Exploring Community Adversity in a Culturally Diverse Inner London Borough: A Thematic Analysis of Professionals' Views in the Context of the Power Threat Meaning Framework

Elliot Miller

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ABSTRACT

Background: In 2018, the British Psychological Society (BPS) published the Power Threat Meaning Framework (PTMF), which acknowledges the role of adversities on distress at the community level. It also acknowledges the influence of culture on the perception of distress. However, originating in the United Kingdom (UK), a Western society which views distress through an individualistic cultural lens, its applicability across diverse cultures and community contexts remains unclear, with limited existing research in these areas.

Aims: This study aimed to explore the extent to which the PTMF can structure discussions among professionals about community adversity in a culturally diverse inner London borough. This question is pertinent given the UK health policy context, which emphasises community-level action that considers various cultural perspectives to address the social determinants of health and reduce health inequalities.

Method: A qualitative methodological approach was employed, consisting of three focus groups with fifteen healthcare professionals experienced in supporting the local community. Focus group data was analysed using a critical realist approach to thematic analysis.

Results: Five main themes were developed from the analysis: ‘adversities facing the community’; ‘threats posed to the needs of the community’; ‘meaning-making of the community’; ‘threat responses of the community’; and ‘resources of the community’. These themes, along with their related sub-themes, are described.

Conclusion: The findings suggest that the PTMF could offer professionals an alternative perspective on experiences of adversity, including cultural perspectives, at the community level. The study's limitations and implications for public health, clinical practice, and future research are examined.

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1. INTRODUCTION

The Power Threat Meaning Framework (PTMF), developed as an alternative to the medical model of distress, aims to re-establish the links between adversity and distress (Johnstone & Boyle, 2018a). The authors state the importance of understanding meaning and distress at cultural and community levels, and as such, the framework is designed to be applicable cross-culturally and with communities. However, as the PTMF originates in a Western cultural context in the United Kingdom (UK), which typically views distress through an individualistic lens, its applicability across cultural contexts and communities remains to be determined. This study explores the extent to which the PTMF can structure discussions among professionals about community adversity in a culturally diverse inner London borough.

1.1. Chapter Overview

The chapter starts by defining relevant concepts. It then provides a brief overview of the medical model. Next, it outlines how the medical model often disregards cultural influences on distress, highlighting limitations in current attempts to address this issue through cultural adaptation (CA) of psychological therapies. Subsequently, it explores how the medical model may obscure the link between adversity and distress, providing an overview of research on this link and its implications for health outcomes. The discussion extends to how this research on adversity may only partially consider the factors influencing health inequalities. Following this, the chapter reviews a public health (PH) approach, which aims to take preventative action at the population level to tackle these factors, along with some relevant models for this work, while also considering the limitations of a PH approach and its interventions.

The chapter then introduces the PTMF as a non-medical alternative to understanding distress, summarising its core features. It proceeds to outline how the framework overcomes the constraints of the medical model, emphasising the importance of understanding distress at cultural and community levels. It then discusses critiques of the PTMF regarding its applicability across cultural contexts and to communities, followed by a literature review of its application across cultures and beyond individuals. Finally, the research rationale is presented, leading to the study's aim and question.

1.2. Definitions of Key Constructs

1.2.1. Culture

This thesis adopts Marsella and Yamada's (2010) definition of 'culture', conceptualised as shared learned behaviours and meanings passed down socially for adaptation. Externally, culture manifests in various forms, such as food, clothing, music, societal roles, and institutions like family and government. Internally, culture influences how we think and feel, shaping our values, attitudes, beliefs, and even our sense of ourselves. Communication of culture occurs through language, images, bodily sensations, and emotions, leading to unique ways of experiencing the world for different people.

1.2.2. Community

The National Institute for Health and Care Excellence (NICE) defines 'community' as follows:

> A community is a group of people who have common characteristics or interests. Communities can be defined by: geographical location, race, ethnicity, age, occupation, a shared interest or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage (NICE, 2016, pp. 7-8).

1.2.3. Adversity

'Adversity' refers to "continuous or repeated very negative experiences, embedded in people's lives and relationships and in the discourses, structures and practices of our social world" (Johnstone & Boyle, 2018b, p. 98).

1.3. The Medical Model

In the Western world, psychological distress is understood mainly through the reductionist ‘medical model’ (Bentall, 2003, 2009; Read et al., 2013). This model views distress as ‘symptoms’ of internal pathology and categorises individuals into diagnostic clusters (Johnstone & Boyle, 2018a). Formal classification systems, such as the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) and the International Classification of Mental and Behavioural Disorders (10th ed.; ICD-10; World Health Organization, [WHO], 1992), are used for this categorisation.

There is growing opposition to framing mental distress as requiring a diagnosis. In 2013, coinciding with the release of DSM-5 (APA, 2013), the UK Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) urged a departure from the disease model (DCP, 2013). They recommended collaborating with service users to devise a contextual approach integrating biopsychosocial factors. This suggests that the medical model may not adequately understand distress within broader cultural and social contexts.

1.4. The Medical Model and the Influence of Culture

1.4.1. The Assumption of Cultural Universality

The medical model assumes cultural universality, asserting that diagnoses and experiences are consistent across cultures (WHO, 1992). However, mental phenomena in Western contexts may not carry the same meaning in non-Western settings (Summerfield, 2008). For example, certain African societies recognise a local condition similar to Western depression, often translated as ‘thinking too much’, which shares some physiological features but has distinct cultural interpretations and remedies (Summerfield, 2008).

Nevertheless, efforts to establish universal diagnostic criteria have been made (Marsella & Yamada, 2010), despite the acknowledgement by DSM and ICD authors that mental disorder categories lack clear boundaries (Kendell & Jablensky, 2003). These categories are often treated as definite diseases, obscuring the fact that psychiatric diagnostic frameworks are essentially "Western cultural documents par excellence", shaped by societal and cultural norms on thoughts, feelings, and behaviour (Summerfield, 2008, p. 992).

This approach overlooks the influence of social constructs within cultures on individual reactions, expressions, and responses to distress (Altweck et al., 2015; Bhugra, 2006; Bhugra & Bhui, 1998; Faulkner, 2014; Fernando, 2010; Hagmayer & Engelmann, 2014), leading to a ‘category fallacy’ (Kleinman, 1977) that emphasises universality while neglecting non-Western perspectives (Fernando, 2019). This oversight dismisses the impact of culture on health (Kleinman, 1987; Mills & Fernando, 2014), including culturally appropriate perceptions of mental health and broader cultural diversity (Codjoe et al., 2013; Fatimilehin & Hassan, 2013; Gopalkrishnan, 2018).

1.4.2. Cultural Variability of Mental Distress

Fernando (2010) highlights the social construction of distress, noting Western culture’s tendency to medicalise complex human problems while other cultures approach them philosophically or spiritually. In Muslim communities, distress may be attributed to Jinn, with faith considered vital to well-being and recovery, often leading to religious support being prioritised over medical approaches (Khalifa et al., 2012). Therefore, it is crucial to recognise how culture and mental well-being interact (Adebayo & Ilori, 2013; Bhugra & Gupta, 2010; Bojuwoye & Sodi, 2010) and to identify how distress manifests differently in non-Western cultures (Cohen et al., 1996; Ventevogel et al., 2013).

1.4.3. Culture-bound Syndromes

The DSM (4th ed., text rev.; DSM-IV-TR; APA, 2000) attempted to address culturally specific expressions of distress by including an appendix of 25 'culture-bound syndromes' (CBS), while ICD-10 (WHO, 1992) has a 'culture-specific disorders' section. However, these CBS have confused the representation of Western 'illnesses’ like depression (Sahoo et al., 2021) and led to misdiagnoses and ethical harm (Marsella, 2009; Marsella & Yamada, 2010), especially in cultures where social and cultural stigmas are attached to ‘mental illness’. For example, in some African cultures, ‘mental illness’ may be attributed to divine wrath, drug abuse, or witchcraft, leading to misconceptions and challenges in providing appropriate care (Amuyunzu-Nyamongo, 2013; Conrad & Barker, 2010; Hassim & Wagner, 2013; Li et al., 2014).

In response to these concerns, DSM-5 replaced CBS with ‘cultural concepts of distress’ (CCDs), defined as the “ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions” (APA, 2013, p. 758). These include ‘cultural syndromes’ (specific symptom clusters and attributions), ‘cultural idioms of distress’ (shared expressions of distress), and ‘cultural explanations’ (labels and attributions for distress causes). The DSM-5 also includes a ‘cultural formulation interview’ to identify these aspects of distress and link them to the most relevant diagnoses (APA, 2013).

Despite DSM-5 acknowledgement that “all forms of distress are locally shaped, including the DSM disorders” (APA, 2013, p. 758), the Western model remains dominant, requiring local ‘symptoms’ to fit into its paradigm (Johnstone & Boyle, 2018b). The widespread acceptance of many DSM diagnoses, potentially originating as ‘cultural syndromes’, is due to their perceived “clinical and research utility” (APA, 2013, p. 758). Similarly, CCDs are valued for confirming 'correct' DSM diagnoses and identifying “patterns of comorbidity and underlying biological substrates” (APA, 2013, p. 759).

However, it is crucial to recognise that Western perspectives of distress are culturally bound and shaped by historical, linguistic, and socio-political factors inherent in Western culture (Marsella, 2009). Viewing them objectively can obscure cultural meanings in expressions of distress (Kirmayer, 2001). However, the power and economic dominance of Western psychiatry has created a false sense of its universality, resulting in the global exportation of Western models of mental distress and neglecting diverse cultural experiences (Hassim & Wagner, 2013; Marsella & Yamada, 2010).

1.4.4. Movement for Global Mental Health

The Movement for Global Mental Health (MGMH) has drawn criticism for being a top-down imperial project that exports Western diagnoses and treatments (Mills & Fernando, 2014; Summerfield, 2013; Watters, 2010). It is grounded in Western concepts of distress as an illness, focusing on diagnosable ‘disorders’ treatable by drugs or psychological therapy (Mills & Fernando, 2014). Its goal is to expand psychiatric services in low- and middle-income countries, addressing a perceived ‘treatment gap’ that limits access to Western interventions for most people (Sax & Lang, 2021).

This follows a series of articles published in The Lancet on global mental health, which asserted that “mental disorders now represent a substantial “though largely hidden” proportion of the world’s overall disease burden”, “every year up to 30% of the global population would develop some form of disorder”, and “there is strong evidence for scaling up mental health services worldwide” (Horton, 2007, p. 806; Prince et al., 2007).

1.4.5. Opposition to the Movement for Global Mental Health

In a 2017 United Nations (UN) General Assembly report, Special Rapporteur Dainius Pūras cautioned against the global imposition of Western mental health models. He criticised the current ‘burden of disease’ approach for its narrow focus within a biomedical model, stating it fails to address mental health adequately at national and global levels (UN General Assembly, 2017). Pūras emphasised the need to avoid scaling up inappropriate interventions. However, a neo-colonial analysis of the MGMH reveals the imposition of Global North ideologies on the Global South, described as a form of ‘medical imperialism’ (Fernando, 2012, 2014; Mills, 2014; Mills & Fernando, 2014; Summerfield, 2012).

Said (1994) highlighted modern imperialism’s guise as an educational movement for modernisation and civilisation. This is reflected in Western models, like psychiatric diagnosis, which are imposed as a requirement for economic aid in modernising health systems (Petras & Veltmeyer, 2001). It is also evident in published research on non-Western populations, which emphasises their limited understanding of mental illness and the importance of mental health literacy for the community and healthcare professionals (Summerfield, 2008).

Consequently, non-Western individuals are expected to conform to Western norms, reminiscent of the colonial era's marginalisation of Indigenous knowledge systems

(Summerfield, 1999). This process contributes to the homogenisation of non-Western cultures, disregarding the culturally embedded nature of mental distress (Fernando, 2014), resulting in inappropriate diagnoses, solutions that are not locally appropriate, and the marginalisation of 'traditional' mental health systems (Fernando, 2010; Summerfield, 2013). Moreover, DSM-5's discussion on CCDs suggests that 'psychiatric diagnostic equivalents' can be deemed as local categories in non-Western societies, allowing Western psychiatry to avoid scrutiny of its epistemological orientations (Summerfield, 2008).

However, Western psychiatric frameworks lack universal validity as they often overlook the individual's cultural context and local forms of knowledge and philosophy (Summerfield, 2008). Psychiatrist Derek Summerfield (2012) suggests that culturally determined understandings that people bring are often dismissed as epiphenomenal, obscuring the actual underlying psychopathological issues. He emphasises the need to move beyond surface-level cultural considerations and address psychopathology's genuine and universal challenges.

Despite criticisms of the MGMH, Western models of distress persist in being globally exported across diverse cultures (Husain et al., 2014; Naeem et al., 2015; Rathod et al., 2010), enforcing Western ways of thinking and therapies worldwide, contrary to individuals' and communities' human rights (Fernando, 2014). This oversight results in mental healthcare provision neglecting individuals' unique cultural perspectives and needs.

1.4.6. The Appropriateness of Western Models

Globalisation, evident in countries like the UK, where approximately 18% of the population belongs to ethnic minority groups (Office for National Statistics, [ONS], 2022), has increased cultural, religious, and racial diversity (Naeem et al., 2019). This trend raises concerns about the applicability of Western mental health models for diverse communities (Naeem et al., 2019). Consequently, healthcare systems must ensure culturally responsive, appropriate and effective clinical services that accommodate diverse cultural backgrounds (Naeem et al., 2019). As such, there is an increasing focus on culturally adapted interventions to meet this challenge (e.g., Barrera et al., 2013; Bhui, 2010; Edge et al., 2018; Leung et al., 2014; Rathod & Kingdon, 2014; Sue et al., 2009).

1.4.7. Cultural Adaptation

Cultural adaptation (CA) involves systematically modifying an evidence-based intervention (EBI) protocol to align with the cultural patterns, values, and meanings of an individual (Bernal et al., 2009). Whaley and Davis (2007) similarly define CA as any adjustment to an EBI, including changes in service delivery (e.g., the therapeutic relationship) or treatment components, to accommodate the target population's cultural beliefs, attitudes, and behaviours.

Falicov (2009) described CAs to EBIs as a middle ground, avoiding the extremes of assuming universal applicability without adaptation or focusing solely on culture-specific approaches. This balanced approach ensures that CA maintains fidelity to the core elements of the EBI while integrating specific cultural features to enhance acceptability and effectiveness (Castro & Yasui, 2017). Examples include cognitive behavioural therapy (CBT; Mir et al., 2019; Naeem et al., 2011; Rathod et al., 2013, 2015, 2017, 2018), family therapy (Davey et al., 2013; Edge et al., 2018), dialectical behaviour therapy (Ramaiya et al., 2017), and interpersonal psychotherapy (Brown et al., 2012).

These efforts aim to address the limitations of Western models and promote culturally sensitive psychological interventions (Castro et al., 2010). Such adaptations are crucial for addressing cultural disparities in accessing services, improving outcomes, benefitting multicultural societies, and reducing overall costs (Kirmayer, 2012). Systematic reviews comparing the effectiveness of CA versus unadapted psychological interventions support this notion (e.g., Arundell et al., 2021; Benish et al., 2011; Hodge et al., 2010, 2012; Huey & Tilley, 2018; Rathod et al., 2018; Smith & Trimble, 2016). However, findings vary, with effect sizes ranging from near zero (Huey & Polo, 2008) to moderate (Griner & Smith, 2006; Hall et al., 2016) to large effect sizes favouring CA psychological interventions (Chowdhary et al., 2014; van Loon et al., 2013).

1.4.7.1. Critique of cultural adaptation: Implicit in adapting Western therapies for specific cultural groups is the assumption that Western culture is neutral and unaffected by power dynamics (Sakamoto, 2007). This approach risks perpetuating a new form of racism by locating culture in the 'other', thereby 'othering' individuals of non-Western cultural groups (Pon, 2009).

However, cultures are not value-neutral, and Western psychotherapies hold assumptions rooted in Western culture (Hwang, 2016). For instance, CBT proposes that emotional distress arises from maladaptive thoughts and behaviours (Fenn & Byrne, 2013). Consequently, these therapies are value-laden and may be more effective within communities with similar ideologies (Kirmayer, 2012; Scorzelli & Reinke-Scorzelli, 1994), raising questions about assimilating diverse cultural groups into these theories and models (Koç & Kafa, 2019).

Furthermore, CA can inadvertently reinforce racism, prejudice and cultural stereotypes by implying uniform behaviour within cultural groups (Castro et al., 2010). This is evident in CA studies comparing Western with non-Western cultures, which often overlook the rich diversity within non-Western cultural groups (Rathod et al., 2018). Similarly, Western contexts can be homogenised. Psychiatrists Kingdon and Turkington (1994) stated that there is greater cultural diversity within Western and other societies than is commonly acknowledged in mental health contexts.

1.4.8 Summary

The medical model, framing 'mental disorders' as universally applicable and rooted in biology, risks marginalising non-Western knowledge and practices. In response, there have been efforts to culturally adapt psychological interventions to increase the cultural accessibility and efficacy of mental health services. However, CA may be seen as an attempt to fit individuals from diverse cultural backgrounds into Western frameworks, potentially reinforcing racism, prejudice and cultural stereotypes.

1.5. The Medical Model and the Impact of Adversity

1.5.1. The Assumption of Individualism

The medical model is inherently limited in understanding emotional and behavioural distress because it focuses on understanding people's bodies rather than their thoughts, feelings, and behaviour (Johnstone & Boyle, 2018a). This approach is influenced by Western philosophical assumptions, including Cartesian dualism, which separates the mind and body (Baggini, 2002). It implies that psychological distress is solely within the mind (Mehta, 2011), prioritising Western cultural values of individualism (Tribe, 2014).

Aligned with positivism, it views humans as objects influenced by causal forces (Ingleby, 1981), often leading to reductionism, such as simplifying complex human experiences to 'chemical imbalances' (Johnstone & Boyle, 2018a). This reductionism extends to viewing 'mental disorders' as entities independent of individuals and disconnected from their historical and cultural context (Johnstone & Boyle, 2018a).

1.5.2. Individualised Approaches to Mental Health Interventions

In Western psychological care, there is a dominant focus on individualistic approaches, prioritising psychiatric medication and individual therapy (Hagan et al., 2022). This pathologises everyday distress, often overlooking the socio-economic and structural factors influencing mental health (Ingleby, 2014; Mills, 2014; Mills & Fernando, 2014; Summerfield, 2013), benefitting the political and economic order by framing distress as an individual rather than a collective problem (Fernando, 2014).

A 2007 Healthcare Commission report found that up to 93% of service users had used medication, indicating an overemphasis on this approach. The rise in community prescriptions for antidepressants in England from 18.4 million in 1998 to 36 million in 2008 (Ilyas & Moncrieff, 2012), subsequently rising to 70.9 million in 2018 (Iacobucci, 2019), reflects this trend. This increase was attributed not only to population growth or higher depression diagnosis rates but also to longer treatment durations and increased prescriptions for anxiety (Ilyas & Moncrieff, 2012). However, meta-analyses suggest that medication efficacy levels barely surpass the placebo effect (Kirsch et al., 2008).

Bracken et al. (2012) argue that the popularity of biomedical interventions arises from a ‘technological paradigm’ that perceives distress as arising from internal faulty mechanisms independent of context. Similarly, Boyle (2022) critiques psychology’s tendency to adopt a ‘discourse of deficit’ (Gergen, 1997), prioritising autonomous individual minds over broader social contexts. Consequently, interventions focus solely on the individual rather than family, community, and society (Harper, 2016), overlooking the link between social context and later health outcomes, particularly regarding adversity (Friedli, 2009; Marmot, 2010).

1.5.3. The Impact of Adverse Childhood Experiences on Health Outcomes

Adversities can arise at different life stages, but those experienced during childhood can profoundly impact health outcomes, as highlighted in Adverse Childhood Experiences (ACE) studies (Johnstone & Boyle, 2018b). The Centers for Disease Control and Prevention and Kaiser Permanente Health Maintenance Organisation conducted the seminal ACE study (Felitti et al., 1998), which included more than 17,000 adult participants from a health insurance plan in the US. This ground-breaking public health survey explored the long-term health effects of childhood adversity through physical examinations and confidential surveys conducted in two phases from 1995 to 1997.

Childhood experiences were grouped into three categories (abuse, neglect, and household dysfunction), comprising ten adverse experiences. An ACE score, ranging from zero to ten, tallied the number of experiences an individual encountered (Felitti et al., 1998). The findings showed enduring implications for future health risks, chronic diseases, and premature mortality due to ACEs. Nearly two-thirds (64%) of respondents reported at least one ACE, with over 1 in 5 experiencing three or more.

Since then, the 'ACEs movement' has gained momentum, establishing robust evidence linking childhood adversity to negative outcomes across the lifespan (Friedli, 2009; WHO, 2013). For instance, studies have found childhood adversity to be connected with various ‘mental disorders’ (e.g., Aas et al., 2016; Bellis et al., 2014; Chapman et al., 2004; Cutajar et al., 2010; Felitti et al., 1998; Green et al., 2010; Kendler et al., 2000; Kessler et al., 2010; McLaughlin et al., 2010; Phillips et al., 2005; Varese et al., 2012).

Multiple ACE studies have also shown a cumulative and synergistic graded dose-response relationship between ACEs and negative health outcomes; in other words, experiencing adversity increases the likelihood of further adversity, and the combined effect of multiple adversities exceeds the sum of individual events (e.g., Afifi et al., 2009; Bebbington et al., 2011; Dong et al., 2004; Finkelhor et al., 2007; Fogarty et al., 2008; F. W. Putnam et al., 2020; K. T. Putnam et al., 2013; Longden et al., 2016; Morgan et al., 2014; Nelson et al., 2002).

1.5.4. Critique of Adverse Childhood Experiences

The discourse on ACEs often takes a fatalistic tone, suggesting inevitable negative outcomes or irreversible neurodevelopment damage (Edwards et al., 2017; Wastell & White, 2012). This perspective overlooks the significant impact that broader socioeconomic conditions have on ACEs (Anderson, 2019; Edwards et al., 2017; Taylor-Robinson et al., 2018). The original ACE research treated socioeconomic factors as peripheral, neglecting adversities rooted in systemic inequalities (Kelly-Irving & Delpierre, 2019; McEwen & Gregerson, 2019). A systematic review by the Glasgow Centre for Population Health found that out of almost 3,000 papers, only six attempted to explain ACEs regarding childhood socio-economic conditions despite a strong correlation between ACEs and socioeconomic disadvantage (Doidge et al., 2017; Marryat & Frank, 2019).

However, the field increasingly recognises that factors like neighbourhood violence, witnessing violence, bullying, poverty, homelessness, and foster care significantly impact children’s lives (e.g., Cronholm et al., 2015; DuMont et al., 2007; Finkelhor et al., 2013; Heberle et al., 2014; Hughes et al., 2017; Kohen et al., 2008; Kumar & Fonagy, 2013; Odgers & Jaffee, 2013; Pachter & Coll, 2009; Winslow & Shaw, 2007). This has prompted exploration into expanding ACEs beyond traditional household experiences to include community-level adversities like unsafe neighbourhoods, bullying, and discrimination.

The Philadelphia ACE Task Force Research Workgroup (Cronholm et al., 2015) studied a diverse urban population from Philadelphia and surrounding areas. Their survey included two categories of ACEs: conventional (household) ACEs and expanded (community) ACEs, encompassing bullying, community violence, neighbourhood safety, racism, and living in foster care. Results revealed higher conventional ACE exposure than participants in the original ACE study, particularly among minority and lower-income populations. The inclusion of expanded ACEs identified 14% of participants facing additional adversities. Consequently, analyses have broadened the definition of ACEs to include family instability, parental separation, low parental education, child poverty, parental unemployment, and lone parenthood (Hughes et al., 2017).

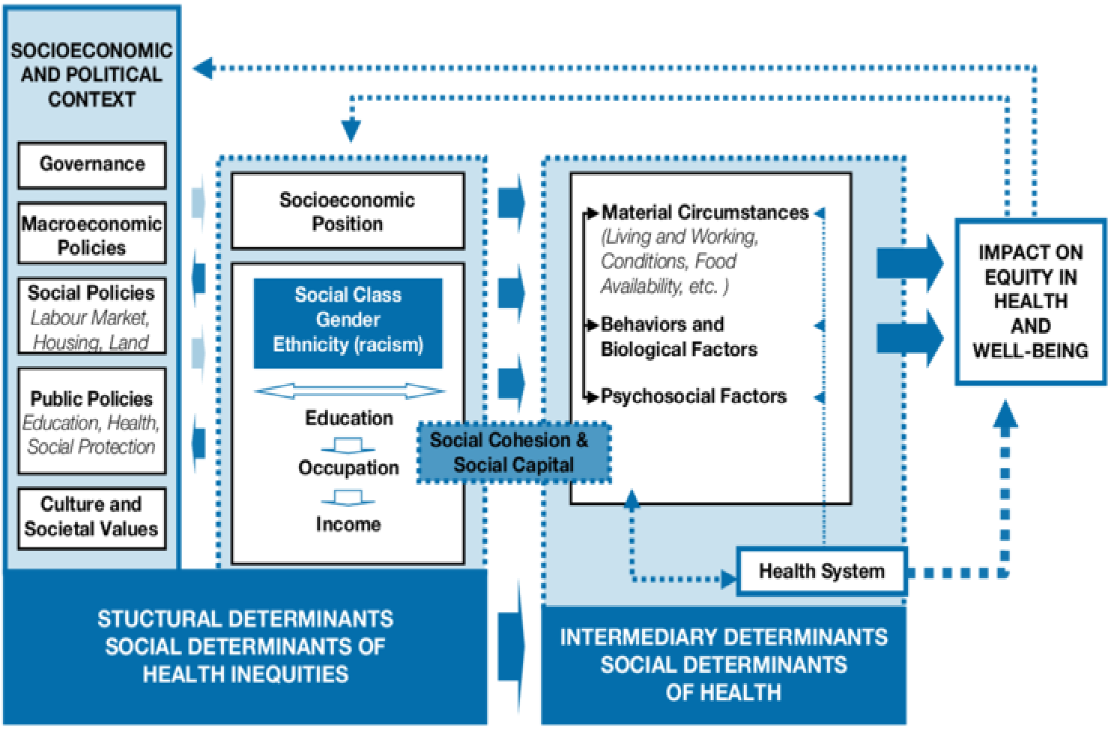
However, Straatmann et al. (2018) argue that this expansion has led to an unhelpful conflation of directly harmful risk factors, such as abuse, with measures of family structure and childhood socioeconomic conditions that may be associated with other risk factors contributing to poor health outcomes. Moreover, labelling all these factors under the term ‘adverse childhood experiences’ is conceptually confusing, potentially stigmatising, and risks overlooking the importance of socioeconomic conditions (Straatmann et al., 2018). Importantly, these broader, modifiable social determinants of health play a crucial role in the risk of ACEs (Metzler et al., 2017; Wickham et al., 2016).

1.5.5. Social Determinants of Health, Health Inequalities and Adverse Childhood Experiences

The social determinants of health (SDH) are the environments in which we are born, grow, live, work and age, and the larger systems and forces that shape our daily lives (Shim & Compton, 2018; WHO, 2014). In 2010, the WHO Commission on Social Determinants of Health (CSDH) introduced a conceptual framework (Figure 1) for the SDH, illustrating how the social, economic and political context shapes socioeconomic positions based on income, education, occupation, gender, ethnicity, and other factors (Solar & Irwin, 2010). These positions influence exposure to intermediary determinants like material circumstances, psychosocial factors, behavioural and biological factors, and the health system, all impacting health outcomes.

Figure 1

Final form of the CSDH conceptual framework



Note. From *A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2 (Policy and Practice)*, by O. Solar and A. Irwin, 2010, World Health Organisation (https://www.afro.who.int/sites/default/files/2017-06/SDH_conceptual_framework_for_action.pdf).

It emphasises the importance of addressing the SDH to reduce health inequalities and recognises the impact of social, economic, and environmental conditions on well-being (Bell, 2017). These conditions are influenced by money, power, and resource disparities and result in an uneven distribution of the SDH (CSDH, 2008; Elliott, 2016; Friedli, 2009; Marmot, 2010), thereby contributing to health inequalities (CSDH, 2008; WHO, 2014), defined as unfair and avoidable and systematic differences between different population groups (WHO, 2018).

Globally, a 'social gradient' in health links lower socioeconomic status to poorer health outcomes (Donkin, 2014). This connection often arises from socioeconomic adversity, exposing individuals experiencing poverty and disadvantage to various adversities impacting both physical and mental health (Braveman et al., 2011). These adversities include inadequate housing, exposure to violence, experiences of childhood abuse, and diminished agency, trust, and a sense of security (Rogers & Pilgrim, 2002). In the UK, higher levels of abuse are linked to lower socio-economic groups (Cawson et al., 2000), and lower-income families are prone to poorer maternal health (Marryat & Martin, 2010). Moreover, lower socioeconomic groups tend to experience co-occurring ACEs, with increased instances of four or more ACEs in children and young people in poverty (Bellis et al., 2014; Felitti et al., 1998; Ippen et al., 2011).

The Marmot Review built upon the work of the WHO CSDH (2008), underscoring the economic and human costs of neglecting health inequality. It emphasised the need for well-being to be prioritised in policy and called for action across all the SDH (Marmot, 2010). The UN Special Rapporteur strongly endorsed addressing the SDH from both public health and social justice perspectives, concluding that "The urgent need for a shift in approach should prioritize policy innovation at the population level, targeting social determinants and abandon the predominant medical model that seeks to cure individuals by targeting 'disorders'" (UN General Assembly, 2017, p. 19). This emphasises the importance of adopting population-based and preventative approaches to address the SDH.

1.5.6. Models of Public Health and Prevention

A public health (PH) approach addresses health at the population rather than the individual level, aiming to prevent illness and promote health and well-being (Harper et al., 2022). Prevention involves addressing factors contributing to the onset or exacerbation of problems (Harper et al., 2022). In psychology, most approaches focus on secondary prevention, involving interventions aimed at identifying issues early rather than primary prevention, which tackles the root causes of distress to prevent problems from arising in the first place (Harper, 2016).

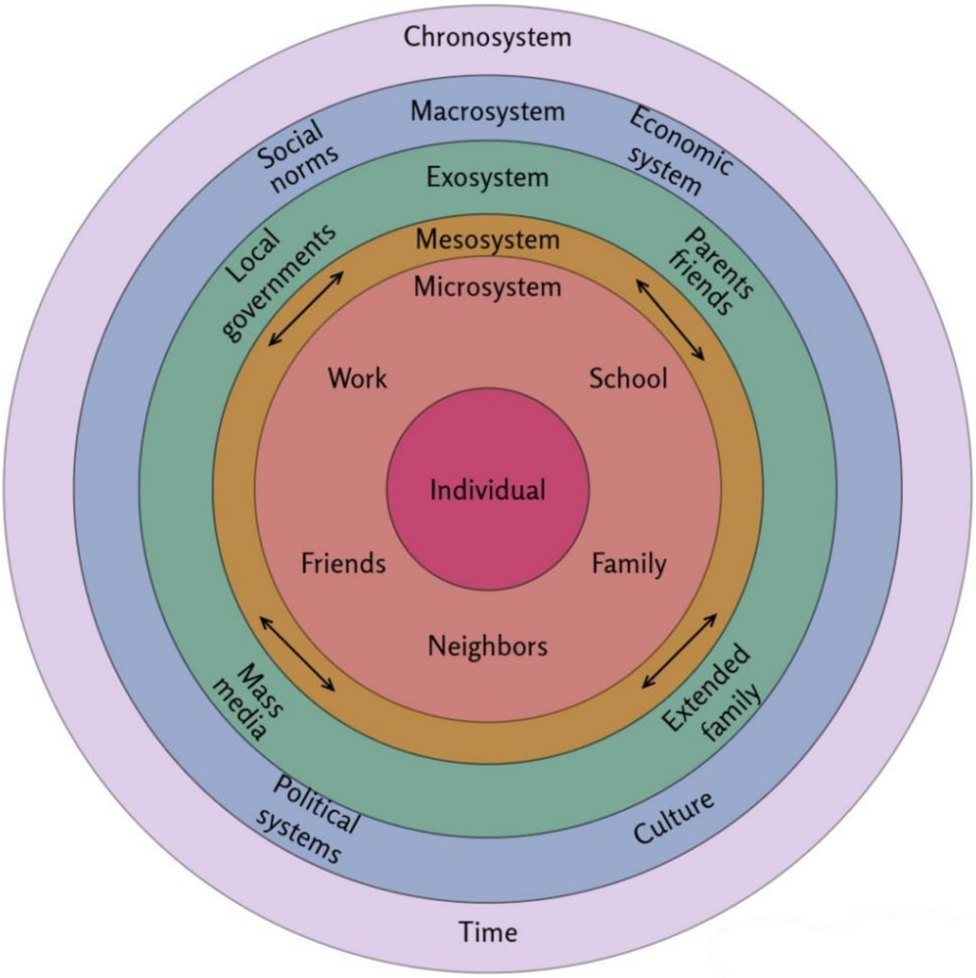
In early 2020, the DCP formed a sub-committee focused on PH and prevention work in psychology. The committee conducted a literature survey of models relevant to PH and prevention to elucidate factors contributing to better health outcomes in the general population. This was summarised by Navya Anand (2022) in an issue of the Clinical Psychology Forum. Two of the models Anand (2022) presents are discussed below.

1.5.6.1. Ecological systems model: The Ecological Systems Model (ESM; Bronfenbrenner, 1992) was developed to describe the interactions between children and their environments and how this shapes their development. Bronfenbrenner (1992) proposed that five ecological systems interact to collectively influence the child and their future development (Figure 2). The microsystem consists of social systems directly impacting a child's experiences, while the mesosystem examines interactions within the microsystem. The exosystem involves broader influences on a child's life, and the macrosystem pertains to more distal influences. Lastly, the chronosystem considers environmental changes over time.

While not initially focused on mental health, this model often guides systems-wide work in community psychology to enhance communities' mental health and well-being (Anand, 2022). For example, it has provided a valuable framework for tracking the effects of austerity on specific communities (Harris, 2014).

Figure 2

Bronfenbrenner's Ecological Systems Theory



Note. From *Bronfenbrenner's Ecological Systems Theory Figure*, by O. Guy-Evans, 2024, Simply Psychology (https://www.simplypsychology.org/bronfenbrenner.html).

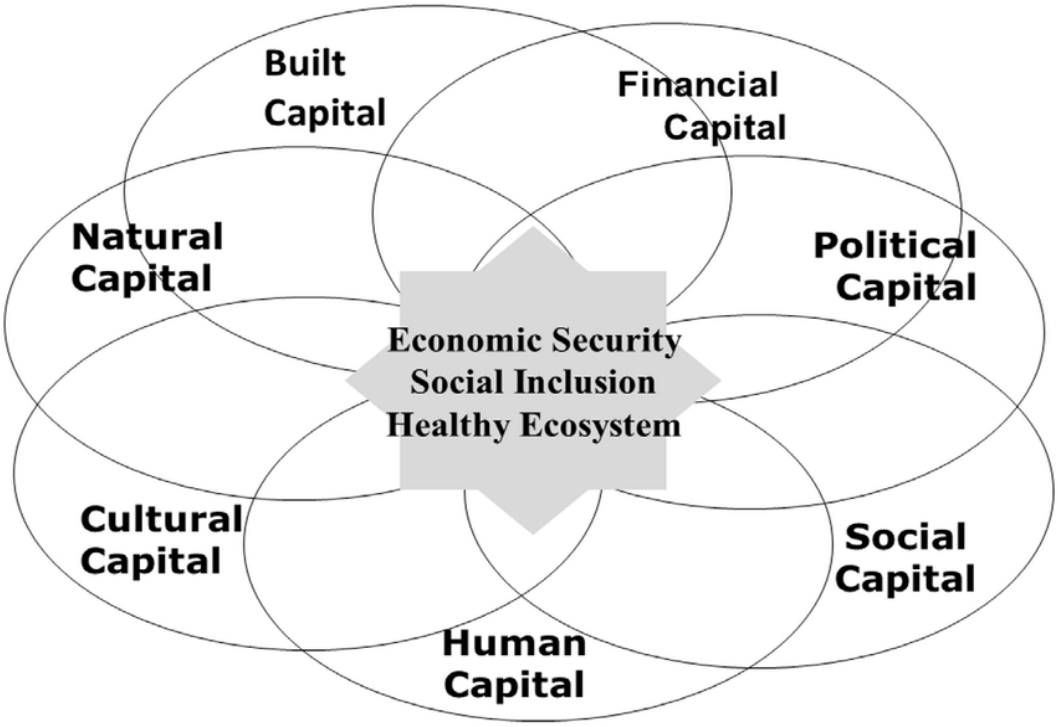
While the model provides a comprehensive theoretical framework, it lacks specific implementation recommendations (Anand, 2022). It also does not detail precise mechanisms of action at each level, particularly regarding the links between ecological factors and psychological mechanisms influencing psychological health outcomes (Anand, 2022). Additionally, the model primarily focuses on individual outcomes, posing challenges in evidencing the impact of preventative work within broader systems, such as the macrosystem (Anand, 2022).

1.5.6.2. Community capitals framework: The Community Capitals Framework (Flora & Flora, 2013) originated in rural America to assess communities' assets and resources for addressing challenges. It identifies seven types of capital: natural (e.g., natural resources, environment), cultural (e.g., values and perspectives), human (e.g., education, skills, health, self-esteem), social (e.g., trust, collaboration, shared vision), political (e.g., ability to influence policies), financial (e.g., monetary resources), and built (e.g., infrastructure). These capitals represent tangible and intangible resources that communities can leverage to generate further resources. Resilient communities aim for balanced investments across these seven capitals.

The authors emphasise that communities possess resources that can be invested in or depleted. The interconnected nature of these capitals enables the creation of positive, upward spirals of change within a community. Conversely, interventions that fail to generate further resources or have negative impacts can deplete community capital. This framework has been applied to the sustainable livelihoods approach (Serrat, 2017), which aims to alleviate community poverty.

Figure 2

Community Capitals Framework



Note. From “Collaborative Community-Supported Agriculture: Balancing Community Capitals for Producers and Consumers,” by C. Flora and C. Bregendahl, 2012, *International Journal of Sociology and Agriculture and Food*, *19*(3), p. 333. (https://doi.org/10.48416/ijsaf.v19i3.208)

However, a limitation of this model is its implicit assumption that all ‘capitals’ are equally available to all community members (Anand, 2022). Furthermore, as the model originated in a sociological context, it lacks clear guidance on implementing interventions for community benefit or the psychological mechanisms underlying these changes, mirroring the limitations of the ESM (Anand, 2022).

1.5.7. Critique of Public Health

While PH increasingly targets the SDH, discussions often frame them as risks, potentially medicalising these issues (Harper, 2023). Additionally, PH heavily emphasises the concept of ‘resilience’ - a blend of assets, capabilities, and positive adaptation aiding individuals and communities to cope with adversity - to enhance population health and wellbeing (Ziglio et al., 2017). However, these concepts lack cultural context and overlook who defines parameters for positive adaptation (Fletcher & Sarkar, 2013).

In Western culture, prevailing 'master narratives' suggest overcoming adversity without fully addressing societal power systems, oppression, and marginalisation (McLean et al., in press). Consequently, PH interventions can be seen as individualistic, implicitly locating problems and solutions in individuals and communities, diverting attention from systemic causes or collective solutions (Friedli, 2013; Harper & Speed, 2012). For instance, Mental Health First Aid (MHFA) England trains individuals to “recognise the warning signs of mental ill health” (MHFA England, n.d.)

1.5.8. Summary

The medical model obscures the effect of adversity on mental health by focusing primarily on locating problems in people’s bodies and brains. While ACE research shows a link between childhood adversities and health outcomes, it may overlook the SDH contributing to health inequalities. Consequently, there is a growing emphasis on PH approaches targeting the SDH to prevent health issues at the population level. However, PH faces criticism for its perceived medicalising and individualistic approach.

1.6. An Alternative Approach: The Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF), developed collaboratively by psychologists and psychiatric survivors, was published by the BPS in 2018 after a 5-year DCP-funded project (Johnstone & Boyle, 2018b). It provides an alternative to the medical model, integrating evidence on the significance of power in people's lives, the threats posed by its misuse, and how individuals interpret and respond to their experiences within their social, environmental, socio-economic, material, and cultural contexts (Johnstone & Boyle, 2018b).

The framework views adversities as socially patterned, reflecting the negative operations of power (Johnstone & Boyle, 2018b). This includes ideological power, which shapes societal messages influencing how we should feel, think, and behave (Boyle & Johnstone, 2020). These adversities threaten core human needs, and individuals actively make sense of and respond to these threats through meaning-making, co-constructed within social and cultural discourses, drawing on available resources to survive (Johnstone & Boyle, 2018b). The framework is summarised in four key questions applicable to individuals, families, social groups, communities, and societies:

- 'What has happened to you?' (How is power operating in your life?)
- 'How did it affect you?' (What kind of threats does this pose?)
- 'What sense did you make of it?' (What is the meaning of these situations and experiences for you?)
- 'What did you have to do to survive? (What kinds of threat responses are you using?)

Two further questions help consider individuals' skills and resources, aiding in constructing a personal narrative:

- ‘What are your strengths?’ (What access to power resources do you have?)
- ‘What is your story?’ (to integrate all of the above)

(Johnstone & Boyle, 2018b, pp. 190–191)

1.6.1. Power

The PTMF highlights the link between power and distress, defining power as a relational force involving societal structures, influencing individuals’ ability to meet their needs (Boyle, 2022). It outlines various types of power, including interpersonal power (e.g., caregiving or withholding affection), coercive power (e.g., violence or intimidation), and legal power (e.g., rules and sanctions; Johnstone & Boyle, 2018b). Understanding power involves critically examining language and discourse (Boyle & Johnstone, 2020). This is crucial for exploring less apparent forms of power, like ideological power, which controls language, discourse, and agendas, influencing perceptions and beliefs (Johnstone & Boyle, 2018b). Ideological power is evident in diagnostic frameworks like the DSM, which individualises social problems (Marecek & Gavey, 2013).

In Western societies, neoliberalism is the dominant ideology, promoting a competitive self-image and equating worth with economic power (Boyle & Johnstone, 2020). Its policies contribute to emotional distress, fostering insecurity and perpetuating dissatisfaction, guilt, self-blame, and shame (Boyle & Johnstone, 2020). This cultivates a cultural narrative pathologising troubling emotions and behaviour as ‘medical illnesses’ (Boyle & Johnstone, 2020). Such a narrative, leading to individual-focused treatments, results in 'hermeneutical injustice’, where marginalised groups lack resources to make sense of experiences beyond dominant discourses (Fricker, 2007).

1.6.2. Threat

The PTMF posits that the negative operations of power can create adverse circumstances in people's lives (Johnstone & Boyle, 2018b). It identifies fundamental conditions, termed 'core needs', for human wellbeing, including safety and security; close attachments; positive relationships; control over important aspects of life;

fulfilling basic physical and material needs; a sense of justice or fairness; feeling valued by others and being effective in social roles; taking part in meaningful activities; and a sense of hope, purpose, and meaning in life (Johnstone & Boyle, 2018b). Though hypothesised to be universal, the significance of these core needs varies based on individual, relational, and cultural factors.

The framework states that anything preventing these core needs from being met can be experienced as ‘core threats’ to emotional, physical, relational, and social safety and survival (Johnstone & Boyle, 2018b). Core threats, opposite to human needs, may manifest in relationships (e.g., rejection, abandonment); emotions (e.g., overwhelming emotions, loss of control); social/community (e.g., threats to roles, status); economic/material (e.g., threats to financial security, housing); environmental (e.g., threats to safety, links with the natural world); bodily (e.g., threats of violence, physical ill health); value base (e.g., threats to beliefs); and meaning-making (e.g., threats to creating valued meanings/imposition of others’ meanings). These threats create adverse circumstances where individuals are more likely to struggle than thrive.

1.6.3. Meaning

The PTMF asserts that individuals actively create meaning in their lives (Johnstone & Boyle, 2018b). While in Western cultures, meaning-making is often considered an internal, language-based process that separates 'thinking' from 'feeling', these distinctions are not universal (Cromby, 2015). Thus, meaning extends beyond cognitions in the framework, recognising that some meanings, such as shame, invoke physical and affective experiences (Cromby, 2022). It recognises that the meaning attributed to threats arises from the interplay of linguistic, material, social, cultural, psychological, and biological factors (Johnstone & Boyle, 2018b). Moreover, it emphasises that biological capacities are inherently intertwined with the social and interpersonal environment.

The PTMF challenges the narrow focus on individual-level meanings, emphasising the importance of considering broader societal discourses, such as common understandings about ‘mental illness’ and underlying ideological meanings (Cromby, 2022; Johnstone & Boyle, 2018b). In Western society, the prevailing 'cultural narrative of distress' views distress as a medical illness, reflecting ideological meanings influenced by neoliberalism (Boyle & Johnstone, 2020).

1.6.4. Threat Responses

The PTMF outlines evolved and acquired ‘threat responses’ – strategies humans employ for emotional, relational, social, and physical survival in response to the negative use of power (Johnstone & Boyle, 2018b). These range from automatic, biological responses like fight or flight to consciously adopted and culturally specific responses such as self-harm, suspicious thoughts, repetitive rituals, restricted eating, drug use, etc. In a Western medical framework, these threat responses are often decontextualised and labelled as ‘symptoms’ of an illness. Conversely, the PTMF reframes them as intelligible responses to complex adverse circumstances (Johnstone & Boyle, 2018b).

The PTMF challenges the assumption of universality in the medical model, asserting that all expressions of distress are culturally bound (Johnstone & Boyle, 2018b). It suggests that response variations emerge across the cultural spectrum, shaped by local norms and meanings. Some threat responses may not be diagnosed as ‘symptoms’ because they are socially acceptable, while experiences labelled as ‘pathological’ in Westernised settings may be integral to life and identity (Boyle & Johnstone, 2020). For instance, in certain cultures, hearing voices is socially accepted and valued (Read, 2016), including in some Western contexts, like spiritualist churches in the UK (Moseley et al., 2022).

The framework encourages understanding threat responses in terms of their functions in meeting core human needs rather than searching for specific medical or psychological causes (Boyle & Johnstone, 2020). It considers how these responses vary over time and across cultures while highlighting common themes. Common functions identified include managing overwhelming feelings, protection from danger, maintaining control, safeguarding against loss or rejection, seeking safe relationships, preserving identity, integrating into social groups, meeting emotional needs, expressing a need for care, and seeking purpose and meaning (Johnstone & Boyle, 2018b).

1.6.5. General Patterns

The PTMF serves a vital role in provisionally "…identifying patterns in emotional distress, unusual experiences, and troubling behaviour as an alternative to psychiatric diagnosis and classification" (Johnstone & Boyle, 2018b, p. 5). These meta-narratives describe how individuals in specific social, cultural, and historical contexts commonly attempt to survive particular constellations of power abuses. The framework describes them as "patterns of embodied, meaning-based threat responses to the negative operation of power" (Johnstone & Boyle, 2018b, p. 191).

The authors propose seven 'provisional General Patterns', organised around adversities rather than 'symptoms', to restore the link between meaning-based threats and threat responses (Johnstone & Boyle, 2018b). These patterns, described as verbs, represent actions and functional roles, cutting across diagnostic categories without assuming 'pathology', and arise from personal, social, and cultural meanings. This approach moves beyond the individualised, medicalised model of 'mental illness', providing an alternative perspective on communities and societies. It enables individuals to interpret their experiences within a socially shared framework (Boyle & Johnstone, 2020), reducing hermeneutical injustice (Fricker, 2007).

1.6.6. Narrative

The evidence-based General Patterns aid in constructing narratives (Harper, 2022). Within the PTMF, the concept of 'narrative' is used in three ways: personal narratives, built by individuals to understand their distress; cultural narratives, representing the cultural frameworks of values and meaning that shape perceptions and experiences; and as a meta-theoretical language, synthesising various theoretical perspectives (Harper, 2022).

The PTMF underscores that cultural narratives influence personal narratives, revealing the impact of prevailing cultural norms on our perception of distress, which is shaped by ideological power (Harper, 2022). Within the framework, narratives are crucial in unveiling ideological power embedded in medicalised approaches that perpetuate dominant narratives of distress (Harper, 2022). This dominance reflects hermeneutical injustice, limiting people's understanding and expression of their experiences (Harper, 2022). By avoiding medicalising language, the PTMF can broaden public discourse on mental health, increasing the cultural availability of narratives concerning problems in living (Harper, 2022).

1.6.7. Relevance to the Medical Model

The PTMF presents a novel viewpoint and potential solution to the inappropriate application of a Western medical model of disorder and treatment to non-Western cultures and expressions of distress worldwide (Johnstone & Boyle, 2018b). According to the authors:

> The Framework predicts and allows for the existence of widely varying cultural experiences and expressions of distress without positioning them as bizarre, primitive, less valid, or as exotic variations of the dominant diagnostic paradigm. Since patterns in emotional distress will always be to an extent local to time and place, there can never be a universal lexicon of such patterns. However, viewed as a meta-framework based on universal evolved human capabilities and threat responses, the core principles of the PTM Framework apply across time and cultures. Within this, open-ended lists of threat responses and functions allow for an indefinite number of locally and historically specific expressions of distress, all shaped by prevailing cultural meanings (Johnstone & Boyle, 2018b, p. 11).

However, it is essential to note that the authors caution against exporting or imposing the PTMF where it is unnecessary, given significant variations in expressions of distress across cultures with non-Western perspectives (Johnstone, 2022). Instead, the framework aims to promote appreciation of the various, culturally specific ways people in the UK and around the world express, experience, and deal with individual and community distress (Johnstone & Boyle, 2018b, p. 215).

The framework also extends beyond the individualism of the medical model, stressing the significance of understanding meaning and distress at social, cultural, and community levels. It offers evidence-based General Patterns that can form the foundation for generating individual, group, social, and community narratives that encourage agency and meaning, instil hope, restore relationships, and support social action (Johnstone & Boyle, 2018b, p. 198).

1.6.8. Critique of the Power Threat Meaning Framework

There are questions about the universal applicability of the PTMF across geographical and cultural contexts due to its UK-based Western origins (Anand, 2022). The authors acknowledge these Eurocentric constraints, recognising that patterns of emotional distress are inherently tied to local contexts (Johnstone et al., 2019). They admit that the framework, including its General Patterns, is inevitably shaped by societal and cultural influences, reflecting Western social norms and standards (Johnstone et al., 2019). Consequently, Johnstone (2022) emphasises the importance of tailored versions for specific social or cultural groups.

Despite these concerns, the PTMF has received substantial international interest. Its documents and resources have been translated into multiple languages, such as Norwegian, Spanish, and Italian (Johnstone et al., 2019), with the '*Straight Talking Introduction to the PTMF'* (Boyle & Johnstone, 2020) available in Japanese. Additionally, the authors have received interest in presenting talks on the PTMF from countries such as South Korea, India, and Pakistan (Johnstone & Boyle, 2018c). This widespread interest highlights the potential applicability of the PTMF across diverse contexts and cultures.

There are also concerns regarding the PTMF's applicability in community settings, as its core constructs can often be interpreted at an individual rather than community level, making it a resource primarily intended for use in individual therapy (Anand, 2022). The authors acknowledge this, noting that the General Patterns mainly apply to individuals and families, reflecting the Euro-American cultural perspective through which distress is interpreted (Johnstone & Boyle, 2018b). Nonetheless, they assert that the PTMF aims to broaden existing practices by introducing new ideas and shifting away from an overly individualistic focus (Johnstone et al., 2019).

Moreover, the authors suggest that patterns describing community-wide traumatisation may offer a more intuitive starting point both within and outside the UK (Johnstone, 2022). There is growing recognition in the United States that ACEs occur within 'adverse community environments' (Pinderhughes et al., 2015). Harper (2023) illustrates how social issues like problem drinking or youth violence could be viewed as threat responses to adverse community experiences, potentially conceptualised within the PTMF as sub-patterns like 'surviving poverty and low socioeconomic status'. This is suggested as an area for further development (Johnstone & Boyle, 2018b, p. 320)

1.7. Literature Review on the Power Threat Meaning Framework

Since its 2018 publication, interest in the PTMF has been steadily growing, prompting Gallagher et al. (2024) to conduct a scoping review of the emerging empirical literature on the framework. While the review highlighted the PTMF's versatility across various disciplines, settings, and populations, there was a noticeable gap regarding its community and cross-cultural applications. Thus, this literature review explores how the PTMF has been utilised across diverse cultures and within settings beyond the individual level. To achieve this, a narrative review is proposed.

Narrative reviews offer a nuanced overview of existing bodies of knowledge, allowing for the inclusion of a wide range of publications (Greenhalgh et al., 2018). This encompasses 'grey literature' - unpublished or non-commercially published research - often overlooked in systematic reviews (Mahood et al., 2014) as they focus on specific research questions and primarily summarise empirical data (Greenhalgh et al., 2018). Moreover, narrative reviews are well-suited to exploring new areas of study that may still need to be addressed in the literature (Ferrari, 2015).

1.7.1. Inclusion Criteria

The inclusion criteria for the literature review were articles attempting to use the PTMF across cultures and from a non-individual perspective (e.g. with groups and communities). Relevant descriptive and conceptual pieces and commentaries were included due to the limited availability of empirical studies. The review focused on articles written in English due to resource constraints.

1.7.2. Literature Search Strategy

I initially searched two electronic databases: EBSCO (Academic Search Ultimate, APA PsycINFO, and CINAHL Complete) and SCOPUS. The following search terms were used: "Power Threat Meaning Framework" OR "PTMF" AND culture* OR ethnic* OR famil* OR group* OR team* OR service* OR communit*. A search on Google Scholar supplemented this. The databases were searched from 2018, aligning with the publication of the PTMF.

I retrieved 46 results from EBSCO and 61 from SCOPUS. Google Scholar yielded a more extensive list with 1340 results. However, it became apparent upon reviewing titles and abstracts that articles beyond the first 50 were less relevant to the research topic. Therefore, I focused on the initial 50 articles.

After reapplying the inclusion criteria, some initially relevant articles were excluded because they lacked a primary focus on the PTMF or did not explore its application beyond the individual level or across cultures. Additionally, some articles referenced the ‘PTMF’ acronym but were unrelated to the Power Threat Meaning Framework, leading to their exclusion.

I identified 17 relevant articles, which I categorised into two groups based on the research question: five articles detailing the framework's cross-cultural application and twelve articles discussing its application beyond individuals.

1.7.3. Overview of the Power Threat Meaning Framework’s Application Across Cultures

Five studies examining the PTMF’s application across cultures will be outlined below.

In New Zealand, Johnstone and Kopua (2019) facilitated a workshop on the PTMF with Indigenous peoples. The session involved a talk on the PTMF, and then Māori speakers shared creation stories (pūrākau), considered to convey essential truths. Attendees related these narratives to their experiences, resulting in diverse reflections. The PTMF's recognition of stories as conveyors of truths resonated with Māori stories. Moreover, Māori stories displayed distinct themes that could be characterised as power, threat, and meaning, highlighting commonalities between Māori pūrākau and the PTMF core themes. The PTMF was described as a “‘distant cousin’ with more commonalities than differences” by the founder of a Māori mental health service (Johnstone & Kopua, 2019, p. 7).

Similarly, Lucy Johnstone and John Cromby conducted a workshop in Australia introducing the PTMF principles, followed by a showcase of community research and interventions with First Nation peoples (Johnstone, 2019). The harmful impact of psychiatric constructs on Indigenous individuals was highlighted, with an Aboriginal speaker sharing experiences of historical trauma due to racism and abuses of power. The speaker emphasised the significance of Aboriginal spirituality and ancestral connections in healing, stating, “The PTMF is relevant to Aboriginal people in this country and Indigenous people the world over" (Johnstone, 2019, para. 25).

Beyond workshops, the PTMF has proven beneficial in helping individuals from marginalised backgrounds understand their experiences. In France and the Netherlands, da Silva et al. (2022) used the PTMF core questions to explore misrecognition experiences among Muslim women students who wear headscarves. These experiences, which involve differences between people’s external and internal social categorisations, threaten one’s identity. The authors framed misrecognition as a materialisation of power, treating it as a political phenomenon instead of a psychological one, where those who misrecognise hold a dominant position. Participants perceived politicians as the primary source of their misrecognition, given their power to construct identities and influence others.

In Greece, Moutsou et al. (2023) introduced a protocol for four individual supportive sessions for unaccompanied minors based on the first author’s work in residential facilities. These sessions represent an initial collaboration between social workers/psychologists and minors, integrating the PTMF with existing practices. The authors demonstrate the PTMF's application in these sessions through a case study from their research. They suggest that the PTMF offers a valuable framework for psychosocial support, enabling professionals to have an understanding of minors' experiences, including cultural loss. This understanding facilitates the co-creation of more comprehensive and hopeful narratives.

In the UK, #Emerging Proud, a grassroots movement reframing madness as a catalyst for positive change, organised an open space conference in London to explore the PTMF’s relevance for those experiencing transformative or spiritual emergencies (Mottram, 2020). The framework resonated with attendees as it recognises the disempowerment and threats faced by those undergoing challenging transformations, including living in a culture resistant to the perspective of spiritual growth. Additionally, the PTMF supported a healthier healing and emergence process by allowing individuals to make sense of their experiences on their own terms.

In summary, the literature indicates that the PTMF has applicability across cultures. However, its scope remains limited, highlighting the need for further research to explore its potential utilisation in broader cultural contexts.

1.7.4. Overview of the Power Threat Meaning Framework's Application Beyond Individuals

Twelve articles detailing the application of the PTMF beyond individuals will be outlined below.

The literature primarily explores the PTMF's application in group sessions. The SHIFT Recovery Community (2022) used the PTMF to support individuals recovering from mental and emotional distress. Through discussions on sections of the 'PTMF Overview' and their relevance to personal experiences, participants could reframe 'symptoms' as understandable reactions rather than abnormalities. They found that the PTMF provided recognition, validation, and legitimacy to their experiences, fostering a sense of solidarity and hope for recovery. Overall, the group recognised the PTMF's potential as an educational tool to raise awareness within diverse communities at a grassroots level.

Moreover, the Clinical Psychology Forum's *'Special Issue: The Power Threat Meaning Framework'* included several articles outlining the PTMF's use in group interventions. Reis et al. (2019) describe a group intervention for prisoners utilising the PTMF to explore and reframe their experiences within the prison environment. Participants identified negative impacts of power, including coercive, ideological, and relational power, alongside various threat responses such as withdrawal, humour, or aggression. The authors concluded that the PTMF holds relevance in clinical practice within custodial settings, enabling the impact of confinement, adversity, and threat to be understood and reframed, thereby enhancing personal agency among prisoners.

Griffiths (2019) explores the application of the PTMF by the York Mental Health Peer Support Group, focusing on self-education and self-advocacy to nurture personal narratives, thereby offering hope and fresh perspectives. Their group session, which was centred around the PTMF core questions, received a positive response, with participants acknowledging that “sharing experiences utilising the framework is an emotive and thought-provoking way to connect with others who have endured similar experiences” (Griffiths, 2019, p. 3). It revealed to group members that they were not alone in their struggles, providing a novel outlook on their distress. This transitioned them from isolation to being part of a wider community of equals.

Collins (2019) investigated the implementation of the PTMF among women who have experienced abuse and the practitioners supporting them. The PTMF was integrated into the ‘Own My Life’ course, a 12-week group programme for such women to depathologise distress and ensure each woman could understand the framework independently. In 2019, the course was piloted in four UK locations, and an evaluation report showed that the PTMF helped participants gain deeper insights into their situations without resorting to self-blame (Collins, 2021). Moreover, facilitators noted that it significantly benefitted their overall practice.

In the same issue of the *Clinical Psychology Forum,* articles discussed the integration of the PTMF into group teaching. Griffiths and Baty (2019) incorporated the PTMF into their critical and community teaching sessions for clinical psychology trainees. Trainees utilised the PTMF template to explore their life circumstances, examining concepts of power, threat, and meaning. The workshop received positive feedback from trainee cohorts, who appreciated the practical links and clinical examples provided. Early exposure to critical psychology teaching allowed trainees to adopt a particular lens throughout their training.

O’Toole (2019) introduced the PTMF in a Master of Education module titled ‘Wellbeing, Mental Health and Education’, targeting qualified teachers, many of whom held or aspired to school leadership roles. The module offered a critical perspective on understanding well-being and mental health, challenging prevailing biomedical models. Informal feedback indicated that students appreciated the shift in language and terminology, which supported a different sensibility or orientation in their encounters with students. Teachers also recognised the PTMF's potential to transform education by providing alternatives to more oppressive perceptions and practices.

Additionally, the PTMF has effectively shaped service design and delivery across various mental health teams. Aherne et al. (2019) highlighted the PTMF's application in 'Jigsaw', an Irish youth mental health service offering individual therapeutic support to young people, community support, and advocacy for policy-level change. They emphasised the PTMF's valuable contribution to a project to engage and support migrant communities and detailed plans to co-produce activity-based projects with young people to improve service accessibility and promote mental health understanding within these communities.

Flynn and Polak (2019) describe their application of the PTMF in a service for individuals with Autism Spectrum Condition (ASC) or intellectual disability. They observed that the PTMF questions initiated discussions on social norms and values, promoting a reframing of ASC traits as meaningful threat responses. By utilising the PTMF, they positioned mental health secondary to experiences of social inequality and exclusion. The authors concluded that the PTMF served as a valuable tool for contextualising individuals' experiences, potentially aiding service users in finding a place in society by reclaiming their identity and asserting their power and agency for change.

Nikopaschos et al. (2023) evaluated the effect of weekly PTMF team formulation as part of a trauma-informed care model in a National Health Service (NHS) adult acute inpatient service across four years. In the four years following implementation, the study compared instances of self-harm and restrictive interventions to the year before. The results indicated a significant decrease in restraint, seclusion, and self-harm. The PTMF team formulation was suggested to have helped staff in adopting a trauma-informed perspective when understanding service users and in approaching distress on the ward differently, reducing the risk of re-traumatisation.

Furthermore, studies have explored the potential benefits of the PTMF to communities, particularly regarding climate change. Barnwell et al. (2020) investigated its application in South Africa, where community members discussed mining-related environmental threats exacerbated by climate change.
The authors framed psychological distress as a result of a series of cumulative psychological adversities at the community level, highlighting how unequal power distribution and racial and environmental injustice contribute to it. They concluded that the PTMF helps practitioners shift toward a more socio-ecological perspective of climate-related distress.

Morgan et al. (2022) elaborate on how the PTMF can support non-pathologising understandings of responses to climate breakdown, centring the role of power abuses and social injustice while promoting positive action for climate justice. They suggest that developing PTMF narratives focusing on the various operations of power can help individuals and communities transition from seeking individualised interventions to recognising the value of collective climate justice struggles.

Isham et al. (2023) contend that frameworks like the PTMF provide crucial insights into climate crises and their challenges while prioritising human well-being. These frameworks advocate for a holistic understanding of well-being that recognises the interdependence of individuals, communities and their surroundings. The authors suggest that adopting such perspectives can facilitate the creation of ‘post-growth’ societies, focusing on objectives like social justice, environmental regeneration, and human well-being.

In summary, the literature suggests that the PTMF has relevance beyond individual application. However, as most studies focus on its use within group settings, additional research is required to investigate its potential application in community contexts.

1.8. Research Rationale

The Western medical model views mental distress through a medicalised and individualistic lens. This approach has raised considerable public concern, with many asserting that it neglects the influence of culture on distress and obscures the impact of adversities. In response to this dissatisfaction with existing methods of understanding and addressing mental distress, both in the UK and globally, there have been increasing calls from professional bodies and public health (PH) policymakers for alternative approaches.

The PTMF presents a valuable alternative to the medical model, promoting a holistic and non-medicalised view of distress that respects culturally specific understandings and recognises the causal role of adversities at the community level. However, as the framework originates in the UK, a Western cultural context in which distress is often viewed through an individualistic lens, concerns about its cross-cultural and community applicability have been raised. While existing literature suggests the framework holds relevance in such settings, evidence remains scarce, warranting further research to explore its cultural and community-level applications.

Such endeavours could assess whether PTMF offers a culturally conscious, community-level approach distinct from the prevailing focus on individual-level interventions despite substantial evidence supporting community-centred approaches in the UK PH system (NICE, 2016). This is particularly relevant within the context of UK health policy, where there is increasing emphasis on the need for community-level intervention and action (e.g., NHS England, 2014, 2016, 2019; Public Health England [PHE] & NHS England, 2015) to address the SDH and reduce widening health inequalities for communities (Marmot et al., 2020; PHE, 2017).

As Bell (2017) succinctly stated, “Addressing social determinants is fundamental to tackling health inequalities. The accumulation of positive and negative effects of social, economic and environmental conditions on health and wellbeing throughout life is largely responsible for inequalities in health” (p. 6). A life course approach that considers diverse cultural perspectives of health and well-being is essential as part of action on the SDH to reduce health inequalities (Bell, 2017).

The PH workforce, including community, social care, and healthcare workers, is seen as playing a crucial role in reducing these health inequalities. In 2015, PHE published a framework to develop PH leadership and workforce capability in mental health. Among its six key ambitions is “a local workforce working with communities to build healthy and resilient places” (PHE, 2015, p. 10). This involves equipping PH professionals with the knowledge, skills, and competence in community-based approaches to work with communities to address community-level factors for improved health and well-being (PHE, 2015).

The BPS DCP’s ‘Public Health and Prevention Sub-committee’ also compiles examples and resources illustrating how clinical psychologists can adopt more preventative practices and models (Hagan et al., 2022). According to Johnstone and Boyle (2018b), the clear implication of the policy and evidence-base regarding the adverse effect of the SDH on individuals’ health and well-being is that psychologists “need to work much more at a preventative, political and community action level, not just through one-to-one therapy” (p. 63).

1.9. Research Aim and Question

1.9.1 Aim

This research, therefore, aims to explore whether the PTMF can provide professionals with an alternative way of thinking about experiences of adversity, including diverse cultural perspectives, at the community level.

1.9.2. Question

- To what extent can the Power Threat Meaning Framework structure discussions among professionals about community adversity in a culturally diverse inner London borough?

2. METHODOLOGY

2.1. Chapter Overview

This chapter describes the methodology that guided the research. It begins by explaining the rationale for taking a critical realist epistemological position. The methodological rationale, including using a qualitative approach and focus group (FG) data analysed by thematic analysis (TA), is then explored. Finally, the procedure, data collection, ethical considerations, and analysis are covered.

2.2. Epistemological Position

The term ‘epistemology’ refers to theories regarding knowledge production. All research is conducted within a theoretical framework that assumes what can be known and how knowledge can be obtained (Braun & Clarke, 2022). Therefore, it is crucial to understand the epistemological stance taken and its implications for the research. This study employed a critical realist approach, which “combines the realist ambition to gain a better understanding of what is ‘really’ going on in the world with the acknowledgement that the data the researcher gathers may not provide direct access to this reality” (Willig, 2013, p. 60).

Pilgrim (2010) states critical realism is founded on three fundamental premises. The first, ontological realism, asserts that the world exists independently of our perceptions (i.e. reality is mind-independent). The second, epistemological relativism, recognises that our knowledge of the world is influenced by language and culture, making it partial and subject to change. The third, judgemental rationalism, posits that we can evaluate truths and probabilities considering the first two premises. However, truth claims remain provisional and context-dependent, as all knowledge is partial and fallible.

It is not assumed by a critical realist approach that our data accurately represents reality (Harper, 2011). Instead, it implies that data interpretation is necessary for enhancing our understanding of the underlying structures that produce the phenomena we aim to comprehend (Willig, 2013). Through this lens, ‘adversity’ is recognised as a ‘real’ phenomenon impacting communities. However, it is also recognised that professionals’ perceptions of community adversity are shaped by sociocultural meanings, which influence their ‘reality’. Moreover, it considers factors beyond surface-level observation, such as cultural or ideological influences, which may only emerge through data interpretation (Willig, 2013).

2.3. Methodological Rationale

2.3.1. The Rationale for a Qualitative Approach

Qualitative approaches capture the depth of people’s experiences, meanings, and perspectives (Braun & Clarke, 2013). A qualitative approach was deemed appropriate since this study aimed to explore professionals’ perspectives on community adversity using the Power Threat Meaning Framework (PTMF). Qualitative methods also consider the context in which data is generated (Braun & Clarke, 2013), consistent with this research’s aim to obtain contextualised knowledge from a critical realist standpoint.

2.3.2. Rationale for Focus Groups

Focus groups (FGs) collect information from several participants simultaneously (Krueger & Casey, 2009). They allow for exploring various perspectives on a given issue without requiring previous empirical knowledge (Frith, 2000; Underhill & Olmsted, 2003; Wilkinson, 1998), making them an appropriate choice for data collection given the limited research on this study’s focus. Also, meaning-making can be facilitated through FG discussions (Breen, 2006; Smithson, 2007), which is advantageous for investigating how professionals interpret the community’s experiences of adversity.

Moreover, involving multiple participants in the research interaction, FGs can reduce the researcher's control and influence during data collection (Barbour & Kitzinger, 1999; Wilkinson, 1998, 1999, 2004). Considering the study’s focus on understanding the role of power, this approach was deemed vital. However, it is essential to acknowledge that the researcher still significantly influences data interpretation.

2.3.3. Rationale for Thematic Analysis

Thematic analysis (TA), a method for analysing qualitative data, identifies patterns of meaning (‘themes’) across a data set (Braun & Clarke, 2006). It was chosen as the analytical approach for this study due to its versatility in exploring diverse research questions concerning people’s experiences and perspectives and its applicability to analysing various types of qualitative data, including FGs (Braun & Clarke, 2013). Moreover, TA’s flexibility allows it to be employed with different epistemological positions (Braun & Clarke, 2006), making it compatible with the critical realist approach to this study.

Adopting a critical realist approach to TA in this study recognises that the data does not directly reflect ‘reality’. Instead, professionals bring their own situated and interpreted ‘reality’ (the data), which may differ from the ‘reality’ of community members. Moreover, TA, conducted through the researcher’s cultural lens, further shapes the interpretation process. Consequently, direct access to community members' perspectives may not be feasible; only professionals' subjective perceptions and interpretations, influenced by their own and the researcher’s contexts, will be available.

The choice to use TA instead of Interpretative Phenomenological Analysis (Smith, 1996) was guided by this study’s focus on capturing professionals' perspectives on community adversity rather than exploring rich, detailed, first-person accounts of individuals’ sense-making of their life experiences (Braun & Clarke, 2021a). Additionally, Grounded Theory (Glaser & Strauss, 1967) was not preferred because the objective was not to use the data to construct a ‘theory’; instead, the aim was to explore whether the PTMF could offer professionals an alternative way of thinking about experiences of adversity within a culturally diverse community by interpreting identified patterns in the data (Braun & Clarke, 2021b).

2.4. Procedure

2.4.1. Inclusion Criteria

The inclusion criteria were professionals (e.g., health/social care/NGO workers) aged 18 or over, employed within borough X and experienced in supporting the local community.

2.4.2. Recruitment

Professionals were deliberately sampled from borough X, which is culturally diverse and characterised by a high prevalence of adversities. This approach enabled the exploration of the research question.

Using purposive sampling, participants were recruited from a recovery community where I had prior work experience. I initiated this process by emailing the recovery community manager with my research poster (Appendix A), which they shared with the broader team. Additionally, opportunistic sampling methods were employed, including sending emails to local services, contacting personal and professional contacts (e.g. former colleagues), and using social media platforms (e.g. ‘X’ and ‘LinkedIn’). Professionals interested in participating received an information sheet (Appendix B) and were invited to raise any queries.

2.4.3. Sample Size

The FG, not the participants, serves as the ‘unit’ of data collection in FG studies (Morgan, 1997). Conducting a single FG session is generally discouraged, as it may only partially represent the broader population. This idea is supported by Fern’s (1982) experimental study, which showed that conducting two groups of four participants rather than one group of eight provides more valuable insights. Therefore, Krueger and Casey (2009) recommend having two or more FGs to increase the likelihood of success.

Sandelowski (1995) emphasises the importance of striking a balance in the number of FGs conducted, as too few and too many can compromise the quality of the study. Researchers must carefully consider the quantity of data and its impact on quality, recognising that abundant transcribed material may limit the depth and richness that can be extracted from the data (Morse, 2007). One concept used to determine when to stop data collection is ‘saturation’, where further data collection fails to generate new insights, and the range of perspectives appears to have been thoroughly explored (Morgan, 1997). Guest et al. (2017) state that two or three FGs comprising four to six participants can effectively capture around 80% of the main themes.

Based on the above, data collection was concluded after three FGs involving 15 participants. At this point, the collected data was sufficient to provide a “rich, complex and multi-faceted story” (Braun & Clarke, 2019, p. 11) in response to the research question.

2.4.4. Focus Group Composition

The active contribution of participants in a group discussion is crucial for generating valuable data, which is often more easily achieved within a homogenous group (Krueger & Casey, 2009). Therefore, it is recommended that FG participants share similar characteristics, including age, gender, and ethnicity. Additionally, ‘naturally occurring’ FGs, such as colleagues working together, offer advantages; participants can relate comments to daily incidents and challenge each other on contradictions between stated beliefs and actual behaviours (Kitzinger, 1995).

However, the concept of homogeneity is contested. Some argue that unfamiliar participants can offer honest and spontaneous viewpoints, potentially overcoming pre-existing relationships and established leadership dynamics within the group (Thomas et al., 1995, as cited in Nyumba et al., 2017, p. 22). Instead, bringing together a diverse group, such as individuals from various professions, can maximise exploring different perspectives within a group setting (Kitzinger, 1994).

Considering the advantages and disadvantages of both homogenous and heterogeneous FGs, this study incorporated a balanced approach. Two FGs consisted of community and peer workers at an NHS recovery community, all familiar with each other as colleagues and able to draw upon shared experiences. In contrast, one FG comprised mental health professionals and a community worker, all unfamiliar with each other as they were from five different NHS and local authority services, thus promoting diverse perspectives.

2.4.5. Participants

A total of 15 participants took part in FGs. Basic information about the participants, including their age, gender identity, ethnicity, profession, and whether they lived in borough X, was collected using a demographic form (Appendix C). Some of this information is summarised in Table 1. To ensure participant anonymity, names are replaced with participant numbers, specific ages are omitted, and ethnicity is reported at the group level to reduce the risk of identification. Participants spanned a wide age range from 23 to 75 years. Most participants identified as either Bangladeshi (N=5) or White British (N=4), followed by two identifying as Black Caribbean, two as Indian, one as Mauritian, and one as Indo-Fijian.

Table 1

Participant Demographic Information

Participant number	Gender identity	Profession	NHS or Local Authority	Lives in borough X
P1	Female	Community Worker	NHS	No
P2	Female	Peer Worker	NHS	Yes
P3	Female	Community Worker	NHS	Yes
P4	Female	Peer Worker	NHS	No
P5	Female	Trainee Mental Health Professional	NHS	Yes
P6	Female	Mental Health Professional	NHS	No
P7	Male	Trainee Mental Health Professional	NHS	Yes
P8	Male	Community Worker	Local Authority	No
P9	Female	Trainee Mental Health Professional	NHS	Yes
P10	Male	Peer Worker	NHS	Yes
P11	Female	Community Worker	NHS	No
P12	Male	Peer Worker	NHS	Yes
P13	Female	Peer Worker	NHS	No
P14	Female	Community Worker	NHS	No
P15	Female	Community Worker	NHS	No

2.5. Data Collection

2.5.1. Focus Group Questions

An interview schedule (Appendix D) guided the FG discussions, adhering to Krueger and Casey's (2009) guidance for concise, conversational, and open-ended questions. Starting with a general question to create a comfortable environment, participants were invited to describe the local community.

Subsequent questions mapped onto core aspects of the PTMF (Johnstone & Boyle, 2018b), covering adversities facing the community (power), the impacts of these adversities (threats), the community's interpretation of these adversities (meaning), the community's responses to these adversities (threat responses), and the resources within the community (power resources).

The session concluded with a reflective question, allowing participants to share their discussion experiences. Following discussions with my supervisor, I avoided using specific PTMF language (e.g., 'threat responses') where possible to enhance accessibility. Prompts were used to clarify, deepen descriptions, and explore diverse perspectives.

2.5.2. Focus Group Procedure

Three FGs, each comprising 4 to 6 participants, were conducted to explore the research topic thoroughly. Two FGs were held face-to-face in a teaching room at the NHS recovery community from which participants were recruited. In one group, all participants attended in person, while in the other, a mix of in-person and remote participation was facilitated by providing a Microsoft Teams (MST) link. The third FG took place entirely online via MST. Each session lasted approximately 90 minutes and was recorded on MST for transcription.

2.6. Ethical Issues

2.6.1. Ethical Approval

The University of East London's (UEL) School of Psychology Ethics Committee granted ethical approval to commence this study after submitting an application outlining the proposed research (Appendix E). Confirmation of ethical approval is provided in Appendix F. Health Research Authority approval was also acquired (Appendix G) due to the involvement of professionals recruited via an NHS Trust. A letter confirming UEL's sponsorship of the study can be found in Appendix H. The local capacity and capability of the NHS Trust were confirmed via email from the Research and Development Office (Appendix I).

2.6.2. Informed Consent

Informed consent was obtained from individuals who expressed interest in participating by asking them to read and sign a participant consent form (Appendix J), and they were advised of their right to withdraw from the study.

2.6.3. Confidentiality and Anonymity

FG audio recordings were converted into fully anonymised transcripts by assigning participant numbers and replacing identifiable information, such as names and locations, with anonymous alternatives. All identifiable participant information, including demographic data and consent forms, was securely stored separately from FG transcripts. Participants were assured that any data extracts used in this thesis or future publications would be presented anonymously to ensure their privacy.

2.6.4. Minimising Harm

Before starting the research, a risk assessment was conducted to evaluate the potential risks for the researcher and participants (Appendix K). Participants were reminded they could take breaks or leave the discussion at any time at the beginning of each FG. I remained alert to anyone becoming distressed during the sessions. After FGs, participants were offered verbal debriefing, and each received a written debrief sheet (Appendix L) containing contact information and resources for further support.

2.6.5. Data Storage

Data storage and management followed an approved plan (Appendix M). Audio recordings and transcripts were securely stored in password-protected files on my laptop and UEL OneDrive account. After uploading to UEL OneDrive, local copies were promptly removed from Microsoft Stream. Paper consent and demographic forms were scanned and shredded, with electronic versions deleted from my UEL email once stored on UEL OneDrive. Consent forms were stored in separate password-protected files, separate from other research data. Demographic data collected was similarly secured in a separate password-protected Excel file. Post-examination, audio recordings will be permanently deleted, and the research supervisor's UEL OneDrive account will be used to securely retain anonymised research data for five years to enable potential publication.

2.7. Data Analysis

2.7.1. Thematic Analysis

The six-phase process of TA, developed by Braun and Clarke (2006), was followed in the data analysis. This is a recursive process, allowing for movement back and forth through the phases as needed.

2.7.1.1. Phase one: familiarisation with the data: Phase 1 involved immersing myself in the data to become familiar with it, starting with the transcription process (Riessman, 1993). Braun and Clarke (2006) recommend producing “a rigorous and thorough ‘orthographic’ transcript - a ‘verbatim’ account of all verbal…utterances” (p. 88). The transcription notation system for orthographic transcription (revised from Braun & Clarke, 2013) can be found in Appendix N.

The audio recordings from each focus group were transcribed using MST’s auto-transcription feature, producing downloadable Word documents. To ensure accuracy, these auto-transcriptions were reviewed, edited, and cross-checked against the audio recordings (Braun & Clarke, 2006). This ensured that the transcripts retained the necessary information in their original form, with no punctuation added, to avoid any potential alteration of the data’s meaning (Braun & Clarke, 2006).

Each transcript underwent multiple active readings to immerse myself in the data (Braun & Clarke, 2006). This process was repeated until I became deeply familiar with the content, and it involved making observational notes on the entire dataset and individual transcripts to aid in the analysis (Braun & Clarke, 2006, 2012).

2.7.1.2. Stage two: generating initial codes: Phase 2 began after familiarising myself with the data, where an initial list of ideas and points of interest was developed (Braun & Clarke, 2006). This phase involved creating initial codes to identify and label data relevant to the research questions (Braun & Clarke, 2006, 2012).

The Microsoft Word 'comments' function was used to initiate the coding process for each transcript, noting codes in the side margin while highlighting relevant data segments. Data segments deemed helpful for addressing the research questions were coded with corresponding labels (Braun & Clarke, 2012), with some segments tagged with multiple codes if multiple meanings were evident (Braun & Clarke, 2006). New code labels were created if existing ones failed to capture the ‘essence’ of relevant data segments (Braun & Clarke, 2012). A coded transcript excerpt is provided in Appendix O.

I employed a deductive (‘top down’) coding approach, utilising the dataset as the coding foundation while drawing on categories from the PTMF, such as ‘threats’ and ‘threat responses’, to code and derive meaning from the data (Braun & Clarke, 2022). Codes were generated at the semantic (explicit and literal) and latent (implicit or conceptual) levels of meaning (Braun & Clarke, 2006), aligning with the critical realist foundations of the research.

A second iteration of coding was conducted on all transcripts to identify which codes facilitated theme interpretation and which could be discarded (Byrne, 2022). This iterative process allowed codes to evolve alongside my deepening understanding of the dataset (Braun & Clarke, 2022). Some code labels were expanded to encompass broader meanings, while others were merged to capture closely related ideas (Braun & Clarke, 2022). The final list of code labels is provided in Appendix P.

I utilised a macro to extract coded data segments into a Word table. This table included all identified codes along with corresponding excerpts from the dataset. The columns listed participant numbers, coded data segments, and assigned code labels. An excerpt of the table displaying a code with its associated excerpts can be found in Appendix Q.

2.7.1.3. Phase three: searching for themes: Phase 3 started after coding all relevant data items (Braun & Clarke, 2006). This phase involved sorting codes into potential themes, defined as capturing “a prominent aspect of the data in a patterned way” (Braun & Clarke, 2006, p. 82) and collating relevant coded data extracts within these themes. Generating themes involved clustering codes that shared concepts or features to reflect coherent and meaningful patterns in the data (Braun & Clarke, 2012).

At this stage, visual presentations aided in sorting codes into themes (Braun & Clarke, 2006). I printed the identified codes and data segments to explore the relationship between themes and consider their collective narrative about the data (Braun & Clarke, 2012). This process resulted in an initial thematic table outlining candidate themes (Appendix R), with relevant data extracts collated for each theme (Braun & Clarke, 2012).

2.7.1.4. Phase four: reviewing themes: Phase 4 began following the development of a set of candidate themes and entailed refining them in two levels (Braun & Clarke, 2006). Level one involved checking themes against collated data extracts for coherence, while level two extended this process to the entire dataset, ensuring the thematic map accurately reflected the dataset's meanings (Braun & Clarke, 2006).

2.7.1.5. Stage five: defining and naming themes: Phase five after developing a satisfactory thematic map of the data. During this phase, I defined and refined the themes by determining their essence and identifying aspects of the data they captured (Braun & Clarke, 2006, p. 92). This involved organising collated data extracts for the themes into a cohesive narrative, considering how each theme contributed to the broader story of the research question (Braun & Clarke, 2006).

As part of the refinement, I determined whether each theme contained sub-themes to structure complex themes and demonstrate hierarchical meaning (Braun & Clarke, 2006). Five main themes and thirteen sub-themes were identified through this process. Each theme and sub-theme were succinctly defined and summarised to convey the data story, with names chosen to be concise and informative (Braun &

Clarke, 2006, p. 93). The final thematic table, including themes, subthemes, and code clusters, can be found in Appendix S.

2.7.1.6. Phase six: producing the report: Phase 6 began with a comprehensive set of themes and involved the final analysis and report writing (Braun & Clarke, 2006). The report aims to present the data analysis clearly and compellingly (Braun & Clarke, 2012). To create a coherent narrative, the themes should be logically presented and, where applicable, build upon one another (Braun & Clarke, 2012).

The write-up must include enough data extracts to demonstrate the prevalence of each theme (Braun & Clarke, 2006). These extracts should capture the essence of the point made and be integrated into an analytical narrative that addresses the research questions (Braun & Clarke, 2006, 2012). Following these guidelines, this TA report is presented in the subsequent results chapter (section 3)

2.8. Evaluating the Research Quality

The quality of this qualitative research was evaluated using the guiding principles proposed by Spencer and Ritchie (2011): contribution, credibility, and rigour. Contribution refers to how much more is known or understood about the topic due to the study. Credibility is assessed by the extent to which inferences drawn from the findings are supported by evidence grounded in the data. Rigour pertains to the systematic and comprehensive nature of data collection, analysis, and interpretation of the research. The discussion critically evaluates the research based on these three principles (section 4.4.2).

3. RESULTS

3.1. Chapter Overview

This chapter details the thematic analysis of the data, presenting five main themes and thirteen sub-themes, as shown below in Table 2.

Table 2

Final thematic table

Themes	Sub-themes
Theme 1: "A Laundry List": Adversities Facing the Community	1. "Socio-Economic Equality Has Always Been an Issue": Structural Adversities 2. "Most of Us Don't Know Our Neighbours": Socio-Cultural Adversities
Theme 2: "Challenges to Basic Survival Needs": Threats Posed to the Needs of the Community	1. "Am I Going to Eat or Heat?": Economic and Material Threats 2. "People Have Gone from Visible to Totally Invisible": Social Threats 3. "The Loss of Culture": Cultural and Valued-Based Threats 4. "The Risk of Death": Bodily Threats
Theme 3: "It All Comes Down to Who's Governing Us": Meaning-Making of the Community	1. "Government Policies Impact Our Lives": Socio-Political Understandings 2. "In the Hands of God": Cultural Beliefs 3. "The System is Against Me": Histories of Inequity and Mistrust
Theme 4: "There Isn't That Cohesion": Threat Responses of the Community	1. "Communities Turning On Each Other": Social Fragmentation 2. "Everything is Me, Me, Me…": Self-Preservation
Theme 5: "Everyone Comes Together": Resources of the Community	1. "Acting Up and Fighting Back": Mobilisation 2. "A Single Part of a Single Organism": Connectedness

These themes were primarily derived deductively, using the main aspects of the Power Threat Meaning Framework (PTMF) to code the data. Each theme is described with example extracts from FGs. To ensure anonymity, modified data is denoted by square brackets [text], and ellipses (…) signify omitted words for conciseness.

3.2. “A Laundry List”: Adversities Facing the Community

This theme concerns the adversities present in the relationships and lives of community members, which arise within a context of unequal power. The PTMF states that these manifestations of power operate through societal structures, institutions, the physical environment, education, media, and social relations (Johnstone & Boyle, 2018b). The adversities mentioned were viewed as leading to a wide range of challenges in people’s lives (section 3.3), with P4 noting an increase in the adversities experienced by community members:

> P4: (…) these adversities that they're facing are just getting longer. It's just becoming more of a laundry list (…)
>
> (FG 1, pg. 10)

Participants talked about ‘structural adversities’ concerning negative experiences in the economic and physical environment linked to the unequal distribution of economic and social resources. Others mentioned ‘socio-cultural adversities’, pointing to negative experiences in social interactions and relationships shaped by social and cultural factors such as ideologies, norms, values, attitudes, and practices.

3.2.1. “Socio-Economic Equality Has Always Been an Issue”: Structural Adversities

Participants discussed challenges within the economic environment. P4 highlighted the cost-of-living crisis, pointing to increased “financial hardship” affecting people, which may present challenges in terms of financial insecurity and difficulties meeting basic physical needs (section 3.3.1):

> P5: I think maybe poverty pre-existed before the cost of living crisis, but I think it's just worse now and maybe like financial hardship I think is affecting like more people (…) than it was before.
>
> (FG 2, pg. 8)

P15 discussed the ongoing issue of socioeconomic inequality, worsened by the cost-of-living crisis. This situation disproportionately impacts those already disadvantaged or living in poverty, deepening the divide between the rich and the poor. These widening disparities pose challenges to the equitable fulfilment of basic human needs (section 3.3.1):

> P15: (…) I think socio-economic equality where like people, you know, basic human needs are met (…) equally I guess (…) I think that's always been like a long-term issue in the community, but it's definitely become heightened in the last year or so, year or two.
>
> (FG 3, pg. 9)

P14 highlighted the issue of digital poverty, suggesting that many individuals lack access to or do not know how to use digital technology. This lack of digital access creates barriers to accessing community groups and support services, potentially contributing to social isolation (section 3.3.2):

> P14: (…) to even access a lot of community groups and support you have to go on the computer (…) and a lot of people can’t even get the access to help that they need (…)
>
> (FG 3, pg. 9)

Participants also discussed challenges in the physical environment, which is closely linked to the economic climate. P4 discussed housing issues like limited availability and poor quality, which can pose physical danger to people (section 3.3.4). The mention of this as a “uniting factor” indicates that this may be a broader systemic issue linked to housing policy:

> P4: So, there's that uniting factor that if you live here (…) you are dealing with (…) not the best housing if you even have housing in the first place.
>
> (FG 1, pg. 2)

P9 discussed how the COVID-19 pandemic has affected community spaces and activities, noting their closure. The observation that many community spaces “never started up again” suggests a lack of investment in maintaining and supporting them. This absence may limit access to recreational and social opportunities, contributing to social isolation within the community (section 3.3.2):

> P9: (…) I feel like a lot of community spaces or community sort of projects or activities had to shut down in Covid, and I feel like a lot of them just never started up again.
>
> (FG 2, pg. 10)

3.2.2. “Most of Us Don't Know Our Neighbours”: Socio-Cultural Adversities

Participants discussed shifts in ideology related to societal values and community dynamics. P15 said that people’s worth within society is often judged based on their financial output. This perspective reflects a neoliberalist ideology that prioritises economic productivity for determining an individual’s value within society (Boyle & Johnstone, 2020), which may lead to the devaluation of specific social roles (section 3.3.2) and a loss of societal values (section 3.3.3):

> P15: (…) people's value of society is based on how much financial productivity they contribute.
>
> (FG 3, pg. 14)

P12 reflected on a shift in the ideology regarding community, noting that the current approach to community building feels more externally "imposed" rather than originating "from the ground up" as it did in the past. It is implied that this current approach may not foster the same degree of mutual support, leading to decreased instances of people helping one another:

> P12: (…) I remember in the 50s (…) you had communities but they were people helping one another (…) now we're bringing in something reconstructed (…) instead of it coming from the ground up it's rather imposed upon us; this is the way a successful community should work.
>
> (FG 3, pg. 13)

Participants provided further insights into the decline in social support structures within the community, which, as mentioned above, is likely influenced by changes in community ideology. P2 noted a growing “apathy” among neighbours to unite and address issues, implying a diminished sense of community members’ willingness to participate in collective action:

> P2: Most of us don't know our neighbours. Before, our estate, we all came together, you know, whatever issues were happening on the estate, we were able to come together and do something. Now (…) there's more apathy, or I don't want to get involved in that (…)
>
> (FG 1, pg. 24)

P6 also mentioned a decrease in social networks and interactions within the community, which may contribute to increasing social isolation (section 3.3.2), adding that people appear to be less inclined to engage with neighbours from diverse racial or ethnic backgrounds in the present day:

> P6: (…) growing up in the 80s, I had to play on the street. My neighbours were black, white, you know, we'd all play together. But I feel like as the years have gone by, people don't do that anymore. So, what's changed? What is it that makes you not want to talk to your neighbour across the road because he's black or he's white or he's Chinese? (…)
>
> (FG 2, pg. 18)

The decline in social connections between individuals from diverse ethnic groups may be interrelated with prejudice and discrimination within the community. Participants described experiencing negative attitudes due to their religious (P2) or ethnic (P3) identity, with unfair blame attributed to them for societal issues, which may potentially lead to physical harm for marginalised communities through hate crimes (section 3.3.4):

> P3: My experience being somebody who's overtly Muslim, I've had negative experiences, and I still do (…) I hear voices and people having issues with, you know, the fact that they feel like things like crime has gotten higher because of certain demographics moving in (…)
>
> (FG 1, pg. 5)

> P2: (…) I travel on the buses in the [neighbourhood], and you still get this thing of, oh, the bloody foreigners are coming and taking our jobs and our money and everything.
>
> (FG 1, pg. 31)

There was also a discussion of experiences specific to the Bengali community. Participants discussed a language gap between generations, which can contribute to a loss of cultural identity (section 3.3.3), as language is a crucial medium for passing down culture, values, and traditions across generations (Light, 2019). P7 pointed out that the older generations primarily speak Sylheti or Bangla, while the younger generation may not be fluent in these languages. This difference can lead to communication challenges between parents and their teenage children:

> P7: (…) I think there's a big difference and difficulty with language for people within a certain generation (…) people that speak Sylheti or Bangla (…) you can imagine how devastating it could be between parents and then the (…) younger sort of children that they have that are still in their teenage years, but maybe they haven't grasped the full spectrum of the Bengali language (…) to (…) talk to their parents that are maybe a bit older (…)
>
> (FG 2, pg. 12)

P8 shared a similar sentiment, mentioning that English has become the dominant first language for their teenage children and living in a multi-generational household, they struggle to communicate effectively with their grandmother, likely as Bengali is their first language:

> P8: (…) I have teenage children and they speak Banglish. They do not speak Bengali properly (…) English is probably their first language more so. But I live in a multi-generational house and they struggle to communicate with their gran.
>
> (FG 2, pg. 12)

Participants also spoke about the stigma and taboo surrounding mental health and substance abuse issues in the Bengali community, with implications also noted in the Somali community. They discussed how this stigma, influenced by cultural norms and practices, can lead to these issues being hidden or ignored within the community, with it well-documented that stigma is known to deter people from seeking help (Corrigan, 2004):

> P1: (…) there’s also the stigma around (…) drug and alcohol abuse, and like even with mental health, there's still stigmas (…)
>
> (FG 1, pg. 17)

> P3: (…) especially when it comes to mental health, the whole cultural practices and cultural expectations and the taboo, stigma within the communities, someone having illness, someone having an addiction, it's all just hush-hush, hidden away (…)
>
> (FG 1, pg. 18)

Even when these communities access services, they often encounter negative experiences due to healthcare providers’ lack of cultural understanding, further discouraging them from seeking support (section 3.5.1). P11 noted that mental health professionals can misdiagnose individuals because they lack knowledge of their cultural background:

> P11: (…) we spoke to a psychiatrist (…) who’s based in [the borough] who said there's people that get misdiagnosed, and we know this because (…) mental health professionals have a lack of understanding of cultural background (…)
>
> (FG 3, pg. 26)

P15 highlighted that despite the high rate of diabetes within the Bengali community, there is little effort to understand its root causes or offer preventative measures tailored to their cultural dietary habits and practices:

> P15: (…) in [the borough] the high rate of diabetes (…) sits highly within the Bengali community (…) there's not a lot done about understanding why that is (…) there's not a lot of preventative support that's culturally sensitive (…) it’s very much like (…) you’re Bengali, so you need to make sure that you don't go over this weight (…) don't eat rice.
>
> (FG 3, pg. 21)

3.3. “Challenges to Basic Survival Needs”: Threats Posed to the Needs of the Community

This theme concerns the negative challenges or ‘threats’ these adversities pose to the ‘core needs’ of the community. The PTMF posits that these core needs represent the state or circumstances humans aim to achieve and maintain to flourish and that anything preventing them from being met can be perceived as a threat to survival (Johnstone & Boyle, 2018b). Participants described a range of challenges that threatened community members’ core needs, though, at the fundamental level, threatened their physical survival, as articulated by P9:

> P9: (…) there are such threats to your basic survival needs that you can't function.
>
> (FG 2, pg. 20)

Participants highlighted ‘economic and material threats’ related to poverty/financial insecurity and the inability to meet basic physical or material needs. ‘Social threats’ were raised, pointing to social isolation and the devaluation of social roles. Additionally, ‘cultural and value-based threats’ were mentioned, underscoring the loss of cultural identity and societal values. Lastly, ‘bodily threats’ were identified, encompassing physical danger and psychological ill health. These threats are interrelated with the adversities discussed in section 3.2, and their connections will be highlighted where evident.

3.3.1. “Am I Going to Eat or Heat?”: Economic and Material Threats

Participants shared their experiences of poverty and financial insecurity resulting from the cost-of-living crisis (section 3.2.1). P2 described dilemmas like having to choose between paying bills or spending money on food and heating, which may threaten their core need for a sense of safety and security:

> P2: (…) and coming to the end of our life, I mean, you know, we shouldn't be (…) having to worry about when the next meal is coming from. Can I have the heating on in the winter? You know, because I ain't got the money for it. With this present crisis, I'm going to have to choose. Am I going to eat or heat? (…)
>
> (FG 1, pg. 16)

P3 shared that their life is consumed by balancing bills and ensuring they have enough food, potentially threatening their core need for safety and security, similar to P2. They also mentioned that the cost of living had forced them to stop engaging in community work due to additional travel expenses they cannot afford, which may threaten their core need to engage in meaningful activities:

> P3: (…) I feel like my life is counting numbers and making sure bills are paid and making sure food is on the table, and I do do a lot of community work, but I have to squeeze it in into my life, but right at this moment in time I'm exhausted because cost of living is like stopping me from doing that. I have to stop these things because I can't afford to do them. I can't afford to travel out it's just an extra expense that I can reduce.
>
> (FG 1, pg. 12)

Participants also discussed how some individuals struggle to meet their basic physical needs, which can be linked to socio-economic inequality exacerbated by the cost of living crisis, with these needs not being met equally (section 3.2.1). P13 mentioned instances where people were "literally starving”, indicating their inability to secure food, which may threaten people’s core need of being able to meet basic physical needs for themselves:

> P13: (…) I do know that sometimes on courses, we have people that are like literally starving, like they haven't eaten (…) yeah, I've seen that a few times actually where like people have said that they haven't eaten like for a little while.
>
> (FG 3, pg. 8)

P3 emphasised the importance of recognising these as basic needs, not extras. This may indicate that the economic and material threats to people's basic needs have become so widespread and severe that they often go unrecognised or are not taken seriously:

> P3: (…) individuals are struggling with their everyday needs, basic needs. They're not even extra needs, this is basic needs.
>
> (FG 1, pg. 12)

3.3.2. "People Have Gone from Visible to Totally Invisible": Social Threats

Participants highlighted the growing social isolation within the community, specifically among older adults, suggesting the presence of possible age-based discrimination. P5 indicates that the social isolation experienced by older adults is due to a decline in social networks and interactions (section 3.2.2), which may threaten their core need to have a sense of belonging in a social group:

> P5: (…) definitely noticing a lot of isolation amongst the elderly, kind of older adults community, just kind of people being very much like left on their own…and maybe not seeing anybody or speaking to anybody for days and days and days on end (…)
>
> (FG 2, pg. 10)

P2 shared their experience of social isolation as an older adult, attributing it to the lack of available social groups to join, possibly linked to the closure of many community spaces (section 3.2.1). This may also threaten their core need to have a sense of belonging in a social group, as well as their need to engage in meaningful activities:

> P2: (…) take my age group. All the people have suddenly gone from, you know, being visible to totally invisible (…) There aren't a lot of groups or social things, so we are very isolated as well.
>
> (FG 1, pg. 16)

Participants also discussed the devaluation of specific social and work roles, which may threaten people's core need to feel valued in their social roles. P13 pointed out how manual labour and service jobs are particularly undervalued, possibly due to their association with low-income status, which is inconsistent with neoliberalism, wherein societal values prioritise economic output (section 3.2.2):

> P13: (…) everyone wants like the top jobs, but people are not understanding that the integral part of community, of society, is like you have a person doing everything, so like you can't look at a refuse collector and be like that's a rubbish job, it's not rubbish, it's literally integral to community.
>
> (FG 3, pg. 14)

P12 also highlighted how residents of the country devalue the roles often associated with "Eastern Europeans", like fruit picking, farm work, and catering jobs. This reveals a contradiction in attitudes: while some residents are reluctant to take on these roles, there are negative attitudes or prejudice towards those willing to fill them (section 3.2.2):

> P12: We don't want the Eastern European and it's the Eastern Europeans there that did the things like fruit picking, working on the farms, the catering jobs (…) which the residents of the country don't want to do.
>
> (FG 3, pg. 15)

3.3.3: “The Loss of Culture”: Cultural and Value-Based Threats

Participants discussed the loss of cultural identity within the Bengali community. Both P8 and P7 attributed this to language, noting that younger generations speak English (section 3.2.2). This shift may threaten the older generation’s core need for security and belonging within their cultural group, as they strongly identify with Bengali culture:

> P8: (…) one thing that I would just add (…) is, especially in the Bengali community, is the loss of culture (…) there is a shift between the younger generation who tend to be more devout and speak English and don't like you know don't seem to like the Bengali culture much, like the folk singers and all this, because they tend to identify with another culture.
>
> (FG 2, pg. 26)

> P7: I think with the language that also adds to the culture itself diminishing (…)
>
> (FG 2, pg. 12)

Participants also discussed the erosion of specific societal values, which may threaten people’s core need for meaning and purpose. P12 highlighted a shift in societal values, prioritising academic achievement as a measure of value and worth. The existence of societal values focused on financial productivity (section 3.2.2) may influence this, with education perceived as a means of acquiring the skills and qualifications to increase income:

> P12: (…) if you want to be valued, you have to strive for education and you have to strive to go to university (…)
>
> (FG 3, pg. 13)

P15 also noted a shift in societal values away from essential survival skills in modern society, suggesting that a focus on material wealth takes priority, as implied by the comment, “if tomorrow, you know, money meant nothing...”. This observation may, too, reflect prevailing neoliberalist societal values that emphasise individuals’ worth based on their economic output (section 3.2.2):

> P15: (…) if tomorrow, you know, money meant nothing, we would still need to know, you know, who can like, I don’t know, make a fire, who can pick food, who can get hunt and gather. But those kind of functions of society have become less valued.
>
> (FG 3, pg. 14)

While there is a noticeable overlap between the loss of societal values and the devaluation of specific social roles (section 3.3.2), participants discuss societal values more broadly here, emphasising a shift towards valuing formal education and wealth.

3.3.4: “There is the Risk of Death”: Bodily Threats

Participants discussed psychological ill health linked to social isolation, which may threaten people’s core need to experience a range of emotions, such as not feeling “loved” and “accepted” (P4):

> P8: (…) loneliness creates so many mental health and other issues.
>
> (FG 2, pg. 18)

> P2: (…) nobody takes into account what that isolation is doing to our mental health.
>
> (FG 1, pg. 17)

> P4: (…) obviously isolation is a humongous like thing about mental health, there's that feeling of not having human (…) contact, not feeling loved, not feeling accepted, all of those things can really really build up (…)
>
> (FG 1, pg. 16)

Despite being discussed concerning social isolation (section 3.3.2), psychological ill health was identified as a separate threat here because the core needs that are threatened by these respective issues can be seen as differing.

Participants also discussed physical danger, including the risk of/actual death, which may threaten people’s core need to feel safe and secure in their physical environment. P5 highlighted the physical danger people face due to inadequate housing (section 3.2.1), mentioning an instance of overcrowding that resulted in the loss of life:

> P5: Like there was a flat like literally just down the road, and there was like 20 people living in like a one-bed flat, and the landlord didn't do anything and then somebody died.
>
> (FG 2, pg. 8)

P4 discussed the heightened physical danger faced by marginalised communities, who are at risk of death, hate crimes and violence, which can be seen as driven by prejudice and discrimination (section 3.2.2):

> P4: (…) there is the risk of death and hate crime and violence, you know, it's not something that has gone away, and the numbers are only increasing for like the amount of like trans people, especially trans people of colour (…)
>
> (FG 1, pg. 15)

Although poor housing conditions and hate crimes may appear distinct, they were both categorised as health threats due to their impact on bodily integrity, encompassing ill health and physical danger within the PTMF.

3.4. “It All Comes Down to Who’s Governing Us”: Meaning-Making of the Community

This theme concerns how the community understands or makes sense of these life events and situations, otherwise called ‘meaning’. In the PTMF, meaning assumes a central role, emerging from social and cultural discourses and belief systems, which in turn are influenced by broader social structures and socioeconomic contexts (Johnstone & Boyle, 2018b), as articulated by P3: “I mean it all comes down to literally who’s governing us” (FG 1, pg. 10). The process of meaning-making can be seen as shaping the community’s experience of adversities (section 3.2), the challenges they pose (section 3.3) and their responses to them (section 3.5).

Participants explored different forms of making-making. They highlighted ‘socio-political understandings’, referring to meanings influenced by people's material and social realities. Additionally, they discussed ‘cultural beliefs’, which concerns meanings shaped by people’s religious and spiritual belief systems. Furthermore, participants addressed ‘histories of inequity’, encompassing meanings influenced by past experiences.

3.4.1. “Government Policies Impact Our Lives”: Socio-Political Understandings

Participants discussed identity politics and how it contributes to social fragmentation within the community (section 3.5.1). P8 noted that individuals are increasingly identifying with their own ethnicity or religious background, leading to communities becoming more “ghettoised”. This has resulted in heightened segregation and isolation within communities, with limited interactions between different ethnic and religious groups (section 3.2.2), despite shared commonalities such as religious beliefs:

> P8: (…) we seem to identify with our own ethnicity or (…) religious background. But even (…) having a common religious background doesn't (…) unite us (…) the Bengali community and the Somali community, even though we are both Muslims, and we go to the same mosque (…) at the end of the prayer time, we go in our different ways (….) we just became much more (…) ghettoised and identity politics became much more prominent (…)
>
> (FG 2, pg. 19)

P4 discussed how individuals are encouraged to “pick an identity”, suggesting a binary approach to identity that categorises people into distinct groups and emphasises differences rather than recognising commonalities in their multiple and intersecting identities, consequently leading to divisions between people:

> P4: There are like divides in that kind of nature of almost kind of pick an identity. You know, you're either this or that, and it doesn't really leave room for, like, intersectionality, in the sense of like people can be lots of different things.
>
> (FG 1, pg. 7)

Participants mentioned how political discourse also plays a part in social fragmentation within the community (section 3.5.1). P1 highlighted how the media’s negative portrayal of particular communities or individuals based on identity, like race, can make people hesitant to approach or trust others, hindering meaningful social interactions within the community (section 3.2.2):

> P1: What happens in the media puts people into this fright, scare, about how to approach certain people or communities or if you're from like a different race background or if you look a certain way, a picture has been painted by the media, so there's people harder to approach now (…) that creates a lack of like people don’t trust anyone anymore.
>
> (FG 1, pg. 24)

P3 added that this divisive political discourse originates from the “top-down”, implying that the rhetoric from political institutions contributes to a climate of division and hostility, with specific demographics blamed for societal issues such as crime (section 3.2.2):

> P3: (…) it's that divisive discourse as well coming from the top down (…) It’s almost like a rotation that they do isn’t it where the different people are targets, different periods of time (…) and they do have a huge impact on how people respond.
>
> (FG 1, pg. 30)

Participants discussed the impact of government policies and laws on various communities. P3 mentioned that political policies implemented at higher levels of government “trickle down” and directly affect communities, likely by driving economic and social inequalities (section 3.2.1) and influencing social cohesion as people prioritise self-preservation to ensure their survival (section 3.5.2):

> P3: (…) there is no way of ignoring the fact that government policies impact our lives, everyday lives (…) the policies, the change of government, the changing of cabinet, everything, it just trickles down, and everything they do has an impact on these communities.
>
> (FG 1, pg. 9)

P4 specifically pointed out how recent legislative changes are failing to provide adequate support or rights for the LGBT community, noting that “hate crimes are going up”. This implies a causal link between negative changes in legislation and a rise in hate crimes targeting the LGBT community (section 3.2.4), prompting individuals to withdraw from their communities to enhance their physical safety (section 3.5.1):

> P4: (…) I think it’s not news to anybody that the laws around queerness and LGBT are getting worse and hate crimes are going up (…)
>
> (FG 1, pg. 8)

Participants talked about the negative implications of political self-interest for the community. P1 noted that people in power often” lack empathy” and prioritise maintaining their status and power over the needs of the community, thereby perpetuating issues such as the “cost of living” (section 3.2.1). This situation may lead to a decline in cohesion within the community as people prioritise their interests to meet their basic needs (section 3.5.2):

> P1: People who have money and power lack empathy. They don't care about people who are going through like something like the cost of living (…) they don't care about those things (…) all they care about is how they can stay there and how everyone can stay there.
>
> (FG 1, pg. 25)

P15 discussed how community members recognise the root causes of many adversities they face (section 3.2) as originating from social and political agendas that prioritise individualistic values, such as educational attainment and money (section 3.3.3), which may not align with the community’s values centred on togetherness (section 3.6.2):

> P15: (…) I think that people are pretty aware that a lot of the challenges and adversities are quite linked to social and political origins and agendas and social frameworks that are really distant from their own personal values and the way they see society, a society they want.
>
> (FG 3, pg. 13)

Participants spoke about the detrimental effects of insufficient funding on community work and services. P3 advocates for community-based approaches over policing to address the social issues that exist (section 3.2) but implies that a lack of funding hinders the success and impact of such initiatives, potentially perpetuating said issues:

> P3: (…) I think community work is better at tackling these kind of social issues than the police will ever be, and unfortunately, it all comes down to funding.
>
> (FG 1, pg. 12)

P4 emphasised the importance of financial support for sustaining community venues and services but questioned where the funding comes from. This suggests that a lack of available funding is the primary factor driving the closure of community venues and services (section 3.2.1), which was viewed as contributing to the social isolation experienced by community members (section 3.3.2):

> P4: You know, like, places need to be funded in order to have community venues, community services. Where?
>
> (FG 1, pg. 12)

Participants also discussed how inadequate education contributes to division within the community. P4 said that communities often lack understanding, knowledge or awareness of other communities, potentially resulting in prejudice and discrimination towards certain marginalised groups (section 3.2.2), leading them to isolate themselves (section 3.5.1):

> P4: I think that's one thing that I've seen like lacking here a lot like different communities aren't educated on different communities and I think that that doesn't help the divide.
>
> (FG 1, pg. 7)

3.4.2. “In the Hands of God”: Cultural Beliefs

Participants explored how challenges are understood within the Bengali and Somali communities through the lens of their religious beliefs (Islam). Two participants discussed the interpretation of challenges as divine punishment, with explanations such as “you’ve done something in your past life, and you're being punished for your child (…) or you’re being punished for yourself” (P1; FG 1, pg. 19) or the belief that “God has cursed you” (P2; FG 1, pg. 19).

Participants mentioned how challenges are also perceived as predetermined by God. P3 suggests that, in general, members of these communities believe that all difficulties within the community (section 3.2) are not random or meaningless events but rather part of a larger plan or divine will:

> P3: I mean, both the Asian and the Somali communities, the underlying framework is Islam (…) So, there is this understanding of like (…) there's a purpose for everything that happens in your life (…) I'm not saying that takes away like all the drug problems, abuse, everything that happens in the community, but in general (…) they think it's in the hands of God.
>
> (FG 1, pg. 13)

P8 similarly expressed that when facing challenges, such as social isolation (section 3.3.2.), individuals in these communities may interpret them as the “will of God”, with the suggestion that this may serve as a coping mechanism, offering a means to find meaning, acceptance or understanding in the face of these challenges:

> P8: (…) if they are lonely (…) then they could say it’s the will of God that children have moved away (…) that's how they understand it.
>
> (FG 2, pg. 13)

Furthermore, participants noted that these communities tend to interpret specific experiences or unusual behaviours related to psychological ill-health (section 3.3.4) in terms of spirit possession. P2 described spirit possession as an “obvious” explanation, indicating that it is commonly accepted within the community:

> P2: The obvious ones are always that you're possessed.
>
> (FG 1, pg. 19)

P1 also talked about the belief in spirit possession, referencing jinns (supernatural beings within Islamic culture), but labelled it as a “misconception”. This suggests that such beliefs may contribute to misconceptions about psychological ill-health, potentially explaining the stigma surrounding these issues (section 3.2.2):

> P1: (…) there's that misconception of being possessed (…) with like jinns and all that stuff.
>
> (FG 1, pg. 19)

The internalisation of this stigma within Bengali and Somali communities was spoken about by participants as influencing individuals’ self-perceptions; specifically, it results in shame beliefs, particularly around issues like mental health and substance abuse, which may act as barriers to admitting to these issues and seeking help and support for them (section 3.5.1):

> P7: (…) there's also this underlying (…) shame still about seeking help (…) it’s still sort of such a shaming sort of thing, especially in certain cultures, and I guess you can broaden it out to all societies as well. But within I think Bengali culture or other cultures, like Somali cultures (…), there's that shame (…)
>
> (FG 2, pg. 23)

> P1: (…) because of like societal cultural norms (…) they feel like a certain shame for facing up to things, or like, admitting to like substance abuse or having a mental health diagnosis as well.
>
> (FG 1, pg. 18)

3.4.3. "The System is Against Me": Histories of Inequity and Mistrust

Participants discussed perceptions of injustice within the community. P5 noted a prevalent perception among individuals within the community that the system is biased against them, indicating the presence of systemic factors, such as structural or institutional racism, that work against certain groups or individuals based on their identity or background:

> P5: Like something that I've sort of heard or, I guess, inferred from like what people say to me is like almost a bit like the system is against me, like I'm never going to get what I want to because if it's something about who I am or I'm just going to have to work 10 times harder to get there.
>
> (FG 2, pg. 16)

P3 highlighted a perception specifically among members of the Somali community that the Bengali community receives more help and support than their own, in line with earlier discussions regarding the unequal distribution of resources (section 3.2.1):

> P3: (…) their perception is there's certain community groups are getting more help than their own, and that's something I come across in my job all the time constantly that they, you know, the Somali community feels like the Asian community gets more funding more support in their own community (…)
>
> (FG 1, pg. 27)

Participants discussed the perception of alienation within specific communities, particularly among those with immigrant backgrounds. They highlighted how generational experiences and stories passed down within families influence these perceptions, leading individuals to believe that certain services or opportunities are not meant for them, which can impact individuals' willingness to access services (section 3.5.1):

> P13: (…) my parents were born here, but all of my grandparents were born in the Caribbean, so I've definitely had that trickle down into me, you know, thinking some things are not for me. I'm from an immigrant background, like, do you get what I mean?
>
> (FG 3, pg. 25)

> P14: I think that communities have internalised all the systematic things, and have assumed that (…) services don't care about us. I definitely see it with like my mums generation who came here. They don't think that the services don't care about us. They just think those services aren't for us (…) we are immigrants in this country, that these things are not for us, don't try to access them.
>
> (FG 3, pg. 25)

Participants spoke about a perception of hopelessness regarding the cultural responsiveness, or lack thereof, within the healthcare system (section 3.2.2). P11 observes a consistent and unchanging approach across primary and secondary care settings, implying a lack of effort or ability to understand the cultural needs of different communities, resulting in them feeling hopeless as a professional about the possibility of change within the healthcare system:

> P11: (…) when you approach services you're gonna have the same, the same approach, and that's going from from primary care through to secondary care, and I can say it from being a professional within the system. So, I see no big change.
>
> (FG 3, pg. 26)

P5 shares similar observations about healthcare but from the viewpoint of community members, who feel that providers cannot address or understand their cultural needs (“they don’t know what it’s like to walk in my shoes”). This results in feelings of hopelessness about receiving appropriate support (“they not going to be able to help me”) and, consequently, an unwillingness to access services (section 3.5.1):

> P5: (…) in terms of thinking about like healthcare specifically and access to that, it’s sort of like (…) these people, they're not going to be able to help me, like they don't get me because they don't know what it's like to walk in my shoes kind of thing.
>
> (FG 2, pg. 16)

The sense of hopelessness is closely linked to the previously mentioned perception of exclusion concerning healthcare, as individuals may feel excluded from services when providers persistently fail to understand their cultural backgrounds. However, here, participants focused on the system’s inability to effectively change and address individuals' cultural needs, leading to a distinct lack of hope.

In addition, participants highlighted widespread mistrust among community members towards public services, particularly the NHS and the police. This mistrust was described as not unfounded but rather originating from experiences of historical abuse and inadequate care from these services, resulting in the avoidance of services (section 3.5.1):

> P1: (…) if you speak to service users or anyone, 95% of the time is that they've received really bad care and services, and I think it's just not having that trust as well, that’s like, they're not trusting these services because they're (…) nothing to show that they can actually trust them.
>
> (FG 1, pg. 20)

> P4: (…) I think there is that kind of feeling of people mistrusting services like their NHS, police, everything (…), but it's on very valid ground, you know, it's not like this mistrust that's coming out of nowhere, like its mistrust because of historic abuse (…)
>
> (FG 1, pg. 11)

3.5. "There Isn't That Cohesion": Threat Responses of the Community

This theme addresses the survival strategies, or 'threat responses', that the community employs to ensure survival amidst threats to their core human needs. The PTMF asserts that threats (section 3.3) and their associated meanings (section 3.4) elicit body-mediated threat responses that are inherently protective (Johnstone & Boyle, 2018b).

A variety of threat responses were discussed, with a significant focus placed by participants on 'social fragmentation' within the community, which relates to a decline in social cohesion among individuals, as articulated by P4: "(…) people aren't really talking and there isn't that cohesion" (FG 1, pg. 7). Participants also highlighted 'self-preservation', which concerns individuals prioritising their well-being and interests over the community's collective needs. The possible purposes or 'functions' these threat responses serve will be elaborated on.

3.5.1. "Communities Turning On Each Other": Social Fragmentation

Participants described how specific communities, like the Bengali community, tend to isolate themselves from other ethnic or cultural groups within their neighbourhood. This may serve as a means of preserving their cultural identity, especially considering the previously mentioned loss of cultural identity, particularly within the Bengali community (section 3.3.3). Alternatively, it may also be a way of increasing their sense of safety amid prevalent prejudice and discrimination against individuals from ethnic and religious minority backgrounds (section 3.2.2):

> P2: (…) I'm in the middle of all the Bangladeshi families on my estate (…) some want to just be you know by themselves, don't want to connect with what they consider outsiders, not part of their community.
>
> (FG 1, pg. 4)

> P8: We did a survey in [an area of the borough] (…) and (…) we were actually shocked to learn that these communities that live parallel lives. The Somali community don't talk to the white British community (…) the Bengali community don't tend to talk with the white British community.
>
> (FG 2, pg. 17)

P4 explicitly highlighted the need for some individuals to distance themselves from or refrain from identifying with their community as a safety measure. This distancing aims to enhance their sense of safety, particularly in light of the heightened risk of physical danger from hate crimes and violence targeting marginalised communities (section 3.3.4):

> P4: I mean I think there is (…) that kind of thing of needing to move away from community because there's actually a feeling of that making you safer, not identifying with the community, being isolated (…) and yeah, you can just see it. There is that kind of withdrawing from community, withdrawing from all these kinds of things (…)
>
> (FG 1, pg. 15)

Participants also highlighted the avoidance of services, such as the NHS, among Somali communities. This avoidance likely stems from the perceived alienation, hopelessness, and mistrust about services (section 3.4.3), potentially serving as a means of protecting oneself from potential hurt, disappointment or harm:

> P3: I mean, it can't be more obvious within NHS services that Somali communities don't access it at all (…) very, very, very rarely unless they have to (…)
>
> (FG 1, pg. 6)

> P4: (…) you won't find yourself being let down by services if you never engage with services. There's that kind of defence mechanism of well, if I never try then I'll be very safe.
>
> (FG 1, pg. 6)

3.5.2. “Everything Is Me, Me, Me…”: Self-Preservation

Participants shared their tendency to focus on the present moment, prioritising their immediate needs amid financial insecurity (section 3.3.1). This may serve as a way to manage overwhelming feelings like anxiety or worry:

> P3: I can't worry about the future. I need to live in the moment and live for each day as it comes (…)
>
> (FG 1, pg. 14)

> P2: (…) I just live day to day and quite a lot of people on my estate also who really have financial issues. How can we manage? Get through one day at a time.
>
> (FG 1, pg. 14)

Participants discussed a survival mode mentality, where individuals prioritise their own needs over those of others in the community due to the challenges they experience. This may serve as a means of preserving their limited resources to ensure their physical survival:

> P3: (…) if you're in survival mode you are going to be apathetic to what's happening around you. You're not going to have the energy, or the time, or the resources to take care of anyone else but yourself (…)
>
> (FG 1, pg. 24)

> P2: (…) I've seen so many changes in people and communities just under one estate it's kind of also going back to the Thatcher years, everything is me, me, me, me, me.
>
> (FG 1, pg. 24)

Participants also noted individuals stealing basic essentials. This behaviour may be viewed as a manifestation of the survival mode discussed above, helping people to meet their basic physical needs in the face of poverty (section 3.3.1):

> P6: (…) this morning, I went to Sainsbury's (…) and there was a young mum, must have been in her 20s, with a child of five years old. She'd been stealing, and she was manhandled by three members of staff (…) And then they ripped her bag, and it was water, bread, and orange juice.
>
> (FG 2, pg. 7)

> P9: (…) people are stealing in order to be able to eat and drink.
>
> (FG 2, pg. 20)

3.6. “Everyone Comes Together”: Resources of the Community

This theme concerns the community resources utilised to moderate and survive the negative impact of these adversities. According to the PTMF, while threat responses may have disabling effects, they can be counteracted by other responses that leverage skills, strengths, and material, relational and social support, fostering social solidarity and leading to collective action (Johnstone & Boyle, 2018b). Despite the previously mentioned lack of cohesion (section 3.5.1), there was still a strong sense of solidarity and togetherness within the community, as articulated by P1:

> P1: (…) the nice thing about being part of [the borough] is like everyone comes together.
>
> (FG 1, pg. 30)

Participants noted several resources available to the community. They discussed ‘mobilisation’, referring to the collective efforts of community members to support each other and address injustices. Additionally, participants highlighted ‘connectedness’, which involves the bonds, support networks, and shared values that strengthen connections within the community.

3.6.1. “Acting Up and Fighting Back”: Mobilisation

Participants highlighted the existence of community-based initiatives during times of need. P8 spoke about the community's ability to mobilise resources and support each other through actions like food donations and volunteer efforts. These initiatives may mitigate against the financial challenges and difficulties individuals face in meeting their basic physical needs (section 3.3.1) and reduce the focus on self-preservation (section 3.5.2):

> P8: I’ve seen (…) communities coming together to offer support, like food parcels and food donations (…) and becoming community champions or volunteers to help out in their neighbourhoods.
>
> (FG 2, pg. 22)

P3 specifically mentioned the Bangladeshi community's tradition of providing food as a form of support, highlighting cultural practices that offer communal support:

> P3: (…) food is huge, like for the Bangladeshi community. So, one of the easiest things for them to do is feed people. So collectively, that's probably been the (…) most common thing I've seen in the Bangladeshi community.
>
> (FG 1, pg. 27)

Participants also emphasised how the community supports each other through collective action. P4 spoke about how community members engage in activism, such as participating in protests to stand against injustice:

> P4: (…) I think there's also a sense of acting up and fighting back, and not necessarily through protest, but there is a lot of that.
>
> (FG 1, pg. 22)

This collective action appears to be a longstanding tradition, as P2 recalled a historical instance where diverse community members united against fascism. Such solidarity may help mitigate the negative experiences of discrimination people face (section 3.2.2) by showing that they have allies standing alongside them:

> P2: (…) going back further to before the Second World War, when we had [a march of fascists], it was not just the Jewish community who were there. Whoever was living in this area, everybody turned out to stop the fascists.
>
> (FG 1, pg. 29)

3.6.2. "A Single Part of a Single Organism": Connectedness

Participants spoke about the significance of communal places like mosques and community centres in providing support and assistance. These spaces also enable the community to come together, with the mosque being mentioned explicitly as a "hub", which may help mitigate social isolation (section 3.3.1) and increase social cohesion:

> P6: (…) mosques, community centres, those types of places, I think are a place of support and help (…)
>
> (FG 2, pg. 24)

> P10: (…) another reason why I think the community's done so well in the face of (…) capitalism, all these kind of destructive forces that are trying to take it down, is because of the presence of the mosque (…) it's such a central hub for the community.
>
> (FG 3, pg. 15)

Participants emphasised the importance of community support systems within families and broader social networks. P3 shared a personal experience where, during a crisis where their building was on fire, various individuals and community groups rallied around to offer support. Such support systems may mitigate against challenges people experience, like the risk of physical danger (section 3.3.4) in this scenario:

> P3: (…) two weeks ago my building was on fire and (…) it really made a difference the response from the people around me (…) I was getting inundated with calls from all different people, like the church (…) and everyone was like literally messaging saying are you okay (…)
>
> (FG 1, pg. 4)

Similarly, P8 talked about the significance of family connections as a source of support, whereby extended family living arrangements offer built-in protection, allowing individuals to depend on relatives for financial assistance. This support structure may help alleviate the economic insecurity that people experience (section 3.3.1):

> P8: (…) some people deal with adversity through family connections (…) they have a built-in protection through extended family connection in the same household. They can reach out to their relatives if they are short on money (…)
>
> (FG 2, pg. 22)

Participants mentioned the role of online platforms in offering mutual support. P1 said that social media groups and online platforms are used to share information about community events like protests (section 3.6.1). This connectivity may bring people together and promote a greater sense of unity:

> P1: (…) having groups where, like, even through social media, where you're able to spread the good, the knowledge, like, the things that are there, like protests marches, like, it's a way of like opening channels on, you know, avenues of knowledge.
>
> (FG 1, pg. 27)

Likewise, P4 highlighted the supportive nature of community group chats, where members come together to assist each other during challenges, which may reduce feelings of isolation (section 3.3.2) by fostering a sense of belonging:

> P4: (…) I've just seen like group chats (…) and I think one thing I've seen on those group chats in this community is that kind of sense of if you're struggling or something, let's find a way to remedy it together.
>
> (FG 1, pg. 22)

Participants also indicated the existence of shared values within the community. P15 discussed a universal value system that prioritises creating a safe and welcoming place for everyone. This shared commitment to safeguarding the rights of all members may help cultivate an inclusive environment and work to reduce discrimination (section 3.2.2) and incidents of hate crimes (section 3.3.4) experienced by individuals:

> P15: There is always this kind of universal value system in [the borough] where people want to protect it as a safe place for all people irrespective of your background, your belief system, the way you look. It needs to be a safe, welcoming space.
>
> (FG 3, pg. 27)

P10 also spoke about shared values of collective responsibility and unity within Jewish and Islamic communities, which helps newcomers integrate quickly into the community by creating a sense of belonging and connection:

> P10: (…) the reason why I think the Jewish community is so strong is because we have laws that (…) ensure that like, you know, if one part of your community is hurting, everyone is hurting and (…) you are a single part of a single organism, and that when you spend money, you spend it within the community (…) and I think Islam shares a lot of those values and (…) it kind of fast tracks people into the community (…) they don't feel as disconnected because of that connection that they all have.
>
> (FG 3, pg. 15)

3.7. Feedback on the Discussion

While there was not enough material for a standalone theme, participants found the discussion on community adversity beneficial. Several participants, who held dual identities as professionals and community members, shared not only the challenges experienced by others in the community but also their own. They highlighted the value of collectively sharing stories and personal experiences, as it reminded them that they were “not alone” in their struggles, which helped to reduce their feelings of isolation:

> P3: (…) one of the common things amongst us is we've all suffered some form of discrimination (…) and (…) it's that having a space and (…) hearing other people's experience and knowing that you're not alone.
>
> (FG 1, pg. 35)

> P1: (…) when you're in that mind of isolation, you feel like you're the only person going through something as difficult as you're going through. But when you come to something like this and you hear people who have similar experiences to you, it really makes you feel like that feeling of isolation becomes less apparent and you feel more like stronger in yourself.
>
> (FG 1, pg. 35)

Participants also stated that the discussion revealed the community's ability to unite despite differences between community groups, emphasising the inherent cohesion and solidarity among people, which may foster a sense of hope:

> P4: I think it shows how individual communities can kind of come together.
>
> (FG 1, pg. 34)

> P11: (…) it's making me realise how cohesive the community is here.
>
> (FG 3, pg. 28)

4. DISCUSSION

4.1. Chapter Overview

This chapter summarises the key findings regarding the research question and relevant literature, followed by a critical review, including limitations, quality assurance, and reflexivity. Lastly, it explores implications for public health policy, clinical practice, and future research.

4.2. The Research Question

Five themes and thirteen sub-themes were constructed to explore the following research question:

- To what extent can the Power Threat Meaning Framework structure discussions among professionals about community adversity in a culturally diverse inner London borough?

A review of the research question and broader literature structured around these five themes will be presented below.

4.3. Findings Concerning the Research Question and Literature

4.3.1. Adversities Facing the Community

Several community adversities were identified, aligning with the work of Pinderhughes et al. (2015), who discuss 'community trauma' and its manifestations at the community level. This is also consistent with research by Warner et al. (2023), who situated individual-level ACEs within broader structural and social domains of community-level adversity and found that community adversity increases the damaging effects of individual adversity.

The macro-level context (Bronfenbrenner, 1992) was emphasised, highlighting social inequality, power disparities, and various forms of deprivation and social injustice (sub-theme: ‘structural adversities’). This aligns with research on the social determinants of health (SDH) - the social, economic, and environmental conditions affecting people’s functioning and well-being (Marmot, 2010; Milner & Jumbe, 2020; Pickett & Wilkinson, 2010; Solar & Irwin, 2010; WHO, 2014) - driven by disparities in wealth, power, and resources (Bell, 2017).

Negative experiences in social interactions (sub-theme: ‘socio-cultural adversities’) were highlighted, reflecting the significant impact of social relationships on health (Holt-Lunstad et al., 2010). The decline in social support structures was linked to more ‘distal’ political determinants (Arah et al., 2005), namely neoliberalist ideology prioritising economic productivity (Boyle & Johnstone, 2020), which has been associated with promoting social disconnection (Becker et al., 2021). Additionally, experiences of prejudice and discrimination were noted, consistent with findings indicating that discrimination produces health inequalities (Krieger, 2014).

Cultural factors were also discussed, such as a lack of cultural understanding in healthcare and the intergenerational language gap within the Bengali community. Culture has been identified as a determinant of health, including the inability of healthcare providers to appropriately address cultural differences and the undermining of language (Knibb-Lamouche, 2012). The stigma attached to mental health challenges within the Bengali and Somali communities was also mentioned, with research showing that stigma contributes to health inequalities (Hatzenbuehler et al., 2013).

The framing of the discussion on community adversities rather than individual issues may explain the lesser emphasis on psychosocial factors such as stress control, self-efficacy, and resilience (Bell, 2017). These factors have been criticised for overly focusing on personal characteristics while potentially overlooking political and material factors (Friedli, 2013). Moreover, the participants in this study were all mental health professionals who may be more likely to adopt formulation-driven, adverse-experience-informed perspectives.

This perspective may not be as prevalent among other healthcare professionals. Research has found that GPs can blame individuals for not taking control of their lives, citing lifestyle factors as primary explanations for health inequalities (Babbel et al., 2019). These attitudes are also common among the British public, who often attribute health inequalities to individual behaviour and access to healthcare despite being aware of disparities in health outcomes (Elwell-Sutton et al., 2019). This may be due to the medical model's dominance in societies like the UK, which continues to influence the understanding of mental health issues among professionals, the public, and service users (Beresford et al., 2010).

4.3.2. Threats to the Core Needs of the Community

Several threats to the core needs of the community were highlighted. This included challenges related to meeting basic physical and material needs (sub-theme: 'economic and material threats'), the need for safety and security (sub-theme: 'bodily threats'), and a sense of belonging (sub-themes: 'social threats' and 'cultural and value-based threats'). These threats to core needs are outlined in the PTMF (Johnstone & Boyle, 2018b) and Maslow's (1943) hierarchy of needs.

The importance of a sense of belonging as a fundamental human need is well-documented in the literature (Psychologists for Social Change [PSC], 2019), with implications for various mental, physical, social, economic and behavioural outcomes (Allen et al., 2021). The loss of culture mentioned within the Bengali community and potential threats to belonging, particularly among older generations, may mirror post-migration experiences whereby individuals experience a loss of cultural identity, leading to a diminished sense of belonging (Bhugra & Becker, 2005).

Additionally, threats to the core need to feel valued within social roles (sub-theme: 'social threats') were discussed, as well as having a sense of meaning and purpose (sub-theme: 'cultural and value-based threats'), also included in the PTMF (Johnstone & Boyle, 2018b, pp. 189-190). The former can be conceptualised as threats to individuals' self-esteem needs (Maslow, 1943), while the latter, 'meaning', is considered central to well-being in the face of challenges (PCS, 2019).

However, discussions did not mention particular core needs outlined in the PTMF as being threatened. These include the need 'to be safe, valued, accepted and loved in their earliest relationships with caregivers', 'to form intimate relationships and partnerships', 'to be able to contribute, achieve, and meet goals', and 'to be able to exercise agency and control in their lives' (Johnstone & Boyle, 2018b, pp. 189-190). Their absence may be because relationship core needs are more individual-centric. In contrast, needs concerning goals and agency pertain to higher-level needs linked to self-actualisation (Maslow, 1943), with individuals within the community facing more immediate threats to their lower-level needs.

However, these core needs could all be argued to reflect individualistic perspectives and may not be universally applicable in discussions with non-Western cultural groups. For instance, First Nation cultures view meeting basic needs, ensuring safety, and creating conditions for expressing purpose as a community responsibility, termed 'community actualisation' (Blackstock, 2011).

4.3.3. Meaning-Making of the Community

Various meanings were identified at the community level. A particular focus was placed on socio-political meanings (sub-theme: 'socio-political understandings'), absent from the PTMF, which primarily centres on individual rather than community-level experiences. The framing of discussions on adversities at a community level may have invited thinking about the causes of these adversities in a socio-political way. This approach has been evidenced in other research utilising the PTMF to explore headscarf-wearing Muslim students' misrecognition experiences, with participants viewing politicians as the primary source of their misrecognition when framed as a political phenomenon (da Silva et al., 2022).

Moreover, the involvement of professionals from the recovery community, including peer workers with lived experience, likely prompted discussions emphasising social factors, as seen in service users' and survivors' rejection of the diagnostically based paradigm (Beresford et al., 2010). This is seen in survivor-led movements like the 'Hearing Voices Network', which advocates for a more social approach to understanding distress (Coleman, 1999; Coleman & Smith, 1997).

There was a discussion of meanings related to historical experiences (sub-theme: 'histories of inequity and injustice'), reflecting meanings found in the PTMF, including feelings of 'exclusion', 'hopeless', and a 'sense of injustice' (Johnstone & Boyle, 2018b, p. 208) about healthcare. This resonates with literature on inequalities in access to, experience, and outcomes of mental health services among marginalised ethnic communities (Kapadia et al., 2022; Memon et al., 2016). There was also mention of ‘mistrust’ of services, conceptualised here as a meaning rather than a threat response as in the PTMF. This mistrust was seen as shaping individuals’ engagement with services, resulting in reduced help-seeking behaviour (i.e. the threat response), a phenomenon supported by existing literature (Keating & Robertson, 2004).

Culture-specific meanings within Bengali and Somali communities (sub-theme: ‘cultural beliefs’) were highlighted, including feelings of shame - a meaning included in the PTMF (Johnstone & Boyle, 2018b, p. 208) - due to negative associations with mental illness, which is in line with the literature (Loewenthal et al., 2012). Additionally, there were religious and spiritual meanings that are not explicitly included in the framework, such as spirit possession (Jinn), the will of God, and divine punishment – all widely accepted beliefs about the causes of mental illness among Muslims (e.g., Dein & Illaiee, 2013; Khalifa et al., 2012; Littlewood & Dein, 2013).

This focus on spiritual perspectives has been found in cross-cultural applications of the PTMF with Indigenous communities in Australia and New Zealand (Johnstone, 2019; Johnstone & Kopua, 2019) and with a grassroots social movement in the UK (Mottram, 2020). However, it is noted that other cultures have different beliefs and values about the nature of suffering (Kirmayer et al., 2009), and the cultural meanings mentioned here were specific to the cultural groups within this community.

4.3.4. Threat Responses of the Community

Several threat responses were identified within the community, indicating a decline in social cohesion. This is consistent with research showing that ‘symptoms’ of community trauma can manifest as ‘disconnected/damaged social relations’ (Pinderhughes et al., 2015, p. 13). It was noted that communities are isolating themselves for safety due to prejudice and discrimination (sub-theme: ‘social fragmentation’), with reduced inter-group contact used as a strategy to mitigate prejudice (Pettigrew et al., 2007), consistent with the PTMF's 'relational strategies' of ‘isolation/avoidance’ (Johnstone & Boyle, 2018b, p. 211).

The prejudice and discrimination experienced by marginalised groups and the subsequent decline in social cohesion may be compounded by material deprivation within this community (Bécares et al., 2012; Chan & Kawalerowicz, 2024). These groups are often blamed for social and economic problems, as was evident in the ‘Vote Leave’ campaign for Brexit in the UK. This resulted in a rise in hate crimes against immigrants and ethnic minorities, damaging community cohesion and increasing polarisation (Awan & Zempi, 2020).

There was mention of how Somali communities avoid services to protect themselves from emotional harm, aligning with PTMF's 'relational strategies' of ‘rejection and maintaining emotional distance’ (Johnstone & Boyle, 2018b, pg. 211). This is consistent with the literature, which indicates the existence of 'circles of fear' (Keating et al., 2002) between Muslim communities and mental health services (Byrne et al., 2017).

The prioritisation of one’s needs over others (sub-theme: ‘self-preservation’) was also highlighted. There was mention of individuals stealing food to meet their basic needs, reflecting societal rises in shoplifting as a survival strategy (McRae, 2023). While stealing is listed as a threat response for children and young people in PTMF (Johnstone & Boyle, 2018b, p. 212), it is evident that this may also apply to adults.

It is essential to acknowledge that many of the threat responses outlined in the PTMF were not addressed, possibly due to their emphasis on emotional reactions, which are typically conceptualised as phenomena at the individual level (Goldenberg et al., 2020). Discussing these responses collectively would have required participants to consider emotional reactions as macro-level phenomena, which may not align with the Western cultural assumption of an independent, bounded self (Markus & Kitayama, 1991).

4.3.5. Resources of the Community

Various community resources were identified, aligning with 'asset-based approaches' (ABA) that prioritise health assets as protective factors (PHE, 2018; PHE & NHS England, 2015). Health assets are defined as "any factor (or resource) which enhances the ability of individuals, groups, communities, populations, social systems, and/or institutions to maintain health and well-being and to help reduce health inequalities" (Morgan & Ziglio, 2007, p. 18).

Some of the resources mentioned, which are also examples of 'community assets' within ABA, included the networks and connections within the community, such as family, cohesion, and religious tolerance and harmony (sub-theme: 'social connectedness'), as well as practical skills, knowledge and commitment of residents, cultural and physical resources, and intergenerational solidarity (sub-theme: 'mobilisation'; Foot & Hopkins, 2010; Rippon & Hopkins, 2015).

The identified resources also resemble examples provided in the PTMF, including 'supporting each other in campaigning, activism', 'using healing attachments/relationships for practical and emotional support', and 'other culturally-supported rituals, ceremonies and interventions' (Johnstone & Boyle, 2018b, p. 247). However, some resources in the framework, like emotional regulation and self-care strategies (Johnstone & Boyle, 2018b, p. 247), were not discussed, as these are more individual-level rather than collective assets (Blickem et al., 2018).

Furthermore, certain assets highlighted in the literature, such as the effectiveness of local groups and voluntary organisations and public, third-sector and private organisational resources available to the community (Foot & Hopkins, 2010), were not mentioned. This omission is unsurprising, considering the discussions highlighted a lack of economic resources due to funding cuts, resulting in the absence of local community spaces and activities.

However, it is possible to leverage existing human, social, cultural and environmental resources within communities to create tangible community resources (Foot & Hopkins, 2010; PHE & NHS England, 2015). The Community Capitals Framework (Flora & Flora, 2013) underscores this notion, positing that investing in existing ‘capitals’ can positively influence others (Emery & Flora, 2006). For instance, building on the ‘social capital’ (i.e., community mobilisation) within this community could counteract the decline in social cohesion by increasing social connections - an important determinant of health and wellbeing (WHO, 2024) - and facilitate positive social change, including increased funding, as evidenced in the literature (Gillespie & Hughes, 2011; Laverack, 2006).

4.3.6. Summary of the Findings

The findings revealed that professionals could identify adversities and the threats they pose to the community's core needs at the community level. They could also articulate meanings constructed about these adversities - shaped by social and material realities, cultural beliefs, and past experiences - within the community and recognise common threat responses and resources available to counteract them at the community level.

These findings suggest that the PTMF may offer professionals an alternative way to understand experiences of adversity, including cultural perspectives, within communities. This builds on previous work indicating that the framework can assist practitioners in shifting towards more adverse-informed perspectives at the collective level (e.g., Barnwell et al., 2020; Morgan et al., 2022) as well as considering people’s cultural differences in experiences, beliefs, and practices (e.g., de Silva et al., 2022; Johnstone, 2019; Johnstone & Kopua, 2019; Mottram, 2020; Moutsou et al., 2023).

4.4. Critical Review

4.4.1. Study Limitations

Identifying and acknowledging research limitations is crucial (Ioannidis, 2007). Although the study’s sample size aligned with recommendations for thematic analysis (Guest et al., 2006), a larger one could have strengthened evidence for the identified themes. This was evidenced in focus groups (FGs) continuing to yield new insights due to the varied community work of the professionals. Nonetheless, discussions on data saturation with the research supervisor confirmed that the data gathered was sufficient.

The degree to which the findings of one study are applicable in different contexts and settings is referred to as ‘transferability’ (Willig, 2019). While this study recruited only healthcare professionals, limiting its direct relevance to the broader public health workforce (e.g., teachers, housing officers, social workers, etc.), its findings may still hold relevance for healthcare professionals working in similar community contexts.

The professionals in this study were self-selected, potentially introducing self-selection bias. Of the fifteen participants, ten were from a local NHS recovery community supporting community health and well-being through educational workshops and courses. These are co-produced by peer workers and aim to help individuals normalise their experiences and find meaning in them. Consequently, these professionals might be more inclined to adopt new and transformative ways of supporting people’s well-being, contrasting with professionals in other mental health services dominated by more individualistic approaches.

In FG discussions, participants mentioned that the Bengali and Somali communities avoid seeking help and support from services. This reluctance can be attributed to what has been termed as ‘circles of fear’ (Keating et al., 2002), with a pervasive mistrust or fear found among Muslim communities towards mental health services and providers (Byrne et al., 2017). Since fourteen out of fifteen participants were from NHS services, their perspectives on adversities within these communities were somewhat limited due to the lack of direct, face-to-face contact. Nevertheless, some participants identified as Bangladeshi, providing valuable insights into the challenges faced by this community based on their ‘insider’ knowledge and personal experiences.

While seven out of the fifteen participants held dual positions as professionals and community members, providing some access to community members’ perspectives, it is essential to note that this is a relatively small number. Moreover, participants were primarily invited to share their professional views on community adversity. Therefore, the findings mainly offer insights into professionals' perspectives rather than community members, which are then interpreted through subjective analysis (section 4.4.3).

Moreover, the dual positions of some participants, who lived and worked in the borough, enabled them to provide insights into specific adversities that those without this dual perspective might not have. Nonetheless, since participants worked with different groups of people across various areas of the borough, each facing its distinct challenges, they were able to contribute unique viewpoints based on their diverse professional experiences.

Two FGs consisted of participants from the recovery community who were already familiar with each other. This familiarity likely created a comfortable environment, encouraging open discussion and information sharing (Krueger, 1994; Morgan, 1998). However, this homogeneity may have resulted in shared assumptions and perspectives among participants, potentially reducing the diversity and nuance of responses (Smithson, 2000). Additionally, participants might have found it difficult to disagree with each other, limiting the exploration of diverse opinions and experiences (Gibbs, 1997).

I also had partial ‘insider researcher’ status (Dwyer & Buckle, 2009) due to my emotional connections to some participants (Sikes, 2008) through pre-existing relationships (e.g., peers and previous colleagues). This may have led to ‘informant bias’ (Fleming, 2018), with participants’ responses in FGs influenced by their perceptions of me and our relationships outside of the research context (Dwyer & Buckle, 2009). Some participants might have withheld information for fear of judgement or impact on our ongoing relationships (Chavez, 2008; Mercer, 2007; Shah, 2004). Conversely, participants may have felt more comfortable sharing detailed information with me.

Furthermore, participant engagement varied across the three focus groups (FGs). Some participants were more vocal than others in the face-to-face FG, leading to unequal contributions. Similarly, in the hybrid FG, in-person participants dominated, resulting in less contribution from online participants. In contrast, the online FG, where participants took turns speaking, led to more equal contributions. However, spontaneous interactions were fewer in the online FG and, to some degree, in the hybrid FG due to this turn-taking. This resulted in fewer ideas and less data compared to the face-to-face FG. Despite this, the quality of data across all three FG mediums was comparable.

4.4.2. Research Quality

This study used Spencer and Ritchie's (2011) framework to assess research quality. The principles of contribution, credibility, and rigour form the foundation of this framework.

4.4.2.1. Contribution of the research: Contribution is determined by the significance and worth of the study's findings and whether they improve current knowledge or practice (Spencer & Ritchie, 2011).

The rationale for the research was discussed in section 1.8, considering existing literature on the topic. The findings, outlined in section 3, are discussed in relation to the research questions and the literature in section 4.3. Implications of the findings are presented in Section 4.5.

The study includes views from a range of healthcare professionals diverse in age, gender, ethnicity, and profession. Additionally, seven out of fifteen participants resided in borough X, where the research occurred. Thus, the findings may be transferred to the broader population from which the sample was taken and local community members (Lewis & Ritchie, 2003).

4.4.2.2. Rigour: Rigour refers to the suitability of research decisions and the transparency of research procedures (Spencer & Ritchie, 2011). This study aimed to achieve transparency by detailing the methodological process and decisions.

The rationale for the choice of epistemology and method is presented in sections 2.2–2.3, followed by an outline of the procedure, including decisions regarding recruitment and participant sampling, in section 2.4. Detailed procedures for data collection and analysis are provided in sections 2.5 and 2.7 to ensure replicability and transparency in theme production. Sections 3.2–3.6 present themes with data excerpts, grounding results in the data and enabling readers to judge the analysis and interpretation.

A research diary was used to support reflexivity (Finlay & Gough, 2003), aiming to make transparent the subjectivities inherent in the researcher and the research process (Ortlipp, 2008), aligned with the critical realist stance adopted. Entries were made after each FG, documenting practical observations and personal reflections and prompting an exploration of my assumptions, values, and beliefs and their impact on the research (Nadin & Cassell, 2006). An excerpt from the reflective diary is provided in Appendix T, with further discussion on researcher subjectivity in section 4.4.3.

4.4.2.3. Credibility: Credibility refers to how well the study's findings and conclusions can be defended and supported by the data and study evidence (Spencer & Ritchie, 2011).

To validate preliminary findings against data extracts, the research supervisor was consulted on initial themes and sub-themes (Lincoln & Guba, 1985). A credibility check (Elliott et al., 1999) was performed to determine how many participants contributed to each theme and sub-theme. This ensured well-balanced and developed themes and sub-themes derived from multiple respondents, enhancing researcher and reader confidence in the findings.

To demonstrate the grounding of interpretations of the data, excerpts of a coded transcript (Appendix O) and a code along with its associated extracts (Appendix Q) are provided. Initial and final thematic tables in Appendices R and S illustrate the development of themes. In section 3, the study's results are presented, supported by data excerpts to evidence how claims and interpretations were directly derived from the data. This enables readers to make their judgements on the claims made. The researcher and supervisor reviewed the findings concerning existing literature to identify consistencies and novel insights.

4.4.3. Reflexivity

Reflexivity acknowledges the researcher's role in constructing meanings and the impossibility of maintaining objectivity (Willig, 2013). It prompts exploring the study, which is influenced and informed by the researcher's involvement (Nightingale &

Cromby, 1999, p. 228). This awareness is vital when adopting a critical realist perspective, which acknowledges diverse viewpoints (Bhaskar, 1978; Willig, 2013).

Willig (2013) makes a distinction between personal and epistemological reflexivity. Epistemological reflexivity prompts reflection on worldview assumptions and knowledge during research, considering their implications for findings. Personal reflexivity involves reflecting on one’s assumptions, beliefs, experiences, and identities and how this has influenced the study. Both aspects will be further discussed below.

4.4.3.1. Epistemological reflexivity: Willig (2008) highlights the ethical and political dimensions of formulating research questions. Informed by the belief that individuals cannot be fully understood in isolation from their culture and community (Johnstone & Boyle, 2018b), my research question was developed under this premise.

This influenced the construction of FG questions. For instance, the question “What are the most important adversities impacting the community?” (Appendix D) suggests a view of distress as a collective issue, potentially eliciting information about broader structural factors. However, participants may not have shared the same conceptualisations of social problems, potentially limiting the findings. Each FG session concluded with a reflective question to mitigate this potential bias, inviting participants to offer additional viewpoints, thereby acknowledging potential differences in understanding.

The participants' lack of explicit identification of the PTMF constructs during FG discussions may have influenced the interpretation of the data. The interconnected nature of these constructs made it challenging to separate them, requiring interpretation to discern implied meanings. This likely influenced how I coded specific data excerpts, shaping the development of themes. Additionally, it may have influenced my selection of key aspects of the data, potentially overlooking nuanced meanings related to sociocultural discourses and ideologies.

In addition, the study’s outcomes may have differed with an alternative epistemological position. A positivist stance might have focused on identifying ‘symptoms’ of community adversity, potentially oversimplifying causality akin to the medical model and neglecting the broader social and cultural context. Conversely, a social constructionist standpoint might have used Discourse Analysis to explore how language structures perceptions of community adversities (Powers & Knapp, 1990). However, this approach may have limited policy and practice recommendations, as it would not have assumed a causal role of adversities in distress (Willig, 2008).

4.4.3.2. Personal reflexivity: I acknowledge that aspects of my identity could have influenced the knowledge produced in this study. While participants discussed various adversities, my intersecting social positions might have constrained or enabled exploration in certain areas. For instance, being male among mostly female participants might have limited discussion on gendered problems within the community. However, being a person of colour may have enabled experiences of prejudice and discrimination to be shared with me.

I considered how my professional identity as a psychologist might have shaped discussions about cultural beliefs within the Bengali and Somali communities. When one participant labelled spirit possession as a "misconception", it prompted me to consider how my profession could have influenced this perspective, as often, mental health professionals misdiagnose spiritual or religious interpretations of unusual experiences as 'psychosis' rather than respecting them as cultural explanations of distress (Moreira-Almeida, 2012).

I also reflected on my dual insider-outsider researcher status and its influence on my relationship with participants and the research (Dwyer & Buckle, 2009). An ‘insider’ researcher shares attributes with participants, while an ‘outsider’ does not (Braun & Clarke, 2013). While I was an ‘insider’ regarding a shared healthcare background, experience working with the local community, and pre-existing relationships with participants, I remained an ‘outsider’ in terms of not currently working within the community or being a member of the studied community.

Despite this, my interactions with participants leaned towards an insider status, facilitating recruitment and fostering rapport during FGs, resulting in a greater depth of data about community adversity. However, there were instances where participants assumed my knowledge due to my previous work in borough X, limiting explanations of their views or perspectives. Additionally, my insider status may have influenced my objectivity (Kahuna, 2000), shaping FGs based on my experiences rather than the participants'. To mitigate this, I maintained an awareness of how my personal ‘lens’ shaped theme development (Lyons & Coyle, 2016) by keeping a reflective diary (Appendix T) and reflecting on my assumptions about the data in research supervision.

During FGs, I observed a power dynamic when participants discussed religious or spiritual beliefs within their communities. As someone who does not identify with any religion, I held a position of power relative to these participants who identified with politically marginalised religious groups. Reflecting on past experiences of being expected to educate others in positions of power about marginalised aspects of my identity (e.g., race), I felt hesitant to ask follow-up questions about these beliefs despite lacking knowledge. This reluctance may have limited the depth of information gathered about cultural meanings within these communities.

Additionally, there were instances where some participants were confused by the term ‘threat’, providing examples of adversities instead of discussing their impact on the community. This confusion may arise from associating adversities with “aversive and threatening” contexts (Boyle, 2022, p. 36). Moreover, the term ‘threat’ can be perceived as a psychological construct (Rose & Rose, 2023), with the accessibility of the language in the PTMF criticised as “hard to understand” (SHIFT Recovery Community, 2020, p. 8) and “too clinically orientated” (A. Griffiths, 2019, p. 13). It may have been better to avoid the term 'threat' when discussing the negative impact of adversities.

4.5. Implications

4.5.1. Public Health Policy

Despite the increased emphasis on prevention by politicians and policymakers, their actions and investments consistently fall short of addressing the widening health inequalities in the UK (Marmot et al., 2020). Several professional networks have committed to delivering PH initiatives, including the Association of Directors of Public

Health (2023) and the Faculty of Public Health (2014). This extends to psychological bodies, exemplified by Psychologists for Social Change (PSC), which released a manifesto in 2019 intending to encourage a psychologically healthy society. In this manifesto, PSC (2019) organised its recommendations around the five qualities of a psychologically healthy society: agency, safety, connection, meaning, and trust.

Regarding ‘connection’, which was identified as lacking within the community in this study, PSC (2019) provide examples of how this could be achieved. Suggestions include investing resources into community-owned activities and ensuring public spaces are available. Thus, some of the findings in this study may align with the manifestos and recommendations of professional bodies, strengthening their evidence base. This can inform PH policy development on factors such as cohesion, a recognised health asset that contributes to positive health and well-being (PHE, 2018)

However, the prevalence of a medical frame in public discourse about mental health may make it challenging to inform PH policy (Harper, 2022). O’Hara (2020) notes society’s tendency to attribute personal responsibility to the impoverished, perpetuating a toxic narrative that shapes policy. The findings emphasise the importance of shifting the conversation to community-level adversities, enabling professionals to highlight broader structural and cultural factors contributing to these challenges. Future directions could involve broader consultation with service users/survivor groups, community stakeholders, the public, and PH professionals to understand better the adversities faced by local cultural communities across the UK.

Through this collaborative effort, it may be possible to develop shared narratives at various levels (local, regional, national), which, with the assistance of professionals working with the media, can shift responsibility from individual communities to the adverse conditions they face. This reframing of the public conversation about mental health could prompt a revaluation of PH policy and legislation priorities, redirecting government spending towards preventative approaches that address the underlying adverse conditions that impact people’s health (BPS, 2019). This could reduce the burden on the NHS and improve people’s lives by addressing the root causes of health inequalities (BPS, 2019).

4.5.2. Clinical Practice

This study demonstrated that professionals could converse about adversities, threats, meaning-making, response to threats, and available resources within a culturally diverse community. These findings have implications for clinical practice at various intervention levels.

In statutory mental health services, where individualistic approaches prevail, clinicians could draw on the PTMF in one-to-one therapy to better consider community-level adversities and their impact on individuals. This can help contextualise people's distress by examining their immediate life circumstances (e.g., housing, finances, social networks) and broader contextual factors (e.g., economics, politics, culture; Tew, 2004). Moreover, the PTMF could be used to support people in exercising meaning or 'personal agency' (the ownership of their own experiences) within their cultural understandings, which is a crucial element of 'recovery' among survivors (Rose, 2022) and can help individuals assert their power for change (e.g., Flynn & Polak, 2019).

The PTMF questions could also serve as a framework for community and service user groups, enabling individuals to share their adverse experiences collectively. This collective sharing can be valuable in reducing feelings of isolation and instilling hope, as highlighted by professionals in this study (section 3.7), some of whom had lived experience, as well as in peer-led survivor groups who have utilised the framework (Griffiths, 2019, p. 13; SHIFT Recovery Community, 2022, p. 9).

There are also implications for community psychology, which aims to prevent distress by acknowledging how social injustice affects health and wellbeing, collaborating with marginalised groups for social change, and identifying resources to promote wellbeing (Orford, 2008). Following BPS guidelines for working with community groups (BPS, 2018), clinical psychologists could provide consultation to key community partners. This could involve using models like the PTMF to co-produce community maps and formulations (BPS, 2022) to assess and develop a shared understanding of the community's adverse experiences and available resources. Such efforts can facilitate interventions that better meet community needs (BPS, 2018).

In addition, the PTMF has implications for service delivery. Clinical psychologists in leadership positions can play a crucial role in transforming mental health services from diagnostic and treatment-focused models to those informed by adversity. This shift could be facilitated by clinical psychologists training healthcare professionals on the PTMF to increase their awareness of the impact of psychosocial adversities on community health and well-being. It may also require collaboration with key stakeholders, such as commissioners, to implement new ways of working in services, like adopting approaches like the PTMF.

4.5.3. Future Research

4.5.3.1. Core constructs: This study examined whether the PTMF could facilitate discussions among professionals about community adversity in a culturally diverse context rather than exploring their views on the framework and its core constructs. Future research could use larger-scale quantitative approaches to assess the framework’s use among professionals working with culturally diverse communities in the UK, providing insights into its utility. Alternatively, qualitative studies could sample culturally diverse groups of professionals to explore their views on the framework and its core constructs, potentially aiding in its further development for better local and cultural fit.

4.5.3.2. Cultural groups: The involvement of culturally diverse professionals in this study and the perspectives identified suggest that the PTMF may be relevant to other cultural groups. However, it is essential to recognise these professionals received Western education, which likely influenced their perspectives. Future research could explore applying the framework to cultural groups from non-Western societies. These groups may identify specific experiences as adversities that others do not, influenced by the degree to which individuals are viewed as embedded within a collective identity (e.g., Marsella, 1993). Additionally, certain aspects of the framework may resonate more strongly depending on cultural and religious beliefs, such as connections to ancestors and the natural world (e.g., Johnstone, 2019; Johnstone & Kopua, 2019).

4.5.3.3. Community groups: This study emerged from my professional and personal interests rather than community groups and their activism (BPS, 2018). Fine (2019) advocates for research conducted “with (not on or for) communities most affected” (p. 85), suggesting that centring the experiences of marginalised groups can lead to reimagining alternatives. Participatory methods, where community members are actively involved in design, delivery, and evaluation, are core to community-centred approaches (PHE & NHS England, 2015) and can directly address marginalisation and power imbalances underlying inequalities (PHE, 2018). Greater community involvement in decision-making to reduce health inequalities is supported by several reviews (e.g., Marmot, 2010).

In hindsight, involving the recovery community, with whom I had a trusted relationship, could have been a key stakeholder connecting me with local community members. This approach would have aligned better with the aims of the PTMF to reduce hermeneutical injustice (Fricker, 2007) by including community members’ voices in research conduct and decision-making (Rose & Rose, 2023). Thus, future research on community adversities could benefit from collaboration with local community groups to generate new insights and mobilise advocacy for more just practices (Fine, 2019).

4.6. Conclusion

This study explored whether the PTMF could structure conversations among professionals about community adversity in a culturally diverse inner London borough. This question was particularly relevant given the increasing emphasis on whole-community action and consideration of diverse cultural perspectives on health to address the social determinants of health and reduce health inequalities. While the framework offers an alternative to the individualised medical model and is intended to be used at cultural and community levels, its development in a Western context has raised questions about its applicability across diverse cultures and communities.

The findings showed that professionals could identify different types of adversities, threats to core needs, meanings shaped by social, material, cultural and historical factors, threat responses, and resources at the community level. This indicates that the PTMF may provide professionals with an alternative way of thinking about experiences of adversity, including cultural perspectives, within communities. The implications for public health policy, clinical practice, and future research are discussed, and recommendations are made.

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6. APPENDICES

Appendix A. Research Poster

RESEARCH INVITATION

ARE YOU A PROFESSIONAL WORKING IN

WHO AM I?

My name is Elliot. As part of my doctoral thesis, we are looking to see whether the Power Threat Meaning Framework makes sense to communities, not just individuals and to cultures other than a white Western culture. The Power Threat Meaning Framework is an alternative approach to understanding mental health problems as responses to various life adversities rather than as medical disorders.

WHAT WILL I BE ASKED TO DO?

You will be invited to take part in an informal conversation with up to five others, for about an hour and a half. This will be face-to-face, on the telephone or online, and I will arrange it at a time that suits everyone. All discussions will be confidential, and any other details will be made anonymous when the research is written up.

WHAT ARE THE BENEFITS OF TAKING PART?

Your contributions will be invaluable in understanding how communities respond to adversities, and cultural differences in which distress is experienced and expressed. This information will be fed back to the authors of this framework to make it more culturally accessible and relevant.

HOW DO I TAKE PART?

If you are Interested in taking part in this research or would like more information, please contact me on **u2195617@uel.ac.uk** and we can discuss further.

This study has received ethical approval from UEL's Research Ethics Committee
IRAS Project ID: 329014
Date: 29.06.2023
Version: 1

University of East London

Appendix B. Participant Information Sheet

PARTICIPANT INFORMATION SHEET (FOCUS GROUPS)

Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities

The Principal Investigator
Name: Elliot Miller, Trainee Clinical Psychologist
Email: u2195617@uel.ac.uk

IRAS: 329014
29.06.2023
Version number: 2

Invitation

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., colleagues) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Elliot Miller. I am a trainee clinical psychologist studying at the University of East London. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

The Power Threat Meaning Framework (PTMF) is an approach to understand mental health problems as a response to different kinds of adversities in life rather than as a medical disorder. My study aims to examine the applicability of PTMF across cultures and to communities.

What are the aims?

The research aims to answer the following questions:

1. To what extent is the PTMF applicable to a culture other than white, Western culture?
2. Can the PTMF be used to understand community-level responses to adversity?

Why have I been invited to take part?
I am inviting professionals working in X to take part in my research. If you are a professional working in X, are aged 18 or above and able to provide full consent, you are eligible to take part in the study. It is entirely up to you whether you take part or not, participation is voluntary. If you are happy to take part, you will be asked to sign a consent form before you can do so.

What will I be asked to do if I agree to take part?
If you agree to take part, you will be invited to a focus group talking about the adversities facing the community you work with. You might be asked things like the impact of these adversities on the community, how these adversities are made sense of by the community, the different ways the community deals with these adversities, and the strengths and resources of the community. You will not be asked to share anything about your private life.

It will be like having an informal chat, lasting approximately 90 minutes in total. Focus groups will be audio-recorded and take place in person at your service site (e.g. mental health trust service), on the telephone, or online via Microsoft Teams.

What are the benefits of taking part?
You will have the opportunity to give your views and opinions of the adversities facing the community you work with. It may be an interesting and empowering experience for you and others to experience together.

The information you provide will also help us to understand how communities respond to adversities, and any cultural differences in which distress is experienced and expressed. This information will be fed back to the authors of this framework to make it more culturally accessible and relevant.

Can I change my mind?
Yes, you can change your mind and withdraw without explanation, disadvantage or consequence. You can request to withdraw your data from being used provided that this request is made within 3 weeks of the data being collected. After this point, analysis will have begun and it will not be possible to withdraw it though any quotes I use will be fully anonymised and it will not be possible to identify you.

Are there any disadvantages to taking part?
The research is not designed to cause you any harm, discomfort, or distress. However, talking about adversities facing communities is a sensitive topic, which may be upsetting. If you did get upset, the discussion will be paused to allow you to

take a break, after which you will have the option to continue or to withdraw from the study. I will be available to discuss any concerns or questions you have following the focus group. I will also provide you with a list of organisations you can contact should you require further information or support.

In the unlikely event that I am concerned about the safety or wellbeing of yourself or others, I would need to share some of the information with my supervisor, and a relevant source of support who may be able to help or may need to know. I will discuss this with you first where possible.

How will we use information about you?
We will need to use information from you for this research project.

This information will include your initials held by the researcher. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your initials. Your data will have a pseudonym or participant number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?
You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?
You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team (details below)
- by sending an email to u2195617@uel.ac.uk

How will the information I provide be kept secure and confidential?
To arrange a focus group, I might need to have some basic contact details, like your name, email address and/or phone number. I will also collect demographic

information about you, such as your age, gender, and ethnicity. To protect this information, I will record it on an Excel spreadsheet and password-protect it on my computer.

Focus groups will be audio-recorded using a password-protected recording device. If focus groups take place remotely, they will be recorded using Microsoft Teams. Only I will listen to the recordings, and I will type it up into a transcript. Each transcript will be saved as an individual Word document. All personal information that could identify you will be removed in the typed version and any names of people will be changed.

The audio files and transcripts will be stored in password-protected files on a password protected laptop, to make sure no one else sees or hears them. The typed transcript may be read by my supervisor at the University of East London and the examiners who test me when I have the research in to be marked. No one else will be able to read the transcript.

Quotes from things you have shared in the focus group may be used in the analysis of the research. However, you will only be referred to by a different name and no details that might identify you will be included.

Any personal data that is gathered for this study will be help securely and processed in accordance with the University's Data Protection Policy and the UK GDPR and the Data Protection Act 2018. Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

How long will my data be kept for?
Audio-recordings will be deleted following transcription. Anonymised written transcripts will be stored securely by my supervisor, Professor David Harper, for a maximum of 5 years and might be used to write the research up into an article to be published in a psychology journal, following which all research data will be deleted

What will happen to the results of the research?
The results of the research will be written up as a doctoral thesis at the University of East London and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Later, the researcher may write the research up into an article to be published in an academic journal. In all material produced, your identity will remain anonymous, in that, all personally identifying information about you will either be removed or replaced. You will be given the option to receive a summary of the research findings once the study has been completed, for which you will need to provide contact details for this to be sent to.

Who has reviewed the research?
My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?
If you would like any further details about my research, would like to ask us any questions, or would like to express your interest in taking part then please do not hesitate to email me.

Elliot Miller
Email: u2195617@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix C. Participant Demographic Form

PARTICIPANT DEMOGRAPHIC FORM

09.10.2023

Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities

Age:

Gender Identity:

Ethnicity:

Profession:

Do you live in the borough?

Appendix D. Interview Schedule for Focus Groups

INTERVIEW SCHEDULE

29.06.2023

Introduction

I am a Trainee Clinical Psychologist at the University of East London. The aim of today is to explore adversities facing communities you work with, the impact of these adversities on the community; how these adversities are interpreted by the community; the different ways the community deals with them; and the strengths and resources of the community. I am hoping the discussion will increase our understanding of how communities respond to adversities, and cultural differences in the way in which distress is experienced and expressed.

Reiterate consent, confidentiality and that participants may take breaks, leave the room, or withdraw at any time. Agree approximate length of interview.

Phase One: Understanding Community

Community can mean lots of different things to different people, such as a shared geography, culture, religion, or heritage.

1. How would you describe the community you work in?
   Prompt: Provide examples
2. Which community/communities do you identify with?

Phase Two: Adversities Facing the Community

I would like us to think about the kind of adversities facing the communities you work with, and/or events which it has faced in the past. Examples of adversities may include experiences of discrimination, racism, poverty, crime etc.

3. What are the most important adversities impacting the community?
   Prompt: Provide examples
4. What is the community's understanding of the causes of these adversities?
   Prompt: Ideas within the culture (e.g., religious/spiritual beliefs, social/political)

Phase Three: Effects of Adversity on the Community

We can use this framework to understand the way in which certain adversities can pose threats to core human needs (e.g., to be protected, valued, find a place in the social group). Threats can include feeling unsafe, a loss of community rituals, belief systems and practices, and a loss of social, cultural, or spiritual identity.

5. What needs do you think the community has?
   Prompt: Provide examples (safety and security, sense of meaning and purpose, positive relationships within families and communities)
6. What threats might these adversities pose to the needs of the community?
   Prompt: Provide examples (isolation and exclusion, ill-health, loss of community histories)

Phase Four: Meaning of these Adversities to the Community

Adverse experiences can be interpreted by communities in different ways. These interpretations can be influenced by a variety of factors such as the, history and shared experiences of the community. For instance, communities that have experience systemic racism may be distrustful of the state such as the health services and the police. This could manifest as a collective belief that no one can be trusted.

7. How does the community make sense of these adversities? What are their perceptions and interpretations of these adverse experiences?
   Prompt: Provide examples (no one cares about us, we don't have access the same opportunities and resources, people don't trust one another)

Phase Five: Community Responses to Adversity

Communities have their own ways in which they respond to adversities Some examples of community responses include staying isolated, coping through drugs/alcohol, engaging in violence, generations not understanding each other and drifting apart, different communities keeping a distance from each other, and youth getting involved in gangs/drugs.

8. In what ways does the community respond to these adversities?
   Prompt: Provide examples (helping each other out, asking for help from police/council/MP/NHS etc)

Phase Six: Strengths of the Community

There are strengths and resources that communities may draw on in responding to adversities. For instance, some communities may organise protests and marches, whereas others may congregate at a place of worship.

9. What strengths and resources does the community draw on in response to these adversities? What resources are there in the community?
   Prompt: Provide examples (prayer at the mosque, community centres, campaigning and political activities, community events/activities/groups).

Phase Seven: Feedback on the Discussion

Thank you all for your participation. Before we finish, I am interested in hearing about your experiences of the discussion.

10. How have you found the discussion?
    Prompt: What has been useful? Less useful?
    Prompt: Is there anything else that we could have talked about or included?

Phase Eight: Debriefing

Is there anything that you found distressing about the discussion? Is there anything that you would like me to leave out of the transcript? Do you have any questions? You can contact me if you have any questions and here are some contact details for support organisations if you feel you would like to talk to someone later one.

Appendix E. University of East London Ethical Approval Application

University of
East London

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites:

	▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: You may also find the following website to be a useful resource:
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	Elliot Miller
2.2	**Your supervisor's name:**	Professor David Harper
2.3	**Name(s) of additional UEL supervisors:**	Dr Trishna Patel 3rd supervisor (if applicable)
2.4	**Title of your programme:**	Professional Doctorate in Clinical Psychology
2.5	**UEL assignment submission date:**	May 2024 Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.		
3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities
3.2	**Summary of study background and aims (using lay language):**	The Power Threat Meaning Framework (PTMF) was developed as a non-medical model to human distress (Johnstone & Boyle, 2018). The Framework posits that individuals' distress arises out of understandable responses to adversities, which raise in context of unequal power relationships (e.g., social inequalities). These adversities are seen as posing threats to common human needs. These threat responses are enabled and learnt through culture, allowing for the existence of widely varying cultural experiences and expressions of distress. These are largely relevant within Westernised cultures, however and so there is a need to develop the PTMF alongside the cultural beliefs of the social or cultural group at issue (Johnstone et al., 2019; Johnstone, 2020). There is also growing recognition that adversity can be experienced on the community-level, in part to the impacts of interpersonal and structural violence (Pinderhughes et al., 2015). Though, the PTMF is conceived as too individually focused (Emerging Proud, 2020) as this is how distress is perceived within Western cultures (Johnstone, 2020). Thus, further development of the Framework is required to describe the adversities facing whole communities (Johnstone & Boyle, 2018). This study will explore professionals' views on the applicability of the PTMF across cultures and to communities. It is hoped that the findings will increase our understanding of how communities respond to adversities, and

		cultural differences in which distress is experienced and expressed.
3.3	**Research question(s):**	1. To what extent is the PTMF applicable to a culture other than white, Western culture? 2. Can the PTMF be used to understand community-level responses to adversity?
3.4	**Research design:**	This study will have a qualitative, cross-sectional research design using thematic analysis. Data will be gathered via audio-recorded focus groups, each lasting approximately 90 minutes, asking questions relating to the research questions. This is considered the best method to examine the participants' personal views and experiences within a wider cultural and social context.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Two to three focus groups with 4-6 participants in each will be sufficient to capture 80% of themes in thematic analysis (Guest et al., 2016). Inclusion criteria are that participants are professionals (e.g. health/social care/NGO workers) working in X, are aged 18 or above and able to provide full consent. There is no maximum age restriction, and participants may be of any gender. The exclusion criterion is participants under eighteen years old.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Participants will be recruited using purposive and opportunistic sampling through personal/professional contacts, email to local services (e.g. charities, community organisations) [see Appendix G and H], and social media (e.g. direct messaging people on Twitter, LinkedIn etc.) with a short request/message). Snowball sampling will also be used, whereby interest participants nominate other potential participants from a convenience sample (e.g., colleagues etc.) using a variety of means (e.g., personal contacts, social media etc.). If recruitment to focus groups prove difficult, then individual interviews will be used instead. Twelve interviews will be sufficient to reach data saturation (Guest et al., 2006). A final back-up

		option will be to recruit UK/international community psychologists to share their views about how applicable the PTMF might be.
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	Demographic (age, gender, ethnicity) and contact details will be collected. Focus groups/interviews will be conducted following an interview schedule (see Appendix A). An audio-recording device will be used to record in-person focus groups/ individual interviews, and facilitate transcription onto a password-protected laptop, which will also be used to store transcripts. If focus groups/interviews take place on the telephone/online, they will be recorded separately (e.g., using an audio recording device placed next to the computer or telephone) or via Microsoft Teams
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Participants will be recruited using purposive and opportunistic sampling, whereby participants who express an interest and meet selection criteria (e.g. health/social care/NGO workers working in X) will be selected. A ‘snowball sampling’ technique will also be used to recruit participants, with interested participants asked to nominate other potential participants from a convenience sample (e.g., colleagues etc.) using a variety of means (e.g., personal contacts, social media etc.). Potential participants will be given an information sheet (see Appendix B and C) to read, outlining the nature and purposes of the study and their rights as participants. Those who agree to participate will be given a consent form (see Appendix D and E) to read through which will be signed before beginning the focus group/interview. Focus groups/interviews will take place only if participants give consent. Focus groups/interviews will be conducted at a community space that is accessible for participants and will be audio-recorded using a password protected audio recording device. If it is not possible to conduct focus groups/interviews in person (e.g., Covid 19

		lockdown, unavailability of a community space), they will take place on the telephone/online and be recorded separately (e.g., with an audio-recording device placed next to the computer or telephone) or via Microsoft Teams. If the research is conducted remotely, electronic consent forms will be created (e.g., using Microsoft Forms) and stored in a separate folder on UEL OneDrive. Before focus groups (or individual interviews) commence, participants will be reminded of the purpose of the focus group/interview, and they will be asked if they have any questions about the study (which will then be addressed) and reminded of their right to withdraw from the study at any time without disadvantage to them and without being obliged to give any reason. They will be informed that they can withdraw within 3 weeks of the data being collected, after which the researcher reserves the right to utilise the anonymised data. Focus groups/interviews will be conducted following the interview schedule (Appendix A). Focus groups/interviews will be audio-recorded and transcribed for analysis by the researcher. At the end of the focus groups/interviews, the researcher will revisit consent to use the focus group/interview data, debrief the participants verbally and give them the debrief sheet (see Appendix F).	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	N/A – the proposed research involves no deception	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	N/A	
	How much will you offer?	N/A	

	Please note - This must be in the form of vouchers, not cash.	
3.11	**Data analysis:**	Thematic Analysis (Braun & Clarke, 2006)

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	All personally identifying information will be removed during transcription by replacing each participant's name with a pseudonym or participant number	
4.3	**How will you ensure participant details will be kept confidential?**	Focus groups/interviews will be audio-recorded. Transcripts will be anonymised and all personally identifying information will be removed or changed (e.g. pseudonyms or participant numbers used instead of name) during transcription. Limits to confidentiality will be explained (e.g. in case of serious risk). The audio-recording of the focus group/interview (i.e., the mp3) and the transcripts will be stored in password-protected files on a password-protected laptop. Demographic and contact details will be stored separately from the sound files and transcripts. Consent forms and focus group/interview transcripts will be stored in different folders. Participants will be informed that quotes from the focus group/interview may be used but they will only be referred to by a pseudonym or participant number and that nothing that might identify them will be included.	

		Any personal data that is gathered for this study will be held securely and processed in accordance with the University's Data protection Policy Act 208. Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up on the research.	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	The data will be stored on my UEL password protected OneDrive account in a folder that is not synchronised on any devices. Data will be sent to the supervisor as a backup during the study and stored on the supervisor's OneDrive account. Consent forms will be stored as password-protected files in a separate folder to other research data on UEL OneDrive.	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	I will have access to the raw data. My supervisor will have access to the anonymised data. Examiners may also have access to the anonymised data if requested.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	The anonymised focus group/interview transcripts are of long-term value.	
4.7	**What is the long-term retention plan for this data?**	Anonymised research data will be securely stored on my supervisor's UEL's password-protected OneDrive account for a maximum of 5 years, following which all data will be deleted. All identifiable information will be destroyed as soon as the allowed withdrawal period is over, and transcripts have been created unless there has been an agreement with the participants to receive an update from the researcher on the outcomes of the study.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☒
4.9	Will personal contact details be retained to contact participants in the future for other research studies?	**YES** ☐	**NO** ☒

	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	The study is not intended to cause any harm or distress to participants. However, given the potentially sensitive nature of the discussion, participants may become upset or distressed within the course of the study. These risks will be minimised by reminding participants that they may take breaks, leave the room, or withdraw at any time before focus groups/interviews commence. The researcher will look out for any signs that someone is becoming upset or distressed during the focus group/interview. If participants become distressed during the focus group/interview, it will be paused whilst the participant has a break. They will have the option to continue or to withdraw from the focus group/interview. At the end of the focus group/interview, participants will be given a list of organisations they could contact if they require further information or support. They could also be directed to their GP. If the researcher is concerned about a participant after the focus group/interview, they can contact the Director of Studies to discuss further.	
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐

	If yes, what are these, and how will they be minimised?	The researcher may become upset or distressed conducting focus groups/interviews with participants in distress. In the unlikely event that any distress is experienced by the researcher, relevant supervisors will be contacted.		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	A community space in London or online.		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	**N/A**		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	**YES** ☐		
5.7	**Additional guidance:**			

	▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the		

	understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	[redacted]	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation).	**YES** ☐	

	Please confirm that you have attached written permission as an appendix.	

7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation’ or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	Elliot Miller
8.3	**Student's number:**	2195617
8.4	**Date:**	05/05/2023

Supervisor’s declaration of support is given upon their electronic submission of the application

Appendix F. University of East Ethical Approval Confirmation

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details

Reviewer:	Please type your full name **Lorna Farquharson**
Supervisor:	Please type supervisor's full name **David Harper**
Student:	Please type student's full name **Elliot Miller**
Course:	Please type course name **Professional Doctorate in Clinical Psychology**
Title of proposed study:	**Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities**

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐

Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐

Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options

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.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, 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 at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	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. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments

Please clearly detail the amendments the student is required to make

Please add the date and version number to the participant information sheets and include this information in the consent forms.

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒

Reviewer recommendations in relation to risk (if any):	Please insert any recommendations

Reviewer's signature

Reviewer: (Typed name to act as signature)	**Lorna Farquharson**
Date:	**19/05/2023**

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

RESEARCHER PLEASE NOTE

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

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

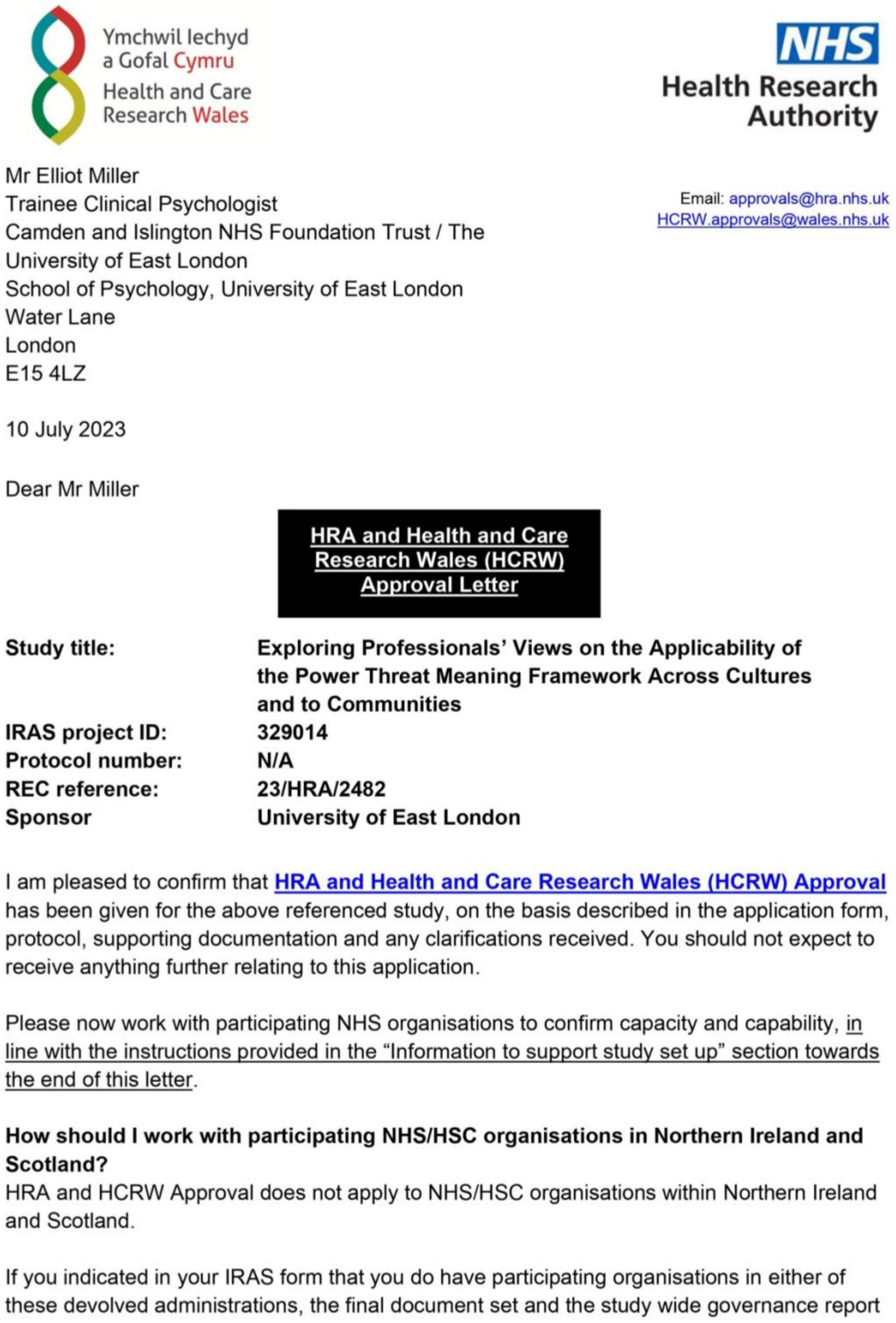
(Student to complete)

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

Student name: (Typed name to act as signature)	**Elliot Miller**
Student number:	**2195617**
Date:	**19/05/2023**

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

Appendix G. Health Research Authority Ethical Approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Mr Elliot Miller
Trainee Clinical Psychologist
Camden and Islington NHS Foundation Trust / The
University of East London
School of Psychology, University of East London
Water Lane
London
E15 4LZ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

10 July 2023

Dear Mr Miller

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

Study title:	**Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities**
IRAS project ID:	**329014**
Protocol number:	**N/A**
REC reference:	**23/HRA/2482**
Sponsor	**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.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

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 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) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

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 *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, 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.

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

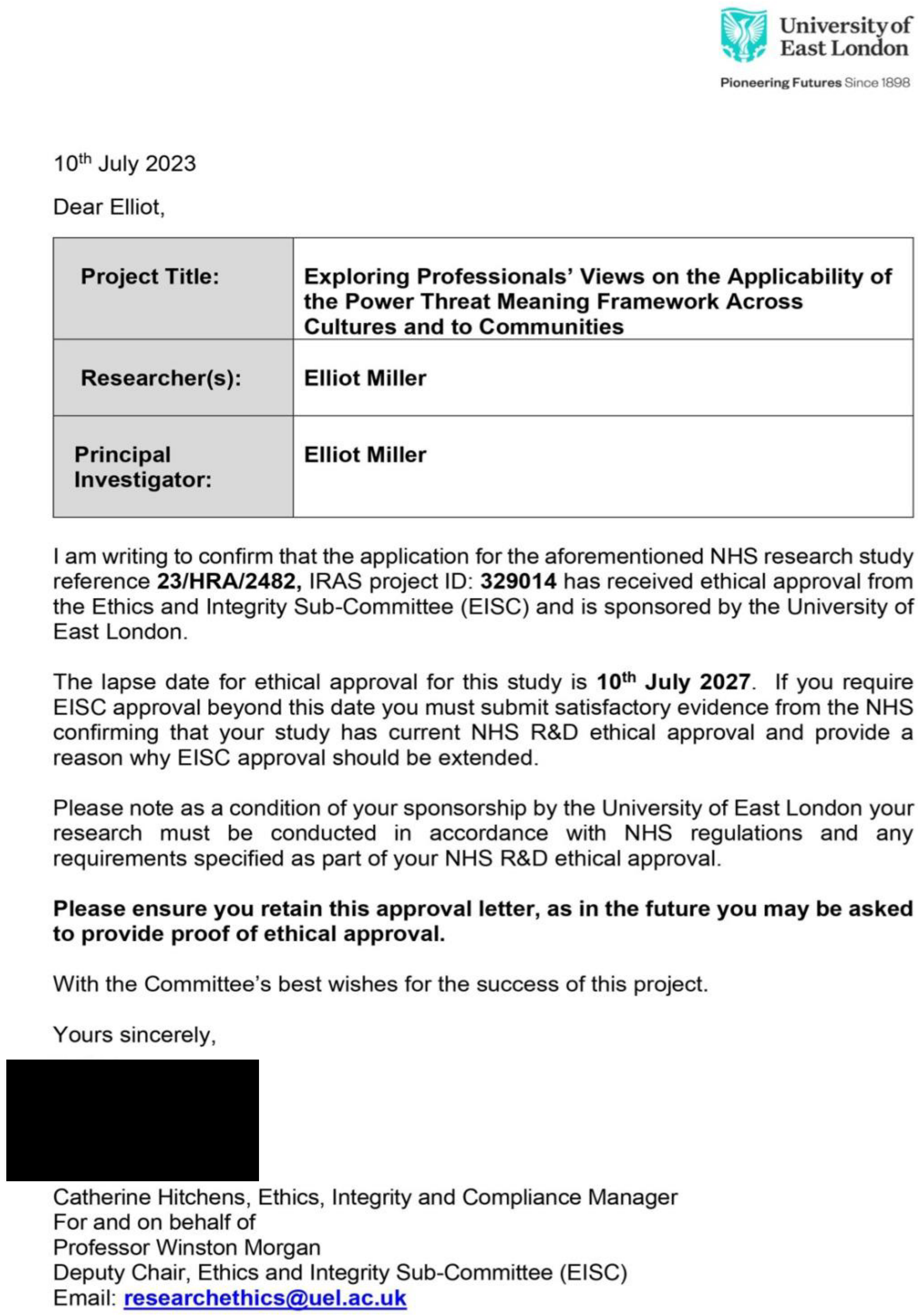
Your IRAS project ID is **329014**. Please quote this on all correspondence.

Yours sincerely,
Chris Kitchen

Email: approvals@hra.nhs.uk

Copy to: *Mrs Catherine Hitchens*

Appendix H. University of East London's Sponsorship Confirmation Letter



University of East London
Pioneering Futures Since 1898

10th July 2023

Dear Elliot,

Project Title:	**Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities**
Researcher(s):	**Elliot Miller**
Principal Investigator:	**Elliot Miller**

I am writing to confirm that the application for the aforementioned NHS research study reference **23/HRA/2482,** IRAS project ID: **329014** has received ethical approval from the Ethics and Integrity Sub-Committee (EISC) and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **10th July 2027**. If you require EISC 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 EISC 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 ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

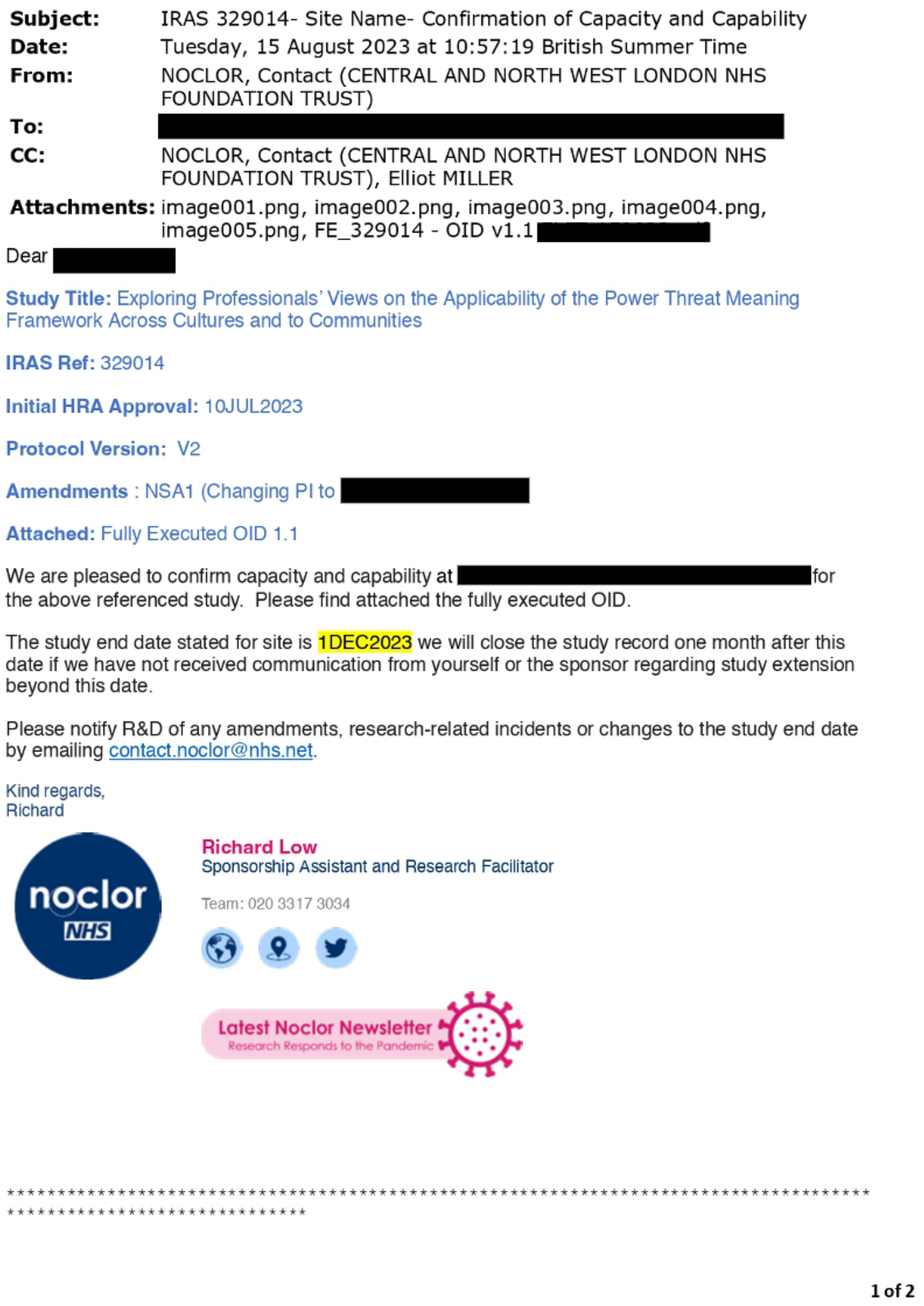
With the Committee's best wishes for the success of this project.

Yours sincerely,

[redacted]

Catherine Hitchens, Ethics, Integrity and Compliance Manager
For and on behalf of
Professor Winston Morgan
Deputy Chair, Ethics and Integrity Sub-Committee (EISC)
Email: researchethics@uel.ac.uk

Appendix I. Email Confirmation of Local Capacity and Capability



Subject: IRAS 329014- Site Name- Confirmation of Capacity and Capability
Date: Tuesday, 15 August 2023 at 10:57:19 British Summer Time
From: NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST)
To: [redacted]
CC: NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST), Elliot MILLER
Attachments: image001.png, image002.png, image003.png, image004.png, image005.png, FE_329014 - OID v1.1 [redacted]

Dear [redacted]

Study Title: Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities

IRAS Ref: 329014

Initial HRA Approval: 10JUL2023

Protocol Version: V2

Amendments : NSA1 (Changing PI to [redacted]

Attached: Fully Executed OID 1.1

We are pleased to confirm capacity and capability at [redacted] for the above referenced study. Please find attached the fully executed OID.

The study end date stated for site is 1DEC2023 we will close the study record one month after this date if we have not received communication from yourself or the sponsor regarding study extension beyond this date.

Please notify R&D of any amendments, research-related incidents or changes to the study end date by emailing contact.noclor@nhs.net.

Kind regards,
Richard

noclor NHS

Richard Low
Sponsorship Assistant and Research Facilitator

Team: 020 3317 3034

Latest Noclor Newsletter
Research Responds to the Pandemic

****

1 of 2

Appendix J. Participant Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY (FOCUS GROUPS)

29.06.2023

Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities

Contact person: Elliot Miller
Email: u2195617@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet related to the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the focus group to withdraw my data from the study.	
I understand that the focus group will be audio-recorded using password-protected recording device or Microsoft Teams	
I understand that my personal information and data, including audio recordings, from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from focus group data may be used in academic journals resulting from the study and that these will not personally identify me.	

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

…………………………………………………………………………………………………

Participant’s Signature

…………………………………………………………………………………………………

Researcher’s Name (BLOCK CAPITALS)

…………………………………………………………………………………………………

Researcher’s Signature

…………………………………………………………………………………………………

Date

……………………..…………………………………………………………………………

Appendix K. University of East London Risk Assessment Form

University of East London
Pioneering Futures Since 1898

UEL Risk Assessment Form

Name of Assessor:	Elliot Miller	**Date of Assessment:**	05/05/2023
Activity title:	Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities	**Location of activity:**	Face-to-face (e.g., community space), on the telephone and/or online via Microsoft Teams
Signed off by Manager: (Print Name)	Professor David Harper	**Date and time: (if applicable)**	Data collection will start in May-July 2023 and finish by May 2024

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.). **If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:**
Data collection for a research project and dissertation. Data will be collected via two or three face-to-face, telephone and/or online focus groups, lasting approximately 90 minutes with 4-6 participants in each. If recruitment to focus groups is not possible, up to 12 individual interviews will be conducted in-person, on the telephone, or online via Microsoft Teams, each lasting between 30-45 minutes.
Overview of FIELD TRIP or EVENT:
N/A – research study

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating
Potential psychological risks for the researcher e.g., emotional impact of conducting a focus group/individual interview with someone in distress)	Researcher	In the unlikely case that any psychological risks are experienced by the researcher, relevant supervisors will be contacted.	1	1	1	N/A	1

Potential psychological risks for participants (e.g., emotional impact of taking part in the study about adversities facing communities)	Participants	The researcher will remind participants that may take breaks, leave the room, or withdraw at any time before focus group/individual interviews commence. The researcher will also look out for any signs that someone is becoming upset or distressed during discussions. If any participants become distressed, the focus group/individual interview will be paused whilst the participant(s) has a break. They will have the option to continue or to withdraw from the focus group/individual interview. At the end of the focus group/individual interview, participants will be given a list of organisations they could contact if they require further information or support. If the researcher is concerned about a participant after the focus group/ individual interview, they can contact the Director of Studies to discuss further.	1	1	1	N/A	1

Physical safety / security in the community space (e.g., fire, people disturbing the space)	Researcher Participants	The researcher will be briefed on, the fire, first aid and local emergency arrangements by the community space contact before the research starts. The researcher will identify their local exit routes and follow local emergency arrangements. In the event that the space is disturbed, the researcher will stop the focus group/individual interview and inform the community space contact immediately.	1	1	1	N/A	1

Review Date

Appendix L. Participant Debrief Form

PARTICIPANT DEBRIEF SHEET

29.06.2023

Exploring Professionals' Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities

Thank you for participating in my research study on the applicability of the Power Threat Meaning Framework across cultures and to communities. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through an article in an academic journal. In all material produced, your identity will remain anonymous, in that, all personally identifying information about you will either be removed or replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details (e.g., email address, phone number) will need to be provided.

Anonymised research data will be securely stored by my supervisor (Professor David Harper) for a maximum of 5 years, following which all data will be deleted.

What if I have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

1. The NHS provides a list of useful helplines if you find yourself negatively affected in any way by this study. https://www.nhs.uk/mental-health/nhs-voluntary-charity-services/charity-andvoluntary-services/get-help-from-mental-health-helplines/

2. Mind – Taking care of yourself. This page includes information on how to support yourself and considerations for how to adapt your workplace to make it a more mentally healthy place. https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-yourself/

   Email: info@mind.org.uk
   Infoline: 0300 123 3393

3. Rethink Mental Illness - provides support and information for anyone affected by mental health problems, including local support groups. https://www.rethink.org/

   Tel: 0808 801 0525

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Elliot Miller
Email: u2195617@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix M. University of East London Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).
Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Elliot Miller
PI/Researcher ID (e.g. ORCiD)	0000-0003-3229-7593
PI/Researcher email	u2195617@uel.ac.uk
Research Title	Exploring the Power Threat Meaning Framework Across Cultures and on a Community Level
Project ID	N/A
Research start date and duration	January 2023 – September 2024

Research Description	The Power Threat Meaning Framework (PTMF) was developed as a non-medical model to human distress (Johnstone & Boyle, 2018). The Framework posits that individuals' distress arises out of understandable responses to adversities, which raise in context of unequal power relationships (e.g., social inequalities). These adversities are seen as posing threats to common human needs. These threat responses are enabled and learnt through culture, allowing for the existence of widely varying cultural experiences and expressions of distress. These are largely relevant within Westernised cultures, however and so there is a need to develop the PTMF alongside the cultural beliefs of the social or cultural group at issue (Johnstone et al., 2019; Johnstone, 2020). There is also growing recognition that adversity can be experienced on the community-level, in part to the impacts of interpersonal and structural violence (Pinderhughes et al., 2015). Though, the PTMF is conceived as too individually focused (Emerging Proud, 2020) as this is how distress is perceived within Western cultures (Johnstone, 2020). Thus, further development of the Framework is required to describe the adversities facing whole communities (Johnstone & Boyle, 2018). This study aims to examine the relevance of the PTMF to other cultures, and whether the framework can be used to understand community adversities, using focus groups X. The study will address the following research questions: 1. To what extent is the Power Threat Meaning Framework applicable to a culture other than white, Western culture? 2. Can the PTMF be used to understand community-level responses to adversity? The study will aim to recruit between 12 to 18 participants in total, through purposive, opportunistic and snowball sapling, to participate in focus groups. Two or three focus groups, each lasting approximately 90 minutes with 4-6 participants, will be conducted in person or remotely via Microsoft Teams. Participants aged 18 or above who identify as X and live in X will be recruited. Focus groups will be audio-recorded, transcribed, and analysed using thematic analysis. It is hoped that the findings will increase our understanding of how communities respond to problems, and cultural differences in which distress is experienced and expressed.
Funder	N/A – Part of Professional Doctorate

Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	11/03/2023
Date of last update (of DMP)	
Related Policies	Research Data Management Policy UEL Data Protection Policy UEL Data Backup Policy UEL Statement on Research Integrity UEL Statement om Research Ethics UEL Code of Practice for Research UEL Code of Practice for Research Ethics UK GDPR and the Data Protection Act 2018
Does this research follow on from previous research? If so, provide details	No
Data Collection	
What data will you collect or create?	Demographic data (age, gender, ethnicity) and contact details for participants will be collected. This data will be stored separately from sound files and transcripts in a single Excel spreadsheet (.xlsx), which will be password-protected and saved on the researcher's UEL OneDrive. Personal data, such as participants' names and signatures, will be collected on consent forms. Consent forms will be scanned and saved as individual pdf files (one each per participant). The hard copies will then be shredded. The consent forms will be saved as individual password-protected files and stored in a separate folder to other research data on UEL OneDrive. Up to 3 audio-recordings of focus groups will be created. The estimated length of each file is 90 minutes (approx. 4GB in total). If recruitment to focus groups proves problematic, up to 12 audio-recordings of individual interviews will be created. In this case, the estimated length of each file is 30 to 45 minutes (approx. 8GB in total) Focus groups or individual interviews will be audio-recorded using a password-protected recording device, saved as audio files (.mp3), and transcribed by the researcher. If remote focus groups or individual interviews take place, they will be recorded using Microsoft Teams.

	All personally identify information will be removed during transcription by replacing each participant's name with pseudonym or participant number. The list of identifiers (pseudonyms or participant numbers) will be stored separately on the UEL OneDrive so participants can be re-identified if they wish to withdraw within the 3-week deadline Each transcript will be saved as an individual Word document (.docx). Audio-recordings will be deleted after the thesis has been examined and passed. A reflexive log will be kept by the researcher. This will contain no identifiable participant information and will be stored as a single Word document (.docx). Documents will be stored on the researcher's UEL OneDrive. Thematic analysis will be used to analyse the data and will be written up into a final report (.docx)
How will the data be collected or created?	Data will be collected in-person, or remotely via Microsoft Teams, using focus groups of approximately 90 minutes duration or individual interviews lasting between 30-45 minutes. In person focus groups or individual interviews will be audio-recorded using a password-protected audio recording device. This data will be transferred from the recording device to the researcher's password-protected computer via USB connection at the earliest opportunity (i.e., on the researcher's return from the interview) and stored on the researcher's UEL OneDrive. The device will be stored in a locked security box and transported by the researcher in a lockable case. Data will be saved and organised using folders and subfolders on UEL OneDrive. Recordings will be stored following the file-naming convention: [ProjectCode]-[InterviewerInitials]-[ParticipantNumber]-[Location]-[Date]. An interview schedule will be developed so that a standard format is followed. If it is not possible to conduct focus groups or individual interviews in person (e.g., Covid 19 lockdown, unavailability of a community space), they will take place using Microsoft Teams. Microsoft Teams will be used to record the interviews and auto-transcribe the recordings. If the research is conducted remotely, electronic consent forms will be created (e.g., using Microsoft Forms) and stored in a separate folder on UEL OneDrive.

	Consent information will be collected via consent forms and will also be gained verbally at the start of focus groups. Paper consent forms will be transported securely by the researcher using a locked case and will be scanned at the earliest opportunity. Paper consent forms will be stored in a locked security box until they have been scanned and shredded. The scanned consent forms (.pdf) will be password protected. The reflexive log will be created by the researcher using word processing software
Documentation and Metadata	
What documentation and metadata will accompany the data?	• Participant information sheets • Consent forms • Debrief sheet • Study advertising materials (e.g., flyer/leaflet) • Researcher’s reflexive log • Interview schedule • List of abbreviations/acronyms used in file names The above documents will be produced using word processing software and saved as Word documents (.docx) or pdf files (.pdf).
Ethics and Intellectual Property	
Identify any ethical issues and how these will be managed	Potential participants will be provided with an information sheet about the study and given a consent form, prior to the focus group. Participants will be provided with information regarding data management. They will also be informed that the anonymised data may be retained for up to 5 years by the supervisor should the researcher wish to publish the research. Participants will be informed of their right to withdraw from the study at any time, without providing a reason, and without negative consequence. Participants will be informed that they can withdraw their research data within 3 weeks of the data being collected, after which the researcher reserved the right to utilise the anonymised data and it will not be possible to remove their individual data. They will be given the researcher’s contact details should they wish to withdraw their consent. If a participant decides to withdraw from the study within this 3- week time period, they will be informed that their

	contribution (e.g., focus group or interview recording and transcript) will be removed and confidentially destroyed. Participants will be required to sign a consent form if they would like to take part. Consent forms will be stored as password-protected files and stored separately to other research data on UEL OneDrive. All potentially identifiable information given during the interviews will be removed or altered at the time of transcription. Each participants' name will be replaced by a pseudonym or participant number, which will be used in all written material (apart from the consent form). Transcription will be undertaken only by the researcher to protect confidentiality of the participant. Focus groups or individual interviews will be audio-recorded using a password-protected audio-recording device or Microsoft Teams. The audio files will be deleted after the thesis has been examined and passed.
Identify any copyright and Intellectual Property Rights issues and how these will be managed	N/A – No known copyright or Intellectual Property Rights issues. No copyrighted materials are planned to be used (the interview schedule used to collect the data is original)
Storage and Backup	
How will the data be stored and backed up during the research?	Research data (focus group or interview transcripts, and MS Teams recordings) will be stored securely using the researcher's UEL OneDrive, which is accessible only to the researcher via the researcher's username and password. Local copies will be deleted from the Microsoft stream library (or audio device) and the download folder once successfully uploaded to OneDrive. The researcher will use SharePoint to back up the data during the research. During the 'active' stage of the project, the researcher will share copies of the anonymised focus group or interview transcripts via OneDrive secure links (to be stored using their own secure UEL OneDrive account). Electronic scans of consent forms, which will contain identifiable information (e.g., names), will be stored as password-protected files and saved in a separate folder to other research data on UEL OneDrive, accessible only to the researcher. The spreadsheet of participants' demographic details and contact information, and coding

	documentation will also be stored in this way, in separate password-protected folders.
How will you manage access and security?	Focus groups or individual interviews will be audio-recorded by the researcher using a password-protected audio-recording device or Microsoft Teams. The recording device will be transported in a locked case and stored in a locked storage box in the research supervisor's locked filing cabinet at their Stratford campus office. Audio files will be downloaded from the device at the earliest opportunity. The audio files will be temporarily downloaded to the researcher's UEL OneDrive to allow transcription. Audio files will be deleted after the thesis has been examined and passed. Anonymised data (e.g., transcripts) will be stored separately from data containing identifiable information (e.g., consent forms, contact details) on the researcher's UEL OneDrive which is secure and encrypted. Security will also be ensured by password protecting all documents and storing the data and meta data on UEL's OneDrive which is secure and encrypted. The researcher will only share anonymised data (e.g., anonymised focus group or interview transcripts) with the research supervisor(s) and examiners. Data sharing with the research supervisor(s) will take place via UEL OneDrive (using OneDrive secure links) or UEL email. Files containing identifiable information (e.g., participant names, contact details) will be accessible only to the researcher, using the researcher's UEL OneDrive. The researcher will use their own password protected laptop to access UEL OneDrive and will access UEL systems using multi-factor authentication.
Data Sharing	

How will you share the data?	The thesis will be publicly accessible via UEL Research Repository. Participants will be required to consent to this prior to participation. Extracts from the anonymised transcript will be written up into a thesis which will be deposited and shared via the UEL's Research Repository. Identifiable data will not be included in these extracts. Raw data (full focus group or interview transcripts) will not be deposited on the UEL Research Repository. This is to best protect participant confidentiality. Quotations, and any feedback from participants, included in the research thesis (or any subsequent publications, presentations etc.) will be carefully monitored for anonymity and any potentially identifiable information will be removed or altered prior to inclusion.
Are any restrictions on data sharing required?	No one outside of the research team will have access to the research data files. Only anonymised data will be shared with research supervisor(s) and examiners (if requested). Only anonymised data will be included in the thesis and any subsequent publications, presentations etc
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Audio-recordings of interviews will be deleted after the thesis has been examined and passed. Electronic copies of consent forms will be retained by the researcher until the thesis has been examined and passed and will then be deleted. Research data stored on the researcher's UEL OneDrive will be deleted once the thesis has been successfully examined and passed. A thesis will be written up using extracts of transcripts and this will be stored on UEL Research Repository (as outlined in the UEL Research Data Management Policy). Anonymised research transcripts will be stored by the research supervisor(s) for future dissemination purposes and retained for a maximum of 5 years, stored by the supervisor on the UEL OneDrive, after which time all research data will be deleted. Consent forms may also be preserved for one year to ensure that

	participants consent can be explicitly checked at further stages of dissemination and review (e.g., at stage of publication).
What is the long-term preservation plan for the data?	The research supervisor(s) will retain anonymised research data (e.g., anonymised transcripts) for dissemination purposes for a maximum of 5 years following thesis submission. This data will be stored on the research supervisor's own secure UEL OneDrive account and will be deleted once this 5-year period has elapsed.
Responsibilities and Resources	
Who will be responsible for data management?	Elliot Miller (Researcher) Professor David Harper (Director of Studies/Research Supervisor) & Dr Trishna Patel (Second Research Supervisor) The researcher will collect, store, and organise the research data. The research supervisor(s) will be responsible for retaining anonymised data once the researcher has left UEL and deleting this data once the retention period has elapsed
What resources will you require to deliver your plan?	A laptop UEL OneDrive Research supervisor's OneDrive UEL email account Password-protected audio-recording device Lockable bag Lockable security box Microsoft Office software (e.g. Word, Excel) Microsoft Teams (if required)
Review	
	Please send your plan to researchdata@uel.ac.uk **We will review within 5 working days and request further information or amendments as required before signing**
Date: 11/03/2023	Reviewer name: Joshua Fallon Assistant Librarian RDM

Appendix N. Transcription Notation System for Orthographic Transcription

The following transcription notation system for orthographic transcription was used to fully capture participants' communication (revised from Braun and Clarke, 2013, p. 163-169):

Notation	Meaning
P:	To signal the identity of a speaker
Interviewer:	To signal the interviewer is speaking
((laughs))	To signal a speaker laughing during a turn in the conversation
((General laughter))	To signal multiple speakers laughing at once
((coughs))	To signal a speaker coughing during a turn in the conversation
((pause))	To signal a significant pause (i.e., a few seconds or more)
((long pause))	To signal a much longer pause
((in overlap))	To signal an overlap in speech
((inaudible))	To signal speech and sounds that are completely inaudible
()	To signal a best guess when the speech is inaudible
-:	To signal moments when speakers are struggling to articulate their thoughts, feelings etc., and cut off speech

Appendix O. Excerpt of a Coded Transcript

Data segment	Code Label
P4: Yeah. Everybody wants a promise that they aren't going to because you were kind of saying, you know you can see why people kind of stick to themselves because there's that kind of feeling of not actually being looked at and pointed at, you know, like you can definitely see like why that happens, you know, it's why like, you know, we have like the kind of queer spaces and there is that kind of feeling of nothing bad should happen here so that could also be why we don't see as much cohesion because there isn't the promise of safety and whatever community you come from it feels like somebody doesn't like that.	Isolation/withdrawal
P3: And one of the things I've learned, like, in my, over the years is like, there is no way of ignoring the fact that government policies impact our lives, everyday lives and everything that happens in politics like when you're a teenager you say, oh it's politics, who cares? But actually we do have to care and like I said like the policies, the change of government, the changing of cabinet, everything it just trickles down and everything they do has an impact on these communities and when you add in poverty, when you add in generational trauma. It's just a horrible combination. It's almost like [the borough] is a melting pot of these communities, trauma, trauma inflicted from outsiders, trauma inflicted from their own childhood, their own background, and it's like a melting pot of this. And we put in the poverty, you know, and people struggling to survive. And then you've got the stark contrast of the rich people living across the in the middle of the whole borough you know.	Government laws/policies Poverty Socio-economic inequalities

Data segment	Code Label
Do you see that it's combination like disparities of wealth as well is ridiculous. It's just, yeah, it's really hard to see. I don't want to be not hopeful, but it's hard not to, but when you've got policies going on and nobody's changing, everybody's coming up with the same things. Like I'm talking about ministers and people in public office. Doesn't help. And every time someone new comes in, like the new mayor coming in was so controversial to this day. Like I work in a different sector and we see it as a huge thing because of all the funding cuts. And this has impact and it's the discourse that I hear from both the community, how they feel, you know. And they're not happy and it impacts how people perceive other communities. That's the bottom line.	Government law/policies Lack of funding/disinvestment
Interviewer: It just trickles down, like, the discourse about particular communities, creates then divisions within a community that actually has probably quite a lot in common in terms of the challenges that they face, but then it's kind of like that division that it creates. And then you mentioned kind of some of the adversities.	
I think you've touched on actually quite a lot already, but you've mentioned kind of like poverty, I think overcrowding you mentioned, any other kind of adversities that you can think of like in this melting pot that you said.	
P2: I mean, the thing is that I don't understand I mean you know we have not bad schools in the borough.	
P3: That's not education ((laughs))	
P2: Yeah coming back to the education.	
P3: The education is horrendous ((in overlap)) .	Inadequate education

Appendix P. Final List of Code Labels

Codes

Alienation
Avoidance of help and support
Collective action
Communal spaces
Community support systems
Community-based initiatives
Cost-of-living
Devaluation of social/work roles
Digital poverty
Decline in social support structures
Divine punishment
Divisive political discourse
Financial insecurity/poverty
Focus on the present moment
Generational language gap
God’s will
Government laws/policies
Hopelessness
Housing issues
Identity politics
Ideological shifts
Inability to meet basic physical needs
Inadequate education
Injustice
Isolation/withdrawal
Lack of community spaces
Lack of cultural understanding in healthcare
Lack of funding/disinvestment
Loss of culture
Loss of societal values
Mistrust
Online platforms
Physical danger
Political self-interest
Prejudice/discrimination
Prioritisation of own needs
Psychological ill-health
Shame beliefs
Shared values
Social isolation
Socio-economic inequality
Spiritual possession
Stealing
Stigma

Appendix Q. Excerpt of a Code Label with Associated Data Segments

Code Label	Data Segments
Mistrust	P3: I mean it can't be more obvious within NHS services that Somali communities don't access it at all…very very very rarely unless they have to and when we met with the communities, we saw, we saw, like the reasons and answers that they had. And a lot of it's like this, they do get a lot, they do, they get neglected and they're used for numbers and then people just forget about them and it's, what it's done is created a culture of where they don't feel very comfortable around people who aren't from their communities, even if they are from services. It's really difficult to work with them because of their own fears and the fact that you take to them you're an outsider who just comes and goes as they please. P1: I think a general mistrust in services is what lies at the heart of it all. Because everyone has a collective, you hear about people having a good sort of like you know thing you it's a good perception of a service very rarely. But in a group and you're talking to like most if you speak to service users or anyone 95% of the time is that they don't have a good like they've received really bad care and services and I think it's just not having that trust as well that's like they're not trusting these services because they're, know nothing to show that they can actually trust them. There's no care, there's no trust and stuff. So yeah, I think there's like a general mistrust with services. P4: Yeah I think it's kind of an interesting thing of like mistrust because I think there is that kind of feeling of people mistrusting services like their NHS, police everything but it's on very valid ground you know it's not like this mistrust that's coming out of nowhere like it's mistrust because of historic abuse you know like why should a lot of people you know in this borough you know trust the police because there's history of like, I think it's literally on this road, like the [squatters] and the police visiting every single day to try and get people to leave, like historic, like abuse, like it was only a couple of months ago that a gay man died because of the police like so like why? You know like they were just and and you know like there are like the NHS hasn't put effort into like funding for certain communities and stuff so there is like there's mistrust but you can see why and there needs to be something massive to change, to build that up and to bring the community together because it's not going to be small things, like, because it's all very small things ((laughs)) and it's not going to make this monumental change.

Appendix R. Initial Thematic Table

Candidate Theme 1	Code Clusters
Adversities Facing the Community	Cost-of-living Digital poverty Generational language gap Housing issues Ideological shifts Lack of cultural understanding in healthcare Loss of community spaces Prejudice/discrimination Socio-economic inequality Stigma

Candidate Theme 2	Code Clusters
Threats to the Community	Decline in social support structures Devaluation of social/work roles Financial insecurity/poverty Inability to meet basic physical needs Loss of cultural identity Loss of societal values Physical danger Psychological ill-health Social isolation

Candidate Theme 3	Code Clusters
Meaning-Making of the Community	Alienation Divine punishment God’s will Government laws/policies Hopelessness Identity politics Inadequate education Injustice Lack of funding/disinvestment Political self-interest Shame beliefs Spiritual possession

Candidate Theme 4	**Code Clusters**
Threat Responses of the Community	Avoidance of help and support Focus on the present moment Isolation/withdrawal Mistrust Prioritisation of own needs Stealing

Candidate Theme 5	**Code Clusters**
Resources of the Community	Collective action Communal spaces Community support systems Community-based initiatives Online platforms Shared values

Appendix S. Final Thematic Table

Theme 1: “A Laundry List”: Adversities Facing the Community	**Code Clusters**
Sub-theme: “Socio-Economic Quality Has Always Been an Issue”: Structural Adversities	Cost-of-living Digital poverty Housing issues Loss of community spaces Socio-economic inequality
Sub-theme: “Most of Us Don't Know Our Neighbours”: Socio-Cultural Adversities	Decline in social support structures Generational language gap Ideological shifts Lack of cultural understanding in healthcare Prejudice/discrimination Stigma

Theme 2: “Challenges to Basic Survival Needs”: Threats Posed to the Needs of the Community	**Code Clusters**
Sub-theme: “Am I Going to Eat or Heat?”: Economic and Material Threats	Financial insecurity/poverty Inability to meet basic physical needs
Sub-theme: “People Have Gone from Visible to Totally Invisible”: Social Threats	Social isolation Loss of cultural identity
Sub-theme: “The Loss of Culture”: Cultural and Valued-Based Threats	Devaluation of social/work roles Loss of societal values
Sub-theme: “The Risk of Death”: Bodily Threats	Physical danger Psychological ill-health

Theme 3: “It All Comes Down to Who’s Governing Us”: Meaning-Making of the Community	**Code Clusters**
Sub-theme: “Government Policies Impact Our Lives”: Socio-Political Understandings	Government laws/policies Inadequate education Identity politics Lack of funding/disinvestment Political self-interest
Sub-theme: “In the Hands of God”: Cultural Beliefs	Divine punishment God’s will Shame beliefs Spiritual possession
Sub-theme: “The System is Against Me”: Histories of Inequity and Mistrust	Alienation Hopelessness Injustice Mistrust

Theme 4: “There Isn’t That Cohesion”: Threat Responses of the Community	**Code Clusters**
Sub-theme: “Communities Turning On Each Other”: Social Fragmentation	Avoidance of help and support Isolation/withdrawal
Sub-theme: “Everything is Me, Me, Me…”: Self-Preservation	Focus on the present moment Prioritisation of own needs Stealing

Appendix T. Excerpt from Reflective Diary

Focus Group X

Before the start of the focus group:

- I felt a mix of excitement and nerves.
- I enjoyed catching up with previous colleagues and hearing about their work.
- Noticed a relaxed atmosphere, perhaps due to my existing relationships with participants.

During the focus group:

- Hearing participants sharing professional and personal experiences related to community adversities was powerful.
- I noticed participants went off track when asked to describe the community they work in as an opening question, focusing on adversities instead and wondered if this indicated prevalent challenges within the community.
- I struggled to balance guiding the conversation and allowing it to flow naturally. Based on my prior knowledge of working in the borough, I felt tempted to prompt participants about certain adversities.
- I found it challenging to cover all the questions within the allocated time, with most of the discussion focused on the community's challenges, leaving insufficient time for discussing resources within the community.

Transcription:

- I noticed participants expressing uncertainly or seeking validation for their responses, possibly due to familiarity with me as a peer and a desire to provide 'correct' answers for my research.
- There was little discussion about how different cultural groups make sense of their experiences.
- Despite feeling that the focus group was rich and detailed, I noticed a lack of information in response to specific questions, especially regarding how these adversities impact community members.

Appendix U. Change of Title Request Form

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Elliot Miller**
Programme of study:	**Professional Doctorate in Clinical Psychology**

Title of research:	Exploring Professionals’ Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities
Name of supervisor:	**Professor David Harper**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Exploring Professionals’ Views on the Applicability of the Power Threat Meaning Framework Across Cultures and to Communities
New title:	Exploring Community Adversity in a Culturally Diverse Inner London Borough: A Thematic Analysis of Professionals’ Views in the Context of the Power Threat Meaning Framework
Rationale:	The title change better aligns with the actual focus of my study, which is the examination of community adversity within a culturally diverse inner London borough through the lens of the Power Threat Meaning Framework (PTMF). This revised title accurately reflects the nature of my research, in that it is the exploring practical application of the PTMF rather than solely inquiring about professionals' opinions on the framework itself.

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student’s signature

Student: (Typed name to act as signature)	**Elliot Miller**
Date:	**08/11/2023**

Reviewer’s decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how**	

	the data are collected or how the research is conducted.
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**
Date:	**14/11/2023**