steps to conceptualise and participant's making sense of their own experiences was aided by relationships often with friends/peers and mothers, but also to varying degrees, the use of the Internet and social media platforms.

3.6.1 Subtheme 1: Additional Struggles

Participants shared various struggles they face as young Black adults, which include both actual and/or perceived pressures impacting on them. This

occurred in the form of societal disadvantages and intergenerational pressures. Participants also referred to specific inequalities pertinent to them as Black young adult

> *I don't think [pause] about race really, or like that I am not concerned about it, but I am aware that obviously White people do have certain privileges on Black people and [that they] have more opportunities (Carmen)*

> *I feel like they (White colleagues) are encouraged more… maybe they have the funds or the capacity to travel or do enjoyable things, I would say, maybe it's financially what's feasible … or it's a cultural thing where Black parents are like you to focus, you need to get school work [done] (Jada)*

> *I feel like there needs to be more opportunity for [Black people] … more job opportunities and more activities that we can get involved in … stop us from being at home and having these low moods (Latifah)*

There were recurrent discussions about not being as privileged when compared to their White counterparts, alongside clear differences in their race and background which increased their vulnerability to feeling low or experiencing symptoms of depression.

3.6.2   Subtheme 2: Bottling Up

> *It's just been an overarching thing where we (referring to Black people) just don't speak about our feelings and we just bottle them up, and I remember I used to find it really hard to talk about my feelings when I first started CBT (Hazel)*

> *A lot of people don't come out and speak about [depression] and I think that is detriment to a lot of people, they either don't talk about it*

themselves, and I don't think people talk about it enough in our community which is why people feel like that they have bottle things inside (Kiara)

Overall participants described how you "can't" and "don't" talk about your emotions. Talking openly about feelings was neither common practice nor was admitting to struggling with emotional distress within the family context. Participants noted that they observed this "bottling up" behaviour in other family members and other Black people, which then influenced their personal perceptions of what was and was not acceptable in relation to expressing their own distress.

I definitely noticed it more when it came to my Black friends, some of them [were] a little more reluctant [to talk about depression], and I don't know if it's because they are African too, but they are a little more reluctant to openly relate to it, but they definitely hinted to me that they are going through exactly the same thing (Kiara)

Some participants recognised that if they felt able to talk to family members about their distress, this may have led them to seek help (and professional support) sooner. Equally, they described how having the opportunity to see family members manage distress could have potentially impacted how they managed their own difficulties. In the below extract, Jada highlights the importance of normalising distress and visibly seeing others (in particular family members) experiencing mood related difficulties.

I think if a family member or somebody else thought depression was a normal thing, that could be treated and managed, people can move pass it, and [knowing] you are not labelled with that forever and written off, then maybe I would have got help earlier because … I would have a bit more awareness …a bit more courage to admit that I'm not feeling great (Jada)

However, 'bottling up' was viewed as the norm within the cohort of participants and from descriptions their families.

I know she would probably say to me why are you depressed you don't have any bills to pay… I only have a silly phone bill, I don't pay rent and under the roof there is food, there's accommodation, there's everything, I can go out, I can do this and do that, [she would ask] so what is the reason that you are so low?" (Carmen)

Above Carmen illustrates a hypothetical conversation with a family member, noting that rather than being understood she would anticipate being questioned and possibly doubted.

Things are more heated [with Black parents] especially when you mention your emotions and like how what they are doing makes you feel (Shanice).

I just think Black parents are like harder on their children and I think [they are] less understanding of emotions and how they are important… they don't really, sorry, they don't take you seriously… they just don't know how to maybe, I don't know (Shanice)

One participant also described being unable to approach her father even when they were aware they struggled with symptoms of depression.

My dad did have depression but it's nothing he has said to me but obviously something I've overheard, but I still wouldn't go up to him and say I think I got depression, I have depression, I wouldn't discuss it with him (Carmen)

3.6.3 Subtheme 3: Stigma and Labels

Participants described how talking about emotions was also an indication of weakness and expressed difficulties with showing a more vulnerable side of themselves.

> *There is a stigma towards that word [depression], likewise with a lot of mental health illnesses, it's stigmatised so people feel as if they have, I wouldn't say a disease, but you just feel like different to everyone else (Cherise)*

> *I just think there is quite a big stigma around Black people having depression because usually Black people just think you can't have that, there is no way you have got depression (Carmen)*

Participants made references to negative connotations broadly held within Black communities around various mental health labels including depression. This negativity also extended to their perceptions about going to therapy sessions and seeking professional support.

> *I feel like in the Black community there is just a stereotype that you don't tell people your business so seeing a counsellor is kind of a taboo (Cherise)*

> *People should kind of stop putting therapy in this box, oh it's only for crazy people, it's only for weak people (Kiara)*

Participants expressed fears around receiving a formal mental health label, which from descriptions often linked with additional judgments. Judgments which include the perception that having a mental illness meant a person was "mad" or "crazy".

Black people classify anyone with a mental illness, everyone as mad, I mean I can't say Black people in general but some of the Black people I know, anyway (laugh) (Jada)

I don't think like depression is a negative thing but I wouldn't throw it around if you know what I mean, for example I could use it in university but I wouldn't like even my work colleagues, my manager doesn't know that I suffer from depression…Because I don't wanna tell them and obviously my family but everyone else I am quite vocal with it in terms of discussing it, I don't have a problem (Carmen)

Participants also expressed a preference for the term "low mood" over the term "depression".

It doesn't help [coming] from an African household we do not like to label ourselves, and also my mum's a nurse and she was really adamant don't label yourself, you know you have anxiety but don't label yourself with anything else (Kiara)

Depression has such a negative connotation …it's just a label…[however] there is a stigma towards that word…likewise with a lot of mental health illnesses…it's stigmatised so people feel as if they have, I wouldn't say a disease, but you just feel like different to everyone else (Cherise)

Given the majority of participants were female; there was an additional reference to the gender stereotype of a "strong Black woman.

Most of my family, they are like, well I see them as very strong … nothing really gets them down and so I was thinking if I start telling them how I feel then I would look like the weak one and I didn't really want to express my feeling and show them my weak side (Latifah)

I guess my culture does play a part because Black women as a whole are perceived to be very strong, erm and I guess I felt like I just needed to stay strong despite all these things happening … I was just suppressing my emotions feeling like I needed to be strong (Cherise)

3.6.4   Subtheme 4: Conceptualising Distress

This subtheme consists of the way that participants came to understand their difficulties. Many stated that peer discussions and using the Internet were influential in helping them understand their difficulties. They also viewed these two avenues as a means of informing them on how and where to seek help. Participants named the importance of friends/peers prior to seeking help but also whilst they were attending therapy sessions. Participants contrasted the interactions with friends/peers to those with family members, with the majority stating they felt more supported by the former.

Linking my experiences to friends' experiences, and experiences I heard whether it was online … you sort of know about symptoms and think maybe I have got [depression], maybe that's something I need to look at (Zion)

I have one friend who was depressed as well but she was very open about it …So I think that kind of helped me to understand what was going on for me …when she told me about what she was going through that made me like understand what I was going through (Shanice)

Equally, participants referred to the usefulness of searching online for information. Some participants used the Internet and named specific websites and platforms that helped them broaden their understanding of the symptoms of depression whilst others used online platforms to explore whether other Black people reported similar experiences to what they were going through. Shanice and Zion highlight this in the following extracts:

I started watching videos as well and Googling trying to see if like [there were] other people I can relate to (Shanice)

When you can link that to your own experiences it's helpful to see other people going through similar things… I've seen a lot of stories about Black people talking about the effect micro aggressions have had on their mental health and stuff like that … I haven't really consciously experienced anything like that myself, but I guess all that sort of adds into a feeling of you (Zion)

3.6.5   Subtheme 5: The Role of Mothers

Mothers were the only family members mentioned consistently across all the interviews. Participant's described how their mothers played an influential role in the process of supporting them to seek professional help. Some participants only attended the GP because their mothers suggested, encouraged, arranged or advised them to go.

I didn't really talk to my family at that time about [my experiences]... Not until after …I thought they wouldn't understand…my mum is a bit more understanding than the rest of them (referring to other family members) (Laila)

I didn't know you could go to the GP and talk about stuff like that I thought you had to go to the GP for a physical problem, or a problem that you could see, so when my mum told me to go, I was like how do I get to that point, and she was like you go to the GP and talk about it and they will discuss all the options with you (Laila)

There was also a sense that participants needed to get their mother's seal of approval before seeking help or going to therapy.

I think obviously depression is normal, but make it normal with African and Caribbean families…letting them know like it's ok it can happen to anyone at any age, sort of normalise it…It's a bit weird because my mum comes from an NHS background…so you would think that should be quite understanding but (pause) yeh she's not understanding of it, but yeh that's just for me, if it was anyone else, for example if my friend had gone to her and said that she would very much be supportive of them and would recommend that they do this and do that (Carmen)

It was my mum that said for me to go in the first place because I didn't really want to do it, I thought it was going to be just like counselling but when I started going it something completely different… but she was fine with it… she was the one that started to realise change…and she was proud of me for going and committing (Hazel)

4 DISCUSSION

4.1 Overview

In this section, I will consider the themes drawn from the data in the context of the study aims and research question. I will highlight some of the key elements of the findings, suggesting what this research might contribute to the understanding of young Black adult's experience of CBT for depression. Following this, I will draw connections with the wider literature (outlined in the introduction chapter), offer an appraisal of the methodology, highlight some outstanding questions and will conclude by making suggestions for future research and practice.

I have aimed to write critically and reflexively throughout, making links to my personal thought processes and my position as a researcher. I have also outlined the links between my findings and a range of theoretical paradigms, recognising that in line with a critical realist position, the links I make to a theory are one possible way of thinking, rather than claiming "a truth" or "facts".

4.2 Contextualising the Analysis

The overarching objective of this study was to explore Black young adults subjective experience of CBT for depression therapy. I argued in chapter one that a key limitation with the current research field is that it is dominated by quantitative data and outcome studies, which focus solely on the effectiveness of CBT for depression. I also highlighted that often these studies do not include participants from Black and minority ethnic groups (Hall, 2001) nor do they focus on people's experiences of this therapeutic model. I hoped that the data from this study would address this gap providing insight into this age group and cohort of Black people. My research question was: *"How do young adults who identify as Black, experience CBT for depression?"*

In total I interviewed nine Black young adults about their therapy experiences. From the analysis of the data I found two broad overarching themes. 'The Therapy Experience', which centred on CBT for Depression sessions and consisted of four subthemes. The second, 'Navigating Getting Help', which consisted of five subthemes and highlighted multiple pressures related to both being Black and a young adult and the impact this had on getting professional support.

4.3 Contribution Towards Understanding the Experiences of CBT

This section will pick up on some key elements of the findings, highlighting its contribution to the understanding of Black young adult's experience of CBT for Depression therapy.

4.3.1 Acceptability of the CBT Model

This study suggests that the young Black adults involved found CBT for depression acceptable and useful to them. Participants particularly liked the practical aspects within the approach and valued being giving tools, strategies and techniques to help manage their feelings of distress. Those participants who had prior counselling experiences found the CBT approach helpful in comparison and highlighted it involved active work and effort within and outside of the therapy room. Therefore, despite the literature suggesting that it is problematic that most psychological therapies (like CBT) are embedded with Western cultural assumptions (Hall, 2001), participants in this study did not express a disconnection between their own worldviews and the views presented within the model. Equally, they did not report experiencing that the model was being imposed on them (Timimi, 2014).

While all the participants in this study could be viewed as sufficiently motivated given, they had engaged in six or more therapy sessions, some spoke about considering dropping out at an earlier stage in their treatment.

The data showed that a participant's personal and/or contextual situations were both relevant and important to them. This appears to fit with previous research that called for evidence-based therapies to incorporate elements that are contextually relevant and meaningful to clients in order to increase acceptability, satisfaction and ultimately effectiveness (Bernal & Sáez-Santiago, 2006; Sue, 2003; Castro, Barrera & Holleran Steiker, 2010).

However, participants did also express some clear tensions within the therapeutic experience. This was specifically around in the therapist's naivety to their social and financial position, which did not appear to be discussed during sessions or considered when setting homework tasks. There was no recognition of their financial status and reports of difficulties experienced discussing race related issues. This is like previous with research that suggests that although ethnicity/race are important differences experienced in therapy, there may also be links to socioeconomic status and class that have an impact within therapy sessions (Karlsson, 2005).

The data showed that participants personal context played a large role in the nature of the difficulties they were experiencing. Findings from this study suggest a problem with the way the model was delivered. It highlights that people's problems cannot be simply framed as cognitive, emotional or behavioural, particularly when there are a number of systemic factors, which could be impacting the mental health of individuals. In sum, participants in this study found CBT for depression acceptable, however, described distinct problems around the lack of acknowledgement of their context, distinct differences between themselves and therapists and the fundamental assumptions held within the CBT framework.

4.3.2 Accessibility and Getting Help

Participants spoke at length about the various factors that impacted on their broad understanding of mental health and seeking help. They highlighted a strong sense of the intergenerational and societal pressures relating to both being Black and being a young adult in today's society. Participants were required to self-identify as Black and provide brief descriptions of their family heritage. This allowed them to openly share their cultural identity and provided me with the opportunity to better understand what it meant to be a Black young adult in this context. Research suggests that one's cultural identity has a profound impact on one's sense of well-being and one's own mental and physical health (Naeem & Kingdon, 2012).

The feeling of fear occurred at multiple levels and appeared to strongly play a role in influencing how participant's navigated getting help. Participants described the stigma held around mental health within their community, and this was pertinent throughout all the interviews. Mental illness/health difficulties appeared to have an interconnected relationship with stigma and fear. It is well documented that Black communities often have higher levels of apprehension about being labelled mentally ill (Keating and Robertson, 2004). This stigma and fear appeared to create an additional pressure for this group particularly when it came to seeking help and considering attending therapy.

In addition, participants described a fear around bringing up certain topics in therapy. As documented in the introduction chapter, this study showed similarities to previous research in further highlighting this group's limited trust, limited engagement and delayed help-seeking around mental health (Keating & Robertson, 2004). Again, fear and subsequent mistrust may provide possible explanations for why Black young adults tend to "bottle up" their emotions and seemingly struggle to "conceptualise their distress".

Strikingly, despite these experiences, participants all felt able to name and talk about these difficulties and fears in our research interview. This made me reflect on issues associated with power (particularly between therapists and

clients). It also highlighted the different power dynamics at play, which meant participants felt unable to raise race/finances in the therapy context (with a White therapist) but able in the research context (with a Black researcher).

Equally, participants openly questioned whether the fears and tensions they were experiencing was associated with the visible differences between themselves and their therapist. Although participants were not overtly asked about the ethnic origin of their therapist, they would often volunteer this information stating that their therapists were from a White background. Participants tended to share this information particularly when describing points of tension in therapy e.g. such as financial circumstances and race related difficulties.

The literature illustrates that fear is not only a feature of the client's experience but is often also the therapist's experience. It is possible that the therapists described by the participants in the study may have been equally fearful about bringing up certain topics, a phenomenon known as "circles of fear" (Keating & Robertson, 2004). Many therapists, particularly those from a White background, find it difficult to ask clients about their ethnic background and consequently run the risk of not thinking about culture and context as an essential part of getting to know their patient (Beck, 2019). This is imperative given the professionals are often not from the ethnic background of the clients they serve; which can perpetuate health disparities and increase the lack of culturally competent care in mental healthcare systems (Gary, 2005).

In sum, the experience of CBT for depression within this group remains a complex picture. This study provides a description on how this model is experienced beyond the usual report of symptomology and recovery rates. Despite the overall sense of a positive experience, the findings also shed light on the multiple issues felt by this group and the several obstacles experienced, both internally and externally when navigating getting help. Accessibility and getting help was a large part of participant's experiences in this study and the data illustrates that this was largely due to their background/heritage (being Black), cultural identity, broad fears around

mental health and the sense of mistrust experienced with a therapist from a different racial background from their own. The experiences of Black young adults would benefit from further investigation and in the next section I highlight the clinical implications and make suggestions for future research.

4.4   Clinical Implications

Based on the findings and the themes in this research, the next section will highlight the key clinical implications identified in this study. I have presented these on three distinct levels – a community, service and research level.

4.4.1   Community Level – Challenging Individualised Problems

At a community level there needs to be greater awareness of the main assumptions inherent in the CBT model. Additionally, the individualisation of problems needs to be contested through the sharing of information and expanding the knowledge of psychotherapy within the Black community. The findings highlight that challenges are needed on both the stigma held by Black people around mental health difficulties and the assumptions intrinsically held within Western models of care and psychotherapy. Additionally, a wider acknowledgement is needed around the power associated with (professionals) giving and (patients) receiving mental health labels. I will illustrate the limitations with the concept of 'help seeking behaviour' in that it places the 'pressure point for change' within individuals without capturing or acknowledging the key social-structural elements and influences (e.g. poverty, racism, discrimination, prejudice and stigma).

4.4.1.1 De-stigmatising Mental Health

To challenge the individualisation of problems, communities need to de-stigmatise individuals with a diagnosis of mental health difficulties. Clinical psychologists need to be able to engage in clear and open dialogues with people from minority and ethnic groups, for them to gain confidence and a

better understanding about what having a mental health label means (advantages and disadvantages). De-stigmatising mental health has the potential to encourage increased discussions within the Black community around how distress is understood and constructed.

4.4.1.2 Client Knowledge and Control

This study highlighted participant's limited knowledge of therapy including what to expect and the processes involved before attending sessions. This could be largely due to the fundamental beliefs about mental health and the treatment implied by the CBT model having origins in Western concepts of emotional well-being and illness (Beck, 2016). For the participants who had prior experiences of therapy, they shared what little they knew by making comparisons between their current experience of CBT and their previous experiences.

Although all the participants were born and raised in the U.K. their descriptions illustrate the influence of the context (U.K culture) on their health beliefs and attitudes. Evidence from the data indicates that age was an important factor and suggests that utilising different ways in communicating mental health information may be beneficial for this cohort. Findings suggest that broader and societal discourses around mental illness need further development, particularly on Internet platforms and useful websites. Going forward, services may also be inclined to take a multimodal approach to providing mental health information to different age groups within the Black community. For young Black adults specifically it may be useful to focus on having mother figures/or figures from this generation giving visible messages about experiences of mental distress and examples about the various struggles faced by Black people in this context and these figures could have the potential to bridge the differences highlighted in generational beliefs around mental health.

Additionally, the CBT model asserts an assumption of client control emphasising that clients are an active agent in their treatment (Knapp & Beck,

2008) and, arguably, holds values that do not appear to be transportable to all cultures (Ametaj et al., 2018). For example, people from collectivistic cultures vary from those from individualistic cultures in important ways, such as core values, cultural orientation and attention paid to cognitions versus emotions (Laungani, 2004). Equally, factors linked individualism; independence, assertiveness, spirituality and illness belief models are perceived in various ways in different cultural groups (F. Naaem, personal interview, June 6, 2020). The research illustrates that often people from BME backgrounds do not experience the process of therapy as collaborative, thus the key element of collaborative empiricism outlined in the introduction (Fenn & Byrne, 2013) is less likely to be achieved.

4.4.1.3 Cultural Assumptions and Western Models of Care

Clinical Psychologists have been (and continue to be) complicit in sustaining a Western model of care, one, which relies heavily on the use of diagnostic labels. Not only has this "kept intact the medical theoretical framework but has substituted aberrant psychological attributes to account for emotional distress and abnormal behaviour" (Boyle, 1997). Thus, there needs to be an increase in the openness within the profession alongside a need to challenge the assumptions on which the current evidence-base is formed. Additionally, emphasis needs to be placed on "the problematic nature of clinical psychology's links to science if the knowledge is not derived from a woman's and man's experience of the world" (Boyle, 1997). Within clinical practice, Clinical Psychologists have a duty to challenge assumptions as well as the racism within the systems in which they work and ultimately within the profession (Patel et al., 2000).

4.4.1.4 Mental Health Terminology and Labels

It is important to acknowledge that psychiatry not only fails to address emotional and relational problems but can reinforce problems due to lack of a whole-person and whole-system way of understanding people (Johnstone, 2000). The data highlights that through the process of labelling (and diagnosing) individuals, the personal meaning of distressing experiences and

the psychological/social origins of difficulties are obscured by turning them into symptoms of an illness located within one individual (Johnstone, 2000). Clinical Psychologist need to acknowledge the power of labelling individuals as "depressed" and the implications of having this label (often in addition to the other labels – such as being Black and/or being young).

This study also highlights the limitations of the term "help-seeking behaviour" as 'access' and 'help seeking' for this group were not only related to participant's current social and cultural settings but also was heavily embedded in intergenerational patterns of behaving and conceptualising distress. Given the under-representation of Black young adults in both clinical practice and related research, this study signifies an important step in better understanding accessibility factors for this cohort. Help-seeking for participants was understood as something, which resided within individuals, and therefore as a result was not conceptualised as a socio-structural phenomenon (Edge & MacKian, 2010). Again, Clinical Psychologists needs to ensure that the common perceptions and possible stereotypes (such as seeing the Black community as having more complex pathways into mental health and a community with different help-seeking behaviours) are questioned and challenged.

4.4.2   Service Level – Acknowledging the Limitations of the Model

At a service level I suggest a need for therapists to receive further training to increase awareness of the additional vulnerabilities within the Black community. This research illustrates that whilst it is useful to consider cultural competency in clinical practice, additional acknowledgments are needed around difference and the social factors that influence mental health. I would argue that the guidance is useful in raising the awareness of the needs of minority groups such as Black communities, however, there appear to be difficulties in translating the recommendations outlined into current practice in U.K services. Lastly, I propose that current service structures need to be changed in order to improve experiences of Black young adults.

4.4.2.1 Additional Vulnerabilities and Further Training

Findings from this study highlight difficulties between the interaction and therapeutic encounters between the therapists and participants. The therapeutic bond between therapist and client is enhanced when a therapist attends primarily to cultural issues while eliciting client information (Thompson et al., 1994). The data from this study showed that therapists were less able to understand (or ask explicitly) the additional risk factors encountered by Black young adults in the U.K. This provides no easy answer other than emphasising the importance of therapists being aware of these additional vulnerabilities (age and race) and the impact they have on the distress experienced by this cohort.

Alongside this, the findings suggest that therapists need to get better at ensuring that Black young adults feel able to share and be open about all aspects of their lives including their wider socio-cultural circumstances. One way this can be achieved is through training (F. Naaem, personal interview, June 6, 2020). Going forward, training programmes teaching CBT, need to highlight key factors that are relevant to Black communities (and minority groups) - a recommendation that is in keeping with Keating, Robertson & Kotecha (2003) who suggested that making engagement with local communities is a priority area for service development. This included increasing capacity building initiatives; health promotion work; and team-based training programmes as ways of improving the outcomes of BME service users (Keating et al., 2003).

Training needs to encourage students to gain more awareness about how different communities understand distress and mental health difficulties. It is important for services and therapists, alike, to consider where the 'pressure point for change' is placed (whether that be on an individual level or societal level) in order to develop more culturally appropriate and responsive mental health services. All mental health professionals have an ethical responsibility to identify and strengthen minority, community support systems and help

initiate strategies to empower minorities to demand an equable health care (Carter, 1994). Clinical Psychologist are well placed to take a more active role in promoting race equality within services.

4.4.2.2 *The Social and Cultural Context*

Gaining an understanding of an individual's sociocultural context is essential for culturally adapted interventions and improving client engagement in therapy (Rahman, 2007). As the data from this study indicates some of the difficulties experienced by the participants were embedded in systemic social, cultural and contextual factors (such as poverty, discrimination, prejudice and stigma) alongside the two key factors of racial disparities and age. Although complex and difficult to influence, a greater recognition is needed of the impact that social, cultural and contextual factors have on one's mental health and wellbeing, particularly for individuals from Black communities.

As outlined in the introduction chapter, culturally competent practice ensures that therapists can address the cultural disparities between themselves and their clients. The framework below can be viewed as a helpful starting point for therapists, particularly when treating clients with a different background from themselves. Sue et al., (2009) demonstrated that cultural competence at a provider level consists of the following three components:

- Cultural awareness and beliefs: the provider is sensitive to her or his personal values and biases and how these may influence perceptions of the client, the client's problem and the counselling relationship.
- Cultural knowledge: The provider has knowledge of the client's culture, worldview, and expectations for the counselling relationship.
- Cultural skills: The provider has the ability to intervene in a manner that is culturally sensitive and relevant.

However, the findings from this study illustrate that whilst the above cultural competences are necessary, it is also important for therapists to have an awareness and respect for the differences between themselves and the clients that present to mental health services (F. Naaem, personal interview,

June 6, 2020). This research illustrates that further work is needed on tackling the belief systems and practices of therapists working in primary care services in the U.K (F. Naaem, personal interview, June 6, 2020). Although, as noted before, it is the responsibility of all professionals to address racial disparities, Clinical Psychologists potentially play a pivotal role in highlighting the power in the position and roles of clinicians and act by stepping away from traditional ways of working and practicing.

Equally, given participants struggle to conceptualise their distress, current services may benefit from targeting existing community based programmes that run for young adults, in physical locations (e.g. universities/workplaces) and similarly online platforms (e.g. social media sites). Information about social/contextual factors and impact on mental health should be broadly highlighted and emphasised. The IAPT BME practice guidance (2019) highlights that IAPT services should be commonly reflecting on the ethnic composition of the communities being served. Therefore, therapists should be increasingly able to recognise and value the diversity of the local communities, whilst being able to adapt to the culture and context of the individual seeking help (Beck et al., 2019).

4.4.2.3 Ethnic Matching and Cultural Differences

There are several studies, which investigate the ethnic matching of clients and therapists, and the effects of this on psychotherapy processes and outcomes (Karlsson, 2005). However, much of this research shows that an emphasis on this type of matching may not improve client outcomes nor is it always the client's preference (Jungbluth et al., 2014). Additionally, there is evidence that simply asking clients about their ethnic background can strengthen the therapeutic relationship and can demonstrate that therapists can understand the social contexts of the problems being brought to therapy (Gurpinar-Morgan et al., 2014).

Beck (2019) highlights that Cognitive Behaviour Therapists from White British cultural backgrounds need to be able to confidently work with BME service

users and think about the impact of racism on their mental health. Equally, therapist should be encouraged to work with and acknowledge the structural inequalities that people from minority group's experience (Shankar, 2009). This study shows the need in therapy to have transparent discussions about the factors that impact mental health (including race, racism, fear and stigma). It may also be useful for therapists to make explicit connections and references to the impact of racism, discrimination and stigma on the mental well-being of young Black adults rather than solely focusing on the symptomology of 'depression'.

This research used the term "Black" to describe a common collective experience of the participants in this study. It was also used as a descriptor of a part of their personal identity. Research shows that identities are not equally and culturally valued but instead are fundamentally enmeshed in relations of power (Roseneil & Seymour, 1999), it may be that going forward there needs to be an increased focus on diversifying the Clinical Psychology workforce. Within the field of Clinical Psychology, figures from HSIC indicate that people from BME groups represent around 9.5% of the workforce. These race inequalities in the workforce may hinder addressing the disparities in mental health outcomes for BME people. Diversity in the workforce can ensure that clients (from BME communities) are able to access services that more readily reflect their own culture and personal identity (Turpin & Coleman, 2010).

4.4.2.4 CBT Adaptations

The data suggests that the recommended adaptations to CBT approaches (in relation CA-CBT and CS-CBT) and those outlined in the IAPT BME practice guidance (2019) does not seem to translate and represent the experiences of participants in this current research. The findings suggest that the more standardised and manualised approaches of CBT are commonly practiced in NHS services and perhaps this study is illustrative of a more general picture of current IAPT practices in U.K services.

Hays (2001) developed the ADDRESSING framework for therapists to become more aware of the cultural identities of their clients. It encourages therapists to develop hypotheses and questions about cultural influences. The ADDRESSING acronym summarises various dimensions of the cultural influences that have been typically overlooked in psychological research and practice and need to be addressed within therapy. These include Age and generational influences, Developmental and acquired Disabilities, Religion and spirituality, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin and Gender (Hays, 2001). Going forward, therapists should consider adapting their ways of working to acknowledge how 'Black' people experience their problems, their explanations of their problems and the ways they might seek help, to ensure that they benefit from the same clinical outcomes as White service users (Beck, 2016).

Equally, it is important to note, that whilst the IAPT BME practice guidance (2019) does not appear to be clearly implemented, the awareness and the publication of such a document signifies a positive move towards the much needed steps to making services more accessible in U.K services (F. Naaem, personal interview, June 6, 2020). The CBT adaptation process should focus on increased awareness of cultural factors, improving assessment and engagement, and adjusting therapy to focus on the client's concerns and connecting these to their therapeutic goals (Naeem et al., 2015). The IAPT BME practice guidance ((Beck et al., 2019) recommends the use of concrete and measurable audit tools, however, services need to acknowledge where responsibility and accountability would lie on to ensure these guidelines/audit tools are executed and used meaningfully in services.

There is currently a lack of institutional and 'top down' support from local managers/senior clinicians in ensuring that the current guidance is implemented (F. Naaem, personal interview, June 6, 2020). Therefore, such guidance is unlikely to shift the current quality of the service for BAME communities in the U.K. Additionally there is an absence of a national strategy that directly addresses the inequalities faced by Black communities. Thus, a more structural approach on a service level is needed to bring about the

changes needed in local IAPT teams (F. Naaem, personal interview, June 6, 2020).

4.4.3   Research Level – Developing the Evidence Base

As noted previously there is a large gap in the research, firstly in the area of qualitative research, secondly research conducted in a specific ethnic group (e.g. Black community) and thirdly, within this precise age range (e.g. 18 – 25-year olds). In addition, this gap extends to the current research published and the implementation of the findings and recommendations highlighted (F. Naaem, personal interview, June 6, 2020). Later in this chapter, I will suggest that Clinical Psychologists play an important role in regularly conducting and publishing research.

4.4.3.1 Practice Based Evidence (PBE)

This study demonstrates that patient experience as recipients of healthcare services can provide a valuable insight into the experience of care they received (Barker, 2015). There needs to be a clearer expansion of the qualitative research around people's experiences of therapy as these could create opportunities to learn from good practice in the absence of published evidence. The publishing of practice-based evidence (PBE) in local services may increase both acceptability and accessibility of CBT for depression. Clinical Psychologists need to utilise findings from qualitative research (such as this study) that shares the experiences of an ethnic minority group. The profession plays an important role in promoting good practice and publishing data that further questions and encourages curiosity in current practice.

4.4.3.2 Client Experience and Research Evidence

Although IAPT commissioned services place a great emphasis on the delivery of time limited interventions, the measurement of client experience is equally important and can be invaluable in assessing the acceptability of new models in service delivery. Client experience can help to provide a wider viewpoint

than that derived from more discrete measures of clinical effectiveness (Barker, 2015). Therefore, Clinical Psychology as a profession should be utilising their multifaceted roles and skills, as clinicians and researchers to gain an understanding of the client experience of the service. A coordinated approach to improving the provision for minority groups by gathering the experiences of clients accessing services across the U.K.

As noted earlier, it is well documented that when compared to people from White backgrounds, people from BME backgrounds are less likely to access IAPT services. Equally, despite the referral rates being amongst the highest in those aged 18 - 35, this age group are the least likely to start or finish a course of treatment (Baker, 2018). It is known that young adults, and specifically those from deprived areas are also less likely than average to recover from conditions such as depression after psychological therapy (Baker, 2018). From these statistics, a useful question to ask is "why" is this the case. Going forward, diversifying the ways in which the research evidence is collected by considering qualitative techniques (over RCTs) may be beneficial. This may lead to a more 360-degree view on what effective therapy may look like. Therapists should allow more avenues for direct feedback from clients.

In sum, the findings from this study highlight clinical implications that require intervention at multiple levels. Above I have highlighted how this could be done at a community level by challenging individualised problems, at a service level by acknowledging the practicalities with implementing the CBT model and finally at a research level through developing and expanding the evidence base. This study has shown that the experience of CBT for depression in young Black adults is influenced by a combination of multiple complex factors.

4.5   Critical Evaluation

This section will evaluate and review the research study in terms of its strengths and limitations. It will provide a critical stance on the research process, and outlines ways this research could have been done differently.

4.5.1   Strengths

A key advantage of this study was the breadth of the research question, which allowed for additional and novel ideas to emerge from the data. The current literature on CBT has tended not to focus on qualitative accounts, nor has it focused on a specific communities' experience of CBT for depression. Although I was aware that the experience of being from a Black community would inevitably vary and depend on the historical and social context of each participant, I recognised that there were key factors impacting this group that were likely to be more similar than dissimilar and therefore did not have any potential implications for this present study.

As Black young adults from BME (specifically Black) communities tend to be underrepresented in current IAPT services (Baker, 2018), this study provides a useful attempt to get a clearer picture of how this model is broadly experienced by those attending and engaging in therapy. The rationale for restricting the age range to 18 – 25-year-old was to further explore the impact age has on mental distress at a time of increased vulnerabilities and pressures.

In this study, the overarching theme of "Navigating Getting Help" largely linked to issues of accessibility and centred on both participant's race and age. The context of being Black and young closely linked with participant's journey into therapy and how they engaged with the model. This was a useful but unexpected finding and highlighted the benefits of my chosen research method. Semi-structured interviews allowed me to be guided by the data and enabled me to follow the lead of the participants in terms of the information

they were raising. This worked well and was appropriate for the research question posed. Interviews also created a private space for participants to candidly share their experiences, which is an added strength, particularly as the research topic was sensitive and personal.

Another strength of this study was that all participants had recent experiences of therapy. The data included a mixture of open and closed cases. As a researcher, I found the interviews held with participants' retrospective of their treatment (closed cases) tended to provide a broader and more overall view of a participant's experience. Interviews with closed cases included examples of ways the therapeutic intervention had impacted on participant's everyday lives, which particularly linked to my research question. This contrasted to those interviews that were conducted whilst the person was still in therapy (open cases), which had a more uncertain sense and where participants seemed less able to identify and describe the helpful and unhelpful aspects of their treatment.

4.5.2 Limitations

Having discussed the strengths, it is important to highlight that there were also limitations within this research. Although this study illustrated that participant's overall experience was positive and exemplified the acceptability of CBT for depression within this group, it is important to note that this was a small-scale study. The themes reflected in this report do not account for the experiences of all Black young adults; therefore, I am not claiming that these findings are representative. This study characterises the views of the nine participants and acknowledges this as a restriction on the generalisability of the results. Furthermore, the upper limit of twelve participants suggested as enough to reach data saturation was not achieved in this study (Guest, et al., 2006).

However, the ability to determine when data saturation is reached is widely debated. Often there is no clear definition or method to reaching data saturation (Fusch & Lawrence, 2015). I understood that data saturation was

achieved when the ability to obtain additional new information had been attained and when further coding was no longer feasible (Fusch & Lawrence, 2015). I would argue that this study did not reach data saturation because although there were overlaps with the initial codes across all the interviews, new information was still emerging in the data from later interviews. Therefore, from the nine interviews I could not demonstrate that the sufficient depth as well as the breadth of information collected had been achieved to address my research question (O'Reilly & Parker, 2012).

The central aim of any research is to extend and advance knowledge (Caelli, Ray & Mill, 2003), and whilst data saturation was not met, it does not invalidate this study but instead illustrates that this phenomenon has not yet been fully explored (O'Reilly & Parker, 2012). Although it was my intention to conduct more interviews, one of the key reasons why data saturation was not achieved was the substantial issues encountered with recruitment. Recruitment was particularly difficult in this study; and this was despite the multiple efforts made and the variety of recruitment pathways taken (Appendix F). Ideally, I hoped to conduct more interviews face-to-face rather than on the phone to increase the data quantity and quality.

As mentioned in the methodology, there were noted differences between the phone interviews and face-to-face interviews. Despite most interviews being conducted over the phone, I observed that without the visual cues (facial expressions and body language) I tended to use my prompts more quickly to ensure participants understood my questions. I also found it harder, especially when my questions were followed by long silences from participants.

Although phone interviews were conducted at the request of participants I reflected and questioned whether participants experienced similar difficulties without the face-to-face interactions. However, I was mindful that had phone interviews not been an option this might have further reduced the number of participants involved in this study. In hindsight, another method that could have been explored further was the use of Skype, Zoom or FaceTime, which

would have allowed the convenience of being in different locations with the face-to-face interaction.

The strict inclusion and exclusion criteria of this study had both benefits and limitations. In qualitative research, demographic homogeneity is often seen as positive as it provides a way of focusing attention on the dimensions of interest. All nine participants had completed a minimum of six sessions. As outlined in the methods chapter six sessions was deemed a suitable amount to ensure participants had grasped the key tenets of the CBT model. However, this cut off resulted in this study not capturing the experiences of those that had dropped out earlier (prior to six sessions). Thus, influencing findings as the data includes a select group of individuals who had invested in therapy for a certain period/length, which consequently allowed them, time to recognise the useful and positive aspects of the model.

It was apparent from the data that gender played a role in those Black young adults receiving CBT for depression therapy. There was a stark comparison between the number of females and males recruited into this study. As a result, this study provides a female dominated picture of the Black experience of CBT for Depression. The effect of only having one male in this study, made me firstly question the broad role gender plays in accessing professional support but secondly the construction of gender specifically within Black communities. One explanation is that "traditional masculine behaviour" explains why men tend to postpone seeking help for psychological problems (Galdas, Cheater & Marshall, 2005). This may further compound the interplay of being Black and a young adult in this context.

4.6   Future Research

The limitations of the study, discussed above, have generated several areas for possible future research.

4.6.1   Triangulation

Future research may benefit from methodological triangulation by combining methods to explore different levels and perspectives of the same phenomenon (Fusch & Lawrence, 2015). For instance, running a focus group before conducting semi-structured interviews could increase the richness of data and ensure data saturation is achieved. Equally, interviews led to individualised accounts and experiences of CBT and future research may benefit from conducting an analytical observation in a group context. It could explore different understandings of distress, how participants come to talk about mental health difficulties and their collective experiences of being Black young adults in a U.K context.

4.6.2   Different Timeframes

Further qualitative research would benefit from gathering data from young Black adults at different time frames across their treatment experience, including those that have had less than six therapy sessions. This may offer similar, more mixed, or even negative experiences to be gathered. In this study the exclusion of participants that had less than six sessions, may have biased my data and ultimately impacted on my ability to fully grasp this cohort's experience of CBT for depression. Further investigations could explore the potential reasons Black young adults choose to drop out and the reasons for not continuing or not engaging further in therapy.

4.6.3   Responsive Adaptations in CBT

As noted in the introduction chapter, further research is required into adaptative and responsive CBT therapy. The findings from this study suggest that there are key and fundamental elements potentially missing from the current CBT treatment model being offered in U.K services. A development in the research is required as the present literature around adapted CBT tends to be predominately found in different countries and is often cited only in the

guidance documents. Further research is needed to scrutinise the different adaptations made to the CBT model when working with different minority communities particularly in the U.K. context.

4.6.4   Mental Health Beliefs in Family Members

Although mothers were mainly spoken about across the data, participants frequently described difficulties speaking about mental health within broader family contexts and wider community. One participant named the "relief" felt once her family were aware of the difficulties she was experiencing. Therefore, there may be merit in future research completing interviews with different family members and exploring how emotional distress is understood and expand the different beliefs around "mental health" across the generations. This would allow a multi layered perspective and will highlight and offer more insight into the socio-structural issues that contribute to help-seeking within Black communities rather than just focusing on the issues of help-seeking.

4.6.5   Collective Voices and Stigma

This study highlighted the difficulties with the multifaceted impact of stigma and mental health. The data showed a large part of the experiences of this group occurred before therapy at a familial and a community level. Further research would be useful in examining the collective voices of Black young adults. Additional exploration is needed to explore and raise awareness of the 'double stigma' and, I would argue, triple stigma faced firstly, by group affiliation of being Black (prejudice and discrimination), secondly, experiencing mental health difficulties (and the burdens associated with this) and thirdly, being young adults (age and identity).

4.6.6 Epistemology

Lastly, although I took the decision to adopt a critical realist stance, which made it possible to take a comprehensive and open approach and draw on a range of conceptual tools, there were drawbacks. For example, whilst the broadness of the interview schedule permitted a degree of freeness, I am aware that possibly adopting a social constructionist stance may have allowed greater focus on the discourses in interviews with participants. This may have allowed greater insight into how the participants constructed their experiences in relation to the wider societal ideas, rather than solely focusing on the current accounts of participants.

4.7 Quality Assessment

The quality of qualitative research has been a longstanding topic of discussion within research realms, with several authors attempting to identify attributes and factors that characterise 'good' quality qualitative research (Willig, 2008). Within psychology there are several ways for assessing the quality. Elliot, Fischer, & Rennie (1999) identified seven attributes that are especially pertinent to 'good' qualitative research. I have chosen to use these attributes to review the credibility of this current study.

Table 5: Evaluation of Present Study (Elliot et al., 1999)

Attribute	How my study meets this attribute
Owning one's perspective This refers to the researcher attempting to acknowledge and be explicit about their values and assumptions and how these influence the research.	I aimed to be descriptive throughout and have detailed clearly the epistemological stance taken. I have attempted to convey reflexivity at each stage and hoped that by writing in first person this has clearly explained my decisions. I have made references to my observations, beliefs and experiences and used a reflective diary to help this process and make explicit my own thoughts. I have acknowledged the power imbalances of my position as a trainee and researcher in relation to the participants, and although I shared a Black background, I have acknowledged there may have been a presumed shared understanding of various constructs and descriptions. The appendices make clear the processes involved in developing the themes in this study.
Situating the sample This relates to providing sufficient details to put the participants in context.	The methods and analysis chapter detailed information about the participants. The analysis chapter outlined the inclusion/exclusion criteria and data gathered at the screening process, which ensured homogeneity of the group. Whilst the analysis chapter outlined the context of participants involved.

Grounding in examples Qualitative methods require the selection of appropriate examples to demonstrate the analysis.	I was careful in selecting examples from the transcripts that optimally demonstrated the data analysis. I chose extracts that concisely demonstrated key points being made. I attempted to include the quotes that were substantial enough to provide the reader with an understanding of the data and its context. Quotes were included from the full breadth of participants (Braun & Clarke, 2013). In the appendices I have included the stages of analysis and refinements made in the development of the themes.
Providing credibility checks This criterion refers to the importance of checking the credibility of the analysis.	During analysis, I shared the codes, quotes and developing themes with my thesis supervisor. I used the feedback from my supervisor to review and amend the themes, which provided me assurance of the standards of my own analysis in line with the aims of the research project and research question.
Coherence This criterion relates to the importance of a coherent account of the analysis in qualitative research.	To facilitate transparency in the theme development I aimed to provide a clear description of the analytical processes involved at each stage. I hoped to provide a clear account of the processes describing where participants overall differed in their experiences. I have demonstrated this process to the reader in the appendices (including my drafts and redrafts of themes).

Accomplishing general versus specific research tasks This relates to the challenge of attending to both shared, general themes and more specific details within the data.	I aimed to achieve the balance of general themes and specific details by focusing on the broad themes whilst providing more precise details gathered within the data. In the analysis chapter, I attempted to highlight general commonalities alongside the nuances found within the data.
Resonating with readers This criterion describes the standard to which the analysis is assessed by readers to have "clarified or expanded their appreciation and understanding" (Elliott et al., 1999, p. 224) of the phenomena.	I hope throughout this report the reader would have assessed that I have achieved this attribute.

4.8   Self-Reflexivity Revisited

Expanding on criterion one, owning one's perspective, I share further reflections. In the interviews, I recognised similarities in what was being said and my beliefs and experiences, however I remained mindful of what were my own experiences and the impact this was having on me in that moment. I found it important in the interviews to stay listening to participants and curious about what they were describing. I feel that my position as a Black researcher helped participants to talk more authentically about their experiences. I was also acutely aware that when participants spoke about issues related to being Black, they would use the pronoun "we" instead of "I". Again, this made me wonder, as a researcher, what was being afforded (and possibly lost) by my Black heritage in relation to participant's responses.

In conducting this research, I have been impacted in several ways. Firstly, it has highlighted the challenges still faced by individuals before getting to therapy. Secondly, it has made apparent the additional pressures experienced by Black young people seeking professional help. Thirdly, it has reinforced my ideas that as a Black person there seems to be a need to make a conscious effort based on one's context, which determines how much you filter and share with people of different races and/or positions. Finally, it highlighted the interplay between the various roles and positions people have and the ultimate power plays in relation to this.

4.9   Conclusion and Final Reflections

To conclude, I hope that this research report has highlighted the complexities I experienced in conducting this research, but also highlighted the significance and importance of asking the research question I did. I also hope I have conveyed the extent to which it has personally challenged me as a researcher and person. I have been profoundly privileged to have nine people take part in this study and have been deeply moved by their honesty and openness. I valued their ability to stick with my questions and allow me to write it up as

part of this thesis. On a broader level, I hope that this study goes a small way towards changing the way therapists work with Black client's and think about their practices and understandings of the distress and difficulties with which people, particularly from BME communities, present.

The findings of my study have made me acutely aware of the importance of conducting regular research and highlighted the importance of my Black identity as trainee and soon to be qualified Clinical Psychologist. It is important that post qualification I ensure that different perspectives and qualitative experiences of clients, specifically those of vulnerable and minority groups are explored, researched and published. In addition, I hope my thesis draws attention to the need for Clinical Psychologists to question their positions and roles (and power) and constantly question whether they truly know enough about the equitability of the services they are providing to people from non-Western and diverse communities.

5   REFERENCES

Abell, J. Locke, A., Condor, S., Gibson, S. and Stevenson, C. (2006). Trying similarity, doing difference: the role of interviewer self-disclosure in interview talk with young people. *Qualitative Research*, 6(2), 221-244.

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

Allmark, P., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A., & Tod, A. M. (2009). Ethical issues in the use of in-depth interviews: literature review and discussion. *Research Ethics Review*, 5(2), 48-54.

Allport, G. W. (1958). *The Nature of Prejudice*. Garden City, NY: Addison-Wesley.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Ametaj, A. A., Sarver, N. W, Anakwenze, O., Ito, M., Rattner-Castro, M & Potluri, S. (2018) *Cross-cultural applications of the Unified Protocol: Examples from Japan and Colombia.* Oxford University Press: New York.

Andrews, T. (2012) What is Social Constructionism? *The Grounded Theory Review* 11 (1), 39 – 46.

Arday, J. (2018). Understanding Mental Health: What Are the Issues for Black and Ethnic Minority Students at University? *Social Sciences,* 7(10), 196.

Arnett, J. J. (2000) Emerging Adulthood, A Theory of Development From the Late Teens Through the Twenties. *American Psychologist*, 55 (5), 469 – 480.

Arthur, C. M, Hickling, F.W, Roberston-Hickling, H., Haynes-Robinson, T., Abel, W. & Whitley, R. (2010) "Mad, Sick, Head Nuh Good": Mental Illness Stigma in Jamaican Communities. *Transcultural Psychiatry,* 47 (2), 252 -275.

Ayalon, L. & Young, M. A. (2005) Racial Group Differences in Help-Seeking Behaviors. *The Journal of Social Psychology*; 145 (4), 391 – 403.

Baker, C. (2018). Mental health statistics for England: Prevalence, services and funding. *Briefing paper 6988*. House of Commons Library.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology: An introduction for students and practitioners*. Second edition John Wiley & Sons.

Barker, K. L. (2015). How can qualitative research be utilised in the NHS when re-designing and commissioning services? *British journal of pain*, 9(1), 70-72.

Beck, A. (2019) Understanding Black and Minority Ethnic service user's experience of racism as part of the assessment, formulation and treatment of mental health problems in cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, 12 (8), 1 – 7.

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

Beck, A. T. (1976) *Cognitive therapy and the emotional disorders. International Universities Press*: New York.

Beck, J. S. (2011) *Cognitive Behavior Therapy: Basics and Beyond* (2nd Ed.) The Guilford Press: London.

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

Bentall, R.P. (2010) *Doctoring the Mind: Why psychiatric treatments fail*. London: Penguin Books.

Bentall, R. (2003) *Madness Explained: Psychosis and Human Nature*. London: Penguin Books.

Benuto, L. T., & O'Donohue, W. (2015). Is culturally sensitive cognitive behavioral therapy an empirically supported treatment?: The case for Hispanics. *International Journal of Psychology and Psychological Therapy*, 15(3), 405-421.

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

Bhaskar, R. (1989). Philosophies as Ideologies of Science. A Contribution to the Critique of Positivism. Roy Bhaskar. *Reclaiming Reality. A Critical Introduction to Contemporary Philosophy.* London: Verso, 49-66.

Bhui, K., & Bhugra, D. (2002). Mental illness in Black and Asian ethnic minorities: Pathways to care and outcomes. *Advances in Psychiatric Treatment*, 8(1), 26-33.

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

Bourdieu, P. (2000) *Pascalian Meditations*. Oxford: Blackwell Publishers.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Boyle, M. (2002). *Schizophrenia: a scientific delusion (2*nd ed.). Routledge: London.

Boyle, M. (1997). Making gender visible in clinical psychology. *Feminism and Psychology*, 7(2), 231-238

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

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

Brown, T. N., Williams, D. R., Jackson, J. S., Neighbors, H. W., Torres, M., Sellers, S. L., & Brown, K. T (2000) "Being black and feeling blue" the mental health consequences of racial discrimination. *Race & Society*, 2 (2), 117 – 131.

Buffin, J., Ahmed, N., & Singh, M. (2009). Using a community engagement approach to ensure equality of access, experience and outcome from the IAPT programme in the North West of England. *Using a Community Engagement approach to ensure equality of access, experience and outcome from the IAPT programme in the North West of England.*

Burr, V. (1995). *An introduction to social constructionism*. London: Routlegde.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical psychology review*, 26(1), 17-31.

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': toward greater clarity in generic qualitative research. *International journal of qualitative methods,* 2(2), 1-13.

Cambridge Dictionary (2019) Definition of Young adults. Retrieved from: https://dictionary.cambridge.org/dictionary /english/young-adult

Care Quality Commission. (2014). From the pond into the sea: children's transition to adult health services. Newcastle: *Care Quality Commission.*

Carter, J. H. (1994). Racism's impact on mental health. *Journal of the National Medical Association*, 86(7), 543.

Castonguay, J., Filer, C. R., & Pitts, M. J. (2016). Seeking help for depression: applying the health belief model to illness narratives. *Southern Communication Journal*, 81(5), 289-303.

Castro, F. G., Barrera Jr, M., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual review of clinical psychology*, 6, 213-239.

Chamberlain, K. (2001). Qualitative health research and the researcher as interpreter. *Health Psychology Update*, 10, 18-23.

Child Poverty (2019) Retrieved from: https://cpag.org.uk/child-poverty/child-poverty-facts-and-figures

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

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

Corey, G. (2000). *Theory and practice of counselling and psychotherapy*. Belmont, CA: Wadsworth/Thomson Learning.

Davison, G. C. (2000). Stepped care: doing more with less? *Journal of consulting and clinical psychology*, 68(4), 580.

Deffenbacher, J. L. (1988). Agreement and response to neglected variables in cognitive-behavioral treatments. *The Counseling Psychologist,* 16(2), 314-317.

Edge, D., & MacKian, S. C. (2010). Ethnicity and mental health encounters in primary care: help-seeking and help-giving for perinatal depression among Black Caribbean women in the UK. *Ethnicity & health, 15*(1), 93-111.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British journal of clinical psychology,* 38(3), 215-229.

Equality and Human Rights Commission, EHRC (2016) Retrieved from: https://tandis.odihr.pl/handle/20.500.12389/22284

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, 5(1), 1-4.

Evans, J., Macrory, I., & Randall, C. (2016). Measuring national wellbeing: Life in the UK. *Office for National Statistics.* Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/2016#how-good-is-our-health.

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

Fernando, S. (2017) *Institutional racism in psychiatry and clinical psychology: race matters in mental health*. Palgrave Macmillian: Basingstoke.

Fountain, J. & Hicks, J. (2010) Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005- 2008.

Francis, E., David, J., Johnson, N., & Sashidharan, S. P. (1989). Black people and psychiatry in the UK: an alternative to institutional care. *Psychiatric Bulletin*, 13(9), 482-485.

Frith, H., & Gleeson, K. (2012). Qualitative data collection: Asking the right questions. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (55–67). Chichester: Wiley-Blackwell.

Fusch, P. I & Lawrence, R. N. (2015) Are we there yet? Data saturation in qualitative research. Qualitative Research. *The Qualitative Report*, 20 (9), 1408 -1416.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: literature review. *Journal of advanced nursing*, 49(6), 616-623.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in mental health nursing*, 26(10), 979-999.

Gilbert, P. (2013) Overcoming Depression – A self-help guide using Cognitive Behavioral Techniques. In *The complete guide to overcoming depression, low mood and other related problems* (Eds. C. Espie, J. Scott & M. Fennell) 307 -1076. London: Constable & Robinson.

Goddard, A., Wolfson, L., & Wolfson, E. (2015). On the margins of medical care. *Why young adults and adolescents need better healthcare. A report to the Future Hospital Programme of the Royal College of Physicians. London: Royal College of Physicians*.

Goffman, E. (1963) *Stigma*. Penguin: London.

González-Prendes, A. A., & Thomas, S. A. (2009). Culturally sensitive treatment of anger in African American women: A single case study. *Clinical Case Studies,* 8(5), 383-402.

GP Champions for Youth Health Project. Toolkit for General Practice (2015) Retrieved from: http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf (accessed 14.12.16)

Gray, P. (1999) Voluntary organisations. In *Ethnicity: An Agenda for Mental Health* (Eds D. Bhugra & V. Bahl), 202–210. London: Gaskell.

Grey, T., Sewell, H., Shapiro, G., & Ashraf, F. (2013). Mental Health Inequalities Facing UK Minority Ethnic Populations: Causal Factors and Solutions. *Journal of Psychological Issues in Organizational Culture*, 3(1), 146-157.

Guest, G., Bunce, A., Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC psychiatry*, 10(1), 113.

Guo, F., & Hanley, T. (2015). Adapting cognitive behavioral therapy to meet the needs of Chinese clients: Opportunities and challenges. *PsyCh journal*, 4(2), 55-65.

Gurpinar-Morgan, A., Murray, C., & Beck, A. (2014). Ethnicity and the therapeutic relationship: views of young people accessing cognitive behavioural therapy. *Mental Health, Religion & Culture*, 17(7), 714-725.

Hagell, A., Coleman, J., & Brooks, F. (2015). Key data on adolescence 2015. *London: Association for Young People's Health* (10th Edition).

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology*, 69(3), 502-510.

Hall, S. (1992). New ethnicities. In *'Race', culture and difference* (Eds J. Donald & A. Rattansi.), 252-259. London: Sage.

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, 47(6), 993-1014.

Harper, D. (2012) Choosing a qualitative method. In *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (Eds. D. Harper & A. R. Thompson), 83 -97. Chichester: Wiley-Blackwell.

Harper, D., & Thompson, A. R. (Eds.). (2011). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. John Wiley & Sons.

Hays, P. A. (2009). Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice,* 40(4), 354 – 360.

Hays, P. A. (2001). Addressing cultural complexities in practice: *A framework for clinicians and counselors.* Washington, DC: American Psychological Association.

Hays, P. A. & Iwamasa, G. Y. (2006). *Culturally responsive cognitive–behavioral therapy: Assessment, practice and supervision*. Washington, DC: American Psychological Association.

Hinton, D. E., & Patel, A. (2018). Culturally Sensitive CBT for Refugees: Key Dimensions. In *Mental Health of Refugee and Conflict-Affected Populations* (pp. 201-219). Springer, Cham.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive therapy and research*, 36(5), 427-440.

Hutchinson, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of participating in research interviews. Image: *The Journal of Nursing Scholarship*, 26(2), 161-166.

Huxley, A. (1932). Texts and Pretexts, An Anthology with Commentaries, (published as part of the Huxley Centenary), Flamingo, London 1994. *First published by Chatto and Windus.*

Johnstone, L. (2014). *A straight-talking introduction to psychiatric diagnosis*. Rosson-Wye, England: PCCS Books.

Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*. Psychology Press.

Joint Commissioning Panel for Mental Health. (2017). He*alth and Wellbeing Needs of Young Adults age 18 -25*. Retrieved from: http://www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/

Joint Commissioning Panel for Mental Health (2014) Guidance for commissioners of mental health services for people from black and minority ethnic communities. Retrieved from: https://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf

Jungbluth, N., Dorsey, S., & Sedlar, G. (2014) CBT+ and Culturally Responsive Practice.

Kalibatseva, Z., & Leong, F. T. (2014). A critical review of culturally sensitive treatments for depression: Recommendations for intervention and research. *Psychological services*, 11(4), 433.

Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: an overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology*, *11*(2), 113.

Kazdin, A. E. (2008). Evidence-based treatment and practice: new opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American psychologist*, *63*(3), 146.

Keating, F., & Robertson, D. (2004). Fear, black people and mental illness: a vicious circle? *Health & social care in the community*, 12(5), 439-447.

Keating, F & Robertson, D. (2002) Breaking the Circles of Fear, A review of the relationship between mental health services and African and Caribbean communities. The Sainsbury Centre for Mental Health. *Open Mind,* Mind Publications: London.

Keating, F., Robertson, D., & Kotecha, N. (2003). *Ethnic diversity and mental health in London: Recent developments*. London: The King's Fund.

Knapp, P. & Beck, A. T., (2008) Cognitive therapy: foundations, conceptual models, applications and research. *Rev. Bras. Psiquiatr*., 30 (2), S54-S64.

Kovandžić, M., Chew-Graham, C., Reeve, J., Edwards, S., Peters, S., Edge, D. & Dowrick, C. (2010). Access to primary mental health care for hard-to-reach groups: from 'silent suffering' to 'making it work'. *Social science & medicine*, 72(5), 763-772.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, 16(9), 606-613.

Laungani, P. (2004) *Asian Perspectives in Counselling and Psychotherapy*. New York: Psychology Press.

Lavis P. (2019) Transforming transition in mental health services: Committing to a service for 0 -25s. Retrieved from: https://www.nhsconfed.org/blog/2019/09/transforming-transition-in-mental-health-services

Layard, R., Bell, S., Clark, D.M., Knapp, M., Meacher, M., Priebe, S. & Wright, B. (2006). *The Depression Report: A New Deal for Depression and Anxiety Disorders (No. 15).* Centre for Economic Performance Report. London: London School of Economics, LSE. Retrieved from: http://eprints.lse.ac.uk/818/1/DEPRESSION_REPORT_LAYARD.pdf

Leahy, R. L. (2003) Cognitive therapy techniques. A practitioner's guide. New York: Guilford Press.

Levinson, M. (2012). Working with diversity. In W. Dryden & R. Branch (Eds.), *The CBT handbook* (162-178). London: Sage.

Lopez, M. A., & Basco, M. A. (2015). Effectiveness of cognitive behavioral therapy in public mental health: Comparison to treatment as usual for treatment-resistant depression. *Administration and Policy in Mental Health and Mental Health Services Research,* 42(1), 87-98.

Lubian, K., Weich, S., Stanseld, S., Bebbington, P., Brugha, T., Spiers, N &Cooper, C. (2016). 'Chapter 3: Mental health treatment and service use' in McManus S, Bebbington P, Jenkins R, Brugha, T. (Eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital. Retrieved from: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-cmd.pdf

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ open,* 6(11), e012337.

Mental Health Foundation (2016) Fundamental facts about mental health 2016. Mental Health Foundation: London. Retrieved from: https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016

Merriam Webster's dictionary (2019). Definition of Racism. Retrieved from: https://www.merriam-webster.com/dictionary/racism

Mir, G., Meer, S., Cottrell, D., McMillan, D., House, A., & Kanter, J. W. (2015). Adapted behavioural activation for the treatment of depression in Muslims. *Journal of affective disorders*, 180, 190-199.

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W. C., & LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology*, 1, 113-142.

Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K, Fearon, P., Dazzan, P., Boydell, J., McKenzie, K, Harrison, G., Murray, R, Jones, P., Leff, J. (2005) Pathways to care and ethnicity. 2: Source of referral and help seeking. Report from the AESOP study. *The British journal of psychiatry*, 186(4), 290-296.

Mosher, L. R., & Boyle, M. (2004). Rethinking the mental health industry. *Ethical Human Psychology and Psychiatry,* 6(3), 237-238.

Muñoz, R. F., & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. *Journal of Consulting and Clinical Psychology*, 73(5), 790.

Naeem, F. (2019). Cultural adaptations of CBT: a summary and discussion of the Special Issue on Cultural Adaptation of CBT. *The Cognitive Behaviour Therapist*, 12.

Naeem, F., Gobbi, M., Ayub. M., & Kingdon, D. (2010) Psychologists' experience of cognitive behaviour therapy in a developing country: A qualitative study from Pakistan. *International Journal of Mental Health Systems*, 4 (2), 1-9.

Naeem, F., & Kingdon, D. (Eds.). (2012a). *Psychology research progress. Cognitive behaviour therapy in non-Western cultures*. Nova Science Publishers: Hauppauge, NY, US.

Naeem, F & Kingdon, D. (2012b) *CBT in Non-Western Cultures (Psychology Research Progress: Focus Civilizations and Cultures)*, Nova Science Publishers: UK.

Naeem, F., Phiri, P., Munshi, T., Rathod, S., Ayub, M., Gobbi, M., & Kingdon, D. (2015). Using cognitive behaviour therapy with South Asian Muslims: findings from the culturally sensitive CBT project. *International Review of Psychiatry*, 27(3), 233-246.

NHS England. (2015). Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. *London: Department of Health*.

NICE (National Institute of Clinical Excellence, UK, 2009) Depression in adults: recognition and management (updated April 2018). Retrieved from: https://www.nice.org.uk/guidance/cg90

NICE (National Institute of Clinical Excellence, UK, 2017). Retrieved from: https://www.nice.org.uk/sharedlearning/innovative-ways-of-engaging-with-black-and-minority-ethnic-bme-communities-to-improve-access-to-psychological-therapies#aim

NICE (National Institute of Clinical Excellence, UK, 2020). Retrieved from: https://www.nice.org.uk/about/what-we-do

Nicholas, A., Holloway, E., Telford, N., & Rickwood, D. (2018). Development of the headspace Family and Friends Satisfaction Scale: findings from a pilot study. *Early intervention in psychiatry*, 12(3), 478-482.

NIMHE (2003) Inside Outside: Improving mental health services for black and minority ethnic communities in England. Retrieved from: https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084558

Office For National Statistics. ONS, (2011) Ethnicity and national identity in England and Wales 2011. Newport

Retrieved from: www.ons.gov.uk/ons/ rel/census/2011-census/key-statistics-for- local-authorities-in-england-and-wales/ rpt-ethnicity.html

O'Reilly, M. & Parker, N. (2012) 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, 13 (2). 190 – 197.

Padesky, C. A & Greenberger, D. (1995) *Clinician's guide to 'mind over mood'.* Guilford Press: New York.

Parker, I. (2005). *Qualitative Psychology: Introducing Radical Research*. Maidenhead: Open University Press.

Patel, N. (1999) Getting the Evidence: Guidelines for Ethical Mental Health Research Involving Issues of Race. *Ethnicity and Culture*, Mind Publications: London.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A. & Miller, A. & Nadirshaw, Z. (2000) Clinical Psychology, 'Race and culture: A training manual. Leicester, U.K: *The British Psychological Society*.

Phelan, J.C, Bromet, E. J., & Link, B.G. (1998) Psychiatric illness and family stigma. *Schizophrenia Bulletin*, 24 (1), 115 – 126.

Pilgrim, D. & Bentall, R. (1999) The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, 8 (3), 261 -274.

Polkinghorne, D.E. (2005) Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52 (2), 137 - 145.

Ponterotto, J.G. (2005) Qualitative research in counseling psychology: a primer on research paradigms and philosophy of science. *Journal of Counselling Psychology*, 52 (2), 126 – 136.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative research in Psychology*, 2(4), 281-307.

Rahman, A. (2007). Challenges and opportunities in developing a psychological intervention for perinatal depression in rural Pakistan–a multi-method study. *Archives of women's mental health*, 10(5), 211-219.

Rai Atkins, A. (2002) Best practice in mental health. Advocacy for African, Caribbean and South Asian communities. *The Policy Press and Joseph Rowntree Foundation*.

Raleigh, V. S., Irons, R., Hawe, E., Scobie, S., Cook, A., Reeves, R. & Harrison, J. (2007). Ethnic variations in the experiences of mental health service users in England: results of a national patient survey programme. *The British journal of psychiatry,* 191(4), 304-312.

Rathod, S., & Kingdon, D. (2009). Cognitive behaviour therapy across cultures. *Psychiatry*, *8*(9), 370-371.

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-journal for the Advancement of Mental health*, 4(3), 218-251.

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems? *Medical journal of Australia*, 187(S7), S35-S39.

Roseneil, S. & Seymour, J. (1999) *Practising Identities: Power and Resistance*. Basingstoke: Macmillan.

Saechao, F., Sharrock, S., Reicherter, D., Livingston, J. D., Aylward, A., Whisnant, J., & Kohli, S. (2012). Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. *Community Mental Health Journal*, 48(1), 98-106.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health,* 23(4), 334-340.

Seligman, L. (2001). *Systems, strategies, and skills of counseling and psychotherapy*. Prentice Hall: Upper Saddle River, NJ.

Shankar, R. (2009). Developing Cultural Competence in Clinical Psychology Work with BME Communities. *Clinical Psychology in Practice*, 226-235.

Smith, J. (1995). Semi-structured interviewing and qualitative analysis. In J. Smith, R. Harre & L. Langenhove (Eds.). *Rethinking methods in psychology*, (9 - 26). London: Sage.

Smith, L. (2008). Positioning classism within counselling psychology social justice agenda. *The Counseling Psychologist*, 36(6), 895-924.

Stickley, T. (2006). Should service user involvement be consigned to history? A critical realist perspective. *Journal of Psychiatric and Mental Health Nursing,* 13(5), 570-577.

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social science & medicine*, 67(3), 351-357.

Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist*, 58(11), 964-970.

Sue, S., Zane, N., G. C. N. & Berger, L. K. (2009) The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*, 60, 525–548.

Summerfield, D. (2006). Depression: epidemic or pseudo-epidemic? *Journal of the Royal Society of Medicine*, 99(3), 161-162.

Summerfield, D. (2008) How scientifically valid is the knowledge base of global mental health? *British Medical Journal*, 336(7651), 992-994.

Suresh, K., & Bhui, K. (2006) Ethnic minority patients' access to mental health services. *Psychiatry*, 5 (11), 413–416.

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology,* 41(2), 155.

Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished. *International Journal of Clinical and Health Psychology,* 14(3), 208-215.

Turpin, G., & Coleman, G. (2010). Clinical psychology and diversity: Progress and continuing challenges. *Psychology Learning & Teaching*, 9(2), 17-27.

U.K Poverty (2017) Joseph Rowntree Foundation. Retrieved from: https://www.jrf.org.uk/sites/default/files/jrf/files-research/uk_poverty_2017.pdf

Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative effect of racial discrimination on the mental health of ethnic minorities in the United Kingdom. *American Journal of Public Health*, 106(7), 1294-1300.

Ward, E. C., & Brown, R. L. (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh Happy Day. *American Journal of Orthopsychiatry,* 85(1), 11.

Waterman, A. S. (1982). Identity development from adolescence to adulthood: An extension of theory and a review of research. *Developmental psychology,* 18(3), 341.

Wenzel, A. (2012). Modification of core beliefs in cognitive therapy. *Standard and innovative strategies in Cognitive Behavior Therapy*, 17-34.

Westbrook,D., Kennerley, H, & Kirk, J., (2011) *An Introduction to Cognitive Behaviour Therapy, Skills and Applications.* (2nd Ed.) Sage: London.

Wilding, C. & Milne, A., (2010) *Cognitive Behavioural Therapy: Teach Yourself*. Hodder & Stoughton General Division.

Wilkinson, R. & Pickett, K. (2009). *The Spirit Level.* London: Penguin

Williams, P. E., Turpin, G., & Hardy, G. (2006). Clinical psychology service provision and ethnic diversity within the UK: a review of the literature. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 13(5), 324-338.

Willig, C. (2008) *Introducing Qualitative Research in Psychology, adventures in theory and method*. Second edition. England: Open University Press.

Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996). Community attitudes to mental illness. *The British Journal of Psychiatry,* 168(2), 183-190.

Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, 47(3), 280-291.

World Health Organization. (1993). *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research* (Vol. 2). World Health Organization. Geneva. Retrieved from: https://www.who.int/classifications/icd/en/GRNBOOK.pdf

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15 (2), 215-228.

6   APPENDICES

Appendix A: NHS ethical approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS Health Research Authority

Miss Krystle Nurse
School of Psychology, University of East London
Water Lane
London
E15 4LZ

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

11 December 2018

Dear Miss Nurse

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

Study title:	**Young adults from Black communities experience of receiving Cognitive Behavioural Therapy (CBT) for depression - A qualitative account**
IRAS project ID:	**248974**
Protocol number:	**N/A**
REC reference:	**18/LO/1803**
Sponsor	**The University of East London**

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

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

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

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

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

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:
- Registration of research
- Notifying amendments
- Notifying the end of the study

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

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Catherine Fieulleteau
Tel: 02082236683
Email: researchethics@uel.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **248974**. Please quote this on all correspondence.

Yours sincerely

Kevin Ahmed
Assessor

Telephone: 0207 104 8171
Email: hra.approval@nhs.net

Copy to: Ms Catherine Fieulleteau, Sponsor Contact, University of East London
             Ms Mabel Saili, R&D Contact, Noclor Research Development

130

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Combined TWIMC Cert]		18 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employers Liability]		01 August 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Combined TWIMC Cert]		
HRA Schedule of Events	1.0	22 October 2018
HRA Statement of Activities	1.0	22 October 2018
IRAS Application Form [IRAS_Form_24092018]		24 September 2018
MHRA Notice of No Objection Letter (Medical Devices) and relevant correspondence [Peer review]	1	18 September 2018
Other [Provisional interview schedule]	1	09 October 2018
Other [Patient leaflet]	2	09 November 2018
Other [Screening tool]	2	09 November 2018
Other [Consent form]	2	09 November 2018
Other [PIS]	2	09 November 2018
Other [Covering letter]		30 November 2018
Other [Debrief sheet]	1	18 September 2018
Research protocol or project proposal [Research proposal]		03 September 2018
Summary CV for Chief Investigator (CI) [CI CV]		
Summary CV for student [CV]		
Summary CV for supervisor (student research) [Supervisor CV]		20 September 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The sponsor has submitted the HRA Statement of Activities and intends for this to form the agreement between the sponsor and study sites. The sponsor is not requesting, and does not require any additional contracts with study sites.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No study funding will be provided to sites, as detailed at Schedule 1 of the Statement of Activities.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments

132

Section	Assessment Criteria	Compliant with Standards	Comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

All sites will be undertaking the same activities therefore there is only one site type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS or on the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net, or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

133

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Principal Investigator should be appointed at study sites.

GCP training is <u>not</u> a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

Where arrangements are not already in place, network staff (or similar) undertaking any of the research activities listed in A18 or A19 of the IRAS form would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they <u>do not intend</u> to apply for inclusion on the NIHR CRN Portfolio.

134

16th January 2019

Dear Krystle,

Project Title	Young adults from Black communities experience of receiving Cognitive Behavioural Therapy (CBT) for depression - A qualitative account
Researcher	**Krystle Nurse**
Principal Investigator	**Krystle Nurse**

I am writing to confirm that the application for the aforementioned NHS research study reference **248974** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **16th January 2023**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Fernanda Silva
Administrative Officer for Research Governance
For and on behalf of
University Research Ethics Committee (UREC)
Email: **researchethics@uel.ac.uk**

Appendix B: UEL ethical approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION **For research involving human participants** BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Helena Bunn

SUPERVISOR: Katy Berg

STUDENT: Krystle Nurse

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: How do young adults who identify as Black experience CBT for depression?

DECISION OPTIONS:

1. **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.

2. **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.

3. **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.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved

Minor amendments required *(for reviewer)*:

1

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):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

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

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

137

Reviewer *(Typed name to act as signature)*: Helena Bunn

Date: 6.6.2018

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

Appendix C: Participation information sheets

PARTICIPANT INFORMATION SHEET

Title of Project: *Young adults from Black communities experience of receiving Cognitive Behavioural Therapy (CBT) for depression - A qualitative account*

Invitation and brief summary

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully. It is important that you ask me if there is anything that is not clear or if you require additional information.

Background to the study

There is generally not much known about how Cognitive Behavioural Therapy (CBT) is experienced by service users in young adult populations. Equally there is limited research exploring how CBT is specifically experienced within cultural groups in which the model was not originally developed and within community groups that tend not to be represented in the studies around the treatment models effectiveness.

What is the purpose of the study?

You have been invited to take part in this study because you have previously been seen for CBT psychological support around symptoms of depression. This research aims to help us learn more about your experiences and it is hoped that your data will provide a useful insight into the perspectives and views of young adults from a Black community. It will hopefully increase our understanding of your experiences of CBT treatment for depression particularly as this is a neglected area in research. The results will form part of a doctoral thesis in Clinical Psychology at the University of East London.

Why have you been asked to participate?

You have been invited to participate in my research as someone who is aged between 18 – 25 and self identify as Black. You have been asked because you may have been involved in therapy and received CBT for depression. I will emphasise that I am not looking for 'experts' and there are no right or wrong answers, but looking for you to share your views and experiences of the therapy you received. You will not be judged or personally analysed in any way and you will be treated with respect throughout.

Do I have to take part?

No, you do not have to take part in the study. It is up to you to decide whether or not to take part and should you refuse to take part this will not have an impact on any care you require in the future. If you do, you will be given this information sheet to

1

keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What would taking part involve?

If you decide to take part, then I will contact you to arrange a convenient time to conduct the interview, which will be either held at [INSERT NHS SITE], the University of East London, Stratford Campus or an agreed convenient location. The interview is expected to last one hour. At this appointment, you will be able to ask any further questions you have about the study and if you agree to participate you will be asked to sign and give informed consent. During the interview, we will discuss your thoughts, views and feelings about your treatment for CBT for depression. I will have an interview guide which will help prompt the questions I ask, however it will be quite an open conversation allowing you the space to talk openly about your experiences. I would also like to ask permission to audio record the discussion to allow accurate transcription of the interview. I will then transcribe and analyse these audio recordings of our conversation.

What if there is a problem?

We do not anticipate any problems, but if you are unhappy about any aspect of the study then you can either discuss your concerns with the researcher or the researcher's supervisor. The researcher (Krystle Nurse) or the supervisor (Katy Berg) can be contacted by calling the numbers provided below.

Will my taking part in the study be kept confidential?

Yes, all of the information about your participation in this study will be kept confidential. Your personal data will be coded and access to this code will only be available to the researcher.

Furthermore, all completed information collected from you will be stored on password protected devices or locked away, and will only be accessible to people who are directly involved in the study. Names and other identifying information will be changed within transcripts, the thesis and any subsequent publications. The data will be kept for five years and then destroyed.

In line with our contractual obligations, if you disclose information that suggests that you are or someone else is at risk of harm then the researcher would need to inform your clinical care team and/or an appropriate agency.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the research study at any time without an explanation, disadvantage or consequence. The University of East London is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of East London will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting the researcher (Krystle Nurse) or the supervisor (Katy Berg) on the numbers provided below.

What will happen to the information that you provide?

The results of the study will form part of a dissertation for a Doctorate in Clinical Psychology from the University of East London. The results, including selected quotations, may also be published in a scientific journal. You will not be identifiable in any of these reports. If you would like to be notified of any publications resulting from this study, inform the researcher and they will be happy to notify you of these.

What will I get for contributing to the study?

I will not be able to pay you for participating in this research but your participation would be very valuable in helping to develop knowledge and understanding of this research area. However, all participants will be provided with a £5 voucher to cover travel expenses. In addition following completion of all interviews there will be a chance for you to be chosen from a random prize draw to win a £25 gift voucher.

Research Team details

Main researcher:
Krystle Nurse
Trainee Clinical Psychologist
School of Psychology
University of East London
Stratford Campus
Water Lane
London E15 4LZ
Email: u1622893@uel.ac.uk

Research supervisor:
Dr Katy Berg
Clinical Psychologist
School of Psychology
University of East London
Stratford Campus
Water Lane
London E15 4LZ
Email: k.l.berg@uel.ac.uk

3

Appendix D: Informed consent form

Consent form
Appendix D
Version 2
09/11/2018
IRAS Project ID: **248974**

Centre Number:

Study Number:

CONSENT FORM

Title of Project: *Young adults from Black communities experience of receiving Cognitive Behavioural Therapy (CBT) for depression - A qualitative account*

Name of Researcher: Krystle Nurse

Please initial box

1. I confirm that I have read the information sheet dated 09/11/2018 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I give permission for the session to be audio recorded and these recordings to be transcribed and used for the purposes of this study.

4. I understand that the results of this study will not include any of my identifiable information and that all quotes will be anonymised.

5. I give permission for the use of quotes from my answers in the write up of this study, which forms part of dissertation for a Doctorate in Clinical Psychology that will be registered on a public database and may also be published in a scientific journal.

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

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

142

Appendix E: Debrief form

DEBRIEF SHEET

UEL
University of
East London

Title of Project:	*Young adults from Black communities accounts of receiving Cognitive Behavioural Therapy (CBT) - A qualitative account*

Thank you for taking the time to talk to me.

What happens now?

I will now type up our conversation into something called a transcript, and will look for themes that are common across the interviews with other people. I will then write up a report, but this will not include identifying information.

I will also send you a summary of my main findings. Please let me know if you do not want me to send you this.

If you think of any questions, you can contact me on u1622893@uel.ac.uk

Where can I get information and support?

If you find you are experiencing any distress following our conversation or feel you may need some additional support please do either of the following:

If you are still being seen within a service please speak to your therapist or the regular clinician you see.

If you are no longer accessing a service please contact your local GP service for additional advice. You may also find the below websites/contacts useful:

⟨ Samaritans - https://www.samaritans.org
⟨ Saneline - http://www.sane.org.uk
⟨ Mindinfo Line - https://www.mind.org.uk/information-support/helplines/

The Samaritans website also has an online chat option, or you can phone them on 116 123 (UK).

If you have any concerns about how this research has been conducted you can contact Katy Berg at University of East London on 0208 223 4409.

Thank you again for taking part.

Krystle Nurse
Trainee Clinical Psychologist
Email: u1622893@uel.ac.uk

1

143

Appendix F: Recruitment pathways
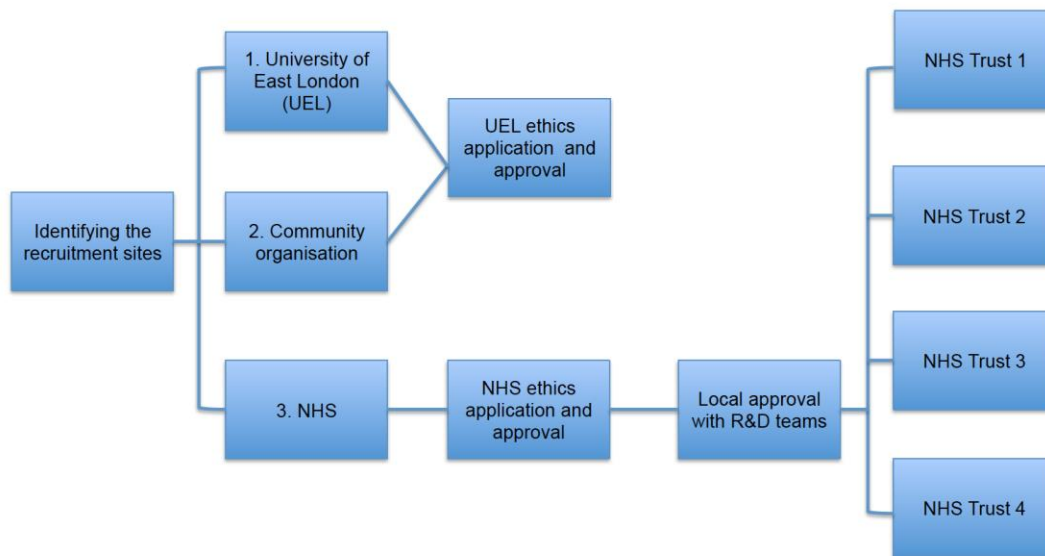
Appendix G: Screening tool

SCREENING TOOL

Title of Project: *Young adults from Black communities experience of receiving Cognitive Behavioural Therapy (CBT) for depression - A qualitative account*

UEL
University of
East London

Are potential participants…

	Yes	No
1. Between the age of 18 and 25 years old?		
2. Able understand written information or verbal explanations given in English (without the need/requirement of an interpreter)?		
3. Are they Black or Black British Caribbean African Any other Black background		
4. Have you received Cognitive Behavioural Therapy (CBT)?		
5. Was the CBT focused on difficulties with depressed mood?		
6. Are they a current case?		
7. Are they a closed case?		
8. If they are a closed case, did treatment occur within the last 6 months?		
9. When were they discharged/closed to the service ………………………………(Insert date)		
10. What generation of your family first moved to the UK?		
11. Where did your therapy take place e.g. was it in… Clinic GP surgery Other…………………………………………………………………		

1

145

Appendix I: Interview schedule

Introductions and explaining the research

- Introduction of researcher and research
- Participant information sheet and consent form
- Re-iterate no right or wrong answers; and that no adverse consequences to their care if they choose to not proceed or to withdraw consent.
- Explain that they can go into depth if they want, but possibly due to time I may move an answer on.
- For the purposes of this discussion I am going to use depression. This is a broad diagnosis and central to it is that a person suffers/suffered from a depressed mood and/or loss of pleasure in most activities. However, I am aware that you may use different words/language for what you experienced and felt.

Background and family heritage

- **In your own words, can you briefly describe your background, and your family's heritage?**
- **How do you think your background influenced your understanding of what you were experiencing before you went to therapy?**
  - *It may not be a thought through answer – how do think your culture/community/background impacted on your ideas*
  - *Similarly, how do you think your age (as a young adult) and gender/sex?*

Different understandings of distress

- **Looking back, how did you make sense of your difficulties prior to the sessions?**
  - *Was the term depression useful/not useful for you?*
  - *Did it fit your own language/ways of understanding what you were experiencing?*
- **What or who influenced your way of understanding the difficulties you were experiencing, before you were offered CBT?**
  - *Friends, peers, family, media etc.?*
  - *Were there other ideas of what could possible help you manage your difficulties?*
- **Were there any differences or similarities between your therapist's way of making sense of your difficulties (using a CBT model), and your own understandings of what you were going through?**
  - *What were they?*
  - *Differences?*
  - *Similarities?*
  - *What impact did these similarities/differences have on you?*
- **What did you think or feel about the therapist's ways of understanding your difficulties?**
  - *Was this useful, if so why? If not, why not?*

- *What did you make of the ideas/their understandings?*
- *Given your background was this way of making sense understandable/acceptable?*

<u>Experiences of CBT for depression</u>

- **Can you describe how you came to see someone for CBT for depression?**
  - *What led you to seek help?*
  - *What brought you to sessions?*
  - *What did you expect/hope for?*
- **How did/have you find/found the CBT for depression sessions?**
  - *What aspects of the treatment/sessions stood/stand out for you – why?*
  - *Did any of your findings link (in any way) to your background?*
- **Has there been/was there anything that you found particularly useful or less useful about the CBT for depression sessions?**
  - *Why/ how?*
  - *In what way was/is it useful?*
  - *In what way was/is it less useful?*
  - *Examples – a time when it was useful/less useful?*
  - *Was there anything from your background that specifically linked or did not link to the CBT strategies/techniques introduced?*
- **As we are reaching the end of our interview, is there anything I haven't asked about? or are there areas that you expected to be asked about that I haven't covered?**

Appendix J: Parker's (2005) transcription conventions

()	Indicates pause in speech
[Unclear]	Indicates speech was unclear
[]	Indicates when a comment has been added by the author
<>	Indicates interruption
/	Indicates overlapping speech
-	Indicates unfinished word

97	Oh yes, yes definitely, but there were things that for example that I had said in
98	our 1st session that she that she had brought back the 5th or 6th session and
99	said maybe that's related, and those are things I hadn't think of in my mind,
100	that they could be linked, or they could be connected or they could be part of
101	the reasons, part of the reasons why I was behaving in that way.
102	**Was there anything that you found particularly useful, because it**
103	**sounds like there has been a lot that has come out from your sessions,**
104	**but for you what most particularly useful about the CBT for depression**
105	**sessions? Would you say?**
106	Erm, I think the most useful was the fact that I was able to walk away with like
107	skills or ways that I could deal myself with to take myself out those low moods
108	or those anxiety attacks, I think that was biggest thing for me, is that, at the
109	start of it I wasn't able to take myself out of a low mood, the first, I think just
110	before I went to this I had a low mood episode for like 3 days, and that was
111	the longest I had, erm and being able to say you having a low mood but being
112	able to take yourself out of that and being like look at the positives and just
113	being able to console yourself I have learnt that through this therapy
114	**So those were the useful aspects, was there is anything that was less**
115	**useful do you think?**
116	Erm, not that I could think of, I don't think there was anything that wasn't
117	useful but there were things I was bit reluctant to do, in terms of the ways that
118	she wanted me to start thinking, just even small things, I didn't realise that I
119	was putting a lot of pressure on myself to things, so just having her say things
120	like why don't you, should do something, say that you would like to do
121	something, I just had this wall up, but it did work, you know
122	**So just in terms of shifting how you were thinking? Is that <**
123	>Yes
124	**Yes so how did that feel initially to hear that shift?**
125	Yeh I wasn't really wasn't down for it, I didn't had my guard up and I don't, the
126	word is not defensive but I was very much this is not going to work, this bit
127	your telling me now is not going to work
128	**Ok, so that was your initial and then what happened with that**
129	It was actually about me going to the gym, so I think we had a 2 week period,
130	week, where we didn't see each other, when I started to try and just thinking
131	I'm going to that, and I ended up going to the gym 3 times in the week, which
132	is a big, It sound like a small accomplishment but is such a big
133	accomplishment for me. I was thinking about going to the gym for months and
134	I couldn't pick myself up to go, so
135	**So that was something you did, and was useful but initially sound less**
136	**useful. So I am a bit curious, I going to go back a little bit. Erm, just**
137	**thinking about being black, in terms of community background and your**
138	**friends and understanding your experience of depression, I wondered**
139	**how much that had an impact on you given you said that it's change**
140	**since you've came out and talked about it more, just what impact it's**
141	**had on you?**
142	Erm, I think it was quite tough at first, I just was just alone with it, and like in a
143	way like I was weak, I think that was the main emotion, I think me talking

Comments (right margin):

Krystle Nurse 30/7/2019 14:35 — Comment [6]: Therapist remembered information

Krystle Nurse 30/7/2019 14:35 — Comment [7]: Sharing a formulation

Krystle Nurse 7/3/2019 07:39 — Comment [8]: Model specific benefits

Krystle Nurse 27/12/2019 11:38 — Comment [9]: A sense that it was important to learn strategies/technique

Krystle Nurse 30/7/2019 14:37 — Comment [10]: Being your own therapist, being able to help yourself

Krystle Nurse 7/3/2019 07:40 — Comment [11]: What does this suggest

Krystle Nurse 30/7/2019 14:38 — Comment [12]: Reluctance trying what her therapist was suggesting

Krystle Nurse 7/3/2019 07:41 — Comment [13]: Skeptical about the strategies

Krystle Nurse 30/7/2019 14:39 — Comment [14]: Activity scheduling?

Krystle Nurse 30/7/2019 14:39 — Comment [15]: Focused goals to accomplish and the impact

Krystle Nurse 30/7/2019 14:41 — Comment [16]: Stigma and associations of being weak

3

Appendix L: Initial codes

1. Being listened to
2. Making progress
3. Inability to relate/not same ethnicity
4. Counseling - One off
5. Mum has an NHS background/Supportive of others
6. Feelings =weakness
7. Lot more pressure
8. Denied the right to feel low
9. Materials online
10. Can't talk openly
11. Reluctance to openly relate to one another
12. Walking away with skills
13. A reluctance to do tasks
14. Feeling judged
15. Weak/weakness
16. Struggles with access to education/employment – statistics
17. Validation
18. Only touch on topics
19. Mum encouraged/told me/said to go
20. I have to do better
21. Cultural thing
22. Noticing patterns
23. Friend opening up about depression
24. Ongoing learning
25. Analysing and putting thoughts on paper
26. Oppression
27. Two-way street
28. Homework tasks
29. Resonating with others symptoms
30. Negative connotations/associations
31. Don't talk to family

51. White and older
52. Wanting to cooperate
53. No judgments
54. Not feeling comfortable
55. Different backgrounds
56. Never found counselling helpful
57. Mum has gone through it (depression)
58. Able to lead discussion
59. Express self
60. Having to work
61. Experimentation
62. Mum referred me
63. Thought CBT would be similar to counselling
64. Involved in the process
65. Blurt everything out
66. Safe space
67. Acknowledgement
68. To talk to someone
69. Black people can't get depressed
70. Wouldn't use depression term everywhere
71. Therapy is for crazy/mad people
72. Lack of opportunity
73. Inequality at job interviews
74. Googled for help
75. MH portrayed in the media
76. Structure
77. Holding back due to fear
78. Problem solving
79. Therapist is a stranger
80. Counselling didn't offer practical advice
81. Friends seeing you down
82. Linking own experiences with others

151

32. Not allowed to have emotions
33. Helping others going through similar difficulties
34. Therapy and MH* not talked about
35. Personal research
36. Media/newspaper/social media
37. Therapy becomes a secret
38. Nobody speaks out about it
39. Being understood
40. Everything is hush/kept quiet
41. Breaking down behaviours
42. Try and cope on your own
43. Don't come out or speak
44. Awareness that it's a normal feeling
45. Suffer in silence
46. Social media influences
47. Don't label yourself
48. Watching videos
49. I would feel worst after counselling
50. Changes in society – more MH talk

83. Links to own experiences
84. NHS website – working out symptoms
85. Low mood preference
86. Repetitive nature of sessions
87. Got to be strong
88. Everything suggested involved money
89. Older generation = brush it off
90. Others noticing your mood
91. Sharing certain issues
92. Warning from others
93. Parents harder and less understanding of emotions (compared to friends)
94. White people have privilege
95. Speaking others realizing not the only one experiencing the same
96. Emotions difficult to talk about
97. Don't talk about feelings
98. Depression and medication
99. Didn't enjoy counselling
100. Increased feelings/feel emotional in counselling
101. Different responsibilities

Appendix M: Coded extracts across data set

Theme	Intermediate codes	Example of extracts
NAVIGATING GETTING HELP	The Bottling Up	• A lot people *don't come out and speak about it* [depression] and I think that is detriment to a lot of people, they either don't talk about it themselves, and I don't think people talk about it enough in our community which is why people feel like that they have *bottle things inside* (Kiara) • [Depression is] like a very negative thing and to be fair I do not know anybody in my family who has seeked some type of therapy or some kind of help and that in itself is quite scary (Kiara) • I think it was quite tough at first, *I just was just alone with it* (Kiara)
		• My dad he's a very resilient person but I think he is a very typical person of the attitude of what do you mean your depressed, just everyone feels that way (Jada) • Maybe I think if I had a family member or somebody else that I thought depression was a normal thing that could be treated and managed erm…maybe I would have help earlier … I would have a bit more awareness erm and maybe a bit more courage to admit you know that I'm not feeling great and this is not a normal feeling because it is going on for a long time (Jada) • I think it probably helped because until then [going to A&E following an overdose] I had been holding it in to myself so it helped really I suppose everybody knew, well my immediate family knew, my mum, my sister, my dad, because I had to go to hospital to have blood tests and things done, so *they knew and I didn't have a secret, I didn't have to hide it anymore* (Jada)
		• There *no such thing as depression when you are talk to the older generation* they brush it off or they come up with they say it's probably like an evil spirit attached to you (Laila)
		• They [family] would literally would just *try and cope on their own* (Latifah).
		• I just *think black parents are like harder on their children and I think less understanding of like emotions* and like how they are important… they don't really, sorry, they don't take you seriously… they don't take you seriously, they just don't know how to maybe I don't know (Shanice)

		• I don't think families tend to be that open about that kind of stuff…Unless maybe one of the family members is going through it then they might be (Shanice)
		• They would probably think like what have you got to be depressed about, like you have got everything, like in terms of you have got a roof over your head, you have got food to eat (Carmen)
		• it wasn't seen as taboo like mental health it was just never really spoken about, like in my family you can't say I'm sad or I'm depressed (Hazel) • it's just been an overarching thing where we just don't speak about our feelings and we just bottle them up and I remember I use to find it really hard to talk about my feelings when I first started CBT (Hazel) • I was quite quiet I would just soak it all up, I would bottle up my stuff but also bottle up my friends what they were going through, I would bottle up their stuff as well (Hazel)
		• Some people to *disregard their feelings you know, you don't want to be a hypochondriac* (Zion)
		• I feel like in the black community there is just a stereotype that you don't tell people your business, seeing a counsellor is kind of a taboo (Cherise) • Just one of those things not to tell people you business were quite private so I do feel like erm seeing a counsellor was not something that was just done in the black community (Cherise) • I don't know if that is the right word I just feel like it is just not it's not promoted, people wouldn't encourage you to do that [seek help] (Cherise) • For some people that are quite open she could probably get to the root of the problem, …probably because black people don't like talking their business (Cherise)

Appendix N: Examples of progressing thematic maps

THE BENEFITS OF FEELING LISTENED TO/EXPRESSING SELF/BEING HEARD

- Being listened to
- Validation
- Being understood
- Involved in the process
- Blurt everything out
- Safe space
- No judgments
- Able to lead discussion
- Express self
- Acknowledgement
- To talk to someone

BEING GIVEN STRATEGIES/SKILLS AND THE LEARNING PROCESS

- Making progress
- Walking away with skills
- Two way street
- Homework tasks
- Ongoing learning
- Noticing patterns
- Having to work
- Analyzing and putting thoughts on paper
- Breaking down behaviours
- Experimentation
- Structure
- Problem solving

LIMITATIONS/DIFFERENCES/ASSOCIATIONS WITH RACE

- A reluctance to do tasks
- Inability to relate/not same ethnicity
- Feeling judged
- Holding back due to fear
- Only touch on topics
- Repetitive nature of sessions
- Therapist is a stranger
- Not feeling comfortable
- Different backgrounds
- White and older
- Wanting to cooperate
- Everything suggested involved money
- Speaking others realizing not the only one experiencing the same

COUNSELLING

- Didn't enjoy
- Thought CBT would be similar
- One off
- Never found it helpful
- I would feel worst after
- Didn't offer practical advice
- Increased feelings, feel emotional

MOTHERS

- Gone through it (depression)
- Encouraged/told me/said to go
- Mum has a NHS background/Supportive of others
- Referred me

THE STIGMA/PERCEPTIONS OF BLACK PEOPLE

- Don't label yourself
- Therapy and MH* not talked about
- Low mood preference
- Negative connotations/associations
- Weak/weakness
- Therapy is for crazy/mad people
- Got to be strong
- Feelings =weakness
- Black people cant get depressed
- Wouldn't use depression term everywhere
- Warning from others
- Don't talk to family

MH* = Mental Health

BEING BLACK BRING ADDITIONAL PRESSURES/STRUGGLES/INEQUALITIES

- I have to do better
- Lot more pressure
- Cultural thing
- Struggles with access to education/employment – statistics
- Denied the right to feel low
- Lack of opportunity
- Oppression
- Inequality at job interviews
- Not allowed to have emotions
- White people have privilege
- Different responsibilities

CONCEPTUALISING AND UNDERSTANDING OWN DISTRESS

- Resonating with others symptoms
- Helping others going through similar difficulties
- Friends seeing you down
- Friend opening up about depression
- Linking own experiences with others
- Sharing certain issues
- Others noticing your mood

SEEKING OWN KNOWLEDGE AND RESEARCHING ONLINE

- Googled for help
- Social media influences
- Materials online
- Watching videos
- Personal research
- Media/newspaper/social media
- Changes in society – more MH talk
- MH portrayed in the media
- Links to own experiences
- NHS website – working out symptoms
- Depression and medication

THE INABILITY TO OPEN UP/ LACK OF EMOTIONAL EXPRESSION

- Nobody speaks out about it
- Everything is hush/kept quiet
- Cant talk openly
- Reluctance to openly relate to one another
- Don't come out or speak
- Awareness that it's a normal feeling
- Older generation = brush it off
- Try and cope on your own
- Suffer in silence
- Parents harder and less understanding of emotions (compared to friends)
- Emotions difficult to talk about
- Don't talk about feelings
- Therapy becomes a secret

BEING BLACK BRING ADDITIONAL PRESSURES/STRUGGLES/INEQUALITIES

- I have to do better
- Lot more pressure
- Cultural thing
- Struggles with access to education/employment – statistics
- Denied the right to feel low
- Lack of opportunity
- Oppression
- Inequality at job interviews
- Not allowed to have emotions
- White people have privilege
- Different responsibilities

CONCEPTUALISING AND UNDERSTANDING OWN DISTRESS

- Resonating with others symptoms
- Helping others going through similar difficulties
- Friends seeing you down
- Friend opening up about depression
- Linking own experiences with others
- Sharing certain issues
- Others noticing your mood

SEEKING OWN KNOWLEDGE AND RESEARCHING ONLINE

- Googled for help
- Social media influences
- Materials online
- Watching videos
- Personal research
- Media/newspaper/social media
- Changes in society – more MH talk
- MH portrayed in the media
- Links to own experiences
- NHS website – working out symptoms
- Depression and medication

THE INABILITY TO OPEN UP/ LACK OF EMOTIONAL EXPRESSION

- Nobody speaks out about it
- Everything is hush/kept quiet
- Cant talk openly
- Reluctance to openly relate to one another
- Don't come out or speak
- Awareness that it's a normal feeling
- Older generation = brush it off
- Try and cope on your own
- Suffer in silence
- Parents harder and less understanding of emotions (compared to friends)
- Emotions difficult to talk about
- Don't talk about feelings
- Therapy becomes a secret

157

THE BENEFITS OF FEELING LISTENED TO/EXPRESSING SELF/BEING HEARD

- Being listened to
- Validation
- Being understood
- Involved in the process
- Blurt everything out
- Safe space
- No judgments
- Able to lead discussion
- Express self
- Acknowledgement
- To talk to someone

BEING GIVEN STRATEGIES/SKILLS AND THE LEARNING PROCESS

- Making progress
- Walking away with skills
- Two way street
- Homework tasks
- Ongoing learning
- Noticing patterns
- Having to work
- Analyzing and putting thoughts on paper
- Breaking down behaviours
- Experimentation
- Structure
- Problem solving

LIMITATIONS/DIFFERENCES/ASSOCIATIONS WITH RACE

- A reluctance to do tasks
- Inability to relate/not same ethnicity
- Feeling judged
- Holding back due to fear
- Only touch on topics
- Repetitive nature of sessions
- Therapist is a stranger
- Not feeling comfortable
- Different backgrounds
- White and older
- Wanting to cooperate
- Everything suggested involved money
- Speaking others realizing not the only one experiencing the same

COUNSELLING

- Didn't enjoy
- Thought CBT would be similar
- One off
- Never found it helpful
- I would feel worst after
- Didn't offer practical advice
- Increased feelings, feel emotional

**THEME 1:
MAKING SENSE OF
THE SPACE**

158

THE STIGMA/PERCEPTIONS OF BLACK PEOPLE

- Don't label yourself
- Therapy and MH* not talked about
- Low mood preference
- Negative connotations/associations
- Weak/weakness
- Therapy is for crazy/mad people
- Got to be strong
- Feelings =weakness
- Black people cant get depressed
- Wouldn't use depression term everywhere
- Warning from others
- Don't talk to family

SEEKING OWN KNOWLEDGE AND RESEARCHING ONLINE

- Googled for help
- Social media influences
- Materials online
- Watching videos
- Personal research
- Media/newspaper/social media
- Changes in society – more MH talk
- MH portrayed in the media
- Links to own experiences
- NHS website – working out symptoms
- Depression and medication

CONCEPTUALISING AND UNDERSTANDING OWN DISTRESS

- Resonating with others symptoms
- Helping others going through similar difficulties
- Friends seeing you down
- Friend opening up about depression
- Linking own experiences with others
- Sharing certain issues
- Others noticing your mood

THEME 2:
NAVIGATING GETTING HELP

BEING BLACK BRING ADDITIONAL
PRESSURES/STRUGGLES/INEQUALITIES

- I have to do better
- Lot more pressure
- Cultural thing
- Struggles with access to education/employment – statistics
- Denied the right to feel low
- Lack of opportunity
- Oppression
- Inequality at job interviews
- Not allowed to have emotions
- White people have privilege
- Different responsibilities

MOTHERS

- Gone through it (depression)
- Encouraged/told me/said to go
- Mum has a NHS background/Supportive of others
- Referred me

THE INABILITY TO OPEN UP/ LACK OF EMOTIONAL EXPRESSION

- Nobody speaks out about it
- Everything is hush/kept quiet
- Cant talk openly
- Reluctance to openly relate to one another
- Don't come out or speak
- Awareness that it's a normal feeling
- Older generation = brush it off
- Try and cope on your own
- Suffer in silence
- Parents harder and less understanding of emotions (compared to friends)
- Emotions difficult to talk about
- Don't talk about feelings
- Therapy becomes a secret

THEME 3:
THE CONTEXT AND
BEING BLACK

THE BENEFITS OF FEELING LISTENED TO/EXPRESSING SELF/BEING HEARD

- Being listened to
- Validation
- Being understood
- Involved in the process
- Blurt everything out
- Safe space
- No judgments
- Able to lead discussion
- Express self
- Acknowledgement
- To talk to someone

BEING GIVEN STRATEGIES/SKILLS AND THE LEARNING PROCESS

- Making progress
- Walking away with skills
- Two way street
- Homework tasks
- Ongoing learning
- Noticing patterns
- Having to work
- Analyzing and putting thoughts on paper
- Breaking down behaviours
- Experimentation
- Structure
- Problem solving

LIMITATIONS/DIFFERENCES/ASSOCIATIONS WITH RACE

- A reluctance to do tasks
- Inability to relate/not same ethnicity
- Feeling judged
- Holding back due to fear
- Only touch on topics
- Repetitive nature of sessions
- Therapist is a stranger
- Not feeling comfortable
- Different backgrounds
- White and older
- Wanting to cooperate
- Everything suggested involved money
- Speaking others realizing not the only one experiencing the same

COUNSELLING

- Didn't enjoy
- Thought CBT would be similar
- One off
- Never found it helpful
- I would feel worst after
- Didn't offer practical advice
- Increased feelings, feel emotional

**THEME 1:
THE THERAPY
EXPERIENCE**

MOTHERS

- Gone through it (depression)
- Encouraged/told me/said to go
- Mum has a NHS background/Supportive of others
- Referred me

161

THE INABILITY TO OPEN UP/ LACK OF EMOTIONAL EXPRESSION

- Nobody speaks out about it
- Everything is hush/kept quiet
- Cant talk openly
- Reluctance to openly relate to one another
- Don't come out or speak
- Awareness that it's a normal feeling
- Older generation = brush it off
- Try and cope on your own
- Suffer in silence
- Parents harder and less understanding of emotions (compared to friends)
- Emotions difficult to talk about
- Don't talk about feelings
- Therapy becomes a secret

SEEKING OWN KNOWLEDGE AND RESEARCHING ONLINE

- Googled for help
- Social media influences
- Materials online
- Watching videos
- Personal research
- Media/newspaper/social media
- Changes in society – more MH talk
- MH portrayed in the media
- Links to own experiences
- NHS website – working out symptoms
- Depression and medication

CONCEPTUALISING AND UNDERSTANDING OWN DISTRESS

- Resonating with others symptoms
- Helping others going through similar difficulties
- Friends seeing you down
- Friend opening up about depression
- Linking own experiences with others
- Sharing certain issues
- Others noticing your mood

THE STIGMA/PERCEPTIONS OF BLACK PEOPLE

- Don't label yourself
- Therapy and MH* not talked about
- Low mood preference
- Negative connotations/associations
- Weak/weakness
- Therapy is for crazy/mad people
- Got to be strong
- Feelings =weakness
- Black people cant get depressed
- Wouldn't use depression term everywhere
- Warning from others
- Don't talk to family

THEME 2:
NAVIGATING GETTING HELP

BEING BLACK BRING ADDITIONAL PRESSURES/STRUGGLES/INEQUALITIES

- I have to do better
- Lot more pressure
- Cultural thing
- Struggles with access to education/employment – statistics
- Denied the right to feel low
- Lack of opportunity
- Oppression
- Inequality at job interviews
- Not allowed to have emotions
- White people have privilege
- Different responsibilities

Appendix O: Extract taken from reflective journal

Following interview with Jada:

This was my first face-to-face interview with a participant. I was initially feeling nervous but also excited. I had prepared as much as possible and ensured I had all the necessary paperwork. We began the interview and it automatically felt like a rapport was built between us. She was open and forthcoming when answering my questions. I noticed very early on that there were aspects of her responses that I found myself relating to and in a way mirrored aspects of my own upbringing growing up in a matriarchal female dominated family. I think I was particularly struck when she named having "strong female role models" and how this in a way made it "hard to really admit you had a problem". This idea of gender expectations and pressures that lead to silencing resonated with me. At this moment I noticed this and acknowledged this without responding in a particular way, however following the interview I wondered how this might have influenced my findings in making that connection, rather than following up and probing/exploring this idea more. I wondered if my identification may have shut down my curiosity and understanding of the participant's experience. In keeping these reflective diaries, I have made a note to review this again when I begin the analysis process to ensure that this does not impact on my findings negatively. This experience however highlighted potential points and blind spots to be aware of going forward when I conduct further interviews.