What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?

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"You carry with you not only the ability to accomplish, but to excel. With it comes the responsibility to follow through". -G. Boston

Abstract

The aims of the study were to explore the experiences of manualised CBT within IAPT services from an Afghan persons experiences. The study sought to understand the depths of the experiences through a cultural lens, with the goal of offering insights to Counselling Psychologists and psychological professionals on how to work with Afghans within IAPT, and a wider hope to offer suggestions for service improvements to enhance an Afghan persons experiences with therapy. There were five female participants aged between 21-35. I conducted semi-structured interviews which were analysed with Reflexive Thematic Analysis. Three overarching themes were presented in the context of a journey: The beginning, the middle and the end. Within each overarching theme were two to four themes and one to five subthemes.

The research found experiences with therapy could be more empowering if IAPT environments facilitate choice, shared decision making and a genuine curiosity about the cultural aspects of being Afghan. Choice refers to how much involvement a person has when allocated a therapist (with discussions around gender, cultural background and modality of therapy, i.e., face to face or online). Participants felt better able to engage when they felt they could relate to their therapist, whilst also gaining a sense that their therapist could relate to them and understand their difficulties through a cultural lens. Contrary to this, the data also suggested that a lack of cultural similarity could also create safety in an Afghan's engagement with CBT within IAPT. Detriments in care tended to relate to wait times, a lack of rapport between therapist and participant and difficulties engaging with the manualised CBT techniques.

Suggestions are made about offering choice and understanding the context of an Afghan's woman's journey during therapy. Cultural competence is considered, and this research expands on this by discussing how IAPT could go beyond cultural competence and consider cultural

humility as a way to combat a lack of cultural curiosity and unconscious biases when working with minority groups.

Recommendations for future research whilst considering the epistemic and ontological gaps in the research which are also addressed through my own ontological and epistemological choices for the current research.

List of Tables and Figures

Glossary of Abbreviations

BAME – Black and Minority Ethnic

BPS – British Psychological Society

CBT – Cognitive Behavioural Therapy

CoP – Counselling Psychologist

DSM – Diagnostic and Statistical Manual of Mental Disorders

EDI – Equality, Diversity and Inclusion

IAPT – Improving Access to Psychological Therapies

IPA – Interpretive Phenomenological Analysis

NICE- National Institute of Clinical Excellence

PTSD – Post Traumatic Stress Disorder

RTA – Reflexive Thematic Analysis

UK – United Kingdom

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Introduction

Overview

I will introduce the context and framework for the proposed research topic and outline the research questions. I present personal context, my philosophical stance (ontological and epistemic positioning), and the research's relevance to Counselling Psychology.

This study aims to explore the way an Afghan individual experiences the therapeutic process in an Improving Access to Psychological Therapies Service (IAPT), with specific reference to accessing Cognitive Behavioural Therapy (CBT) within a National Health Service (NHS) environment.

The purpose of this research comes from my goal to produce a meaningful piece of work that considers a minority group's experience of CBT therapy, and provides insights into how to work with Afghans. The Afghan diaspora epitomises one of the most profound humanitarian crises of modern times. Having seen decades of war and devastation, there are an estimated 79,000 Afghan born citizens in the United Kingdom (Office of National Statistics, 2019), a figure that would have increased due to the recent crisis in Afghanistan whereby the Taliban (recognised as a terrorist organisation by the UK government) have taken rule. Trauma is a by-product of war, so there is a high probability that intergenerational trauma would feature prominently as a lived experience of Afghan families (Saleem et al., 2021; Alemi et al., 2017a). Therefore, it is possible that Afghan individuals may need to access mental health services (Alemi et al., 2016). However, the Afghan community are seldom mentioned in psychological literature in the context of receiving psychological therapies in the United Kingdom (UK). This research is relevant to Counselling Psychology (CoP) as the profession requires psychologists to work within IAPT services and these environments can be a conflicting place of work for a CoP because of the manualised and economically driven nature of the work which can directly clash with the CoP relational (working with the relationship at the forefront of therapy). way of working (Rizq, 2019). The research will offer some insights into how to work with Afghan people specifically, and offer insight into the importance of cultural competence.

The challenge with psychological interventions created within Westernised cultures like CBT (see further down), is it can neglect the need to adapt to specific ethnic groups (Harper

Shehadeh et al., 2016). For example, evidence from qualitative studies conducted with Afghans suggest illustrations of symptoms, conceptualisations of mental health issues and their treatment contrast from Western perceptions (Alemi et al., 2016; Yaser et al., 2016; Sulaiman-Hill & Thompson, 2011)

There is a gap in the literature relating to Afghan individual's engagement with primary care CBT. Primary care services such Improving Access to Psychological Therapies (IAPT) are at the forefront of mental health care and there is a high likelihood minority population will use them. The IAPT model and overall evidence-base is grounded by quantifiable outcomes due to the NHS functions under a business model which requires strong evidence-based outcomes to operate services (Mason & Reeves., 2018). It has been heavily criticised for the lack of focus on a recovery narrative but has dominated the standards of therapy in the NHS due to government investment (Williams, 2015) Providing an interpretive approach to research can contribute to understanding helpful ways of working with specific groups (Williams, 2018). Exploring the journey in IAPT services for an Afghan person can possibly create a space for empowerment and for a group of people who are under-researched to express their voice, with a wider hope that IAPT could consider the findings in future positive practice guides which are created directly for IAPT workers (Roscoe, 2019).

Personal context

The reflexive process of my research and chosen methodology means I must be open and willing to understand how my personal experiences have impacted the research journey, including the knowledge I produce. Therefore, I have worked to incorporate my experiences and identity in the research. As an Afghan woman, raised by two religiously conservative Afghan parents, I have a unique experience of being a third generation Afghan in the UK. In addition to this, I am an individual who has a diagnosis of PTSD having accessed IAPT. I am also a qualified psychological well-being practitioner who worked in IAPT for 5 years, and future Counselling Psychologist (CoP) therefore this piece of research is close to my heart. This is a topic I believe must be critically explored. I have experienced stigma from the Afghan community, my family and from mental health services. Mental health is not openly spoken about in the community and is often either looked down upon or dismissed as a spiritual misalignment; with this comes its own stigma, i.e., people who are not religious enough deserve to experience mental health distress.

My own experiences started my journey in Psychology, where in my undergraduate degree I conducted a qualitative study with 12 participants exploring mental health stigma in the Afghan community. A key finding is that guilt, shame and fear of judgement and religiosity/spirituality all played a role in how mental health was experienced by the Afghan community. I came to see the integration of spirituality/religion as a double-edged sword, it being something necessary for healing from the perspective of Afghans, but also the thing that often-stirred judgement from communities.

As a former IAPT therapist I am aware of the issues that exist in the IAPT system in relation to cultural competence, for example a lack of cultural awareness, or willingness/openness to understand others, and being subject to this from the perspective of a 'patient'. The experience of the Afghan person experiencing mental health distress can be complex. I always endeavoured to conduct this specific piece of research to open the conversation around difficulties with accessing therapies and advocating for change in my community. I bring all these ideas with me in the research process through journaling and reflexivity, but also, I am clear on where I must attempt to 'bracket' my assumptions when engaging with the research process, knowing fully that it is impossible to be absolutely reflexive.

Positioning as a researcher (The scientist-practitioner model)

As a scientist-practitioner in Counselling Psychology, one is thought to spend their time integrated between evidence-based practice and practice-based evidence; time is dedicated equally to clinical work and the development and immersion in research (Strawbridge & Woolfe, 2010). The scientist-practitioner applies psychological knowledge gained from theoretical evidence to the therapeutic work by applying a scientific attitude, and time spent contributing to the field of knowledge through research. The reflective practitioner utilises supervision and a self-critical stance to uphold ethical and positive practice (Strawbridge & Woolfe, 2010). Finding the balance between the two in Counselling psychology can cause tension, as the ethos of holistic and humanistic care can often-times conflict with paradigms that conceptualise what is known as reality. In healthcare, including for CoP's, care is provided based on the bio-medical model (Blair, 2015) and care is defined by measured outcomes, i.e., if there is no evidence of change measured by quantitative outcomes, services are less likely to be funded (Chen et al., 2013. As a future Counselling Psychologist, my values align with the subjective need of the individual although I know in reality due to the way the systems of care

are operating, this can be almost impossible to practice. I will go into more depth within the methods chapter.

Literature review

This literature review will consider the research related to the concept of culturally competent practices in mental health care, with a specific link to (CBT) in Improving Access to Psychological Therapies (IAPT) services. (see appendix A for description of literature search). I will discuss the Afghan community and the commonly discussed aetiology of mental health concerns in this group and the Black and Minority Ethic or "BAME" construct to make links to my current research proposal. I will also deconstruct the term "BAME". I will reflect on my ontological and epistemological positions, methodological flaws, the philosophical underpinnings of the current research, and lastly present a proposed research question with sub-questions.

The context

Mental health professionals have become increasingly aware of the barriers individuals from minority groups experience accessing and engaging with therapeutic services (O'Brien & Oakley, 2015). This is concerning because there is a plethora of evidence suggesting an individual's socio-economic status including individual characteristics like race, gender, religion and culture along with environmental factors like war can trigger the onset of developing mental or physical concern. One's socio-economic status including individual characteristic like race, gender, religion and culture along with environmental factors like war can trigger the onset of developing mental or physical concern. Other triggers might include trauma and are associated with increased inequalities in accesses services (Grey et al, 2013; Williams, 2018; Vahdaninia et al., 2020; Maura & Mamni, 2017; Arundell, 2020; Mowafi, 2011; Rathod et al., 2019). This is true if an individual possesses more than one of the nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation according to the Equality Act, 2010). Minority groups also face multiple structural barriers resulting in higher rates of unemployment. There compounding factors add a further layer of difficulties that may lead to the formation and maintenance of poor mental health (Beck, 2019; Williams, 2018; O'Brien & Oakley, 2015).

Emphasised in the literature are discriminatory issues in the overall healthcare system (Kirby, 2020), for example, it has been suggested belonging to a minority ethnicity group predicts stronger mental health deterioration in comparison to White British individuals (Proto & Quintana-Domeaque, 2020), and it has been suggested that full health-checks ought to start at 25 years old for "BAME" individuals (O'Dowd, 2020).

Individuals described as a minority are under-represented in primary care services like IAPT and over-represented in secondary care services like community mental health teams and secure wards (Mercer et al., 2019; Naz et al., 2018). Ethnic minorities are at greater risk of involuntary detention in the Black other, or Any Other Ethnic group (Alemi et al., 2023; Barnett et al., 2019). Primary care is at the forefront of mental health services (Stone et al., 2018), and must be developed to meet the needs of the UK population equitably (Ajayi, 2021).

It becomes apparent it is not possible to saturate the experiences of a large group of people in one amalgamated label. There is a need for further investigation into how specific ethnic groups experience mental health and access services in order to improve service provision in meaningful ways (DaCosta et al., 2021; Royal College of Psychiatrists, 2019).

Defining Culture

Culture is a complex and ever-changing mix of shared beliefs, values, practices, symbols, language, and behaviours that define a group of people. It includes both tangible elements like language, food, and clothing, as well as intangible aspects like attitudes, traditions, and social expectations. Ultimately, culture shapes how people view the world, interact with each other, and understand themselves.

Hofstede (1980, p.25) describes culture as "the collective programming of the mind that distinguishes the members of one group or category of people from others." His research identifies key cultural dimensions, such as individualism vs. collectivism, and the role of gender in shaping norms and behaviours. This framework suggests that people develop "scripts" for how to behave and interact with others based on cultural values, which are learned and passed down through generations. This is particularly important when considering how different cultural groups, including Afghan communities, understand and approach mental health.

Culture is not static; it's a dynamic and evolving concept, shaped by external influences and internal changes. It's deeply tied to a group's identity, helping individuals understand their place within society and in relation to others. Cultural practices and values are often adaptations to the specific environment, history, and challenges faced by a community. For example, individualism may thrive in societies where personal autonomy is key to success, while collectivism, as seen in Afghan culture, might emerge in environments where cooperation is necessary for survival. In this study, it's crucial to recognise how these cultural norms are intertwined with patriarchal systems, especially since the focus is on Afghan women and how these are further meshed with Western values of healthcare.

Understanding differences in cultures

Before understanding the Afghan culture, it is imperative to apply a critical gaze to deconstruct the term 'BAME', as oftentimes understanding the cultural and societal needs of marginalised groups and the care required are created through this homogenised lens. Originally an anti-racist term introduced in the early 1980s and later adopted by Parliament, "BAME" became an umbrella term for diverse ethnic groups. Although it helped bring attention to the unique needs of marginalised groups, the term risks oversimplifying the vast diversity within and between these communities (Aspinall, 2020).

Individuals who intersect across a range of cultures and ethnicities do not experience the world in a homogenised way, and it is argued terms such as 'BAME' produce unequal power relations, as it suggests 'Whiteness' is a privileged identity (Aspinall, 2020).

The term 'BAME' excludes groups that are marginalised in the UK like those a part of sub-groups or pan ethnicities (Aspinall, 2020). Although there is literature suggesting *some* heterogeneity in particular groups, for example, Bangladeshi, Indian and Pakistani, (Proto & Quintana-Domeaque, 2020), it does not suggest the heterogeneity of all minority groups.

An argument for the use of this term is there is an absence of an alternative; alternatives cannot be achieved when dealing with something as subjective as identity (Moshie-Moses., 2023). Services are beginning to replace BAME with other terms, like Equality, Diversity & Inclusion (EDI), yet this is as problematic as equality, diversity and inclusion can pertain to a spectrum of things outside of those difficulties that relate to ethnic identity. An individual holds a number of characteristics which influence their experience of the world, (often described as 'intersectionality') however, in line with much of the literature (Williams, 2018), ethnicity appears to be a ubiquitously cited characteristic that disadvantages an individual's care; it is questionable why these labels need placement at all.

Placing differing groups of people into amalgamated labels creates unconstructive assumptions and generalisations, when considering the current socio-political climate, with increased hate crimes, surfaced racism post-Brexit, Islamaphobia, and the Black Lives Matter movement (Hankir et al., 2019; Alexander, 2020; Burnett, 2017). This term then associates itself with unhelpful biases, assumptions and labels like 'hard-to-reach groups'; however, practitioners and researchers alike fail to question the reality of who is hard to reach; the people or the services (Bucci et al., 2019). With this knowledge, I choose not to use the term 'BAME' in line with my constructivist position, and an initial step towards breaking down these barriers is to think about groups individually (Moshie-Moses., 2023).

While focusing on Afghan individuals may seem like another form of homogenizing, this approach aims to offer insight into specific cultural and social practices that could inform evidence-based practice. The purpose of this thesis is not to generalize to the entire Afghan population in the UK but to deepen understanding of this group's unique experiences, which may enhance engagement and support from mental health and social service providers. The following sections will explore literature directly related to Afghan culture, providing the context necessary to understand the complexities surrounding Afghan identity and community dynamics.

The Afghan Community

Identity

Afghanistan, translated as 'land of the Afghans', is a landlocked country located in Central Asia, bordering Tajikistan, Uzbekistan and Turkmenistan to its north, Iran to its west, China to its northeast, and Pakistan to its east. It is a country rich and abounding with history, poetry, literature, music, fashion, dance, art, architecture, and cuisine (Saleem., 2021; Dupree, 2002). Afghanistan is made up of several ethnic groups including Pashtun, Tajik, Hazara, Uzbek Turkmen, Baloch, Aimak and others. The two official languages of Afghanistan are Pashto and

Dari (Persian) and some unofficial languages including Turkmen, Uzbek, Hazaragi, Arabic, Balochi and others with an array of dialects. The Afghan identity has many layers fostered in principles of upholding honour, hospitality, patriotism, respect, candidness, and an abhorrence of ostentation (Runion, 2017; Green, 2008; Dupree, 2002).

Officially recognised as a nation in June 1926, Afghanistan exhibits a tapestry of ethnic and religious diversity, embodying a multifaceted historical heritage shaped by interactions among Achaemenid Persia, Alexandrian Greek, Buddhism, Christianity, Sikhism, Judaism, Hinduism, and Islam (Barfield, 2023). Afghanistan is well known for its beauty seen in Mosques, mountains, rivers, valleys, and some remaining Buddhist landmarks. Each ethnic group in Afghanistan claims varied heritage; for example, Pashtuns claim descent from the Greeks whereas Hazara's claim descent from Mongol's (and Genghis Khan in particular) – this diversity across Afghanistan means that the nation is culturally diverse and is not homogenous. With this comes varied traditions.

Although a stunning country abundant with culture and tradition, decades of conflict, poverty, insecurity, compounded by weak infrastructure and institutions have created cataclysmic consequences resulting in political upheaval and challenges resulting in large scale human rights violations – particularly those of children and women, including the set back to girls and women's rights to participate in society, largescale famine, the lack of security from a stable or internationally recognised government, and a struggling economy with inadequate institutions unable to meet the basic needs of Afghans (Barfield, 2023). Unsurprisingly, mental health difficulties may be rife but unrecognised (Alemi et al., 2019).

Mental Health in the Afghan Community

When examining mental health in the Afghan community, it's essential to recognise the limitations of medicalised labels. In a context where war trauma, displacement, and adjustment challenges significantly shape mental health experiences, labelling can risk oversimplifying or stigmatising these complex experiences. Following a constructivist approach, I view each individual's experience as unique and subjective, as utilising labels can be stigmatising, pathologising and suggest that experiences can be treated as one; this opposes my philosophical position of critical realism and constructivism, that although experiences may be grouped together, said reality will be experienced on an individual and subjective basis, therefore labels problematise this position.

However, for the purpose of reviewing relevant literature, I will use medical terminology to discuss common mental health concerns in the Afghan community, acknowledging that no culturally specific terms currently exist.

The Afghan people's mental health landscape is interwoven with a complex history of oppression, war, and emigration, which has led many to experience high levels of psychological distress (Saleem et al., 2021; Ho, 2018; Pashang et al., 2018; Green, 2008). Afghan refugees and asylum seekers, particularly those who have experienced prolonged exposure to conflict, often struggle with trauma-related issues. Studies indicate that cultural conflict and loss are significant antecedents to distress, with women, young people, and those with disabilities facing higher risks for mental health difficulties. Emerging issues such as suicidality and substance misuse are noted, though under-researched (Alemi et al., 2014; Husni et al., 2014), such as in a survey-based study of 158 Afghan immigrants residing in Istanbul which found that risk of suicide increases, and high levels of debilitation are cited (Alemi et al., 2016). Afghan conceptions of mental health often integrate physiological, spiritual, and familial dimensions, suggesting the need for culturally sensitive support services.

Explanatory models of depression related to Afghan individuals suggests understanding underlying belief's regarding the aetiology of a disorder are imperative for providing appropriate and holistic care, and to reduce the likelihood of miscommunication between the therapist and client – the concept of problems being 'situational' is an integral part of treatment – a potential conflict with manualised CBT (Alemi et al., 2014; Ho, 2018). War-trauma is not the only driver of mental health deterioration and disrupted life circumstances like building relationships and achieving personal goals. A quantitative study of 18 Afghan immigrants found that depression symptoms in Afghan people in the US were associated with loss; loss of friends, family, career, possessions, language, culture, and identity (Alemi et al., 2016). The findings in this research of the experience of depression in Afghan individuals coincide with what is medically understood about depression and PTSD; such symptomology cited are: fluctuating temperament, impact on cognition and function, overthinking, psycho or socio-somatic arousal, irritability, self-isolation, avoidance behaviours, loss of interest, lack of motivation and dissociative symptoms. This conceptualisation of trauma is also exemplified by De Rond and Ratika (2016), who argue that post-traumatic stress disorder (PTSD) is not considered abnormal in Afghan society—it's "nowhere because it is everywhere." This perspective highlights the need for culturally adapted approaches when providing mental health services to Afghan individuals.

Quantitative studies underscore the prevalence of chronic mental health conditions among Afghan populations in other countries. The research has shown that mental health issues among Afghan immigrants are commonly linked to losses—of friends, family, culture, and identity—reflecting the layered nature of depression and trauma within this group (Alemi et al., 2016). For instance, research in the Netherlands found that Afghan individuals were at higher risk for depression, anxiety, and PTSD compared to other refugee groups, with asylum seekers facing particularly elevated risks due to unresolved immigration status (Gerritsen et al., 2006; Ichikawa et al., 2006). In the UK, Afghan youth similarly experience heightened mental health challenges linked to immigration-related stress (Gladwell, 2020; Chase, 2020).

Additionally, emotion regulation, defined as the ability to manage one's emotional responses, is identified as a central difficulty for Afghan individuals in the context of various common mental health issues diagnosed in this community. Challenges in emotion regulation are associated with trauma, depression, anxiety, and insomnia, highlighting the potential need for transdiagnostic interventions that address these overlapping issues (Koch & Ehring, 2020).

Gender and Mental Health

Gender oppression significantly impacts mental health within the Afghan community, especially for women. High rates of domestic violence, both from intimate partners and extended family members, contribute to increased symptoms of depression, suicidal thoughts, and PTSD among Afghan women (Jewkes et al., 2019). Cultural taboos, societal expectations regarding women's roles, and limited access to information often discourage Afghan women from seeking help (Amiri et al., 2018). Afghan women in the UK may face unique challenges, balancing "Western" values with their cultural and religious identities, adding another layer to their mental health struggles (Rostamy-Povey, 2007). It is widely acknowledged that gender inequalities in Afghanistan are deeply intertwined with a kinship and family system resembling what Kandiyoti (1988) termed "classic patriarchy." Men's values are upheld in ability to provide and protect, upholding family honour, whereby a woman's values are attached to a more domestic sphere, often having complete dependency on a male guardian (Kabeer et al, 2007). A woman's conduct is intricately linked to her family's honour, referred to as '*namus'*. This principle governs her movement, clothing, and social interactions, with any deviation from cultural norms potentially resulting in harsh repercussions including ostracism or violence (Kabeer et al., 2007). With this in mind, it is important to acknowledge that over time and dependent on context, these ideas can evolve which is relevant to this study as the focus is on

Afghan women who are accessing care via a Western lens, and have spent a considerable amount of time of their life in the UK.

Qualitative research in Australia has identified barriers Afghan women face when seeking help for domestic violence, including cultural issues, lack of appropriate services, language barriers, and partners acting as gatekeepers (Due et al., 2018). Community outreach programs that provide culturally relevant mental health education could help to improve help-seeking behaviours among Afghan refugees, as well as addressing the issue of poor self-recognition in mental health (Slewa-Younan et al., 2017). Studies also advocate for the translation of treatment materials to enhance the effectiveness of care for Afghan clients (Abu-Ras, 2007; Tribe & Lane, 2009; Tribe, 2002). These factors hold high relevance when considering the nuances of this study, as the overall experience of the Afghan woman will possibly not only be influenced by cultural norms but also the evident lack of power women in Afghanistan inherently hold due to societal and patriarchal structures engrained into the country as a whole.

Given the high prevalence of mental health issues and the complexities that are associated with such difficulties, these challenges must be examined within the context of cultural stigma, which significantly hinders individuals from pursuing professional support despite their needs. Recognising the stigma provides crucial insight into the barriers that complicate both seeking and engaging with professional mental health services, and can help contextualise the journey with mental health services.

Help-Seeking and Stigma

Stigma surrounding mental illness poses a significant barrier to help-seeking within the Afghan community. For instance, a qualitative study in Australia found that many Afghan participants viewed mental illness as “shameful,” which deters individuals from seeking support (Rintoul, 2010). This sense of shame underscores the importance of culturally sensitive mental health services that validate clients’ experiences and work to mitigate these feelings. Research also suggests that Afghans may turn to faith and community support instead of professional services, further underscoring the need for a holistic mental health framework that integrates both traditional and contemporary healing approaches (Alemi, 2018).

For effective treatment, understanding the cultural beliefs surrounding mental health is crucial. In Afghan culture, mental health issues are often seen as situational rather than pathological. Consequently, therapy models that rigidly adhere to manualised treatments, such as cognitive behavioural therapy (CBT), may clash with the Afghan understanding of mental health, where broader situational factors are considered central to treatment (Alemi et al., 2014; Ho, 2018).

Deconstructing the Diagnostic Statistical Manual of Mental Disorders (DSM – 5)

Understanding that Afghanistan is made up of a range of culturally diverse ethnic groups and tribes, compounded by the complexity of evidenced mental health suggests that it is important to acknowledge western constructs of treating mental health may not be suitable or need adaptation.

IAPT services utilise the DSM-5 mental health diagnostic criteria to formulate an individual's difficulty, create a 'provisional' diagnosis to thereby utilise the NICE guidelines to decipher a treatment plan (Binnie, 2015). One could argue that the system is flawed from its foundation due to the ongoing debates around the feasibility of the DSM's use. Warelow and Holmes (2011, p.1) state:

> *"The DSM-IV-TR colludes in a system of psychiatric care in which all people, by virtue of characteristically human foibles and idiosyncrasies, are potentially classifiable into a variety of diagnostic mental health categories"*

The development of the *DSM* and diagnoses are associated with substantial controversy, therefore placing mental health workers in a role of practicing in unethical ways, subsidising oppressive practices and social problems (Cantu, 2023). Sobo (2001) suggests a dilemma lies between scientific rigour and opinions in the creation of the DSM, the suggestion being that the DSM contradicts antiracist practices due to its fundamental flaw that it is informed by white culture (Riquino et al., 2021). The use of the DSM-5 reinforces this 'one size fits all' notion that often IAPT is known for (Faheem, 2022); this is not to say that diagnostic criteria's do not have a place in mental health care, but if they are used as a standalone tool to provide care, the risk of missing factors that are integral to a person's mental health journey increases. Using the DSM-5 can offer order and organisation in a system of chaotic care, and an evidence base to inform safe and effective dissemination of interventions, but this opposes the values held in CoP practice which relate to social justice and equity in care because of the root in which this 'evidence base' was created, this including the widely accepted use of the NICE guidelines which utilise the DSM to inform practices (Larsson & Loewenthel., 2012).

Professionals are expected to universalise westernised medicalised concepts (Larsson & Loewenthel., 2012), yet working in a multicultural society means that this model of care may not always be applied, and it is suggested that alternative models like the Power Threat Meaning Framework which recommends professionals to enquire about individual narratives and experiences, how these are formed and maintained through the influence of power imbalances rather imposing labels (Boyle., 2022; Strong, 2019). Through rigorous processes, qualitative research can have positive impacts on understanding lived experience. A culturally competent approach challenges 'Western' ideals and will be further examined below.

IAPT and CBT

Understanding the constructs which influence IAPT, we can now more carefully consider how this service works. IAPT is a service aiming to increase the accessibility of scientific evidence-based psychological treatments informed by the NICE guidelines, within the NHS for depression and anxiety disorders (Clark, 2011). CBT is a widely used psychological therapy available on the NHS within IAPT, generally with no associated cost, and is usually the most accessible entry point for the engagement of CBT (Williams, 2015). CBT is a skills-based therapy emphasising appraisal and information processing of maladaptive thoughts and behaviours, as opposed to distress related experiences (Beck, 1964). The perception of the self, world and others is what causes distress, as opposed to circumstances themselves (Fenn & Byrne, 2013).

Psychological research studies have recognised the public benefit of such services existence, like with positive access rates, cost-effectiveness and reliable recovery rates (Clark, 2018; Clark et al., 2018). There is an argument to suggest IAPT based studies are biased and reliant on randomised control trials (Williams 2015). Publicly funded independent evaluations are required to enhance the understanding of the services effectiveness (Scott, 2018). Scott (2020) highlights the positivist epistemological nature of IAPT-based research, further highlighting that independent qualitative studies of client's experiences are essential, and Beck (2005) suggests lived-experience is pertinent in providing effective care.

It is argued that Westernised CBT in IAPT is "one-size-fits-all", heavily medicalised; little interest is shown in the pathological development of psychological illness, and it promotes a dichotomous polarisation, whereby one can either be considered "well" or "unwell"

(O'Loughlin, 2020). This is problematic when considering the concept of "ordinary human suffering" in the context of diversity. This one-size-fits all construct fails to consider the subjective experience, and the use of the self in therapy (Bruun, 2023). Practitioners should cognise how negative appraisals are not always faulty, unhelpful behaviours can be necessary acclimatisation's depending on one's circumstances, when deliberating race (ism), culture, ethnicity and religion (Iwamasa, 2021). There is an increased need for awareness in these areas when considering assessment and formulation (Beck & Naz, 2019; Beck, 2018).

IAPT is not without flaws; such detriments are limits on time and number of sessions, reliance on objective outcome measures causing a "revolving door" environment, the profound dropout rates (Scott, 2019; Cotton; 2019; Wakefield, 2020; Scott, 2020). The nature of the manualised environment may make it difficult to apply a cross-cultural gaze on the therapeutic work. According to NHS digital (2017) in IAPT services, higher recovery rates are found in white individuals compared to other ethnicities due to difficulties like discrimination or a lack of understanding of needs (Sadler et al., 2018; NHS Digital, 2017) Considering this is the latest data, it highlights although the NHS is considering cultural-competence, an ever-existent disparity persists (Faheem, 2023), which will be examined below.

Cultural competence in mental health services

The literature often cites the importance of cultural competence in mental health service provision (Camphina-Bacote., 2002; Rathod et al., 2019; Mason & Sawyerr, 2018; Cross, 2020). One should not be expected to be cognisant of all aspect of cultural existence, but should be versed in working cross-culturally (Mason & Sawyerr, 2018; Cross, 2020). At a systemic level, it has been defined as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" (Cross et al 1989, p. 13). At an individual level it is defined as "the ability to identify and challenge one's cultural assumptions, one's values and beliefs… Developing empathy and connected knowledge… at the very least recognise that others may view the world through different cultural lenses" (Fitzgerald, 2000, p. 184; Belenky et al., 1986).

The process of cultural competence requires cultural awareness, knowledge, desire, skills, encounters, and desire; all five constructs should be experienced in health care providers

(Camphina-Bacote, 2002). This process involves self-examination and reflection into one's cultural and progression background, the ability to seek and acquire educational foundations about diverse groups, collect relevant cultural information about presenting problems, incorporating the client's values, beliefs, biological and physiological symptoms, active engagement with diverse groups and a genuine motivation to do so (Camphina-Bacote, 2002). There is some debate as to how applicable the above principles are in health care cross-culturally as there is an overemphasis on 'mastery' over competence (Camphina-Bacote, 2019). It is suggested by Camphina-Bacote (2019) that healthcare professionals should move toward a stance of 'cultural humility' which focuses more on the intrapersonal and interpersonal, thereby encouraging a person-centred approach (Foronda, 2022; Kibakaya; 2022; Camphina-Bacote, 2019). Emphasis is put on a subjective enduring commitment to critically appraising one's self-awareness. The aim is to instil the skills to learn about other cultures but also internally examine one's own belief and cultural identity, and mitigating power imbalances and taking institutional accountability. It requires the professional to create an impersonal stance to suitably consider the other and be humble about what they do not know to promote equity and inclusivity (Akbulut & Razum., 2022; Foronda, 2020). This is especially important in the context of stigma, where the professional's cultural sensitivity can significantly impact a client's willingness to engage with services.

Stigma

Cultural competence is critical when working with communities who experience high levels of stigma (Rathod et al., 2019). Stigma has been defined as an having an "attribute that is deeply discrediting." (Goffman, 1963, p. 3) Stigma can exist within the community and external to it, for example from services. Stigma is often deeply engrained within communities because of judgments and beliefs held up by generations of thinking, so it is plausible that these cultural concepts that are engrained into the stigma are an important part of formulating a person's mental health experience (Rathod et al., 2019). Stigma links to fear of prejudice, discrimination, conscious and unconscious stereotyping, maltreatment, misdiagnosis and overall distrust in people, services and systems; in particular for minority groups research suggests this issue goes further with the concept of "double stigma", whereby the race or ethnicity and mental health needs are a "cross-cutting phenomena" (Gary, 2005). Stigma around the understanding and fear of perception associated with mental health concerns create barriers to health care (Stolk et al., 2003; Cheng et al., 2018). Gary (2005) proposes an issue exacerbating this stigma is an absence of diversified workforces. If the relevant workforces are not exhibiting skills in cultural competence, there is a risk of creating a further stigmatising experience which can have clear consequences (disengagement from services, deteriorations in health status).

A qualitative study on Afghan individuals in Istanbul regarding the experience of depression suggests that providing a culturally sensitive therapeutic process and a holistic framework of support is required to ensure clinicians are open and receptive to the information they receive from clients, and not dismiss them as situational (Alemi et al., 2016). Stigma is cited as an issue and it is suggested that preventative interventions structured around resilience by utilising religion and family support as coping mechanisms are vital; therapeutic work outside of non-stigmatising environments can be effective like in Mosques to give a sense of community connection (Alemi et al., 2016). Conversely, integration with non-Afghan communities can be helpful, including finding meaningful employment, training and educational opportunities (Alemi et al., 2016). Alemi (2016) suggests that Afghans must feel safe and able to engage in a therapeutic process that showcases non-judgemental and non-biased therapeutic practices to reduce stigma. A sense of community and a system that offers containment seems to be important, which when considering the data collection process is logical, as participants often cited a lack of support in the Afghan community as being an elucidation for poorer mental health experiences.

Beagan (2018) suggests that the "culture" in cultural competence models are reduced to race and ethnicity, overlooking other intersectional needs and framing race and ethnicity as existing only in the "Other," leaving dominant cultures unproblematised and creating a culture of 'othering' (Dervin, 2012). Culture appears only to be significant to 'others. while minimised in relation to professionals. Cultural competence models' position professionals as apparent participants of the 'dominant group' (Beagan, 2018). It is understood as something that can be attained, which can misconstrue structures power balances between professionals and those who seek care (Beagan, 2018). A professional's competence may be measured in terms of their confidence, which may not be sufficient when working across differences. (Beagan, 2018).

It is suggested in contrast, 'cultural humility' with critical reflexivity is an ethical stance that asks professionals to take responsibility for privileges they may hold, reflecting on individual practices and considering power structures and imbalances (Beagan, 2018). These ideas will now be examined in the context of CBT as it pertains to this study.

Cultural competence in CBT

There is evidence that cultural considerations have a critical role in disseminating CBT (Naeem, 2019) and that culturally adapted interventions had a 4.68 times greater chance of producing remission from psychopathology (Hall et al., 2016). The ubiquity of CBT in the UK means there is a requisite to acclimatise to diverse populations (Stone et al, 2018) to reduce the likelihood of invalidating one's experience (Jankowska, 2019).

Transcultural CBT has been proposed as a way of integrating values, beliefs and practices of clients in therapeutic practices (Beck, 2016; Rathod et al., 2019). It encompasses literature around language, communication, adapting metaphors, the importance of matching therapists by ethnicity and gender if necessary, adapting the use of the collaborative versus didactic style of therapy where appropriate, establishing goals and allowing therapy techniques to reflect the practices of the specific community (Bernal & Saez-Sangriago, 2006; Beck, 2016). Beck (2016) outlines how to discuss ethnicity and culture, and specific adaptations to depression/anxiety specific disorders and the use of supervision. Beck (2016) proposes there is an extensive amount of research needed regardless of these adaptations to increase quality of treatment and access to therapy.

Four key themes have been identified as areas of significance for culturally competent CBT: the ability to conceptualise relevant terms synonymous to minority groups, developing confidence and awareness of the political context affecting a client's mental health, a need for mangers to work alongside commissioners to fund services adequately, and reminding practitioners of the duty of care associated with the Equality Act (2010) (Naz et al., 2019).

CBT practitioners have suggested adaptations are grounded in a "Triple-A" principle, which comprises of awareness, assessment and adjustments; encompassing philosophical positioning and alignment of the self in practice, practical adjustments related to societal identity and health-system dynamics. They suggest methodological adjustments of therapeutic approaches/proficiencies and theoretical adaptations of specific therapeutic concepts; this involves a process of understanding acculturation and systemic issues relating to help-seeking, choosing appropriate environments for therapy, collaboration in assessment, formulation and treatment endings, and adapting language to explain concepts (Rathod et al., 2019).

Transdiagnostic frameworks related to psychopathology for refugees and ethnic minorities by taking into consideration a client's process, for example incorporating "cultural ideas about symptoms", and identifying associated cognitive stigma; Hinton and Patel (2017) suggests psycho-education and translated materials are a key factor providing culturally competent and adaptive care (Hinton & Patel, 2017). Translation is critical in culturally competent work in the context of the Afghan community, as there are languages spoken with sub-dialects determined by ethnic group and region. Mis-translation or misinterpretation of information can result in negative consequences like misdiagnosis (Raval & Tribe, 2014).

Presented next are examples of relevant research relating to individual groups across cultures:

A qualitative study focused on 12 South-Asian women in the UK suggests manualised CBT can be effective in symptom reduction, but there is a lack of exploration of cultural issues in treatment, and improved integration of religion and culture are required for improved service provision (Yasmin-Quereshi, 2019). Manualised CBT disseminated in a culturally sensitive manner was effective for decreasing symptoms of anxiety and depression in Pakistani and South Asian Muslim clients Pakistan (Naeem et al., 2010) and when compared to treatment as usual (Naeem et al., 2010; Naeem et al., 2015). Cultural grounding and explanatory model bridging were found to support treatment adherence in Egyptian individuals (Jalal et al., 2018). Taking this into consideration, I will now focus on the literature that relates directly to Afghans and the gaps in research methodologically.

Epistemological and Methodological Critique

Culturally adapted CBT has seldom been researched for Afghan refugees (Jalal et al., 2018; Kananian et al., 2017) and what little literature exists has a positivist focus. A pilot study on transdiagnostic culturally competent CBT with male Farsi-speaking refugees (both Afghan and Iranian) in Germany found CBT "may" reduce general psychopathological distress (Kanaian et al., 2017); ter~~minology like 'may' is ambiguous for a quantitative piece of work one may question the validity of the results overall.~~ The primary statistically significant effects of treatment were associated with general depressive and anxiety symptoms, improved emotional-regulation mechanism and quality of life as opposed to a reduction of trauma symptoms.

What this suggests is trauma symptoms are not as effectively treated in a transdiagnostic model, as compared to depression and anxiety; there is scope to generalise the effectiveness of this method for depression and anxiety symptoms. It is difficult to understand the full extent of the results in this research due to ambiguous language and undefined terms, which is problematic for a research methodology that is based on mathematical probability, correlations and causations, and does not necessarily meet the objectives of 'philosophical realism' (Ponteretto, 2005). In this study, participants participated in hour interviews prior to the research to gain a perspective of mental health problems. This data was not analysed qualitatively, but rather discussed reflectively within the research team. Subjects that arose from these interviews were considered in the proposed research, for example themes around difficulties with housing, loss of cultural identity and financial hardships as explanations of depression.

The research focused solely on Farsi speaking Iranian and Afghan males. The sample size is small for a quantitative piece of work (9 participants, 7 of whom completed the treatment); within the already small sample that excluded women and individuals outside of a particular education level, the participants voices are absent.

Significant affects were established for reduction in symptoms in comparison to Narrative Exposure Therapy found in meta-analysis of randomised control trials for refuges including Afghans in Germany (Nose et al., 2017); they suggest an approach encouraging support around coping with uncertainty around asylum status is required. The study proposes culturally adapted CBT is a promising "initial low-threshold" transdiagnostic treatment approach when applied in a stepped-care method, Kananian et al (2017) highlights the issue of complex co-morbidity. Despite these advancements in care, gaps in the literature persist which will be discussed below.

Gaps in the Literature

While there is extensive research on Afghan refugees and asylum seekers, gaps remain concerning other Afghan groups, such as migrants who have successfully adapted to new environments, children of Afghan immigrants, and individuals experiencing intergenerational trauma in the UK (Alemi et al., 2017a; Alemi et al., 2017b). These populations may have unique mental health needs that differ from those of refugees, highlighting the importance of future research that accounts for the diverse experiences within the Afghan diaspora. This need for culturally specific insights also brings into question the adequacy of standardised diagnostic tools like the DSM-5, which are primarily based on Western constructs of mental health. Given Afghanistan's rich cultural diversity and distinct understanding of mental well-being, there is a strong argument that Western frameworks may not fully capture or address the nuanced mental health experiences of Afghan individuals.

The above research is valuable when considering little to no research has been done in this area, as it is highlighting the value of adapted therapy, in addition it would be useful to utilise a qualitative/interpretive approach which this research endeavours to do. It is possible that Afghan people may not always meet the inclusion criteria for IAPT (which tends to be mild to moderate depression and anxiety [National Collaborating Centre for Mental Health, 2018]) due to the complexity of mental health concerns, but this does not mean absolute exclusion, which now links to the proposed rationale.

Rationale

The issues of the Afghan community are complex. It is important that the experiences of Afghan people not be reduced to a homogenised terminologies and indiscriminate assumptions. Services may create provisions that are oversimplified methods of adaptation as a result of research that has considered the complexity of Afghan identities. There is an effort to create services that consider the idiosyncratic experience; the above literature suggests mental health services are at the early stages of this process. Unspecialised interventions and out-reach can cause increased health difficulties. CoP's will work in various settings throughout their careers, one of these places IAPT, (Clark, 2011) and so it is critical that deeper understandings of how to work with individual groups are formed, like Afghans.

The definition of recovery in IAPT has positivist foundations, with emphasis on psychometric measures, and an interpretive paradigm can collaboratively assist the development of services-based cultures and standards of care by encompassing the individualistic client narrative, in under-represented groups (Williams, 2015). Both have merit, as it provides a range of subjective and objective proficiencies that at times Counselling Psychology research can lack (Corrie & Callahan, 2000). Nevertheless, the positivist approach diametrically opposes the nature of my study as it suggests reality can be measured, and labels can define an individual (Hwang, 2019). My critical realist positioning contests this view.

There is a lack of understanding of specific culturally competent models or adaptations of CBT for individual groups in the context of IAPT services; which is at the forefront of mental health services (Stone et al., 2018), and so research that considers this gap is needed, which I will now explore through my rationale.

I propose there is a gap in the literature relating to how Afghan individuals access and engage with primary care. By gaining an understanding of their experiences of CBT in IAPT, I go beyond the barriers and suggest purposeful implications for service provision and increase the likelihood of exploring preventative care, thus, providing part of the roadmap to decrease mental health deterioration. By doing this, the research will remain true to the core and ethos of Counselling Psychology, which is to promote holistic, equitable and ethical care, working towards a social justice agenda (Woolfe, 2016).

Fundamentally, I am aligned with the critical-realist ontological position and the constructivist epistemological position (Ponterotto, 2005; Moon & Blackman, 2014). I am arguing that a reality can exist that is experienced uniquely dependent on individual experiences. The philosophical underpinning of this research is to take an emic perspective, make sense and meaning of given data (Boyle et al., 2014). This philosophical stance requires the researcher to be a co-constructor and reflexive in the process of sense making. The process will not impose a framework, but rather examine patterns and phenomena in the process (Ponterotto, 2005; McLeod, 2011).

I propose a qualitative study in line with above recommendations, utilising semi-structured interviews to gauge experiences of manualised CBT in IAPT. The aim was to recruit participants both male and female to explore gendered themes, however, this was not possible due to a lack of male volunteers. This study is valuable for Counselling Psychologists and professionals alike, by allowing insight into an under-researched group's experiences, in the context of a widely disseminated therapeutic approach and scrutinised mental health service. The concept of the research is meaningful as it could improve the delivery of CBT within the NHS.

I recognise the findings of this study could be deemed ungeneralisable, however the goal is not to universalise, but rather contribute to a more personalised approach to CBT creating a more cost-effective form of therapy, with the offer of a preventative approach to deterioration in mental health which might begin to close this marginal gap in relation to the oversubscription to secondary care services versus the under-representation in primary care services. From the above literature review, I will now present the research question and aims.

Research Aim and Questions

The aim of the study is to explore the Afghan individuals' experience of and receiving psychological therapies (manualised CBT) that uses an IAPT model. I will aim to understand if participants feel understood in their journey and if/how their experiences were framed in a cultural context.

Research Question

What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?

Methodology

Overview

I will present a rationale for my philosophical positioning, and design and procedure for recruitment, data collection and analysis.

Philosophical Positioning

The ontological, epistemological and other methodological aspects of research are an essential component of producing a meaningful piece of research for the field of Counselling Psychology; therefore, it is important to review, explore and evaluate one's own positionality when developing the scientist-practitioner identity.

Major perspectives

Within Counselling Psychology, there are various ontological and epistemological positions that fall on a spectrum between objectivism and subjectivism (Crotty, 1998). Objectivism utilises quantitative methods to conduct research, meaning numerical or survey data can be controlled and statistically measured. This type of research looks for causal or correlational relationships between variables (Denzin & Lincoln, 2011). Subjectivism lends itself to qualitative methods whereby the subject of 'lived experience' is observed and analysed through individual interviews, or generally the spoken word (Ponteretto, 2005). This paradigm grounds itself in relativist ontology, whereby it is suggested that reality a subjective experience (Denzin & Lincoln, 2011).

One must consider the meaning behind the concept of ontology, epistemology and methodology. In philosophical terms, ontology refers to the existence of objects, and epistemology regards what we know of this existence, and how we come to know it. (Ponteretto, 2005). Methodology is the analysis of the methods and procedures within a research process, including philosophical positioning.

The most dominant paradigm in Psychology is positivism. Positivism is suggested to be a form of 'philosophical realism', whereby a prior hypothesis is produced and verified (or not) through the research method via mathematical and statistical significance (Ponteretto, 2008; Cacioppo, et al 2004); This position suggests reality is measured, and labels can circumscribe an individual (Hwang, 2019). This type of methodology prescribes well to clinical and bio-medical models of research, whereby the effectiveness of a therapeutic modality may be measured in order to ascertain a cost-benefit analysis for its application in health services like with randomised control trials (Faheem, 2022; Brent, 2004).

Epistemologically, literature in Counselling Psychology/Psychology is moving toward a constructivist position; however, it remains informed by positivist/post-positivist and pragmatic paradigms (Ponterotto 2005); both measured and some reference to subjective experiences (Crotty, 1998).

On the other end of the ontological spectrum is relativism/subjectivism, or the constructivist-interpretivist epistemic position. The constructivist-interpretivist paradigm suggest that multiple and equally valid realities exist, constructed by the individual and their lived experience, so is copacetic to subjectivism (Ponteretto, 2005). The researcher co-constructs the reality utilising a double-hermeneutic approach, namely, they make sense of the participants sense-making (Ponteretto, 2005).

To be positioned somewhat in the centre is to identify with critical realist perspective, specifically, the critical realist paradigm, which is considered post-positivist. Post-positivism was established to critique positivism due to its inability to apprehend 'true reality' (Ponteretto, 2005); the objective reality exists, however, there are limits to how possible it is to measure this in quantifiable terms. This critical-realist position differentiates between the real-world and observable world; it argues that language can construct social reality, however, these constructs can be influenced by the intrinsic 'material world' (Willig, 2017) i.e. the body. The researcher attempts to discover behavioural patterns (Willig, 2013), it is also acknowledged that reality is imperfectly measured (Bhaskar,2013; Ponteretto, 2005;).Critical Realism focuses on three domains – empirical (what is observable), the actual (all events that occur despite whether they are observed, and the real (the causal mechanisms which generate or cause events to transpire (Bhaskar, 2008).

The current position

Both objective and subjective perspectives have value (Crotty, 1998). It can be argued that psychology is dominated by positivist research, however Counselling Psychology can be dominated by constructivist research (Corrie & Callahan, 2000), as the philosophical position lends towards subjectivism. The positivist position diametrically opposes the proposed study. When constructing my research question, I grounded myself in my Counselling Psychology identity which is led by humanistic qualities, therefore my position is that of critical-realist ontology (Denzin & Lincoln, 2005) and constructivist epistemology (Ponteretto, 2005). I am proposing that realities exist (mental health disorders, mental health services and protocol-based therapies) by my participants subjective voice and experiences are essential in understanding how services and widespread therapeutic modalities are utilised in the UK, and how accessible they are. My participant group are considered to possess 1 (if not more) of the 8 protected characteristics (Equality Act, 2010), which suggests they will have difficulty accessing services for a variety of reasons. I propose to create a platform to understand these experiences in depth and amplify an under-researched group by co-constructing and interpreting the overall reality of experience.

Exercising a critical-realist ontology combined with a constructivist epistemology has allowed me to create and analyse what creates discernments that proceed individual lived experience alone, which I believe is important when considering the context in which the experiences are being lived (IAPT). The aim is to acquire an enriched understanding of experiences that are influenced by the reality of common healthcare practices, which have the potential to influence how services work with minorities when they are creating polices around working with ethnic minority groups.

This reflective process has bought up tensions when considering my ontological and epistemological stance. I recognise that my process could allow me to be positioned on various areas of the spectrum, for example, a critical-realist lens would focus on the observable, but acknowledge the inherent material world, but for example, a relativist would focus purely on subjectivity which has such merit for under-researched populations. IAPT and CBT are medically constructed systems, which I must overtly subscribe to as both concepts exist in my research, therefore it feels impossible for me to take a relativist position, although this at times feels uncomfortable for me as a Counselling Psychologist. I am therefore supporting the notion that evidence-based concepts exist as a result of empirical and measured study, and simultaneously acknowledging the observed or lived experience of the participant.

Critical-realism has been criticised due to the extent of its broadness, as it can lend itself well to either a positivist or interpretivist epistemology, some even arguing that critical-realism is an epistemology in its own right (Zhang, 2022). I believe that regardless of these arguments, a critical-realist approach allows room for flexibility when considering research aims (Maxwell & Mittapalli, 2010) and epistemic groundings for analysis.

I could argue as a constructivist, I am denying the social constructionist position, which explores shared culture and the use of language, suggesting that language constructs reality (Willig, 2017). Shared cultural experiences and language for my participants may be substantial when considering the shared strife amongst Afghanistan, especially when considering the contrast in Western and non-western language. This could create limitations because, though multiple, discernible realities exist (Ponteretto, 2005), we are social beings; the world is experienced through social interfaces, relational experiences and interactions. The study focuses on one ethnic group, so they will to some degree have a shared and lived experience which is exhibited in their homogeneity.

I am not focused on language and social interaction as construction of reality; my focus is on lived experience as opposed to suggesting there is an ontological realism from the perspective of my participants and aim of research. This lack of 'realism' is accentuated through the qualitative research that highlights the difference in conceptualisations of mental health for Afghan people versus western conceptualisations.

The chosen method of data analysis is RTA and it is implicitly considered realist (Braun & Clarke, 2015). According to Braun & Clarke (2019), RTA will typically be conducted within a constructionist paradigm and will not pursue focus on individual psychologies and processes, but rather pursues to theorise the 'socio-cultural contexts, and structural conditions', that produce the individual experiences. I considered the usefulness of latent and semantic content, which meant I would have the scope to explore the meaning of implicit and explicit data. I acknowledge that through acquisition, social singularities may arise through the data, but regardless there is no pre-conceived aim or assumption that focuses on this. The nature of RTA is to find patterned meanings, which I believed was important to this study when considering the wider implications for Counselling Psychology and mental health care.

An Interpretative Phenomenological Analysis (IPA) (Smith, 2011) lends itself well to the constructivist position as the focus is on phenomenology or 'lived experience', and understanding these experiences through an inductive analysis. The participants make sense of their world, and the researcher makes sense of this, namely, double hermeneutics (Smith et al., 2011). The process looks for individual details and depth of experience and through coding general and reoccurring themes are created through the meaningful parts of the data. Beneficially, an idiographic approach can be taken whereby there is less concern to make general claims, but there is the flexibility to do so if possible. When considering my position, I believe that because of the layers of my research topic which do include that of a 'measured' reality, it was important for me to utilise a method that took the semantic content into consideration and the latent. I think by making this decision, I can present a more accurate depiction of my participants story, as it will allow the space their own perspective to be narrated, and mine only intertwined within that. I believe that it is not that case that everything can and must be interpreted, it is sometimes important for the data (and therefore the participants voice) to be represented as it is and speak for itself.

I considered the descriptive phenomenological methodology (Giorgi, 1985) but deemed it incongruous due to the objective to uncover general characteristics of a phenomenon in its essential form, as opposed to the focus being on experience. Discourse Analysis would be unfitting due to the focus on language, and Grounded Theory unfitting due to the relevance of creating a theoretical account which is not the aim of this research or epistemic position.

Reflections on the methodological choices for the proposed research project

As discussed, my positionality has skewed mostly between critical realism and relativism. As a trainee Counselling Psychologist, I hold onto a specific set of values that deter me from taking a perspective that operationalises the world (like critical-realism), however I am a scientist-practitioner that believes in evidence-based science. Although I have justified my perspective, this tension stays with me, and I acknowledge that I do not need to stand firmly on any one paradigm.

I believe the orientation of my research could be future forming as there is no research on the experience of IAPT services for Afghan individuals from a critical realist/constructivist position.

Design

This study used semi-structured interviews to facilitate an in-depth discussion and exploration of Afghan people's experiences of accessing IAPT services (see appendix A, p152)

Recruitment

Two organisations in the public sector (counselling charity and Mosque) were approached for research advertisement and those who agreed to advertise the research agreed to provide written consent to advertise and this was further submitted to the UEL Ethics Committee (see appendix A). Other public sector organisations were approached; however, many offered no response and others declined to advertise. The research process required me to work closely with the organisations who were willing to participate, for example I went to speak to men and women visitors within the community centre and mosque about the research to attempt to create and build trust. Although I believe I formed good relationships with people, many did not meet eligibility for the study and there was also an overall reluctance in some to participate due to an unwillingness to speak to a stranger about their experiences.

The research was also advertised on social media like Instagram and Facebook, which is where all the participants were recruited from, partially via snowballing. I believe that it was more straightforward recruiting from social media as I reached a younger generation of Afghans who hold a less stigmatising view of mental health therefore were more likely to participate. Due to timing restraints, I was unable to obtain NHS ethical approval for recruitment which meant participants were not directly recruited from IAPT services. I have strong conviction in the narratives of my participants experiences, though I acknowledge that non-direct recruitment could create some uncertainty around the authenticity of data collected.

Once participants volunteered interest, I conducted a screening phone (phone numbers obtained via private secure messaging on social media) call to ensure eligibility for the study. I then conducted a short risk assessment screening for suicide and self-harm risk (see appendix A, p150) to ensure the risk levels were low and participants were safe enough to volunteer. There were no risk concerns, and interviews were scheduled in the same week of risk assessments being conducted. Further to this, participants were required to sign a consent form to participate which was emailed to them the secure UEL email.

All participants were offered a choice of a face-to-face interview or Microsoft Teams' interviews and all opted for the latter. This may have been a way to create safety for participants in their view, or it may have been more pragmatic to do so. Although I held a belief that face-to-face interview would support more efficient information gathering, in my reflexive journal I noted the importance of offering choice to my participants to ensure the journey in the research process is the least arduous it can be, and this method of data collection still allowed me to gain rich data. The distance between the research and participants on Teams can be a positive for the participant, it also gives them a sense of control, especially when considering Afghan females (Sah et al., 2020; Alemi & James., 2011).

Procedure

Ethics

Ethical approval for the study was granted by the University of East London Ethics Committee (see appendix A). Participants who meet the eligibility criteria and provide signed consent to participate; their details (i.e., name and email address) and a participant numerical code was noted to protect confidentiality. Participants were sent via email a participant's information sheet and a consent form was given asking participants to confirm having read and understood the information sheet (see appendix A, p132).

At the start of the research process participants were informed of their right to withdraw from the research; they were made aware that they can request to withdraw the data from being used even after taken part in the study, provided that this request is made within two weeks of the data being collected (after which point withdrawal will not be possible).

The interviews ranged from 60-90 minutes and were audio-recorded on Microsoft Teams, using my UEL Teams account and were deleted immediately after being transcribed verbatim by the author. All interviews were conducted in English. I plan to destroy all stored data 3 years following the completion of thesis in accordance with British Psychological Society guidelines (BPS, 2021).

As mentioned, there was no risk during screening calls related to suicide and self-harm, however sensitive topics about mental health, trauma, suicide and self-harm were addressed, therefore each participant had an extensive debrief, and a debrief sheet with numbers of support services were emailed to participants after the interviews. Although there was not a severe enough level of distress caused by the interview process, I also offered to have follow up debriefs with participants in the future, however these have not been needed.

Materials

There is a research advert (see appendix D), participant information sheet, screening questionnaire, risk assessment, consent form, debrief form and an interview schedule (see appendix A).

Sampling

Overall, a total of 12 participants expressed an interest in participating. I recruited n=5 participants in total (out of six) who fully met the inclusion criteria, with one dropping out due to personal circumstances. All five volunteers. were female (see below for further discussion). It was unfortunate that I was unable to recruit more than 5 participants. Finding participants was an arduous task and required me to work in the community and on social media platforms

(Instagram and Facebook) to build relationships and trust with individuals. It was a positive experience to see how many people came forward with enthusiasm to participate, but unfortunately 50% of volunteers did not meet the criteria for the study, because the CBT they accessed was not offered from an IAPT service, or after discussion it was established that CBT was mistaken for an alternative therapy. Drop-outs are also not uncommon, which is why I tried not to feel too discouraged by this. I continued to try and recruit participants even up until the point of creating initial codes.

I used purposive sampling which is an approach used to select participants which are most likely to yield useful and appropriate information and useful for small datasets (Steve et al., 2020). The following inclusion criterion were applied:

Participants were included in the study if they were:

- Of Afghan heritage
- Female or male aged between 18-40.
- Accessed psychological therapy at either Step 2 or Step 3 CBT within a service that offers an IAPT model and complete treatment within 6 months of taking part on the study
- Must be able to speak English.
- Not currently accessing a mental health service.

Participants were included if they had not completed a full course of CBT because I felt it would be important to understand if a person dropped out, disengaged or ended treatment early.

Participants

Each participant had accessed CBT via IAPT and all participants had at least 6 sessions and up to 12 sessions face-to-face. Participants were given a numerical assignment to protect confidentiality. Three out of five participants had a provisional mental health diagnosis. I captured a range of experiences, however, unfortunately I was unable to recruit male participants. It is possible to anecdotally hypothesise why this might be the case from an Afghan perspective, and literature also evidences that men are less likely to seek help for mental health struggles (Grandi et al., 2023; Alemi et al., 2023). It was always a likelihood this would be the case, but I wanted to keep my recruitment pool as wide as possible, considering this is a ‘seldom heard’ group (Alemi. & James., 2011). Table 1 provides on overview of the characteristics of the participants (see appendix B).

Data collection

The semi-structured interviews (see appendix A, p152) consisted of 12 open-ended questions modified from Yasmin-Qureshi’s (2020) IAPT study which focused on South-Asian women’s experiences of IAPT. Participants were made aware that due to the sensitive nature of the topics as they referred to mental health experiences, they were free to refuse to answer questions, request breaks and were all offered a debrief and a choice to debrief at any point within the research process. I kept a reflexive journal during the interview process not only to be aware of what themes were appearing across the data, but also to be aware of my adjacent thinking processes and how this was guiding my interview technique. I remained sensitive to my participants and ensuring that at the end of the interviews they were given the space to add anything they felt relevant or they felt was not properly covered or important for me to know. Although I found it challenging in my first interview to probe as I believe I had some anxiety around being overly invasive and causing distress, I felt comfortable and confident by the second interview to utilise the rigidity of my interview schedule to my advantage; using the interview schedule allowed me to keep my boundaries as a ‘researcher’ psychologist, and separate this from attempting to apply therapeutic techniques which would not be warranted in a research capacity. In this way, I believe I kept interviews on topic and relevant to the research question.

I noted my thoughts and feelings about the data in my journal, where I found myself relating to my participants on a personal level, as I believe this relational aspect enhanced my interviewing techniques and allowed me to illicit information in an organic way, consequently allowing my participants to open up the discussion themselves. I made notes at times where I felt defensive about IAPT but also the times where I felt defensive of my participants and the difficulties they had in their experiences. This type of methodological, epistemic and ontological reflexivity is critical when conducting research as it shapes my reflexive analysis (Willig., 2023). I felt that I could detach from biases that came from a place of defence and consider my participants story from a more helpful perspective. These aspects allowed be to be intentional and conscientious with the data.

Data Analysis

The data was analysed using Reflexive Thematic Analysis. Given the limited research in this area, an inductive approach was used to identify themes both semantic and latent. In this way participants are giving a voice to the experiences of the world around them (Braun and Clarke 2013) and also allows the researcher to interpret the data and co-construct themes through reflexive analysis. Reflexivity involves drawing on one's own experiences, pre-existing knowledge, and social position (like ethnicity, gender, class, etc) and critically interrogating how these aspects influence and contribute to the research process and potential insights into qualitative data. Data collected from the interviews was transcribed and analysed using Braun and Clarke's (2022) six-phase method.

There are arguments that discuss sampling in relation to data saturation; the dominant idea in thematic analysis is that data collection can stop once no new themes or concepts are emerging from the data. This was a difficult tension for me to sit with as my sample size was smaller (by one) than I had hoped. Braun and Clarke (2019) have argued that the concept of saturation does not align well with the values a researcher who is conducting a *reflexive* thematic analysis would hold, as it is interpretive in nature.

Theoretical foundations

The 4 domains of reflexive analysis

Orientation to data

Inductive analysis is an outcome of reviewing the data and identifying the standout themes. It presupposes, in its purest form, that participants' voices can be accurately captured and fairly represented objectively and without any subjective interference, however, Braun and Clarke point out that this can't be fully realised because of what we, as researchers, inevitably and unavoidably bring to the analysis. Deductive analysis begins explicitly with the researcher, in particular, a theoretical or conceptual model that is used as a framework and lens to interpret and extract meaning from the data. I do not endeavour to bring in a specific theoretical framework, so I subscribe more to an inductive analysis, whilst bearing in mind as suggested it is impossible to be completely inductive with RTA and my own experiences will be reflected in the data analysis as a part of reflexivity.

Focus of meaning: Semantic and Latent content:

Semantic analysis explores the meaning on a surface level, drawing out themes that are explicitly identifiable. The researcher chooses to remain close to the meaning overtly articulated by the participants, thus tending to produce a descriptive analysis. Latent analysis focuses on exploring the underlying, covert, and implicit meaning of the data. They tend to be derived from the researcher, or theory-seeking connections and meaning that aren't self-evident and require some hypothesising from the data. For this analysis, I choose to apply both a semantic and latent approach, as I believe it was important to explicitly identify verbatim what my participants narrate to properly justify and represent their story, but my latent analysis will delve into the semantic with more depth through a reflexive lens. The data coding process required semantic and latent coding.

The 6 phases of thematic analysis (Braun & Clarke)

Phase 1: Familiarisation

Phase one contains two stages; rigorously engaging with the data, then creating distance from it. This phase requires total data immersion. Creating verbatim transcripts supported my process of immersion and reading/re-reading the final transcripts and noting down initial thoughts (see appendix G). Once familiarity is achieved, the researcher employs with 'critical engagement', whereby reflexivity is applied. Braun & Clarke (2022) suggest there are helpful questions one can ask to elicit reflexivity like:

- How would I feel if I was in that situation?
- Why might they be making sense in this way rather than another?
- Why might I be reacting to the data in this way?
- What does my interpretation rely on?
- How socially normative is this depiction or story?

Braun and Clarke suggest that this stage requires note taking throughout; I also found myself noting things down in my reflexive journal in relation to some of these questions when initially transcribing. the question of 'why might I be reacting to the data in this way' as I believe I was close to my participants and experiences which would inevitably influence how I view their experiences based off my own emotions. I recall at different times feeling angry, sad, upset and hopeless, but also contrary to this, genuinely pleased and hopeful when positive experiences were cited, as I began to think about how these positive experiences could translate to positive practice in the future.

Whilst familiarising myself with the data, I could see common patterns emerging, and I was beginning to consider what data could be grouped together; for example, I thought about things like 'choice', 'waiting', 'the relationship' and 'culture'. My experience being a 'patient' meant that I was already skewed towards thinking about the above ideas, but I ensured that I saw these patterns emerge before being assumptive. I also saw moments where I felt close to the dataset and times where I felt a proximal distance from my participants experiences. This at time posed conflicts for me when considering future interpretations; it was important for me to note these down and also engage in reflexive discussions in supervision.

Phase 2: Coding

Coding (both semantic and latent) requires methodically reviewing the data and searching for the relevant and thought-provoking data that relate to the research question and writing a brief description or 'code' next to them. Coding creates insight into the data and also provides rigour because it is an interrogation of the data by reviewing the breadth and depth and finding initial patterns and themes. Insight and rigour make it less likely for the researcher to be overly selective in the analysis process, i.e., it deters utilising pre-conceived notions or collusion with biases. It is critical at this stage of coding that the researcher is clear about their ontological and epistemic position as the use of the self is imperative in RTA, and subjectivity enhances the data analysis process. In this case, I am always considering my position that a reality exists (the engagement of a protocol based therapeutic process to reduce distress) but this process is experienced on an individual basis. Within this process, I noticed how difficult it was to juggle between the nature of coding in thematic analysis versus a *reflexive* thematic analysis. It was critical not to collude with any negative assumptions, but also remember that the use of myself and own experiences would enhance my interpretations in a balanced and non-biased way. I began by creating comments on each transcript individually, eventually creating codes. By going back over transcripts in the initial coding phase (see appendix G), I looked for common words and phrases and used these as final codes (see appendix I), and recoded transcripts for a second time utilising a set of concrete codes (see appendix J). Within my second process of coding, I worked backwards from participant 5 to 1 as Braun and Clarke (2022) suggest switching up the coding process can help ensure rigour. With this, I left reflexive comments on each code to aid the theme creation process. I believe this was helpful as I grasped more meaning from data that I had not initially observed. These were then collated together with data excerpts via line numbers (see appendix K). This allowed me to have the space to begin to think about the data reflexively and objectively and begin to generate theme ideas.

Phase 3: Generating initial themes

Themes are created by capturing patterns of meaning across the full dataset. Single codes can begin to be clustered together to ascertain shared meaning (Braun and Clarke., 2023). It can contain multiple facets (i.e., different codes) but must have a centralised concept. The themes must be generated thoughtfully and draw upon the researcher's position, knowledge and own interests, for example the personal and evidence-based concepts I introduced in the literature review. When collating codes, I began to see where similarities in experiences began to emerge but also where there were discrepancies in individual experiences in relation to the seamlessness of the journey; , even though discrepancies appeared, over time I came to realise they only appeared across the data dependent on a person's placement in their 'journey' – although participants had different experiences at various points in their journey, it seemed that they shared those differences across different parts of the overall experience. Collating codes was time consuming and required me too often code and recode to ensure I had considered all the data I was presented with. I made reflexive comments on each code at this stage to also support my analysis write up. As mentioned, because of the variation and discrepancies, collating was an arduous task and the data sets were complex and multi-layered. I grouped data across the five transcripts together by having an initial centralised concept or code (see appendix J) which were labelled with one- or two-word descriptions that represented the excerpt like 'assessment' or 'therapist skills' and backed up with a line number which corresponded directly to the data. I grouped together relevant collated coding files using mind maps into a possible overarching theme for example 'the beginning' of the journey with these later being refined in stage four with themes and subthemes. This stage overlapped a great deal with stage due to the nature of the small dataset.

The question of 'how socially normative is this depiction or story' I felt was important when creating interpretations; I believe I was cognisant of this when analysing my data because it is plausible that some of the experiences described by participants are not unique to an Afghan person, so it was important not to make interpretations that did not account for the wider socio-political constructs that impact the way a person (Afghan or not) engages with IAPT. Alongside this, I was acutely aware that all my participants were female, which once again means it is even more difficult for me to make interpretations about 'Afghan people' because it is likely a male's experiences would vary from a female, so I ensured not to do this.

Phase 4: Developing and reviewing themes

This phase is an extension of the previous phase. This allows the researcher to ensure that the themes are not too disconnected from the data set and the research aims and questions. The process of reviewing themes is a useful way to identify themes that may have been generated unconsciously with a pre-conceived notion creating a more rigorous analysis product. I began to organise the earlier codes into groups to begin creating themes. Again, Braun and Clarke (2023) suggest the researcher asks:

- Are there enough meaningful data to evidence this theme?
- Are there multiple articulations around the core idea, and are they nuanced, complex and diverse?
- Is the presented data too diverse and wide ranging?
- Does the theme convey something important?

It is important in this phase to consider that the frequency of data does not denote importance, however, I believe that the frequency of data in this case often did hold significance to the participants' journey. I believe that in the themes that are being created, extracts were nuanced, complex and diverse without becoming too diverse. This is something I contended with often, as I did not want to be in a position where I was forcing data into a theme with no real justification, so often I would define and redefine themes/sub-themes to ensure that I was not creating an inaccurate depiction of the data.

When developing and reviewing themes, I contended with how best to represent the data; throughout the data analysis process I have referred back to what I believe is the core of my research question, which is the ‘journey’; alongside this is the cultural lens by which the journey is experienced. It felt natural to create themes that following a process of ‘beginning, middle and end’. This was sometimes confusing and challenging because no journey is straightforward but helped to capture the experiences in a concise way. This meant that sometimes I had to relegate some data I felt was important but became too anomalous from the perspective of creating a ‘journey’. It was at these points I would often question whether an IPA approach with a sole focus on lived experience could be more suitable for my participants stories because the nature of their individualised lived experiences, however, once again when considering my ontological and epistemic roots, RTA considers wider social contexts within a dataset which I nevertheless feel is important when considering the context of this research.

I utilised Braun & Clarkes (2022) three-layered theme creating, whereby there are overarching concepts, themes and subthemes (see appendix C). The overarching concept I utilised was the ‘journey’ i.e., there being a beginning, a middle and an end; within these concepts were larger themes and sub-themes to help group together shared meaning which I attempted to create through a cultural lens, as this is the core of my research questions. I created a mind map to help make sense of this process (see appendix L).

I often found myself questioning whether I was being reflexive enough when considering creating topic summaries versus creating shared meaning themes, and I partially believe this was because my dataset is small therefore creating themes and patterns could at times be challenging. Braun and Clarke (2022) argue that topic summaries do not have a place in RTA, although at points I found it difficult to reach deeply into ‘reflexivity’. It required a great deal of thinking, re-thinking, reviewing and re-reviewing, but also highlighted further the need for me to enhance rigour via investigator triangulation.

Phase 5: Refining, defining and naming themes

Once themes started coming together, I recall feeling surprised by some of the finishing products, reflecting on things that I assumed would emerge from the data, and things I was not necessarily expecting. It is often argued that in TA, it is impossible to allow the data to speak for itself; I do believe my some of the themes emerged organically from the data and some required more of a construction and thought from a reflexive space.

As my process was written from the position of the ‘journey’ I also found myself making links and relationships between different themes as there were overlaps, which I believe was helpful when considering the complexity of individual journeys.

Phase 6: Writing up

Writing up the analysis can take two approaches: establishing a gap or making an argument, the latter being the preferred method of analysis write up in RTA as it lends better to a constructivist position and qualitative research. Within my analysis I took the approach to ‘make an argument’ by collecting the shared insights of the participants, looking for similarities and differences between narratives and creating a conclusion that looked for both positives and negatives in the therapeutic journey, whilst considering the bigger picture for the research; I was attempting to co-construct. Once again, this unfortunately being such a small dataset meant that that times the writing up process could be challenging.

Reflexivity

As mentioned in the literature review, I hold ideals and biases around CBT, IAPT and mental health experiences as an Afghan woman who has accessed IAPT and as a professional who has been employed by IAPT. For example, my experiences have showed me that my community do not understand me, therefore cannot support me, mental health practitioners I have had interactions with including those within IAPT were unable to relate to me and vice versa regarding my protective characteristics (specifically gender and ethnicity) therefore making the therapeutic process arduous. Lastly according to the evidence-base, individuals from minority groups often reach the point of serious deterioration before accessing help or being offered help.

I have also been mindful of not disparaging the IAPT process, the therapists because that is not the research aim. It has been important to apply a critical lens to the data analysis process and ensuring that I position myself somewhere between critical and reflective as there are many factors that influence the way in which therapy is disseminated and engaged with; it was important to remember that therapists are employed and trained specifically into an institution of medicalised health care, in the same way that clients are placed into a system of care, so often even if there was an action I disagreed with on an individual level, it was crucial to be cognizant of system in which the action was created. However flawed the medical model is, the goal is not to undermine one profession over the other, but rather look at more holistic, integrated and non-oppressive ways of working, and I subscribe to this idea tremendously as a future Psychologist.

In my journal, I am picking on things that mean I am being completely transparent in my data collection and analysis process because I do not believe it is favourable to bracket these.

Assumptions and Presuppositions about being Afghan and accessing IAPT

Some of the common assumptions I had were:

- Participants may not be understood from their cultural position (because I was not)
- Choices around therapist preference would not be provided.
- Women's experiences would be massively influenced by males, and this would be further impacted if male therapist were a part of treatment.
- IAPT and manualised CBT would not be able to meet the individual needs of participants.
- The relationship between client and therapist and overall relational working would be important.

Potential Impact

When I look back at my process as the interview, I think because of how closely positioned I felt to my participants I unconsciously tried to create distance by not asking probing questions about their actual individual mental health experience as I did not want this to influence my line of questioning, nor did I think the individual deeper context answered my research questions. I also felt that the content was so relatable that at times I did not probe because I felt I already had a deep enough understanding. It is not to say I did not gain rich data, but I believe my data could have been richer had I of veered more away from my questionnaire index.

On reflection I see this as a dilemma because what I may have done unconsciously created a barrier for my participants, yet I also have to remember my position in this context is of ‘researcher (future) psychologist’ and not ‘therapist (future) psychologist’. Because of this ‘closeness’, at points I may have failed to ask for elaboration, there missing opportunities to attain more nuanced material about the participant’s experience and therefore caused my data to be less rich, because I assumed I understood without always asking. I am attempted to be transparent about both of these things within my research process.

What I also found was that my assumptions were not always valid, around gender. I had assumed male therapist may have been problematic for participants, (especially as all of my participants were evidently female); superficially this did not appear to be the case, however, I offer my interpretation of this within the final themes.

Overall, each individual experience often filled me with sadness, because of issues, like those that exist within the Afghan community and those that exist within services. When feeling this sadness, I tried not to over personalise the experiences by utilising the reflexive questions Braun and Clarke highlight to support a reflexive analysis process. It is important to use my ‘self’ to understand the data, but I also was mindful not to get lost in the data.

Reflexivity in TA

Taking a reflexive approach to TA allows the researcher to explore, understand, emphasise and make explicit their values, the world, and their beliefs. Then consider how these may influence how they interpret and make sense of the data. Reflexive research stresses that knowledge obtained is treated as situational an outcome of an interaction between the researcher and the data. Analysis and interpretation under this framework cannot (and will not) make simple claims to truth or objectivity. A reflexive account of the researcher, methodological approach (like a journal), and situational nature of the research can be superficial; a more compelling analysis will be characterised by depth and thoughtfulness.

Rigour and transparency

To amplify rigour, transparency and trustworthiness I have made it a critical part of my data analysis process to utilise data triangulation, specifically investigator validation, by asking an external member of the research community to review and comment on the final analysis, this being an PHD awarded RTA researcher whose focal point of academia is working with minorities. By applying this step with the combined support of my supervisor, I could ensure my interpretations were balanced and also gave me a perspective of another researcher who could confirm, challenge and develop my ideas thereby enhancing the credibility of findings.

Yardley (2017) suggests four criteria to apply when considering quality in qualitative research. Firstly, ***sensitivity to context***: I believe I remained sensitive to my participants context and created an interview schedule that covered a breadth of issues related to the therapeutic journey, with explicit reference to cultural competence. I ensured my participants felt safe in their environment to speak, which is why I offered them a choice of communication modality.

Second and thirdly, ***commitment to rigour and transparency and coherence***: I believe I have demonstrated not only in my commitment to consistently following the RTA protocol through rigorous. coding and recoding, but also in my choice of triangulation. This was also facilitated through reflexive journaling as I believe I have been constantly transparent. I was transparent with my research supervisor about the difficulties I had across processes which meant I had the space to triangulate with a external researcher when barriers presented themselves in recruitment and interviewing, again displaying transparency.

Lastly, ***impacts and importance***: I believe this piece of research is important to both Counselling Psychology and Afghan people. I considered individual lived experience and attempted to present an accurate depiction of the difficulties that are present when a group who is considered marginalised engages with a Westernised model of care. I attempted to understand these experiences from the Lens of CoP, considering holistic working, alternative models of health care and social justice.

Analysis

Overview: The Journey

I will now present a reflexive thematic analysis of the collected data. I attempt to depict an analysis that represented a journey via the cultural Afghan lens. When creating this analysis, I referenced the research question and aims throughout. I begin by describing the context in relation to the difficulties that presented in the data, followed by the full data analysis (see appendix C for table of themes).

Context

As noted in the literature review, common reasons for seeking therapy include depression, anxiety, and PTSD. In this study, four out of five participants were diagnosed with 'social anxiety,' while one had no clear diagnosis. My interpretation suggests that social or domestic issues triggered their mental health difficulties, such as divorce, post-natal depression, family problems, and inter-generational trauma. Participants connected their struggles to their upbringing, cultural stigma, and community lack of understanding. Two participants seemed to have short-term anxiety, while three had long-standing depression and anxiety, all with prior therapy experiences. All participants accessed services in London or Greater London. This analysis is primarily interpretive, focusing on individual experiences while considering semantic content.

1. The beginning – Accessing IAPT

1.1 Reaching out for help and the influence of family dynamics

As for most people, accessing therapy can be a daunting experience and so the initial step in reaching out is critical. A persons personal and social circumstances can make this reaching out process more complicated but also highlights the necessity of the therapist working with the individual to understand these complexities. There was a consistent trend that involved the importance for participants to tell me about the nature of intersectionality between having a mental health difficulty and being Afghan, and how often these two constructs may not ‘intersect’ seamlessly. The Afghan participants described various mental health issues, including depression, anxiety, and PTSD, often linked to social or domestic challenges like divorce, postnatal depression, family strife, and intergenerational trauma. Despite these issues, they also encountered significant cultural barriers that made accessing mental health services daunting. This aligns with existing research that highlights the influence of cultural stigma on mental health treatment, particularly in collectivist societies where mental health issues are frequently viewed as private or shameful (Alemi et al., 2017a; Alemi et al., 2017b).

> *P1: We have great family friends, but I wouldn't. I wouldn't… I wouldn't dare to feel… Like, I wouldn't dare to speak to them about my feelings and that. And then on that level to them, no way. I feel like that the Afghan community is improving is definitely improving in terms of being more aware of mental health, but I still wouldn't feel that that confidence to speak up about it like that. (Line 130)*

> *P2: Um, obviously Afghan community is so hard to do something like that. Like it took me ages to like, muster up the courage… Literally to this day, no one in my family knows that I had those therapy sessions and none of my friends. (Line 50)*

> *P3: Let's just say that in the wider Afghan community things like mental health is not - people are not open about it and its just always kind of deal with it and you don't talk about it. (Line 217)*

For Afghan women, mental health challenges often intersect with community expectations and cultural norms that stigmatize discussing or addressing such issues openly. Participants expressed that mental health struggles are not typically acknowledged within Afghan communities, and the language to discuss such issues is limited, adding further barriers to communication. Powerful phrases like "muster up the courage" and "toxic" suggest the intense internal and social resistance they face. These experiences are compounded by family dynamics, where participants feel unsupported or judged for seeking mental health services. The participants' hesitation to disclose their therapy to family or community members highlights the pervasive stigma and fear of judgment, which discourages open dialogue and makes seeking help a clandestine, isolating experience. P2 expresses fear at the concept of being open about her feelings with people that are close to her, meaning that reaching out would be precarious but also fear inducing. I interpreted that if individuals feel unable to turn to family and friends, reaching out to strangers in services may also pose difficulty. At this point in the interview with P2, I remember not probing too much into this difficulty thinking that it likely took a lot of courage for her to explain this me; my reflection of interviewing this participant was that she was not forthcoming with information and I questioned whether she found it difficult to speak to me, as I may have represented the community she is afraid to share her vulnerabilities with.

1.1.2 Access and Relationship with the GP

In all cases, the participants expressed that they initially reached out to their GP for mental health support. There were some positive and swift responses from the GP. Some participants appeared to have a seamless journey in relation to accessing IAPT services. This is reflected in the following quotes:

> *P4: This one I did self-referral ... I just went with it, so online referral I self-referred online. (Line 13)*

> *P1: She was a very understanding and she said that she'd referred me straight away, so there was no delay in in that sense from my GP (Line 27)*

.

For 2 participants, there were examples of their GP exhibiting dismissive behaviour and trivialising of mental health difficulties, which consequently made it difficult for them to confidentially self-refer to the IAPT service or have confidence in their GP's to help them in the future. Participants 5 and 3 were not referred in their first contacts with the GP.

> P*3: Because I was young It was kind of dismissed. So anytime I did go to the GP and sort of tell them like how I was sort of feeling. It would be like all you're too young to start anything… in the back of my head it was. I didn't get help the first time. I don't think I'm gonna get help this time. (Line 218).*

> *P5: Because I was pregnant at the time, he couldn't prescribe any medication. So, I had to wait for my son to be born. (Line 8).*

In both cases during the first point of call, the two participants seemed to have been overlooked. It is my interpretation that those who presented as more complex would have benefitted from the GP taking the step to create the referral, as at the time there was a mix of social difficulties and risk to self. The findings show that one's first experience with the GP to discuss mental health plays a critical role in how they engage with the health care system. These participants appear to be doubly impacted, first by their family and community and then by the negative experience of engaging with their GP. This is of immense significance for Afghan individuals who have to contend with cultural norms that reinforce beliefs that make stigma palatable and disempowering.

The first point of call can often be critical to a person's care, so language like 'dismissed', or 'I had to wait' suggest that the GP in these cases were overlooking signs of mental health decline. The point at which the two participants returned to the GP the second time were at the point of crisis. The negative impact of a lack of understanding during the first point of call when entering a service is powerful; in Afghan culture where it is understood that there is stigma attached to mental health, the act of reaching out is substantial and can reinforce beliefs that may be held by individuals about care and the concept of being open about mental health. Reinforced negativity around mental health experiences can therefore compound help seeking experiences and for some affected the way they engaged in therapy.

> *P3: Then it was only until my GP actually referred me on when the situation got really, really bad. Um, that that's when It's, it's almost like someone believed that something was wrong, whereas before that anytime I would go, no one would really listen to understand and it just had to. There had to be evidence of what I was doing or what I was saying or how I was acting for someone to actually and help me like refer me on… I mean, I got to a point. OK, I got to the point of self-harming and It was only then that someone actually decided to help if help is the right word….* And from then on, it was just shrugged off. And there obviously at the point there was a lot of male doctors in the GP. And again, from an Asian background… from the get go, going to the GP and seeing Asian doctors…, who are male and obviously not getting anywhere with it. *(Line 29)*

P3 experiences a downward trajectory in her mental health and the resultant impact was what drew the attention of health professionals. She also highlights a religious and cultural issue that further compounded her experience. She attributed this to cultural similarities and gender disparities, feeling dismissed, as mental health is rarely discussed within Afghan communities. Individuals may find it difficult to find solace within the community, or with friends and family when mental health is concerned, an additional difficulty arises when professionals mirror the community's detachment, as participants described GPs lacking empathy, regard, and listening skills in supporting their mental health needs.

I interpret that when professionals display a degree of separation from those that reach out to help them, be it through a lack of understanding or empathy related to mental health, this could re-trigger participants earlier experiences with dismissal or toxicity within their own communities. This can create such hopelessness and helplessness that other outlets for regulating may be used, like self-harming. It is difficult to say whether this cultural clash was present, but from the perspective of the participant, she felt the similarities were a point of contention and made her journey into services more difficult and it is my interpretation that cultural clashes likely impacted this.

Participants in this study highlighted the same dismissive nature of GP's and were advised to self-refer. There is an added complexity layer of each of the participants cases. It is relevant to highlight the nature of the referral being made; i.e., if a person is in a state of mental distress, hopelessness, depression or anxiety, making a self-referral may not feel feasible, especially if they believe their circumstances are not widely accepted due to the lack of acceptance in the Afghan community of such difficulties. What is being highlighted in this excerpt is that a lack of initiative to make an initial referral caused an escalation or deterioration in mental health state and risk.

This reveals an essential insight into the critical role of GPs as gatekeepers to mental health services. A dismissive or culturally insensitive GP response may discourage Afghan individuals from pursuing help further, reinforcing the internalised stigma and complicating their help-seeking journey. The literature suggests that initial experiences with healthcare providers can be crucial in determining whether individuals persist in seeking mental health care (Binnie, 2015). For Afghan women, whose cultural background might already impede help-seeking, a negative GP experience can further entrench their reluctance to engage with services.

In summary, this reflects how cultural and societal factors, such as stigma around mental health, and a lack of awareness or sensitivity from healthcare providers, can undermine the effectiveness of mental health services. For individuals from Afghan or similarly stigmatised backgrounds, negative early experiences with mental health care providers can deeply influence their future engagement, making it crucial for GPs and mental health professionals to be attuned to the cultural and emotional significance of seeking care.

1.2 Assessment with IAPT to decipher treatment plan and the importance of creating a trusting environment

The IAPT (Improving Access to Psychological Therapies) assessment process represents a pivotal stage in the therapeutic journey, serving as the first point of contact between a patient and mental health services. For Afghan women accessing this service, a trusting environment is essential to enable openness and engagement. However, the use of telephone assessments, while efficient, brought mixed responses from participants, reflecting both benefits and limitations of this approach, particularly in terms of building rapport, cultural sensitivity, and understanding the complexities of individual needs.

> *P1: And for me I felt safe just to do it on the telephone. I didn't want him to kind of know who I was or like what I look like. In a sense. It was just a voice across the phone. That's all it was. But it's crazy how much of a connection you can have just through the telephone. (Line 37)*

> *P2: It felt like a random stranger over the phone, like I didn't get to see who I was talking to. And she was asking me like, what was going on and stuff like that. And I was like, like, how do I tell her that, you know, like the Afghan community is, like, really toxic, you know? (Line 56)*

> *P4: I think the assessment I saw it more as if, like okay, just a screening, I didn't feel like uh, it was uh, cause the person was someone else then the actual therapy ahead with. So, I saw the assessment didn't feel like a session. I didn't treat it as one as well. (Line 22).*

> *P5: I feel like my situation was so much more complex. It wasn't. It was really hard to sort of pinpoint to one thing that led to the way I was at the time. Sometimes it was really difficult to explain why these why I had these feelings, why I had these anxieties and. I don't know. I think it was It was just difficult, I think, to explain… I think definitely no, we had no conversations about of you know about the demographics or anything that level. (Line 29).*

There is a link related to trust; both speak about how the environment impacted the way they engaged and how much they trusted their therapist to be open. Not knowing the identity of the assessor could pose a risk to P2, whereby a lack of transparency in who the therapist was there could have been fear around confidentiality, being misunderstood or judged, or overall lacking the space to build enough rapport to feel safe enough to disclose personal details but also bigger details about the Afghan community. As she expressed distress around being open about her mental health with close family members, I interpret that it is reasonable to why talking to a stranger would pose difficulties, specifically, this illustrates a challenge within telephone-based assessments: they can inadvertently create barriers for those from tight-knit or culturally conservative communities, where discussing mental health is already stigmatised. The absence of face-to-face cues and the unfamiliarity of the assessor intensified P2's concerns about confidentiality and the assessor's ability to fully understand her cultural context. This lack of trust may have restricted her openness, which could have limited the depth of her assessment and impacted the accuracy of her treatment plan. However, for others, anonymity posed a barrier; they felt a sense of shame or hesitation in disclosing intimate details over the phone to a stranger who may lack understanding of Afghan community dynamics. Due to cultural and familial pressures, many Afghan women may value privacy and may be reluctant to share personal matters, especially those that could bring dishonour to their family or community. This can be especially true for sensitive issues related to mental health, domestic violence, or sexual matters, where cultural stigmas may prevent women from speaking openly.

For P1, her safety was in the remained proximity in the relationship with the assessor. Again, it is plausible to see why being unidentifiable would create safety for an Afghan individual if there are ramifications from the community having awareness of a person's struggle in mental health. The proximity also seemed to create anxiety, which I interpret is because there is an overarching cultural concept that mental health is unacceptable, therefore it is difficult to open up to a person without knowing who they are and if they are capable of passing judgement. I interpret this could also have posed a difficulty if there of the therapist being Afghan which could have perceived consequences for the Afghan person accessing the service; this understandably would cause uncertainty because of the fear, shame and stigma associated with having a mental health concern. There are core issues highlighted in the assessment journey for Afghan women. There was a consistent narrative around trust, safety, security and trust. What this has amplified the need for professionals to take into consideration the holistic journey up until the point of referral and accessing assessment in order to properly assess and formulate individual needs.

Within this, I also interpreted a level of shame attached to the notion of the Afghan community being ‘(P3), ‘toxic’ which could be a conflicting experience, especially not one that is simple to openly speak about, layered with the proximity and anonymity created through telephone work. This observation holds particular significance for Afghan women due to the cultural and societal pressures that often frame mental health concerns as shameful or stigmatizing. The notion of the Afghan community being described as "toxic" by P3 highlights a deeply conflicted experience: while the community may provide a sense of identity and belonging, it can simultaneously perpetuate dismissive or judgmental attitudes toward mental health struggles. For Afghan women, this duality can create a unique barrier to openness, as they may fear the personal and social repercussions of voicing such critiques or vulnerabilities.

From a broader psychological perspective, these dynamic underscores the tension between individual well-being and collective identity in collectivist cultural communities. The shame associated with mental health issues may lead to internalized stigma, further inhibiting help-seeking behaviours. Societally, it reflects the ways in which traditional gender roles, honour-based values, and communal expectations intersect to suppress discussions of mental health.

Moreover, assessments were often perceived as perfunctory screenings rather than substantive therapeutic engagements. This perception may reflect a failure of the assessment process to establish a trusting and collaborative environment, potentially leading participants to disengage early in their therapeutic journey. The lack of curiosity in the assessment about the participants' intersectional identities, such as ethnic background, religion, and community pressures, potentially resulted in missed opportunities to address core concerns, leading to treatment plans that may not fully resonate with the patients’ lived realities. I interpret that this could create an unconscious feeling of trivialising the problem, if it is seen as a tick box exercise.

The assessment process is more than a preliminary screening; it can set the tone for the entire therapeutic journey, so when participants perceive the assessment as superficial or lacking in cultural sensitivity, this can have lasting consequences for their engagement and treatment outcomes. A comprehensive assessment should go beyond mere information gathering; it should establish rapport, foster trust, and demonstrate a genuine interest in understanding the patient's unique background and concerns. In the cases described, the lack of a holistic approach to assessment may have compromised the effectiveness of subsequent treatment, particularly for participants with complex and culturally nuanced needs. I interpret that assessment processes were not as beneficial or comprehensive as would be desirable. For Afghan women accessing IAPT services, trust and cultural sensitivity are foundational to their engagement in therapy. Without these elements, the therapeutic alliance—essential for effective treatment—can be weakened from the outset.

1.2.1 Waiting

Waiting for initial contact by a service and start time for therapy between assessment and treatment were also mixed, two participants waiting a couple of days to be contacted by services, compared to weeks, or not at all, which meant that re-referrals happened in the future.

> *P1: I think I had quite a long waiting... waiting period until he could have some appointment availability. (Line 23)*

> *P2: And then like, by the time that they had gotten back to me, it was like it was just so bad. Like not even I could help myself, like, you know. (Line 34)*

> *P5: It was. It was quite quick actually. I remember. I think it was like a a week maybe between two days, something like that. (Line 21).*

Those with extended wait times also cited deteriorations in their mental health, with some expressing a lack of communication from services within this interim period.

> *P2: I do think that it is quite a long time to wait. I mean, I'm sure it's not their fault, but, you know, um. Yeah, for me, I think the timing was really bad because they called like when it got really bad. (Line 34)*

> *P3: Because I didn't get the right help from the start is what led the situation to get worse for my mental health to get worse. (Line 33)*

Long wait times combined with a lack of interim support can cause deteriorations in one's mental health state and increase hopelessness. What is interesting is the spectrum of empathy and understanding participants had towards services; there is evidence of the participants being grateful and accepting of what services do exist, as outside of this Afghan's women's experiences have so far been presented as lonely, and this is a possible testament of values held by an Afghan woman, such as respect, modesty and honour towards others. Further to this, I also interpret this as a testament to resilience and adaptability of Afghan women. Due to decades of conflict and socio-political upheaval in Afghanistan, resilience is a deeply ingrained value. Afghan women often display strength and resourcefulness in the face of adversity.

I interpret that P3 holds onto anger and resentment in her journey which led to a circumstance of acting out (self-harm) and P2 was keen to express her consideration or insight of the elements of accessing therapy that are out of her control, like waiting times. While the complexity and severity of each participant's case influenced GP referrals, the key takeaway is that deteriorations can occur regardless of these factors.

I felt this was important to highlight because it coincides with this idea that individual experiences are much disposed by the constructs built around them, in this instance, the understanding that NHS service are stretched, and this participant having the awareness that their experience is influenced by a system. From my perspective, I felt an increased level of empathy for both participants which was coming from a place of hopelessness for me as an Afghan person who accessed and worked for IAPT services. For Afghan women, these experiences could possibly evoke a sense of helplessness, particularly when mental health support is scarce and access is fraught with logistical and cultural barriers.

2. The Middle – Engaging with Therapy

2.1 Modality (Telephone, Video, Face-to-Face)

Therapy modality was a key consideration for all participants. Three were offered a choice of communication modality, which significantly influenced their engagement, while two were not offered options.

> ***P1:*** *"I was offered if I wanted to do it in person or via a video call or just telephone. For me, I felt safe to do it on the telephone… I felt more comfortable and safer… maybe (because of) a fear of judgment, potentially. It felt like that would have some sort of bias or influence." (Line 36-44)*

Having a choice positively impacted engagement. For some, anonymity provided protection from judgment, a significant concern given the cultural stigma around mental health in Afghan communities. P1 feared judgment not only from the therapist but also from the broader cultural environment. Telephone sessions allowed physical and emotional distance, mitigating these fears.

However, not all experiences with telephone therapy were positive:

> *P3: "I didn't know who I was talking to... it's not like being on the phone with your friends... I didn't know this guy, only his name and that he was a therapist." (Line 177)*

> *P5: "I was hoping I could just let everything out... but the telephone was a big barrier. If it was face-to-face, I think things might have been different. I wasn't taking it so seriously because I was just on the phone." (Line154)*

P5 also faced additional challenges as she had a young child and could not leave home due to family tensions. Her experience highlights the need for flexibility and safe spaces to ensure therapy focuses on the individual.

While anonymity was protective for some, it posed challenges for others who felt a lack of connection or confidence in sharing deeply personal issues. This suggests that rapport and trust-building are critical regardless of the chosen modality.

2.2 Manualised CBT Techniques

Participants had mixed experiences with CBT techniques, influenced by the complexity of their mental health issues. Those with milder anxiety-related difficulties responded well to structured CBT:

> *P1: "The techniques he helped me build and learn… I still use those techniques to this day. He'd give me, like, little goals to try for the next week and check in with me." (Line 77)*

For those with more complex challenges, engagement was hindered by life circumstances, difficulty retaining information, or insufficient rapport with the therapist.

> *P2: "It started off slow... a lot of the homework he gave, I wouldn't do. But the more I engaged with the education they give... it got the ball rolling." (Line 14)*

> *P5: "I think we need to do more practical, real-life situations. Just doing it on paper wasn't helpful for me... I needed to see these things put into action." (Line 65)*

Low-intensity CBT techniques seemed more effective for participants with milder symptoms, supported by shorter sessions and psychoeducation. For those with complex needs, the structured approach felt rigid and insufficiently personalised, emphasizing symptom reduction over relational rapport.

2.2.1 Homework

Homework, central to CBT, presented challenges for several participants due to overwhelming life circumstances and pressure to complete tasks.

> ***P5:*** *"She gave me homework, but I couldn't get myself to sit down and do it… it was hectic at home. At my next appointment, she seemed sad I hadn't done it, like I wasn't taking it seriously." (Line 65)*

> ***P4:*** *"Sometimes the homework itself gave me anxiety. One time, I even cancelled the session because I was too anxious." (Line 177)*

Participants felt pressure to complete tasks, which sometimes led to heightened anxiety, guilt, or disengagement. This suggests a need for flexibility in balancing structured therapy with individual emotional capacity. For example, creating a secure environment allowed participants to express their struggles with tasks, but responses from therapists did not always reflect understanding or compassion.

When homework takes precedence, it risks overshadowing the individual's needs, reducing space for emotional processing. This imbalance can hinder engagement, amplify anxiety, and prevent positive outcomes.

2.3 Therapist Characteristics

Active listening and the therapist understanding the participants experience was deemed as important. As seen below, being listening is valued because it is seen as a characteristic that not everyone holds/values – this is pertinent to P3 who had difficulties with feeling dismissed in her journey, so to lack this from her therapist would reinforce beliefs she held about being heard/listened to.

> *P1: He was he was really good, actually calm, listened really well. Umm. And I think listening it is it's something that not everyone* takes on… And then he'd address everything all all my concerns that I had and it and feeling sympathy but not feeling like very thin line between sympathy and pity. I didn't want anyone feeling pity for me. So, he wasn't feeling pity for me, but he had felt sympathetic, which is which was nice. *(Line 134)*
>
> *P3: It would have been a lot better than rather than sitting on the phone with someone who's humming and arring when I'm saying things rather than giving me stuff back or making it look like their engaging with me or they're listening to me. (Line 200)*
>
> *P4: When it's someone that can't really know me because they're so different to me. How can I share things with them? They're not gonna get it. (Line 92).*

From a societal perspective, this issue reflects a larger cultural stigma around mental health, especially within Afghan or other tight-knit communities. In these cultures, mental health struggles are often viewed as a source of shame or dishonour, which can make individuals hesitant to engage with therapy or fully open up during sessions. When the therapist fails to communicate genuine empathy, it could reinforce these cultural barriers, leading clients to feel invalidated, dismissed, or misunderstood. This sense of dismissal might be even more pronounced when the therapist and client share a similar cultural background. For the client, there could be an underlying expectation that the therapist, coming from the same culture, should understand their struggles, especially those related to cultural pressures, identity, or stigma. If the therapist doesn't meet this expectation, it could lead to a sense of betrayal or disappointment, as the client might feel that even those who share their cultural context can’t offer the understanding or compassion they need.

In this sense, the therapist's use of verbal cues, which may have been appropriate in face-to-face settings, can fall flat in a telephone-based format where non-verbal cues (such as body language or facial expressions) are missing. This technological barrier can exacerbate feelings of disconnection and reduce the therapist’s ability to effectively convey empathy.

Moreover, the participant’s biases stemming from both their cultural expectations and previous experiences could amplify the perception of a lack of empathy. The participant may have pre-emptively projected their own doubts and fears about the therapist’s understanding, particularly if they feel that their cultural values may not be respected or understood. This perception, whether or not it is accurate, can further hinder the therapeutic process, leading to a diminished therapeutic alliance and less effective engagement.

The broader psychological processes at play here include the dynamics of trust-building in therapy and with services overall, which are central to successful outcomes. Trust can be particularly fragile in clients from culturally marginalised or stigmatised groups. If a therapist’s approach lacks cultural humility or sensitivity, it risks reinforcing existing emotional and societal barriers that prevent individuals from seeking or fully benefiting from mental health services. This highlights the importance of cultural competence in therapy, particularly for clients from immigrant, refugee, or minority backgrounds where the therapeutic process must acknowledge not only individual mental health struggles but also the larger cultural, familial, and societal contexts that shape these experiences.

In summary, the interplay of cultural stigma, therapeutic empathy, technological barriers, and client biases all contribute to the broader psychological and societal dynamics that affect engagement with mental health services. The therapeutic process is not just about addressing an individual’s mental health but also about navigating complex social and cultural factors that influence how individuals relate to their mental health and to the care they receive.

2.3.1 Rapport, relational working and curiosity

Positive relationships with therapists appeared to have a positive impact on therapy. When participants felt they could relate to their therapist and this is seen even when there are differences between the participant and therapist.

> *P2: It was really it was it was a really good relationship, I think. I think we got on like. Like really, really well, even though we were quite different. Um, it was just weird how much we related because like, one thing that. I feel like we bonded over was like, I'd say how I'm feeling. And then he'd like, be like, yeah, I can relate. Sometimes I feel like this. And then he'd give an example from his life. So, I feel like that built a really good relationship. (Line 46).*

This example underscores the significance of empathy and the ability to relate to the client, even when there are cultural and experiential differences between the therapist and the client. The use of self-disclosure, where the therapist shares their own experiences, helped P2 feel understood and validated. This approach strengthened the therapeutic alliance, demonstrating that shared human experience rather than identical cultural backgrounds can foster connection and trust.

What is seen here is that the relationship between therapist and service user has a clear influence on how one engages with therapy, thereby highlighting the relevance of contrasts in experiences of participants journey dependent on how positive the relationship was with the therapist

> *P3: It being over the phone… just don't think helped at all because it just didn't it just. I just didn't feel like I could talk. Um, and there was like, no empathy. There was no that was not like rapport... I didn't really know how to go into detail about things. Um, whereas like if you were doing it on face to face or if you're doing it like on teams or whatever way you could actually see the person, you can tell that whether they're engaged with you, you can see… how they act, when you say things, um what their body language is like. (Line 230).*

> *P4: Even if I had explained it, you know the response was more like ohm OK, I see no more like not like yes, I understand. Because if the other person understood, you know, say if I'm a therapist, I have all this information and all these experiences and those understanding. And if I was the therapist and I would completely understand the other*

> *person because yes, I have gone through it... But my therapist obviously had not experienced any of it. (Line 107).*

In P4's case, the perceived lack of empathy and understanding stemmed from the therapist's inability to relate to her personal struggles, particularly due to cultural differences. Although the therapist may have had the knowledge and professional skills, P4 felt that they lacked the lived experience to fully comprehend her situation. This lack of shared experience created a sense of disconnect, which is compounded by the participant's desire for a therapist who could relate more closely to her struggles.

> *P5: I just. I couldn't build that rapport with her. It's it was very hard to do. It was. And I know if you got to that point which is why I just felt like I don't wanna do this anymore. (Line 66).*

In the cases of P3, P4, and P5, listening alone was insufficient for emotional support, highlighting the importance of *active listening*, which involves empathy, engagement, and validation to build trust. However, CBT training often prioritises structured techniques over relational skills, which can overlook these critical elements. This is particularly relevant in culturally sensitive contexts, like the Afghan community, where trust is a significant barrier to mental health engagement.

The telephone modality worsened these challenges, as participants struggled to trust without visual cues like body language or facial expressions. This lack of connection reinforced feelings of distance and hindered rapport. Participants drew parallels between mistrust in therapy and cultural hesitations to confide in family or community due to stigma. The therapist's anonymity further heightened anxiety, amplifying concerns about confidentiality and understanding.

Gender dynamics revealed that rapport was more influenced by feeling heard and understood than by the therapist's gender. Although P4 found it easier to discuss some issues with women, most participants did not view gender as a major factor. Instead, relational dynamics and trust were critical.

Interestingly, these findings challenged assumptions that therapist gender significantly impacts therapy outcomes. While occasionally relevant, trust and emotional connection proved far more influential, emphasizing the need for individualised, relationally focused therapeutic approaches.

Curiosity is an important facet of therapy and an added layer to this is cultural curiosity. Throughout the data it is seen that there are similarities and differences between participants, but overall, no one was directly asked about their cultural differences, shown sensitivity to this context, and how these may (or may not) have influenced the persons experiences with mental health, services and therapy. P5 explains that

> *P1***:** *We didn't go into much depth on my - on the cultural at all… I guess it didn't really come up in the conversation. Umm yeah, don't think it was asked and I didn't bring it up either… It would have been good, but then again, it's hard for someone outside of the culture to try and understand, so I wouldn't have expected him to fully understand. (Line 141)*

> *P4***:** *you know where… I come from, where I have been, you know, things like that, they are not, not asked. If you didn't, if you… weren't asked, and if so, if you didn't tell that information I've been sharing in the space. Yeah, I don't know if I hadn't shared on, he didn't ask. I don't know. He would just been, it would be even more surface level okay I'm feeling this way why I'm feeling this way. (Line 45).*

> *P5: It was kind of like what I'm feeling at the moment and what's going on in my current situation. And I think definitely no, we had no conversations about those kinds of you know about the demographics really know anything that level. (Line 117).*

The issue with lacking curiosity is that this implies a reliance on recipients of therapy to have the capability, language and insight to disclose this information with no prompting. As is seen in excerpt 4, the participant explains that from her upbringing, if you were not asked you would not tell; this could relate to the concept of keeping issues/problems to oneself or within a familial setting for reasons related to shame or guilt, which relates back to an earlier idea of presenting with agreeableness. In the case of P4, she felt able to share some of her cultural background where she felt it relevant, but stifled in other venerations; otherwise she felt her experience would have been 'surface level' specifically having too much emphasis on the technique over the individual experience. It can be argued that there is a likelihood that others may not hold the same confidence or insight as P4.

> *P5: ...So I can't share deep things anyways because to me, just feel like okay. Maybe I knew that... there was connection, but you know that therapist doesn't see or don't let it. Doesn't let me know that they, you know is connected to that something in the past or maybe? You know, then I there's no point me even sharing that information. (Line 160).*

The idea that therapy also felt ‘surface level’ was ubiquitous in the data for those with more complex presentations. This was attributed to therapists not taking a specific interest in the individual circumstances, like culture, childcare, history, social circumstances like divorce, relational and interpersonal issues. The relevance of neglecting these factors is that it contributes to the idea that important values held by Afghan women are being neglected in therapy, such as marriage, family, honour, Islamic and traditional values, and therefore could reinforce a negative or critical idea of the self-related to their importance in society as Afghan women. CBT has person-centred roots; however, it is plausible that the manualised version of it neglects critical factors of a person’s journey thereby creating unhelpful therapeutic environments and poor outcomes and reflects less of a person-centred approach. It is important to be aware that these manualised protocols are in place to make therapy more ‘accessible’, however, a contrasting effect occurs not in relation to the number of people who access therapy, but for individual therapeutic and inclusion needs as is seen in the data excerpts.

2.4 Cultural understanding and influence on therapy

Participants spoke about the way in which their cultural backgrounds influenced their values and belief systems. There was an emphasis on familial roles and systemic pressures, and also earlier references to the Afghan community being toxic. P1 speaks about the importance of keeping close links to family and giving back to them because of the sacrifices they made as refugees. It is possible that these feelings (guilt to give back) are a result of intergenerational trauma that stems from displacement and adjustment. A consistent theme from the data pointed to how the participants struggled to be candid. This challenge was borne out of cultural norms that dictate and influence behaviours to be agreeable, unemotional and for women to acquiesce to men. This appeared to create a type of dyadic relationship with the therapist that disadvantaged the women

> *P1: Afghanistan's culture is we obviously a family is very important to all of us and so so are our parents. And… it is may not be the case in other cultures like you know, the British culture. (Line 160)*
>
> *P3: But then with like obviously I mean Asian culture. His Asian culture. You can't really change that, but being Asian yourself and speaking to someone about things that they probably just like, ohh, that's nothing, you know? They don't. They wouldn't sympathise with you, there's no empathy there. (Line 248).*
>
> *P4: That's how it generally I am that you know I wouldn't voice my concerns too much. And I think it's just to do with more my background again. We're always taught to not talk so much. (Line 105).*

The pressures associated with being accommodating and agreeable may then reflect in the therapeutic process, i.e., a recipient of therapy may not express their needs or emotions, challenge their therapist, or may become overly agreeable towards the therapist; but if this is not highlighted, spoken about or explored at the point of formulation, it would be difficult to ascertain the full effects of therapy. This is also reflected in P4’s data excerpt. This is a formulation skill that requires time which can be difficult in time restricted services, but if neglected can have negative impacts on the individual journey with mental health.

> *P5**:** Maybe on some aspects if maybe we were on the same from the same culture, she might have understood me a little bit more or maybe even religion. (Line 109).*

I interpret that despite an individual’s presentation, if they feel judged, there is always a chance that there are judgments present whether these are unconscious or conscious. This highlights a point about how regular training for therapists is needed to explore unconscious biases.

2.4.1. Fear of judgement

Cultural perspectives were embedded throughout the data. Participants spoke in different ways about how their cultural experiences created a lens around they experienced therapy and their therapist. The fear of judgment is not only external but is also rooted in the internalised expectations of the community and family honour. Many participants, such as P2, expressed that cultural differences could cause them to feel misinterpreted by therapists, making it harder to communicate effectively.

> *P1: But initially it was difficult for me. I had never spoken to someone on that level about my feelings. I almost didn't know how to go about it or how to speak about my feelings. It's just not something that people from my community commonly do, you know, it's just so I would say it took me time for me to actually be able to speak properly about my feelings (Line 77).*

> *P2: Opening up about these things, it was just a lot easier and like, a lot less confusing, a lot less awkward because the guy was like, I knew he'd be able to relate. And if it was like having to explain it to someone who, like, doesn't understand how things work culturally, it would be like a whole separate issue. And then I feel like that would have just given me more anxiety because then there's also an element of like, oh my God, would they judge me… And then that would affect what I'd tell them and then maybe they'd misinterpret how I'm actually feeling. (Line 87).*

> *P3: Maybe is it best to kind of find somebody from completely different culture and you know, talk maybe that way you can talk openly about anything and it there wouldn't kind of judgement you because there is that thing where person from the same culture might be more judgmental. So, it's kind of really difficult to find the line. (Line 126).*

There were mixed responses in regards to shared cultural background. There was an argument that shared cultural characteristics would make it easier for the participants to feel heard and understood by their therapist, whereby the counterargument was that cultural similarities may also be accompanied by judgement and biases about mental health that they as individuals have experienced across their lives.

> *P5: I think. I think the therapist might have been able to give me more structured advice that was sort of suitable for me for, for, for my background. Um, there are certain things that will work for a person who's not religious or from my culture. (Line 119)*

The idea that a therapist "doesn't understand how things work culturally" creates an additional layer of complexity for Afghan clients seeking therapy. The concern is that a lack of cultural competence could lead to misinterpretation or stigmatization of emotions, resulting in a breakdown of trust. This fear of judgment is a critical factor that could explain why Afghan individuals may avoid seeking therapy or disengage once they do. I perceive that this lack of openness will likely have an attachment to shame, fear and even guilt associated with feeling distressed. Societally, the fear that a therapist is culturally unknowledgeable can contribute to the broader issue of mental health stigma within Afghan communities and an exacerbated lack of help-seeking. Afghans may already perceive seeking therapy as a sign of weakness or failure, especially as it is a culture that prioritises familial unity and social honour.

> *P3: It could be because it's not very common for maybe a young Afghan girl… And maybe that's why I found it patronising… it I didn't feel like I could be fully like I didn't feel like I could be open. (Line 158).*

In the case of P3, she had a difficult journey throughout her engagement with services with male Asian professionals. The difficulties she faced with male professionals may not necessarily rooted in gender alone, but in the cultural disconnect between herself and the therapist. While she acknowledged that the gender of the therapist might have played a role in how she felt, her broader concern was about the therapist's ability to understand her cultural context. This highlights that, while gender dynamics might influence therapy, cultural understanding is also significant determinant of trust and rapport. Her struggle could also stem from the broader cultural norm in Afghanistan where men hold significant power in the family and society, potentially making her interactions with male therapists feel even more fraught with power imbalances, therefore exacerbating difficulties with her engagement. I cannot fully interpret why there is a discrepancy between her difficult experiences with male practitioners and her lack of linking between this and her poor experience with therapy; it could be that making this link would be painful, or the reality is that gender did not matter to her; this would have on reflection have been a topic that required more probing during the interview process.

The difficulty with gender difference was not seen across the data; P1 and 2 had positive experiences with male therapists, and P4 had a mixed experience, whereby she cited she would have worked better with a female but did not disparage working with a male.

What is presented is a double stigma; a fear of judgement from professionals is rooted in that of judgement experienced within the journey of mental health from within communities and families. It is important to consider this idea, as I interpret that it gives a glimpse into a possible justification behind why Afghan individuals may not access therapy. As highlighted by P5, being asked about these factors and having the space to explore may have created a more individualised, less stigmatising care approach.

1. The End: Leaving IAPT

3.1 Ending therapy and reflecting on the journey

Endings can often be difficult for recipients of therapy and can trigger difficult feelings whether the course of treatment was positive, negative or mixed. Participants 1 and 2 finished a full 6 session course of treatment, and participants 3, 4 and 5 dropped out. Participants 3 and 5 described that they did not feel able to engage with the style of therapy and maintain the relationship with the therapist, whereas P4 felt that therapy became repetitive for her in relation to skills and techniques learnt.

> *P3: I stopped taking the calls. And he then reached out to me on e-mail. And said obviously I've tried to call you who've got session booked in for this day this time, and I basically wrote back saying I don't feel like it's appropriate for me to carry on. And that was it. There was no why…There's just no point in me trying or anything so that that second time I felt like I wasted a lot of time as well Um, I wasted time and space being on the waiting list. (Line 282).*

> *P5: I had to say I'm afraid it's just not... I don't wanna attend anymore. More of these sessions. So, um, yeah. I mean personally. I was very hopeful that it would help me, but it didn't. It just didn't meet my expectations unfortunately. (Line 41).*

My interpretation is that the above participants felt let down by the therapeutic process therefore decided to detach themselves from therapy. The participants in question appeared to detach from therapy due to feeling let down by the process. P5 expressed dissatisfaction to her therapist, but despite some rapport, the lack of follow-up or inquiry about additional support left her feeling unsupported. P3 ended therapy abruptly, likely out of a sense of hopelessness after experiencing dismissive attitudes from professionals. Her decision may have been an expression of anger and frustration, as she seemed to reject the therapist as a way to cope with abandonment and judgment. This feeling was reinforced when services attempted to reach her but then stopped contact once she responded. It was difficult to hear this, as I felt empathy for the participant and anger towards the therapist's lack of care; it is unsurprising that P3 did not think her treatment had any positive aspects.

3.1.1. Positives: A space to share

Despite the difficulties, almost all participants held high hopes for the services potential. There was a theme of understanding/managing emotions better, reductions in anxiety and also the positive influence having an outside space to talk can have on mental health.

> *P1: Treatment ended well. I felt a lot more able to manage my emotions to at the end of my therapy sessions than I did to begin with. So, I really left on a high and I was happy that I had completed that and kind of done that for myself. So, it was it was a it was a proud moment and it definitely helped. (Line 188)*

> *P2: It helped me understand my emotions better, I would say for sure, I don't understand them fully. Why am I feeling this emotion or what is leading me to feel this emotion? So, I think it made me very self-aware. Umm. And also, being able to manage some stress and anxiety… Maybe in our culture we tend to be very selfless and we put other people first before we put ourselves first and that's one thing that I always did, but only now have I really started to realize that being selfish is OK and you need to put yourself first sometimes. (Line 141)*

The therapy process for P1 and P2 in particular appeared to be an empowering journey, as both spoke about how being a part of an Afghan family can often require one to be selfless, and therapy empowered them to consider their own mental health as a priority. This is significant because if it can be understood that from cultural perspective, grounded in patriarchal constructs, that putting one's self first is considered 'selfish', it is something to be considered within a therapeutic space; for example, if attending therapy or engaging in therapy tasks from the perspective of the participant is 'selfish' or impact factors for them that exist outside of therapy (like family or community) it may be more challenging to engage with the process inclusively if such dynamics are not formulated as a part of the individual's difficulty.

> *P5: I think the positives are, is it's nice that you can, if you feel like a point where there's nobody else that you can talk to, like family, friends. Then it's nice to have that other person where you can just, you know, pick up the phone and say, look, I need to talk to you. (Line 148).*
>
> *P4**:** I think it definitely had positive in the sense that at that time when I what I was feeling, my anxiety was very high, you know, going there even though I stopped sharing a lot of, you know, things from a deeper level I still had that space to share regardless of the person understood it or not. (Line 126).*

Of significance is therapists and services being considerate of the needs of individuals who experienced life through the lens of a collectivist culture which does naturally conflict with Western ideals; bearing in mind that IAPT CBT protocols are based on Western medicalised measurements of distress. It is seen that having the space to identify and explore this as an issue is beneficial. I interpret that it is also is possible to see these differences being missed as a part of treatment because of the adherence to the protocol, and this segment exemplifies why this can be impractical; treatment protocols may not entirely capture the essence of what the presenting difficulty is, and therapy recipients may find it difficult to openly express their needs.

P4 describes that the treatment course she engaged with did what it was designed to do, specifically reduce symptoms. But within describing her positives, she also explained that she stopped sharing information with her therapist about herself which she considered 'deeper'. This could be seen as a breakdown in trust and rapport which meant her engagement in treatment diminished because of this lack of cultural curiosity and awareness. Based on the participants accounts, the environment created and the relationship built are two critical factors for therapeutic engagement; both of these are at the core of a relational way of working.

I considered whether there was a reluctance in participants to show me that they only felt negatively about services, maybe because of the awareness they had of my role as the investigator and future psychologist; this could have been speaking to something around power imbalances. I hope that participants felt comfortable enough with me as a fellow Afghan woman to be honest in the interview process. I am aware of the lack of trust participants felt they had in the community and that this could have transposed onto me too, meaning they may not have been completely open with me as an Afghan woman, in interviews, I tried to create an atmosphere from the recruitment stage to the interview that made them feel comfortable and open.

3.1.2 Negatives: Shutting the door

The negative aspects of therapy were wait times, a lack of depth and understanding within treatment sessions and the therapy feeling surface level, the limited time within the sessions, treatment being offered over the telephone (theme 2.1) and a lack of focus on context. Manualised CBT is understandably not designed in nature to be explorative, but this does not mean that important factors about an individual experience should be neglected, especially if it is significant to an individual's journey and presenting difficulty. P1 for example speaks about how it was impossible to 'shut the door' on the aspects of her life that were causing distress; this further highlighted that the manualised protocols veer away from context and is heavily focused on symptom reduction.

> *P1: Maybe more of my lifestyle choices and might have elaborated more on… The fact that stuff that you have going on around you, I couldn't just shut the door and be like, I don't want that part of my life. So, I'm just gonna block it all out. (Line 106)*
>
> *P2: the duration of the sessions and maybe the time limit on how long it took for me to actually be able to be treated with this cognitive behaviour therapy. (Line 84)*
>
> *P3: I don't think there was any positives of the 1-1 sessions. (Line 180).*

> *P4: Some of the thing that especially that came from a deeper level are still there. You know, I guess that needs to be dealt with the different way. (Line 126).*

The words 'shut the door' are powerful, as it signifies an experience that many people face when accessing services that are not designed to consider individual needs. If service users feel they have to compartmentalise important aspects of themselves that likely influence their mental health, (like culture, religion, family dynamics, possible trauma/intergenerational trauma) combined with a lack of curiosity by therapists, therapy can become an invalidating and meaningless experience. It appears that services are not designed or equipped to manage intersectionality and systemic difficulties. Metaphorically 'shutting the door' seems to work both ways, as I interpret that services also shut the door on those they feel they cannot help because of complexities, which is why when participants ended treatment prematurely there was no real exploration into this.

3.1.3. Suicidal ideation and self-harm

A negative aspect of the treatment process also appeared to be suicide and self-harm management. Suicide and self-harm management from the perspective of participants was somewhat deplorable. Although it was not recurrent in this dataset, the significance of what was highlighted has made it a significant finding. It was disconcerting to see that participants were left in positions of such hopelessness that they felt too detached from services to reach out for help. Although this experience was not consistent across the dataset, it struck me in its similarity to my own experiences and I felt it critical to discuss. This experience will be similar to the general population, but there are possibly other compounding factors for Afghan people that increase their risk, like family/community isolation, stigma and shame, all which are themes that have been extracted from the data.

P3 describes that her wait for individual therapy was so extensive she resorted to self-harm as a form of regulating, and P5 describes that negative experience with therapy made her choose to terminate the course early, which thereby increased her hopelessness and concrete suicidal ideation. Because of how disjointed and prolonged her journey was, there was a clear escalation of events that lead to a compromise in her safety.

> *P3: Like I said, it wasn't tailored to me. So, who's gonna know that I was doing that? (Line 316).*

> *P5: And there were certain things that I couldn't tell my family. I couldn't. I felt like almost, you know, guilty that they I'm dragging them into my problems… I had this therapist and I just thought… she's not understanding this at all… I felt at the time that maybe she just Is not taking it so seriously…. I couldn't really sense like her understanding in, in, in her voice. It just didn't come across as though she… understood how desperate I was desperate I was. (Line 79).*

P5 explains that her hopeless developed into suicidal ideation, which further developed into more concrete thoughts about how and when she would take her life. As she explained and is seen across themes, she did not feel understood by her therapist nor did she believe they were could build rapport over the telephone; these factors could have contributed to the lack of safety created around the ability for her to disclose the suicidal ideation. If themes of hopelessness had started early on in the journey, I conceive that suicide would have been challenging to disclose if there is an assumption based on personal evidence that the therapist would not understand or help. For example, if this is understood from the perspective of the individual Afghan values system the guilt associated with discussing suicidal thoughts with family members underscores the cultural emphasis on familial roles and responsibilities. Afghan women may often prioritise the well-being of their family over their own, making it difficult to express struggles that could burden loved ones or bring shame.

Further exacerbating this difficulty is that the participant felt guilty discussing suicide with family members and it is also known that suicide is considered a sin within Islamic faith (a belief this participant subscribes to), which could possibly create an intense internal conflict of distress. This could create a psychological barrier to help-seeking, as the individual may feel their suffering is morally unacceptable or incompatible with their faith, making it more difficult to disclose their thoughts to others, including professionals. What is left is an individual with frequent suicidal ideation, thoughts and plans to action it and a lack of assurance to reach out for help. It would of course be difficult for a professional to intervene without the knowledge of such ideation being present, but I believe had there been an environment being created early on that facilitated a space of safety for such disclosures, it is possible that firstly a deterioration would not have occurred, but even if it did, there would be a higher likelihood of disclosure. A lack of understanding can lead to a misalignment between the therapist's approach and the client’s needs. Recognising the significance of concepts like shame, family honour, and religious ideologies is essential to providing effective help. On a broader societal level, the inability or unwillingness to seek help due to the fear of stigma reflects systemic issues related to mental health awareness and cultural competence in mental health services particularly for marginalised communities

3.1.4 Is the DSM one size fits all?

IAPT services primarily rely on DSM-5 criteria and NICE guidelines, which align CBT therapy with symptom-based protocols. Four out of five participants were provisionally diagnosed with social anxiety, with some following a ‘social anxiety’ protocol while others focused on worry. However, for participants like P4 and P5, the label of ‘social anxiety’ often missed the mark, making the manualised techniques less effective. Although some symptoms, such as fear of judgment or social interactions, align with social anxiety, the core issue of internal self-focus was not apparent in these cases. This suggests that while therapists were not strictly bound to DSM criteria, there was still insufficient consideration of individual circumstances, resulting in key contributing factors being overlooked.

This highlights the limitations of a ‘one size fits all’ approach. Literature often critiques diagnostic labels for being overly medicalised and symptom-focused, neglecting holistic, individual needs. Labels can be stigmatizing and invalidating, framing reality-based thoughts and feelings as ‘abnormal’ to be ‘challenged.’ This procedural invalidation may not be mitigated by only empathising and listening. While diagnoses can provide a useful framework, rigid adherence to protocols risks turning therapy into a systemic process rather than a personalised, therapeutic journey of healing.

The emphasis on fear of judgement is rooted in their experience within their families and communities. There is not necessarily a perceived judgement but rather a tangible fear of being judged at a high standard based on experience. This is plausible when considering the experiences of individuals were circumstances that were deemed to be’ frowned upon’ by the Afghan community like divorce. The shame associated with this could be stigmatising and therefore Afghan women may find it difficult to talk about such things, or to be social with others due to the associated shame, which is why therapist curiosity is critical. Within this is the innate issue of patriarchal norms which can increase the likelihood of being faced with societal stigma for seeking divorce, leading to feelings of shame or guilt, especially if they are expected to uphold family unity, which therefore may create fear of judgements both from the community and family; the interlink between shame and family perceptions can be seen in the below quotes.

> *P1: I feel like understanding - understanding my point of view on how important my parents and my family are to me. Is what would have potentially made a difference on the overall experience… if you're so emotionally affected by something that's going on in your family, it's going to be inevitable you're gonna feel these feelings of guilt and worry and anxiety that you made links between basically relationships and what you were feeling at the time. (Line 163)*

> *P2: I'm having episodes of not wanting to go out or not wanting to socialize, constantly having a fear of something bad's gonna happen, or feeling a sense of responsibility because of some sort of issue that was happening at home (Line 12)*

> *P5: I think on a deeper level it was mainly my mood. It was these negative, horrible thoughts. I don't think I was worried about socialising at that point. But I think what she took from that is she thought maybe if I learned to socialise, meet friends, you know. And It might help my mood in my sort of give me a little bit more support. (Line 90).*

When participants discussed social anxieties, these were often tied to life circumstances like disrupted relationships, familial guilt, or intergenerational conflict. Their challenges could be better understood beyond a rigid framework like social anxiety, especially within an Afghan cultural context. Afghan women may face societal expectations around family loyalty, honour, and reputation, which can amplify feelings of guilt and anxiety when these ideals are disrupted. For example, familial strife may evoke deep-seated shame, a cultural aspect that doesn't align with Western medicalised views of mental health. With this is also the fear of possible catastrophic consequences that are associated with not upholding values related to honour/family honour.

> *… And, you know, life experiences are based on culture, religion, what not… I mean, it wasn't something that ever came up in our conversations, but it might have helped. I think, you know, maybe because certain things like, you know, the way I was feeling*

> *from my family that could be due to, you know, I had pressure from my family. And you know how divorce or separation was really frowned upon in my culture. Um, so those things, I don't know if she had, she would have understood very well if even if there were brought up. (Line 113).*

In therapy, particularly when framed clinically, participants often felt that their cultural and social experiences were misunderstood. If therapy was too diagnostic rather than collaborative, it may have felt impersonal and insufficiently attuned to their needs. Afghan women navigating cultural expectations, familial pressures, and personal trauma, may find medicalised approaches alienating. Such rigidity overlooks the cultural nuances of anxiety and distress, potentially hindering therapeutic engagement.

Moreover, Afghan women may often struggle to challenge these therapeutic approaches due to power dynamics within Afghan culture, where women's voices are frequently marginalised. Trusting a professional may be a significant step, but if therapy oversimplifies or misinterprets their experiences, it can foster disconnection and mistrust, not just of the therapist, but of the mental health system as a whole. This deepens their reluctance to seek help in the future.

The compounded impact of these cultural and social factors may make it challenging for Afghan women to engage in therapy that fails to recognise or validate their lived experiences. They may hesitate to challenge a diagnosis or therapeutic approach due to respect for authority, fear of being seen as problematic, or a lack of confidence navigating the healthcare system. These power imbalances create a dynamic where the participant’s needs are secondary to the therapist’s perceived expertise, leading to feelings of inadequacy and mistrust in therapy.

Therefore, a culturally competent approach to therapy is essential, one that goes beyond medicalised frameworks and considers cultural, familial, and social contexts. A collaborative, culturally sensitive approach would allow therapists to build trust, validate the client’s experiences, and avoid harmful labels. This would promote more effective therapy while addressing the cultural issues of power, identity, and stigma that shape the therapeutic journey for Afghan women.

What is highlighted is the problematic nature of a ‘one size fits all’ approach. Diagnoses can be problematic as it takes a medicalised and psychiatric/symptom-based approach as opposed to looking at holistic idiosyncratic needs. Reducing an individual to a label can be stigmatising and invalidating, as it suggests that thoughts and feelings that are based in reality are ‘abnormal’ and to be ‘challenged’; empathy and listening may not be enough to counteract this procedural and systemic invalidation. This is not to say that these labels cannot be helpful when thinking about working with an individual, but when this is further subsumed by a process that requires rigid procedures to be followed in order to support a person to reach ‘recovery’, participants become a product of a systemic process as opposed to a therapeutic journey.

Lastly, it was seen in the data that symptoms like hypervigilance, panic and withdrawal were being mistaken for social anxiety, whereas one may frame some of these difficulties from the lens of trauma if they are being guided by the DSM. One participant cited flashbacks as being one of her difficulties, but without clear reason I interpret that this was overlooked. For risk prevention and safety purposes, it was beyond the scope of this research project to effusively probe into the specific details of what is being described as trauma (i.e., the type of trauma, the root causes and context) for each individuals journey, but what can be deduced is that this was not explored as a part of the therapeutic process for the participants in question.

> *P4: A lot of things were getting shared and you know, maybe a bit of trauma or maybe if things were getting triggered and maybe that's why I was giving me anxiety. (Line 67).*

> *P5: I was alone with two kids and now we need this kind of big flat. It was it was massive and I just felt a little bit scared at night and I was just having flashbacks at night. So, I just thought she's not gonna understand what I’m going through. (Line 86).*

This observation implies several broader psychological processes and societal dynamics related to trauma, therapeutic engagement, and systemic limitations within mental health services. Firstly, trauma as a central issue: Trauma often lies at the core of mental health struggles, even if not directly addressed in therapy. Participants brought it up naturally, suggesting that trauma is frequently overlooked unless explicitly explored by clinicians. Secondly, the limitations of manualised CBT: The 60-minute CBT sessions with participants dealing with complex trauma show the tension between standardized treatment protocols and the need for more flexible, individualised care.

Trauma requires a deeper, more nuanced approach than what a rigid CBT model can offer. The issue of quantitative vs. qualitative care: Focusing on quantitative measures of recovery, such as questionnaires, risks missing the emotional and relational aspects of trauma. A more comprehensive, empathetic approach is needed to fully address clients' lived experiences. The issue of systemic and structural gaps: Participants facing significant vulnerabilities—like managing PTSD while caring for a new-born highlight the strain on under-resourced services, where trauma may go unaddressed due to systemic limitations or lack of trauma-informed care. And lastly, wider cultural dynamics for Afghan women: In communities where mental health is stigmatized, a lack of attunement and validation from professionals can deepen feelings of alienation and distrust in the system. This can perpetuate disengagement and undermine recovery.

Considerations for the future: "It could be very life changing"

All participants also stated that they would recommend this service to others, Afghans, and also offered recommendations:

> *P1: I would say maybe it's a just touch on that and try to understand that as much as possible on the cultural because it wasn't mentioned or picked up on so I feel like maybe if that could be picked up on that would be that would be beneficial. (Line 171.)*

> *P3: But I would tell them to make sure that they've got options. And… just make them aware of how long these things take and yeah, I think the most important thing would be to make sure that they know to ask for options and to do and to really think about what might be better for them. (Line 344).*

> *P5: I recommend the service I think if it's designed a bit better, I think it could be very life changing. It could be very, very helpful… it just needs(s) to be planned a little bit better and kind of. And structured a little bit more around the individual. (Line 162).*

It was important to consider the cultural contexts of the individual experience and, be presented with information to support the process of informed and shared decision making as a part of the therapeutic process and having a better management or contingency plan for extensive waiting times. Taking account of a person's cultural context has been embedded throughout the data analysis as important to an individual's journey in how they want to be seen, heard and understood. Normalising conversations around culture, faith and belief are integral to providing any service user regardless of their background with support which is tailored to their needs and is something which all trusts must be equipped to provide.

3.2.1. The importance of choice and shared decision making

Of importance was having a better designed service that took into consideration individual needs and choice, like being asked about preferences for therapist. All participants said that they were not asked about preferences in relation to therapist allocation. For some, this did not pose any issues, for others, I believe the differences impacted therapy, especially as these differences were not adroitly bought to the forefront of therapy. Being given a choice or at least asked about preferences is powerful, and has the potential to build and earn trust between clients and therapists.

> *P1: I wasn't given the preference of or a choice, but I was happy you with him. The way he made me feel and how comfortable he made me felt in the assessment. (Line 55)*

> *P3: It just comes to a point where you don't even know whether you should ask if there are other options. Because do I have to wait another few weeks or a few months for me to get someone to video called me. (Line 209).*

And this, a lack of choice around modality which has also been highlighted in the themes thus far was challenging for engagement. There was an important point made around the difference between having a preference, and having that preference truly exercised or considered by services. There are several issues to consider around choice, preference and shared decision making. Although these three factors are likely to enhance care, limited-service recourses mean that the likelihood of these being met are low, so the scepticism within the data is not unsubstantiated, nevertheless is critical to then reflect on how this lack of recourse contradicts with the primary goal of the CBT service which is to ‘improve access’ to psychological therapies. It is an issue that has been saturated on the foundation that ‘access’ means to open to the door to therapies on the basis of quantity, not quality. What is thought-provoking is that participants are cognizant to this lack of choice and system of care that they have entered.

> *P5: They said that this all this therapy will be done over the phone and it will be an hour-long session. Um, I I wasn't really asked whether I wanna be seen in person. Um and no, I mean it was it was quite limited in that aspect. (Line 34).*

> *P4: I guess I could have chosen to, you know, not go with that therapist after first session. I think I had that choice, but again… if I say no, for example… I don't think I was very convinced that the fact that if I had said no… and then they would give me someone of, say of my preference. (Line 44).*

As has been mentioned in earlier themes, preferences around therapist varied with different rationales of what mattered and what did not, but mostly having a male therapist did not impact relationships in therapy. What did matter were characteristics like culture, religion and sexuality. For example, Islam can be an integral part of many Afghan women's identities, influencing their beliefs, behaviours, and how they approach mental health. A therapist who acknowledges and respects the role of religion can foster a therapeutic environment where clients feel understood, rather than judged. In some cases, aligning therapy with religious values can make the process more acceptable and meaningful. With this, Afghan women may often face societal expectations around gender roles that can make discussing personal issues, particularly around sexuality or mental health, difficult. A therapist who is sensitive to these issues and offers a non-judgmental, empathetic space is more likely to support these women in overcoming the cultural stigmas surrounding mental health, gender, and sexuality.

> *P3: I think giving a choice of the therapist, you know, do you want a therapist, who is of similar background or somebody who is from a completely different background that might be helpful sometimes… I would probably say a non-Asian. Whether it was male or female it, I don't think it would matter, but just not from like the same background or culture… I think highlighting the choice thing… is quite important. (Line 242)*

A discrepancy in the data is presented with the relational aspect of therapy and how this impacted their journey. It is evident that each person's needs vary in accordance with what their own individual experiences were. Once again, a mixed view of who feels more/less comfortable in the therapeutic space depending on what the shared differences are between client and therapist. In the case of P4, she explains that herself and her allocated therapist could not relate to each other, that she felt others in her position may not tolerate the differences because of biases and judgements that exist within the Afghan community. This further highlights the complexity of something even as simple as therapist assignments because what is ostensible is that biases and judgements can be held on both sides, much dependent on person experiences. In this instance, P4 alludes to the conflict between religious values and ideals and the sexuality of her therapist. The complexity lies in where a line is drawn in relation to 'tolerance'. Emphasis has been placed on service/therapist responsibility towards clients, but it is also important to consider how therapists will work delicately if clients cannot tolerate a clash of values. Therapists must also feel equipped and protected to do their job should they be faced with differences that could cause tension. Again, this further highlights the importance of identifying and reflecting on the differences rather than operating like they do not exist.

> *P4**:** Maybe, you know, to have given a bit more choice in terms of the kind of therapists I choose. Or at least, or even if I'm not given a choice, at least consider my background, and when you know giving me a therapist by completely two opposite kind of people, you know, you're. I'm someone of colour brown colour, you know, Muslim strong cultural* background *and then you give me a therapist who is male. Uh not even heterosexual, you know. So, then it's like very different. If it was someone else, like I said, they might have had biases and judgement of the kind of therapists that I had, for example. (Line 183).*

Lack of choice or being asked about preferences creates an environment whereby participants felt they were not 'considered', especially when there were obvious personal characteristic differences.

The lack of choice or being asked about therapist preferences made participants feel 'not considered,' especially when personal differences were apparent. In cultural contexts where exclusion is common, this lack of consideration can further diminish engagement with services. While assumptions should not be made about who treats whom, services should be equipped to ask about personal needs when allocating therapists. This helps ensure clients feel their identities are respected.

Creating an environment of shared decision-making, where clients are informed and given options, can empower them and improve engagement. This is especially important in cultures where mental health stigma exists, as not considering cultural or individual needs can reinforce feelings of alienation. Offering flexibility in choices, whether about the therapist or therapy modality, can be therapeutic and empowering, ultimately enhancing outcomes by fostering a sense of autonomy and trust.

Discussion and Conclusions

Overview

I will now summarise the findings from the research study, including the overall themes and broader conclusions in relation to previous literature. I will examine and critique the findings in relation to the research process in its entirety, and consider the possible implications for practice in Counselling Psychology and IAPT services. With this, it is important for me to specify recommendations for future research.

Summary of findings: *Did participants feel understood in their journey and were their experiences framed within a cultural lens?*

I will begin by synthesising the results in relation to themes. The findings suggest that the frameworks that exist for cultural competence are not being followed according to the data contributing to potential unhelpful processes in therapy. CBT is a common therapy often offered to individuals as a first point of call when experiencing a mental health difficulty, so it is likely that this service will be widely utilised. Evidently, through this data set it appears it is not designed to accommodate everyone realistically it cannot, therefore should not be promoted as though it can. In particular, it is critical to note that this study focuses solely on Afghan women and so cannot represent the entire Afghan community.

The themes revealed that culture often had either a significant or underlying function within an individual's presenting difficulty, how they engaged in therapy and how rapport was built with their therapist, and this was true of the beginning, middle and ending of the journey. Experiences were difficult when crucial information was undermined, dismissed or invalidated, and this even before entering the services due to interactions with the GP. The GP's role appears to be critical to engagement with services – if the experience of invalidation and dismissal occur early on, biases can possibly to be created that make engagement more challenging further down the line.

With this, it appeared to be that these difficulties were compounded by the complexity of everyone's situation, for example, if this was not the participant's first-time accessing therapy, and / or there were social and circumstantial difficulties and familial/relational difficulties.

The four key findings relate to cultural curiosity, relational working, 'choice' and 'preference' and diagnosis (or potential misunderstanding of diagnosis). Participants presenting difficulties were not framed through their cultural lens, specifically therapists did not ask about their individual cultural experiences so often the participant then would not speak of it. Positive relationships were built but often there were barriers to this like having therapy on the telephone, feeling misunderstood, judged and lack of empathy.

Research suggests that the therapist-client relationship is equally or more important to the therapeutic technique (Okamoto et al., 2019); the current data highlighted that feeling understood by the therapist supported positive relationships; self-disclosures and having the ability to relate to the therapist was deemed beneficial, but regrettably this was not the dominant experience.

Difficulties also presented whereby participants were not offered a choice or asked about preferences in relation to their care. Differences and similarities with the therapist in terms of relatability impacted individuals differently. The themes suggested that having a preference of shared characteristics with the therapist had a positive impact on treatment. Conversely, a pattern emerged suggesting that it is possible that working with someone that has too many shared characteristics can cause biases and judgements to be present which may also have adverse effects like feeling judged. it was suggested that being offered the opportunity to express a preference and having the ability/choice for this to be fulfilled was important regarding gender, culture, religion and ethnicity where possible. Lastly, cultural curiosity had secondary impact I believe on formulating and diagnosing the presenting difficulty. The data showed that social anxiety was a primary diagnosis, but when unpacking individual circumstances, this diagnosis would fail to appropriately represent the difficulty. What was being perceived as social anxiety I believe were being mistaken for trauma responses, although this had more negative impacts on those with more complex presenting problems.

Discussion of findings and links to existing literature

The Beginning: Accessing IAPT

There were a mix of experiences in entering IAPT and having an assessment. Some participants described the initial assessment as being more for the benefit of the service as opposed to the service user, and participants stated that they were not asked about how their experiences linked to their wider intersectional needs. This falls in line with previous literature whereby it is stated there is an overall lack of understanding individual needs for ethnic minority groups (Sadler et al., 2018), which could stem from a lack of thorough assessment. Rathod et al., (2019) suggest that collaboration in assessment and formulation is key for providing culturally component CBT. The data collected here suggests that this did not happen. Assessments are cited as a key factor in creating adaptations for service users, as it falls under the 'Triple-A' principle of 'assessment, adjustment and alignment' (Rathod et al., 2019). It did appear that a lack of coherent assessment impacted treatment for some participants.

The findings suggested that relationship with the GP had influence on referral and engagement with IAPT, especially if personal relationships in service users' lives did not necessarily advocate for the experience of mental health/care. This has also been seen in previous literature where service users that must make self-referrals is seen as a barrier to accessing treatment and they have felt their needs were undermined (Thomas et al., 2020). Better relationships between the GP surgeries and IAPT services could enhance the way in which the services are viewed, and therefore increase the chance of referrals being made. With this, the relationship between the GP and service user also has influence on the likelihood not only of referrals being made, but also participants following up with said referrals and engaging with services (Thomas et al., 2020).

The beginning of treatment also consisted of long waiting times. Yasmin-Qureshi's (2019) study found for South Asian women that long wait times were associated with poor coping skills and deteriorations in mental health, which was mirrored in the current research. My interpretation of this was that a lack of help from services combined with a lack of support from family, friends or even judgement from the Afghan community could possibly leave participants feeling hopeless and therefore reliant on unhelpful coping strategies like avoidance and deliberate self-harm.

The Middle: Engaging with therapy

The literature suggests that PTSD, depression, anxiety, emotion regulation and increased risk of suicide and self-harm are common issues amongst the Afghan population (Alemi et al., 2016; Ho, 2018). Although only a small dataset, this appeared to be commonly present, in particular reference to trauma and emotion regulation. Difficulties with regulating emotions was problematic for those with more complex difficulties as distress developed into intense suicidal ideation and deliberate self-harm.

As suggested in the literature review, explanatory models of depression for Afghan individuals suggest that understanding underlying belief's regarding the aetiology of a disorder are imperative for providing appropriate and holistic care, and to reduce the likelihood of miscommunication between the therapist and client (Alemi at el., 2016). This was seen across the data firstly in how presenting difficulties were provisionally diagnosed, and secondly in a lack of curiosity shown by practitioners which led to decreased empathy and rapport building. Therefore, a lack of willingness from participants to share their story. What is also interesting is that participants highlighted that if they are not asked about something, they would not tell. With this, it is suggested in that cultural curiosity or 'desire' is a critical part of working in a culturally competent way (Camphina-Bacote, 2002); other than self-disclosures, it was apparent within the data that cultural curiosity was not present.

Fear of judgement was a common theme in the data, suggesting that individuals many often come into therapy with biases and fears that will unavoidably impact their engagement, so as practitioners we must be aware of this. Existing literature suggests that stigma related to mental health is a prevailing issue in the Afghan community (Alemi et al., 2016); relevant to stigma is thereby fear of prejudice, discrimination, maltreatment and misdiagnosis, and distrust in people services and systems (Gary, 2005), and are known barriers for accessing mental health treatment (Cheng et a., 2018). These themes were presented in the data, at 'the beginning' and 'the middle', whereby there were underlying difficulties with trust towards the therapist, and fear of judgement and dismissal. This became exacerbated by the therapist when these issues were not identified, a lack of empathy and curiosity was shown and had clear consequences on engagement, and mental health deterioration. This aligns with earlier findings that there is an increased need for awareness of issues such a culture, ethnicity and religion in therapeutic processes, but at the assessment and formulation stage (Beck & Naz., 2019; Beck, 2018).

With this, it is critical to consider the patriarchal issues that significantly impact the dynamics surrounding difficulties such as divorce. One significant way this influence is felt is through rigid gender roles and expectations. In patriarchal societies, men are often positioned as the primary breadwinners and decision-makers, which creates an imbalance of power that complicates divorce proceedings. Women may face intense societal stigma for seeking a divorce, often feeling ashamed or guilty for not maintaining family unity. This cultural pressure can create a barrier to accessing social support, as evidenced in the experiences of some participants. After a divorce, women may struggle to find support networks, fearing judgment from family and friends who uphold traditional values. This fear of rejection can lead to social isolation, making it difficult for them to express their needs or seek help, which only deepens their sense of loneliness and vulnerability. Furthermore, the emotional weight of conforming to traditional roles can lead to feelings of inadequacy or failure, potentially triggering anxiety or depression.

It's also important to distinguish between evolving cultural norms and entrenched patriarchal beliefs, especially when dealing with sensitive issues like divorce. Cultural practices are not static; they evolve over time in response to changing societal conditions. Understanding the complexities of conflating patriarchal norms with cultural values is essential, particularly when examining the autonomy of women and their mental health.

For Afghan women, these intersecting factors create a particularly challenging situation. Addressing these issues calls for broader societal change such as creating safe spaces for women to voice their struggles and increasing access to resources that protect their rights and promote gender equity. On an individual level, therapists can help by gently guiding clients through the feelings of shame and guilt associated with these societal pressures. By fostering compassion and creating a space where difficult emotions can be explored from a different perspective, therapists can attempt to separate culturally engrained expectations from the gender-based power dynamics that possibly shape these difficult feelings. This approach may not only helps alleviate feelings of shame but can also empower Afghan women, simply by creating a distinction between what is culturally engrained/acceptable/unacceptable and what is a product of gender-based power.

As is earlier suggested, systems of care are required to acclimatise to diverse population (Stone et al., 2018) to reduce the likelihood of invalidating individual experience (Jankowka, 2019). Although this research suggested that choice and preference for the therapist was important, if these needs cannot be fulfilled on a systemic level because of a lack of diversified workforces, the minimum standard should be for cultural competence factors to be at the forefront of the treatment process, like reminding practitioner of the duty of care associated with the Equality Act (Naz et al., 2019). Having awareness, knowledge, skills, encounters and the desire to work competently (Capmhina-Bacote, 2002).

Alongside this, Yasmin-Qureshis's (2019) study on South-Asian women suggested that manualised CBT can be effective in symptom reduction, but there is a lack of consideration for cultural context, and that the integration of religion and culture are required for improved service provision. Similarly, in this study, the topic of religion and cultural sensitivity were very much highlighted as problematic areas of exploration in that they were not addressed at all, also highlighting that integration of such aspects are critical to the therapeutic process.

The literature suggests that incorporating cultural ideas about symptoms is useful when taking a transdiagnostic approach to treatment (Hinton & Patel., 2017), as the misinterpretation of information can result in negative consequences (Raval & Tribe., 2014), which the findings of this study support for Afghan women. Beck (2016) and Rathod et al (2019) suggest that integrating values, beliefs and practices in treatment and matching therapists by ethnicity and gender if necessary. What I have cited as possible misunderstandings within the data analysis may have arisen due to factors like a lack of awareness and significance given to these cultural aspects within therapy like with stigma. Lack of cultural curiosity/desire and misunderstanding genuine reactive behaviours towards triggering and emotionally distressing situations that are grounded in cultural experiences, can be pathologised which can then increase the stigma and shame about experiencing difficulties for Afghan women. Afghan women may internalise these misjudgements, reinforcing feelings of inadequacy or alienation, as the societal norms within their communities often associate mental health difficulties with dishonour or weakness, and 'dishonourable' actions can possibly have catastrophic consequences such a disownment or even irreversible violence (Kabeer et al., 2007). Shame can manifest as an internalized sense of failure or fear of judgment, which prevents individuals from openly addressing their struggles with those around them and professionals, perhaps also due to the fear of the consequences. For Afghan women, this may lead to self-silencing, avoidance of vulnerability, and reluctance to engage in therapy.

Adopting an integrative approach, as previously suggested, possibly holds promise in addressing this complex aspect of therapy. Moreover, the data strongly emphasised the importance of offering flexibility in choice, preferences, and shared decision-making regarding therapist allocation. These findings align with existing literature and highlight the significance of accommodating individual preferences in therapy settings.

It is suggested that adopting a flexible approach, seamlessly transitioning between collaborative and didactic styles of therapy when appropriate (Beck, 2016; Rathod et al., 2019). This appears to be an important conclusion in line with the current study as there was emphasis on the didactic style of therapy, suggesting that the therapeutic approach requires more leniency for participants to have felt more engaged. This not only fosters a sense of agency but also creates a safer, less judgmental space for Afghan women to engage openly in therapy, reducing the barriers imposed by cultural shame.

Not only this, it is useful to consider diagnosable experiences alongside other frameworks, like the Power Threat Meaning Framework (Boyle., 2022). As mentioned previously, it is not beneficial or constructive to attempt to create further divides in how practitioners work, but rather find ways to amalgamate diverse frameworks to create holistic structures of care. One of the difficulties I believe on reflection that makes the dissemination of manualised CBT so complex is that therapists are expected to do exorbitant amounts of work that they may not be qualified to do. Teams that work in multidisciplinary systems where social workers, nurses, supports workers all could take one role meaning that therapists and psychologists can focus on therapy. The IAPT system is structured in such a way that one practitioner is responsible for all these different components which objectively is unmanageable (Bruun, 2023). It is then comprehensible to apprehend why IAPT practitioners may possibly produce less favourable work in some instances. A person's individual journey is complex and requires sensitivity to contextual needs.

Moreover, Participants 3, 4 and 5 were offered hourly long sessions, and there does not appear to be a justification as to why these were on the telephone as opposed to video or face to face (other than COVID restrictions in the case of participant 3), highlighting the prescriptive nature of IAPT treatment and lack of shared decision making. There are no NICE guidelines that suggest hour long high intensity CBT sessions should be delivered digitally (NICE, 2013). For anxiety disorders, face to face sessions are also encouraged to combat avoidance (NICE, 2013), so it is further difficult to comprehend why this was not offered. Despite the earlier argument that the NICE guidelines appear to be outdated and inconsiderate of individual needs due to its medicalised nature (Larsson & Loewenthel., 2012), it appears from the data that services perhaps select guidelines which benefit service needs as opposed to individual needs, highlighting that these guidelines are both not as beneficial as they should be, neither are they implemented robustly. Guidelines and evidence-based practice are critical to mental health care, but these must be bought up to date consistently with both quantitative data like randomised controlled trials and qualitative data which looks at lived experience.

The ending: Leaving IAPT and reflection on the journey (Implications and Recommendations)

Practice in Counselling Psychology

As discussed, the likelihood of Counselling Psychology trainees and qualified practitioners working in IAPT services is probable. What is highlighted in the findings of this thesis is that the core values of a Counselling Psychologist are an acute part of offering care to Afghan women; like working relationally, culturally competently, holistically and with social justice as the forefront of care (Rizq, 2020). These ideals may be instilled in us, but working in rigid systems of care may prohibit the use and dissemination of such ideals. This research highlights the need to hold a strong grounding whilst working in such services, especially when considering Afghan women.

Positive recollections of therapy were characterised by the presence of choice, a collaborative therapeutic approach, and a strong sense of rapport and relatability with the therapist. Furthermore, when participants did not feel understood by their therapist, the data suggests they experienced greater difficulty in engaging with therapy. Although there was not enough consistent data to suggest that therapist gender impacted the experience with therapy, it is relevant once again to note that the concept of offering choice should issues arise around gender specific complexities even from the point of accessing the GP, considering the cultural and patriarchal nuances of the issues that were presented in the data. This finding was consistent with the second research aim, which explored the extent to which individuals felt understood within their cultural context. When this ‘understanding’ was lacking in therapy, participants reported feelings of being misunderstood, fearing judgement, and struggling to establish a connection with their therapist. The importance of factors like empathy, understanding, and a genuine desire to comprehend the individual's needs emerged as crucial elements. These findings underscore the need for therapists and services to place greater emphasis on cultural competence in order to better serve their clients.

A possible consideration contingent to the issue of gender is the use of interpreters. The data highlights the possible challenges faced when clients who prefer therapists outside their community encounter language barriers that require interpreters. A sensitive situation possibly arises when a female Afghan client, already hesitant to discuss personal matters, is paired with a male interpreter from her own community. This scenario can exacerbate discomfort, as it conflicts with the community’s gender norms and concerns about privacy. Services and therapists should be cognizant of this, firstly, by showing curiosity, providing a safe space to openly explore and problem-solve around their needs. The author recognises that this is a complex undertaking, and resource limitations may present a barrier to meeting these needs; however, every effort should be made to accommodate individuals in therapy whenever feasible. For example, if meeting specific needs means that the individual must wait longer for intervention in order to find the appropriate interpreter/therapist, services should strive to mitigate this delay by implementing "keeping in touch" strategies such as regular welfare check-ins, rather than engaging in more substantive work during the waiting period. This is also pertinent to the broader issue of prolonged wait times.

Being curious about an Afghan woman’s journey from different intersectional aspects of their lives is essential, which supports previous literature suggesting that Afghan women in the UK find that navigating the intricate balance between Western values and their individual cultural/religious norms can pose a considerable challenge (Rostamy-Povey, 2007). Asking questions, being inquisitive and having the desire to understand with the chance to enhance not only the relationship, but one’s own empathy is imperative. Being mindful as practitioners that the journey from distress to accessing therapy could have been an arduous one due to many contributing factors, like stigma, internal biases about mental health, dismissive attitudes from close ones and services; all which can be relevant in understanding an Afghan woman’s journey. Understanding cultural background and influences would likely have a positive impact on their engagement, and the understanding of their difficulties and overall needs. I believe that these aspects can be woven into the core ingredients of the manualised CBT approach with care and sensitivity, without compromising the goal of CBT which is to decrease distress or symptomology. It is important for practitioners to create environments whereby judgement is suspended, or at least bought to the forefront of therapy for example in supervision to enhance relational working.

What’s more, as previous literature stated, CBT is helpful for general symptoms of depression and anxiety and less so for trauma symptoms (Kananian et al., 2017) which was also seen in this research when service users present as more complex, elements of trauma-informed care can be applied to increase curiosity about experiences; the trauma-informed approach requires professionals to ask ‘what happened to you’, rather than ‘what is wrong with you’ (Forkey et al. 2021), which I believe is a gentle and sensitive way of working which could benefit Afghan women.

If we consider the context of the Afghan woman we come to understand that there are possibly cycles of intergenerational trauma fuelled by decades and even centuries of conflict, devastation, poverty, violence and destruction. (Pashang et al., 2018). This compounded by in many cases limited understanding of western concepts of mental health, often overlooked and explained away using faith or belief have left many communities without support, or the knowledge of how to get it. There are many layers that an Afghan woman may have to fight through including stigma and shame, compounded by suppressed layers of intergenerational trauma and self-developed unhelpful emotion regulation techniques (Alemi et al., 2017a). The concept of shame in particular is pertinent, as it is highlighted in the data that there can be consequences associated with acts that considered ‘dishonourable’ or ‘shameful’, especially when these are family-based values related to divorce. This exemplifies why help-seeking and unreserved engagement in therapy may be a unsettling task for an Afghan woman if these feelings and ideas are engrained. This possibly creates a wall they must break through before even arriving to the point of help-seeking, which from what participants in this study shared, was a huge and overwhelming step. Afghan women’s help-seeking journey may often intersect with gendered societal norms that marginalize their voices. Empowering these women within therapeutic contexts challenges systemic gender disparities while fostering meaningful engagement. Therapists and services alike must be attuned to their professional responsibility to acknowledge, validate and explore these difficulties without judgements or assumptions, and with the ability to empower their therapy clients to work through the difficulties associated with the layers of emotions carried by an Afghan woman. Therapists may want to consider challenging what is perceived as 'socially, culturally or patriarchally normal' to Afghan women to support in creating autonomy in their journey.

Moreover, for some, the perceived rejection from GPs upon help-seeking was reflective of the rejection from their own community and posed a barrier for entrance into IAPT. These factors must be considered by IAPT when working with Afghan women, and further with communities who hold similar values, for example, in collectivist cultures.

Limitations

Recruitment/Participants

A limitation in this study relates to recruitment and participants. As explained, recruitment was arduous and careful decisions were made in the process of creating inclusion criteria to ensure the research would reach as many people as possible. All participants recruited were female, so the optimism I held for recruiting a mix of genders and establishing themes that pertained to gender were not fulfilled. It is suggested that men have difficulty accessing/engaging services and stigma associated with mental health (Grandi et al., 2023; Alemi et al., 2023), which could then mean there is a smaller population to reach out too. Future research should consider the time and difficult in accessing both female and male Afghan participants and allow time and space for this to happen.

Despite this, having all female participants provides a unique perspective. On reflection, whilst this is a technical limitation, it is also a strength as it allowed me to draw a more in-depth analysis and provide insights into the nuances of Afghan women's experiences, as this further highlighted the need to understand the role of patriarchy within the context of accessing Western services and receiving therapy, and distinguish between the idea of culture and gender norms. The importance of this issue highlights the need not to conflate the two ideas together to ensure a culturally sensitive view that acknowledges both culturally engrained ideas and the influence of patriarchal issues. As mentioned previously, Afghan culture is deeply engrained with gender inequality which limits women's rights, therefore it has been critical to understand how these values may shape the experience of women who possibly carry these difficulties with them in the context of their experience in therapy in the UK.

Secondly, a limitation was that I was not able to directly recruit from the NHS/IAPT services; this creates a limitation in that utilising NHS recruitment would concretely authenticate my participants engagement with IAPT, though I believe there was enough evidence to showcase the authenticity of my participants experiences. I do not believe that the method of recruitment impacted the findings, but I acknowledge the possibility that the findings could have been influenced by this. For example, by not recruiting directly through the NHS, the sample may disproportionately reflect individuals who are more proactive or engaged with external networks (e.g., community groups, social media). These individuals might have different perspectives, demographics, or levels of satisfaction compared to the broader NHS service user population, leading to findings that are not fully representative, though regardless this limitation still stands due to the small sample size. With this, those recruited externally may be individuals who hold a particular bias about therapy experience, therefore having a motive to participate, potentially amplifying extreme views and reducing the diversity of perspectives.

Reflexivity and use of self in RTA

Reflexivity overall was contentious; it was difficult to find the line between reflexivity, interpretation and accurately representing the data whilst attempting to create a rigorous and transparent data analysis process.

Reflexivity and use of the self are a critical part of the data collection and data analysis, and it is impossible to claim objectivity or neutrality with regards the nature of this study. I am aware that my own experiences not only in relation to personal context and biases, but when also considering ethical conundrums and risk for my participants. Early in the research process, I was overtly cognisant of the risk associated with asking individuals to discuss their mental health. From and ethical perspective regarding participant safety, I undertook a risk assessment (see appendix A, p.150) which screened for risk related to suicide and self-harm, to ensure participants were not at acute risk to themselves before participating, being mindful that the interview process could be triggering considering the nature of the topic. Although no risks were identified, I believe the anxiety I associated with this meant that in the interviewing process I may have held back probing questions so as not to distress my participants. I believe I did the right thing; however, this would have certainly impacted the richness of the data.

The distress associated with my own personal experiences also impacted my interviewing technique at times which I have reflected on within the data analysis process. As mentioned, my ability to relate sometimes meant I did not probe further as I felt like I could create an understanding based off my own experiences. Other times when I did not relate at all, it is evident that my questioning style became more probing.

Lastly, I wanted to fully immerse myself and connect with the participants experience and therefore chose to separate the data analysis and discussion so that I did not go into the analytic process embedding previous literature, this way I stayed close to the data.

Quality and rigour

I have outlined steps in ensuring quality and rigour in chapter two. To expand on this, I found it was occasionally difficult to decipher between what was considered 'descriptive' and 'reflexive' analysis, especially as I endeavoured to have both semantic and latent content in my analysis to ensure I was accurately depicting the voice of my participants. Coding and recoding were an arduous part of this, but positively enhanced rigour. I was very mindful of distinguishing between the two, but often found myself asking 'how socially normative is this depiction' therefore, I would go back to my research question and ensure I was interpreting through the lens of 'cultural understanding'. When I believed what was presented was 'socially normative' I highlighted this within the analysis to have a clear differentiation. The difficulty with this is that one might ask what is: what is considered 'socially normative'? I believe that I made these distinctions with the evidence I held from existing literature, mixed in with what my participants semantically expressed, and my interpretation. It was very important when considering rigour to reflect on Yardley's (2017) work, but also that of Braun and Clarkes (2022) suggestions for ensuring conscientious reflexivity. What helped was also discussing my analysis with my supervisor and with an experienced RTA researcher who specialises in care for marginalised groups.

Future research

Based on the above findings, it could be useful to make cultural competence training (which already exists) more widely utilised or mandatory at specific intervals to ensure practices are not neglected. Within this, it was identified that biases were possibly present from therapists from the perspective of the participant, therefore this study identified a need for regular access to courses that increase awareness of unconscious bias as the previous literature states there is too little emphasis on the experience of the interpersonal and intrapersonal processes of the professional (Beagan, 2018). This further highlighted the need to bring focus to cultural humility, and the need for research that focuses more deeply on the concept of unconscious bias, awareness of power structures and therapeutic work within IAPT services from the perspective of the therapist to examine the quality of the therapy. This could be designed as a larger scale mixed methods study which investigated awareness of unconscious bias and how this would influence a therapist's therapeutic style.

In my view, it is crucial for future research to place a heightened emphasis on exploring the perspective of the service user, the therapist and the larger IAPT system. At the core of these (my) concerns lie an arbitrary system designed to manufacture therapists and rapidly expedite the flow of service users entering and ending therapy. Without affording therapists the necessary space and tools to integrate research finding into their evidence-based practice, the value of understanding individual experiences remains inherently restricted.

Future research could replicate this exact study with a wider range of participants, or with a sole focus on men. Having a goal to gather more data and create more generalisable conclusions could support in the change of practice and policy, for example in primary care positive practice guides. This could be conducted via a mixed methods approach with surveys and qualitative data to bolster rigour, or alternatively by harnessing a comprehensive/larger qualitative dataset and employing RTA.

Conclusions

The findings of this research project highlighted important issues that expand on earlier work that relate to Afghan individuals and CBT and overall mental healthcare. With this, I believe this research also further exemplified the importance of necessity of focus on unconscious bias and how this impacts therapy for both recipients of therapy and therapists bringing difficulties and differences into the therapeutic space is important. This links back to the concept of cultural humility and the necessity of cognizance relative to the self; professionals must be afforded the appropriate space for reflection and reflexivity about the individual work they do, and not just the outcomes they are/are not achieving.

Based on the findings of this research, it was observed that Afghan women in this study did not universally reject manualised CBT as unsuitable for their needs. There were instances where the therapeutic process became less beneficial and more obstructive when significant aspects of an individual's personal journey were overlooked or neglected. The study revealed that when individuals did not feel understood, (this inclusive of cultural considerations), their overall therapeutic experience appeared to be less seamless and less effective. Conversely, when individuals felt understood, listened to, and experienced a sense of relatability within the therapeutic space, they reported a more positive journey, this being the case from the start of the journey (referral) to the end (finishing therapy).

In light of these findings, the study acknowledged its limitations and identified potential areas for future research expansion. Additionally, it offered recommendations for Counselling Psychologists and practitioners to consider when working with Afghan women within a manualised therapeutic framework. These recommendations aim to increase awareness of what creates a positive therapeutic encounter and enhance the effectiveness and appropriateness of therapy for this specific population.

Within Counselling Psychology, it can feel uncomfortable to work in an environment like IAPT as it can conflict with the values held about the relational way of working. I believe this gives more justification as to why CoP’s should immerse themselves in these settings and encourage relational ways of working as this study suggested. The findings of the research can support CoP’s and other professionals should they work in this setting with Afghan individuals. As mentioned, an optimistic hope is that future positive practice guides could also consider these findings. In essence, engaging with Afghan women necessitates a delicate balance between promoting empowerment by positively utilising Western models of care whilst honouring deeply rooted cultural and traditional values to ensure well-intentioned care with successful outcomes.

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Appendices

Appendix A

A summary of how literature review was conducted included databases

I conducted a search on the following electronic databases; google scholar, PubMed, JSTOR, ScienceDirect, MedLine PsychInfo, BMC Psychiatry and SAGE Publications, I used the following search terms: Afghan, mental health, Afghans and CBT, CBT, culturally adapted CBT, cultural competence, cross-cultural, minority groups BAME, DSM-5 critique, access to IAPT, stigma, counselling psychology, relational working. In spite of the existence of a large amount of material, the majority focused on non-Afghan ex-war veterans and much ‘post-war’ related discourse. There are seldom research papers that investigate experiences of the Afghan person in mental health. The distinctive experiences of those accessing (or not) mental health services in the UK remains un-investigated. Consequently, with the lack of research undertaken in the UK regarding Afghans accessing IAPT/mental health services, the following review will be based on international literature.

Appendix B

Ethics Form with Amendments and Approval

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, and 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: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ 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 like 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: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
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:**	**Hana Ullah**
2.2	**Your supervisor's name:**	**Dr Sharon Cahill**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Lucy Poxon**
		3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Counselling Psychology**
2.5	**UEL assignment submission date:**	**TBC**
		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	What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?
3.2	**Summary of study background and aims (using lay language):**	The aim of the project is to explore the Afghan individuals experience of and receiving psychological therapies (manualised CBT) that uses an IAPT model.
3.3	**Research question(s):**	What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community? The overall aim is to understand: 'Do they feel

		understood in their journey? What are the experiences of the whole therapeutic encounter/are they framed in the cultural context?
3.4	**Research design:**	Qualitative study using semi structured interviews.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	I am suggesting to recruit 6-10 male and female adult Afghan's aged between 18-40, who have accessed IAPT services within the last year (6 months) of the research start date. I am suggesting one year to take into consideration the aforementioned waiting times associated with IAPT services. I would like to recruit participants who have experienced both the assessment and treatment process both in the context of guided self-help and CBT. An exclusion criterion is high risk related to suicide and self-harm. It would be important to identify current high levels of risk, by using an electronic risk assessment screening questionnaire (See appendix E). I would not screen out past risk, during the treatment episode, as I believe it would be essential to understand this in the context of the 'journey'. Should high levels of risk present at the point of screening, clients will be signposting to the appropriate services, for example the GP, or suicide hotlines like the Samaritans. I will also require participants to communicate in English (please see

		Appendix F for exhaustive list of screening questions).
p.3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	To enhance recruitment chances, I will reach out to charitable organisations who work specifically with Afghan people to support them with mental health and social needs. And this I will recruit and advertise directly in IAPT services, and utilise social media platforms by accessing CBT and IAPT groups on Facebook, Instagram and Linkedin, using the snowball recruitment method. I will advertise in community centres and places of worship.
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	An interview schedule created by myself will be used with prompts. I will provide an electronic risk assessment as a part of the screening process to ensure participants are not presenting with high levels of risk at the time of the study.
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	I will ask my participants for informed consent. They will be given enough information to voluntarily make the choice to participate, and have the right to withdraw within 2 weeks of the data collection process. In terms of safeguarding risks: Confidentiality and anonymity are ensured in reference to health and safety risks. To mitigate risk around leading questions in the interview process, I will conduct a pilot interview prior to the formal

		interview process (Willig, 2017). To reduce any potential for psychological harm by prefacing interviews with the notion that sensitive topics may be addressed, but also have signposting information available for services that can support with psychological distress should it occur. The purposes of this study and the goal to collect rich, thick data, it would be essential to conduct semi-structured interviews that utilise open ended questions. With this the data will be collected using an encrypted recording device. I will provide debriefs for my participants at multiple stages throughout the research process if necessary (Smith, British psychological Society, 2021).	
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?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer?	Please state the value of vouchers	

	Please note - This must be in the form of vouchers, not cash.	
3.11	**Data analysis:**	A thematic analysis (reflexive) will be undertaken to analyse data. Latent and semantic themes will be drawn from the data utilising a coding method. Data will be grouped together by analysing reoccurring themes (Braun and Clarke, 2006; Braun, 2019). The reflexive component will allow me to take an interpretative data analytic approach. (Braun, 2019).

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, 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?**		**No ☒**
	If yes, please provide details of how the data will be anonymised.	**The data will be anonymised numerically (i.e. participant 1, participant 2).**	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES**	

	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	**The identifying information will be removed within the transcripts, and participants will be referred to by their assigned number.**
4.3	**How will you ensure participant details will be kept confidential?**	I will substitute numbers for participant identifiers and will store data in a secure location on a password protected laptop. All files will be encrypted and password protected.
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 collected safely on an encrypted recording device, and securely stored in a locked cabinet. Recorded data will be digitally organised and stored securely on my password protected personal computer and external hard-drive, locked in a secure location.
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	**Myself, and my research supervisors will have access to the data. Research supervisors will only have access to anonymised transcripts**
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	**The data will not be retained for long term use.**
4.7	**What is the long-term retention plan for this data?**	**The data will be retained for the minimum 3-year period, wherein it will be destroyed by myself.**

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 participants could be viewed as vulnerable as it is likely they will have OR be experiencing a mental health difficulty, or at minimum distress associated with their mental health. It is also possible that the participant group have experienced a range of strife/trauma as a result of migration from Afghanistan. To reduce any potential for psychological harm by prefacing interviews with the notion that sensitive topics may be addressed, and I will also not ask leading/intrusive questions. I will also provide signposting information available for services that can support with psychological distress should it occur. I have not specified what these will be as it will be location dependent. With this I will provide debriefs for my participants at multiple stages throughout the research process if necessary (Smith, British psychological Society, 2021). Prior to interview there will be a short conversation held with participants about what the study entails, and explore whether participants feel able to participate.	
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?	Management of working with emotion driven research questions, and potential sensitive topics. I	

		will utilise research supervision and personal supervision		
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?	**Confidential spaces i.e., private rooms in libraries.**		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	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	**YES** ☐		

	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.	
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?**		**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?**		**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	Please enter your DBS certificate number	
	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.	**Al Manaar, the Muslim Cultural Heritage Centre, MCHC**	
	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). Please confirm that you have attached written permission as an appendix.	**YES** ☒	
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 like ‘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)	**Hana Ullah**
8.3	**Student's number:**	**U2068220**
8.4	**Date:**	**09/04/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

Student checklist for appendices – ***for student use only***

Documents attached to ethics application	YES	N/A

Study advertisement	☒	☐
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐
Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐
Country-Specific Risk Assessment Form	☐	☒
Permission(s) from an external organisation(s)	☐	☒
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☐	☒
Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☐	☒
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

Appendix A: Participant Information Sheet (PIS) template

PARTICIPANT INFORMATION SHEET

What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?

Contact person: Hana Ullah

Email: u2068220@uel.ac.uk

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., friends, family, etc.) 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 Hana Ullah. I am a Postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Professional Doctorate in Counselling Psychology. 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?

I am conducting research to explore how Afghan individuals experience the engagement of Cognitive Behavioural Therapy (CBT) within a National Health Service (NHS) environment, specifically an Improving Access to Psychological Therapies (IAPT) service. In essence, I would like to understand the experience of utilising a specific mental health service in the UK.

This study is valuable as it will support mental health professionals to gain insight into the experiences of the Afghan persons journey in a widely used mental health service, in the hopes that we can improve service provision and quality for the community.

Why have I been invited to take part?

To address the study aims, I am inviting male and female English-speaking Afghan individuals aged 18-40 to take part in my research. If you are an Afghan individual within this age frame wherein 6 months have passed since engaging with an IAPT service for the purposes of addressing a mental health concern, you are eligible to take part in the study. You should not be currently accessing a mental health service. We hope to be able to create positive change in the mental health system for Afghan people!

Definition of ‘engaging’ with an IAPT service:

Participants should have completed a CBT treatment course of at least 6 sessions. However, the research study will also consider participants have been unable to complete a full treatment course. This can be discussed further.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

You will firstly be asked to answer some questions on an electronic screening tool to ascertain whether you are suitable for this study.

If it is deemed appropriate for you to engage with this study and you agree to take part, you will be asked to partake in a 45-60minute interview whereby I will ask you questions about your experience of using the above-mentioned mental health service. I am asking participants to meet for interviews on the University of East London campus in Stratford, however video conference meetings can be utilised should this help the process of engaging with the research. The interview process will be much like an informal chat, and for the purposes of the research process will be audio recorded on an encrypted and secure device for the purposes of analysing the data later. All data will be anonymised.

Can I change my mind?

Yes, you can change your mind and withdraw without explanation, disadvantage or consequence. If you would like to withdraw, you can do so by informing me directly. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 2 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

The nature of the study means that sensitive topics may arise from the interview process, which may cause emotional or psychological distress, as the topic is mental health. To minimise this, I will be providing information for services that can support you throughout the process of research. Details of contacts are: the Samaritans (116-123), Saneline (0300 304 7000, Afghan Helpline: 0044 (0) 7950 243992.

How will the information I provide be kept secure and confidential?

- Participants will be assigned a numerical marker in place of their personal data (i.e., full name) throughout the collection and data analysis process. Should identifiable information be audio recorded, these will be redacted or replaced if used later in the write up of the project
- The interviews will be recorded on an encrypted recording device, to be later transcribed by the researcher. The recorded will be deleted once the data has been transcribed.
- Recorded data will be digitally organised and stored securely on the researcher's password protected personal computer and external hard-drive.
- If necessary to transfer data, this will be done using secured University email addresses.
- Only the researcher will have access to the participants contact details (identifiable information) which will be stored securely and separately to the research data.

- The collected data will be anonymised and may later be seen by supervisors, external examiners, and by the public should the research be deemed appropriate for publication.
- The digital data will be destroyed after the 3-year retention period if no longer required for the write up of the thesis via a secure deletion software.

Confidentiality statement: Throughout the research process, confidentiality can be breached in the event of imminent risk to participants or the general public. Should this happen, the research team will be transparent with you about any necessary steps required to ensure safety.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the ‘public task’ condition contained in the General Data Protection Regulation (GDPR). Where the University processes sensitive data (known as ‘special category data’ in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. 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. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

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 journal articles, conference presentations, and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as all data will be anonymised through numerical labelling.

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 will need to be provided.

Anonymised research data will be securely stored by Hana Ullah for a maximum of 3 years, following which all data will be deleted.

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 further information about my research or have any questions or concerns, please do not hesitate to contact me.

Hana Ullah: u2088220@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Sharon Cahill School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: cahill@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

Student checklist for Participant Information Sheet (PIS) – ***for student use only***

Information to include in PIS	**TICK**
Study title	☒
Who you are	☒
Purpose of research, including any advantages to taking part	☒
Inclusion/exclusion criteria	☒
What participation will involve: location, duration, tasks, etc.	☒
Right to withdraw participation: withdraw involvement at any point without the need to provide a reason or negative consequences	☒
Right to withdraw data: a time specified to do this within (typically a three-week window)	☒
Participation is voluntary	☒

Potential risks to taking part (pain, discomfort, emotional distress, intrusion)	☒
Attempts to minimise risks	☒
Contact information of supporting agencies/relevant organisations	☒
How data will be kept confidential	☒
When confidentiality might be broken	☒
How data will be managed by UEL	☒
How data will be securely stored (e.g., where, who will have access, etc.)	☒
How long data will be retained for, where and by whom	☒
Dissemination activities	☒
Clearly communicated that participants will not be identifiable in any material produced for dissemination purposes	☒
Your name and UEL email address	☒
Your supervisor's name and UEL email address	☒
The Chair of the SREC's name and UEL email address	☒

Appendix B: Consent Form template

University of East London

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?

Contact person: Hana Ullah

Email: u2068220@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated XX/XX/XXXX (version X) for 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 2 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using an encrypted recording device.	
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 my interview data will be used in material like conference presentations, reports, articles 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 C: Participant Debrief Sheet template

University of
East London

PARTICIPANT DEBRIEF SHEET

What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?

Thank you for participating in my research study on understanding the experiences of using a mental health service, specifically IAPT. 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 journal articles, conference presentations, and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally, as personally identifying information will removed and replaced via numerical classification.

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 will need to be provided.

Anonymised research data will be securely stored by Hana Ullah for a maximum of 3 years, following which all data will be deleted.

What if I 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:

Samaritans: 116 123
Saneline: (0300 304 7000)
Afghan Helpline: 0044 (0) 7950 243992.

Service specific details can be provided dependent on catchment area.

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.

Hana Ullah U2068220@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr Sharon Cahill School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: cahill@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 D: Screening questions

Have you accessed an IAPT service and 6 months have passed since accessing?

Did you receive an assessment and treatment (regardless of whether the treatment was completed or not)?

What is your ethnic background?

How long have you been in the UK?

What gender to you identify with?

How old are you?

Do you speak a proficient level of English?

Are you currently accessing a mental health service?

Risk screening to be given (appendix G).

Appendix E: Demographic questions

Occupation/employment status

Education level

Any religious beliefs

Living status

Were you born in the UK? If not, what is your immigration status (if applicable)

Appendix F: General Risk Assessment Form template

Guidance: A comprehensive guide to risk assessments and health and safety in general can be found in *UEL's health and safety handbook*. A comprehensive guide to risk assessment is also available on the *Health & Safety Executive's website*. An example risk assessment (for a wellbeing conference/event) is presented below, please replace text in RED with your own/study specific information. This form should consider both or psychological risks and how these can be minimised.

DO NOT LEAVE ANY RED TEXT IN THE FINAL VERSION OF YOUR RISK ASSESSMENT FORM

University of East London
Pioneering Futures Since 1898

UEL Risk Assessment Form

Name of Assessor:	**Hana Ullah**	**Date of Assessment:**	**27/7/2022**
Activity title:	**Professional Doctorate in Counselling Psychology research**	**Location of activity:**	**UEL Campuses at Docklands, Stratford.**
Signed off by Manager: (Print Name)		**Date and time: (if applicable)**	

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:

Doctoral research proposal, requiring 6-10 participants to partake in semi structured interviews.

Research question: What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?

The aim will be to understand the participant groups experience of accessing a mental health service for a mental health concern.

Overview of FIELD TRIP or EVENT:

I will be conducting interview on UEL campus or via video chat. The interviews will last 45-60minutes and ask questions that are of a psychological nature; i.e., about the persons journey with a mental health service.

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

Emotional or psychological distress.	Participants	Offering signposting agency information to access should there be any distress experienced, even at the point of screening. I will also offer my participants debriefs throughout various stages of the research study if required, i.e., after interviews, after data has been	2	1	2	Should it be deemed by participants that a more streamlined level of support is required (for example as a result of refuge status, an issue that omits to a protective characteristic or risk around suicidality/self-harm, the appropriate measures will be taken through supervision	2
						Distress protocols are cited in Appendix H for interview/data/ transcription management.	

Review Date:

26/7/2022

Appendix G: Risk assessment screening matrix (PCMIS)

Please consider the last 2 weeks specifically when answering the following

Intention – Thoughts

Do things ever feel that bad that you think about harming or killing yourself?	Yes	No
Do you ever feel that life is not worth living?	Yes	No

Plans

Have you made plans to end your life? Yes No

Do you know how you would kill yourself? Yes No

Actions

Have you made any actual preparations to kill yourself? Yes No

Have you ever attempted suicide in the past? Yes No

Prevention

How likely is it that you will act on such thoughts and plans? (On a sliding scale of 0 to 10, with 10 meaning certain)

0 1 2 3 4 5 6 7 8 9 10

What is stopping you killing or harming yourself at the moment?

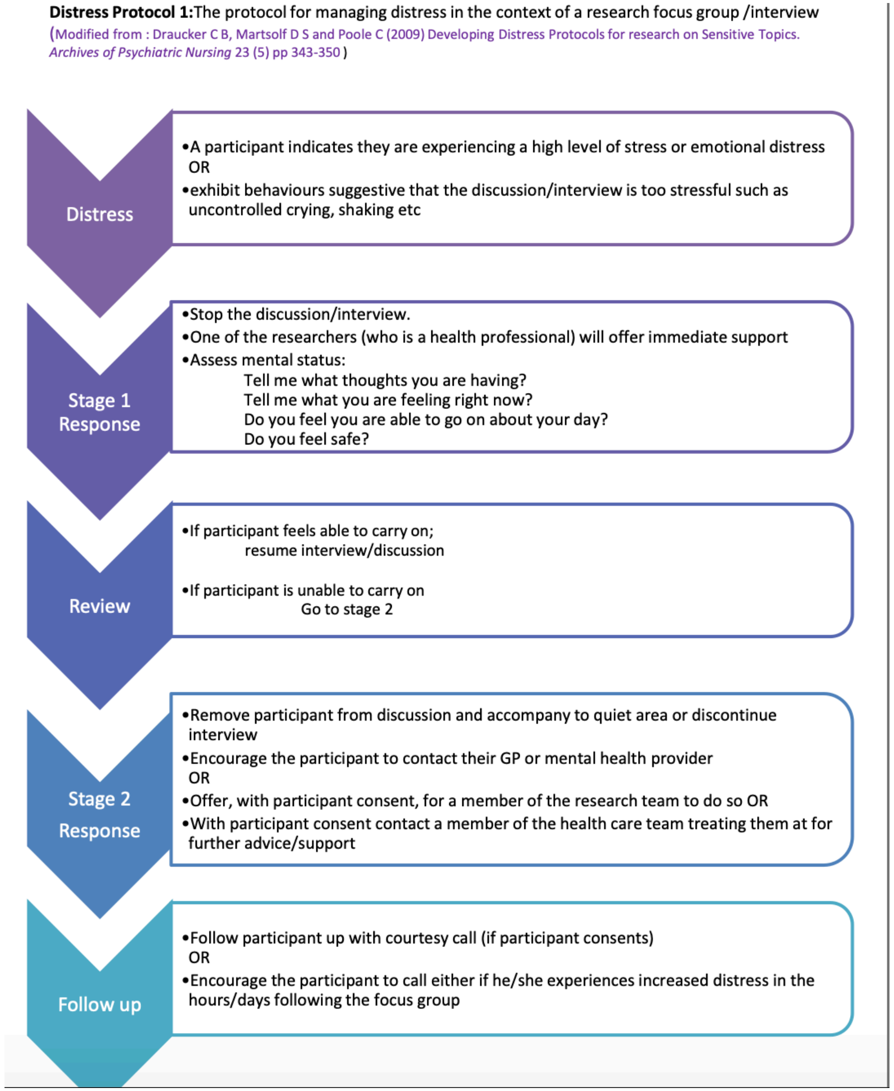
Appendix H: Interview Schedule adapted from (Qureshi & Ledwith, 2020)

Greetings, introduction, set ground rules and explain issues ‘i.e., I will ask a question, I will not interrupt you, if you feel you need to stop, take a break or feel there is a question you cannot answer, you can inform me of this. Discuss confidentiality, risk and reiterate the debriefing process.
Ice Breaking Question: “Tell me about yourself”

1. Can you tell me about the psychological therapy service you use/previously accessed? (probes – how long have they been under the team, what type of therapy they are seeking, the place they access the therapy).
2. Can you tell me about your overall experience with the IAPT service? (probe- statutory? voluntary? Pick up any positive or negative aspect)
3. Can you tell me about the process of accessing therapy? (How easy or difficult was it? How long did it take?)
4. What was your experience like with the therapy?
5. What were the positive aspects?
6. What were the negative aspects? (probe – explore the process of access, assessment process and engagement in therapy. Ask for an example)

7. What part of the service made therapy accessible for you? (Probe – consider issues around therapist characteristics, ethnic background of therapist, location of therapy, integration of beliefs/culture/religion and issues around shame/stigma).
8. What do you think your therapist understood about your culture?
9. What are your thoughts about the service as a whole? (prompts around cultural accessibility, what kept you in/made you leave therapy?)
10. How did your treatment end?
11. How were your needs met?
12. Would you recommend this service to others?
13. What changes, if any, do you feel are needed to improve access to psychological therapy for Afghan people (Probe-Explore steps needs to be taken).

Appendix I: Distress protocols for participant and data management



Distress Protocol 1: The protocol for managing distress in the context of a research focus group /interview
(Modified from : Draucker C B, Martsolf D S and Poole C (2009) Developing Distress Protocols for research on Sensitive Topics. *Archives of Psychiatric Nursing* 23 (5) pp 343-350)

Distress

- A participant indicates they are experiencing a high level of stress or emotional distress OR
- exhibit behaviours suggestive that the discussion/interview is too stressful such as uncontrolled crying, shaking etc

Stage 1 Response

- Stop the discussion/interview.
- One of the researchers (who is a health professional) will offer immediate support
- Assess mental status:
  Tell me what thoughts you are having?
  Tell me what you are feeling right now?
  Do you feel you are able to go on about your day?
  Do you feel safe?

Review

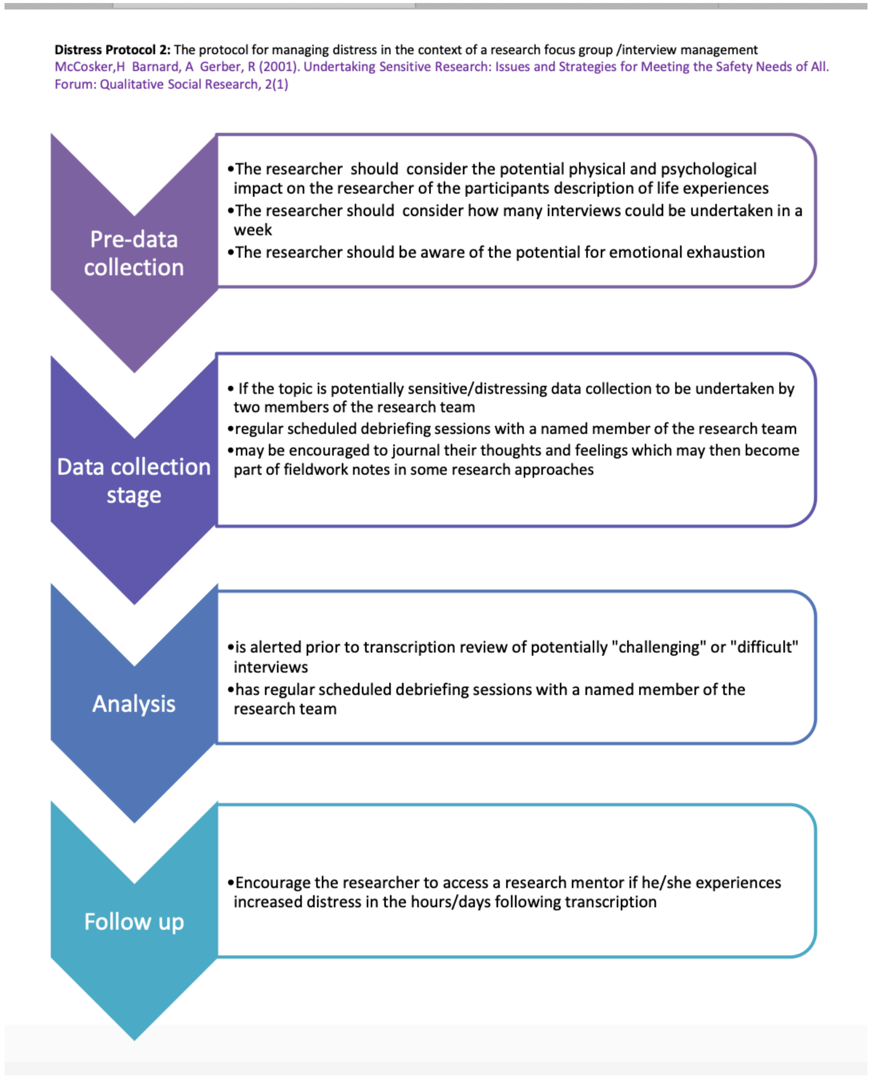
- If participant feels able to carry on;
  resume interview/discussion
- If participant is unable to carry on
  Go to stage 2

Stage 2 Response

- Remove participant from discussion and accompany to quiet area or discontinue interview
- Encourage the participant to contact their GP or mental health provider OR
- Offer, with participant consent, for a member of the research team to do so OR
- With participant consent contact a member of the health care team treating them at for further advice/support

Follow up

- Follow participant up with courtesy call (if participant consents) OR
- Encourage the participant to call either if he/she experiences increased distress in the hours/days following the focus group



Distress Protocol 2: The protocol for managing distress in the context of a research focus group /interview management
McCosker,H Barnard, A Gerber, R (2001). Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All. Forum: Qualitative Social Research, 2(1)

Pre-data collection

- The researcher should consider the potential physical and psychological impact on the researcher of the participants description of life experiences
- The researcher should consider how many interviews could be undertaken in a week
- The researcher should be aware of the potential for emotional exhaustion

Data collection stage

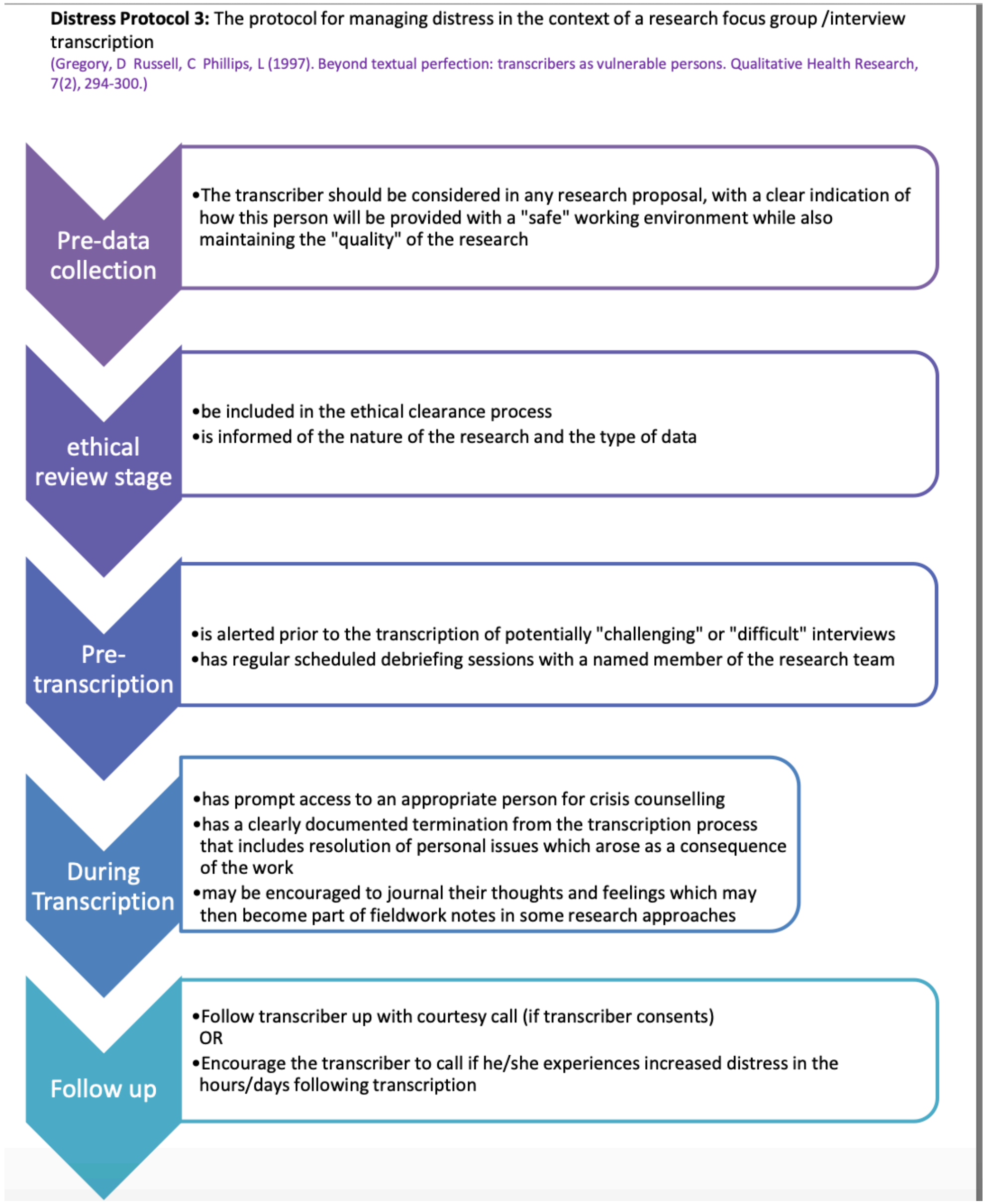
- If the topic is potentially sensitive/distressing data collection to be undertaken by two members of the research team
- regular scheduled debriefing sessions with a named member of the research team
- may be encouraged to journal their thoughts and feelings which may then become part of fieldwork notes in some research approaches

Analysis

- is alerted prior to transcription review of potentially "challenging" or "difficult" interviews
- has regular scheduled debriefing sessions with a named member of the research team

Follow up

- Encourage the researcher to access a research mentor if he/she experiences increased distress in the hours/days following transcription



Distress Protocol 3: The protocol for managing distress in the context of a research focus group /interview transcription

(Gregory, D Russell, C Phillips, L (1997). Beyond textual perfection: transcribers as vulnerable persons. Qualitative Health Research, 7(2), 294-300.)

Pre-data collection

- The transcriber should be considered in any research proposal, with a clear indication of how this person will be provided with a "safe" working environment while also maintaining the "quality" of the research

ethical review stage

- be included in the ethical clearance process
- is informed of the nature of the research and the type of data

Pre-transcription

- is alerted prior to the transcription of potentially "challenging" or "difficult" interviews
- has regular scheduled debriefing sessions with a named member of the research team

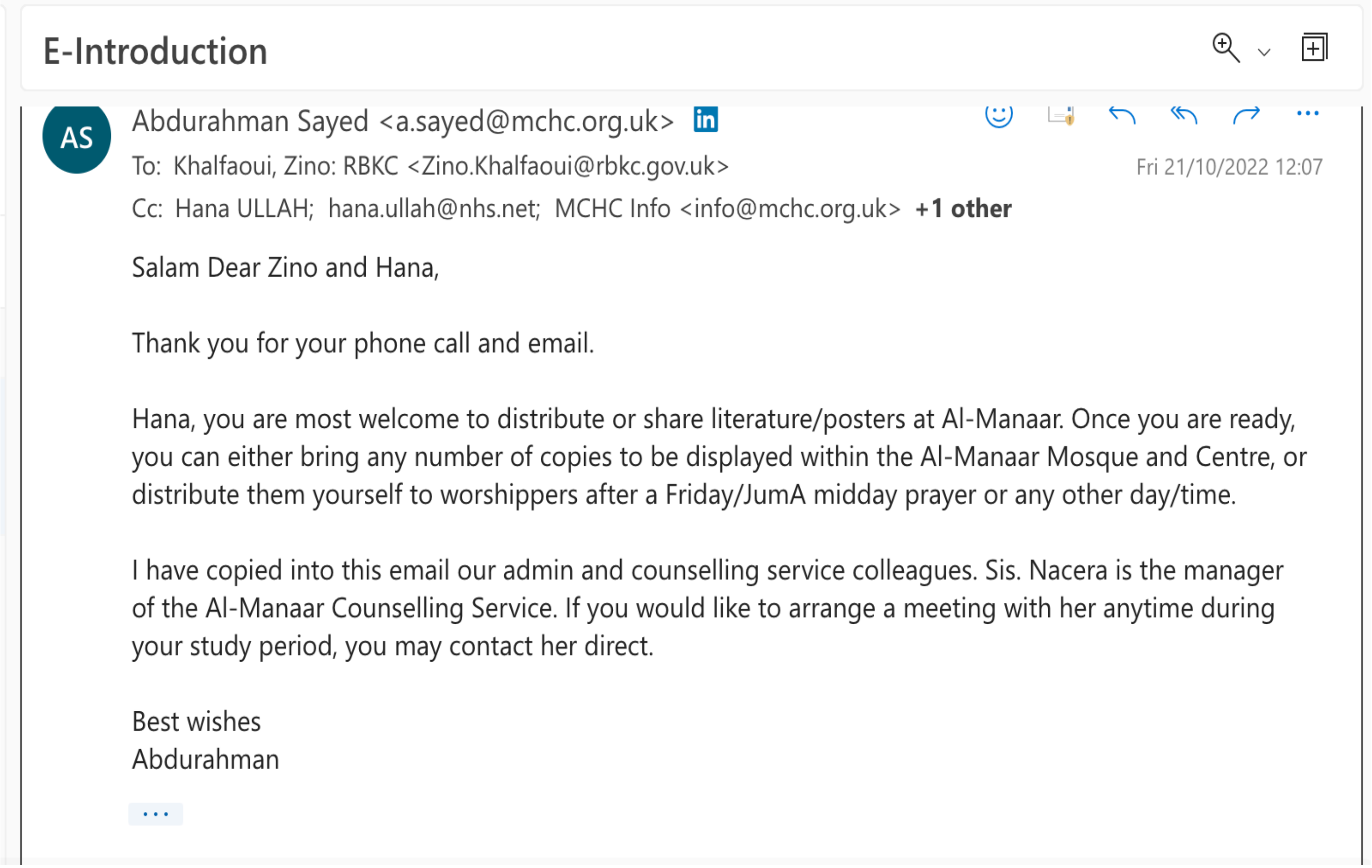
During Transcription

- has prompt access to an appropriate person for crisis counselling
- has a clearly documented termination from the transcription process that includes resolution of personal issues which arose as a consequence of the work
- may be encouraged to journal their thoughts and feelings which may then become part of fieldwork notes in some research approaches

Follow up

- Follow transcriber up with courtesy call (if transcriber consents)
OR
- Encourage the transcriber to call if he/she experiences increased distress in the hours/days following transcription

Appendix J: Email confirming consent to advertise research poster with organisation.



E-Introduction

Abdurahman Sayed <a.sayed@mchc.org.uk>

To: Khalfaoui, Zino: RBKC <Zino.Khalfaoui@rbkc.gov.uk>

Fri 21/10/2022 12:07

Cc: Hana ULLAH; hana.ullah@nhs.net; MCHC Info <info@mchc.org.uk> **+1 other**

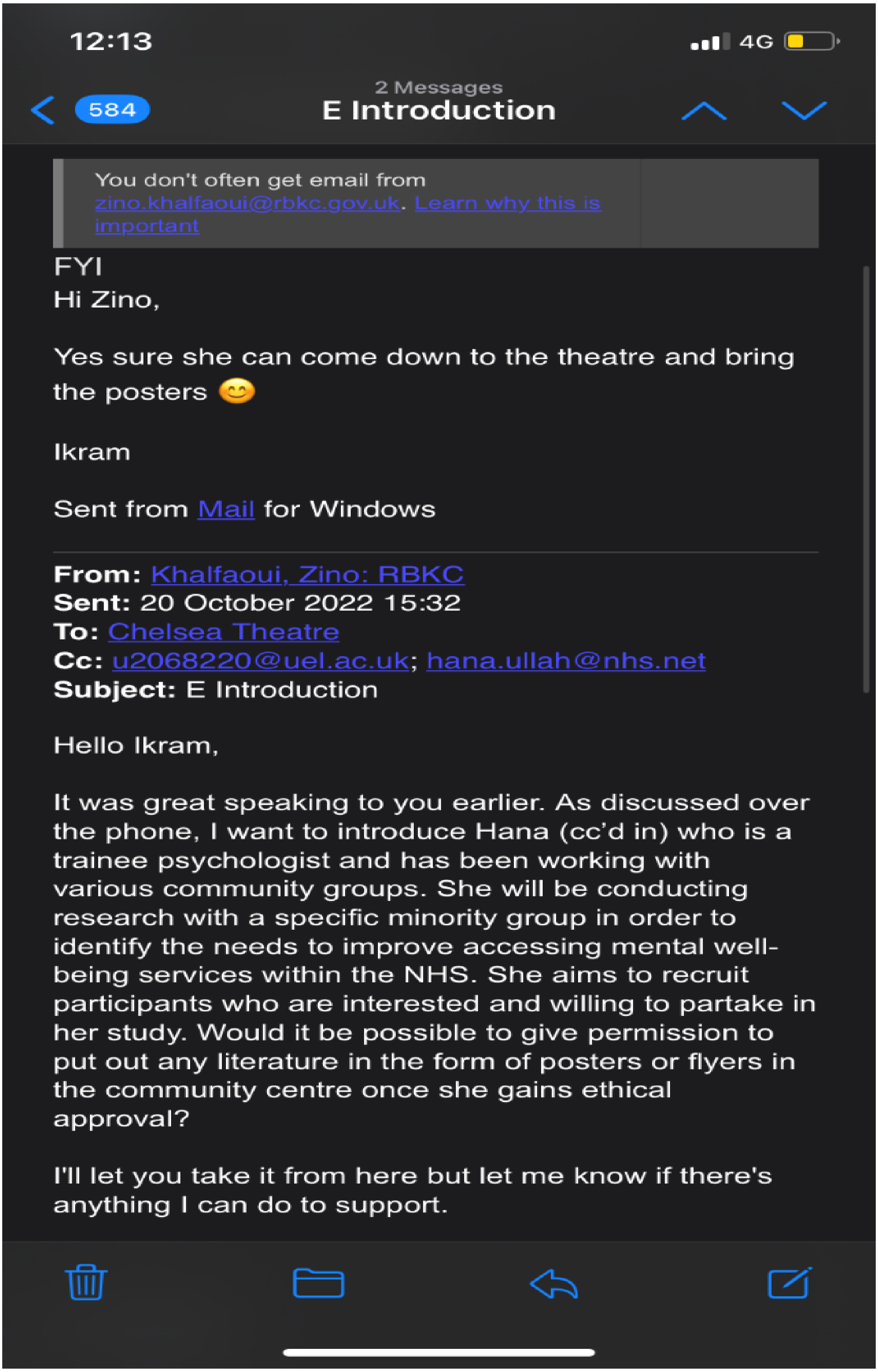
Salam Dear Zino and Hana,

Thank you for your phone call and email.

Hana, you are most welcome to distribute or share literature/posters at Al-Manaar. Once you are ready, you can either bring any number of copies to be displayed within the Al-Manaar Mosque and Centre, or distribute them yourself to worshippers after a Friday/JumA midday prayer or any other day/time.

I have copied into this email our admin and counselling service colleagues. Sis. Nacera is the manager of the Al-Manaar Counselling Service. If you would like to arrange a meeting with her anytime during your study period, you may contact her direct.

Best wishes
Abdurahman



E Introduction

You don't often get email from zino.khalfaoui@rbkc.gov.uk. Learn why this is important

FYI

Hi Zino,

Yes sure she can come down to the theatre and bring the posters 😊

Ikram

Sent from Mail for Windows

From: Khalfaoui, Zino: RBKC
Sent: 20 October 2022 15:32
To: Chelsea Theatre
Cc: u2068220@uel.ac.uk; hana.ullah@nhs.net
Subject: E Introduction

Hello Ikram,

It was great speaking to you earlier. As discussed over the phone, I want to introduce Hana (cc'd in) who is a trainee psychologist and has been working with various community groups. She will be conducting research with a specific minority group in order to identify the needs to improve accessing mental well-being services within the NHS. She aims to recruit participants who are interested and willing to partake in her study. Would it be possible to give permission to put out any literature in the form of posters or flyers in the community centre once she gains ethical approval?

I'll let you take it from here but let me know if there's anything I can do to support.

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:	**Lucia Berdondini**
Supervisor:	**Sharon Cahill**
Student:	**Hana Ullah**
Course:	**Prof Doc in Counselling Psychology**
Title of proposed study:	What are the experiences of the journey in an Improving Access to Psychological Therapies service for individuals in the Afghan Community?

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 <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** 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	In this circumstance, a revised ethics application **<u>must</u>** be submitted and approved **<u>before</u>** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt,

RE-SUBMISSION REQUIRED	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 clarify in Section 3.8 Data Collection whether the data will be collected in person (where) and/or online (using Microsoft Teams). I can see these info in the letter for participants and the risk assessment form, but they need to be included also in the Ethical form.

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)	Lucia Berdondini
Date:	**16/11/2022**
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)	**Hana Ullah**
Student number:	**U2068220**
Date:	**23/11/2022**
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 C

Table 1

Demographics of participants

Participant number	Age	Treatment received	Other background information	Current risk related to suicide and self-harm, screened via risk assessment tool developed by iAPT.
1	21	8 1-1 sessions, step 2 CBT	Female, UK citizen, born in Europe, student, Muslim, first experience with IAPT.	No risk to self, related to suicide and self-harm.
2	22	6 1-1 sessions, step 2 CBT	Female, UK citizen, UK born, student, Muslim, first experience with IAPT.	No risk to self, related to suicide and self-harm.
3	32	12 1-1 sessions, step 3 CBT	Female, UK citizen, born in Afghanistan, full time employed, Muslim, 2 episodes with IAPT (one generic counselling).	No risk to self, related to suicide and self-harm.
4	26	6-week group, CBT	Female, UK citizen, UK born, full time employed, Muslim, 2 episodes in IAPT.	No risk to self, related to suicide and self-harm.

		5 session 1-1 step 3 CBT		
5	35	12-week 1-1 step 3 CBT	Female, UK citizen, born outside of UK/Europe, full time employed, Muslim, first contact with IAPT.	No risk to self, related to suicide and self-harm.

Appendix D

Table 2

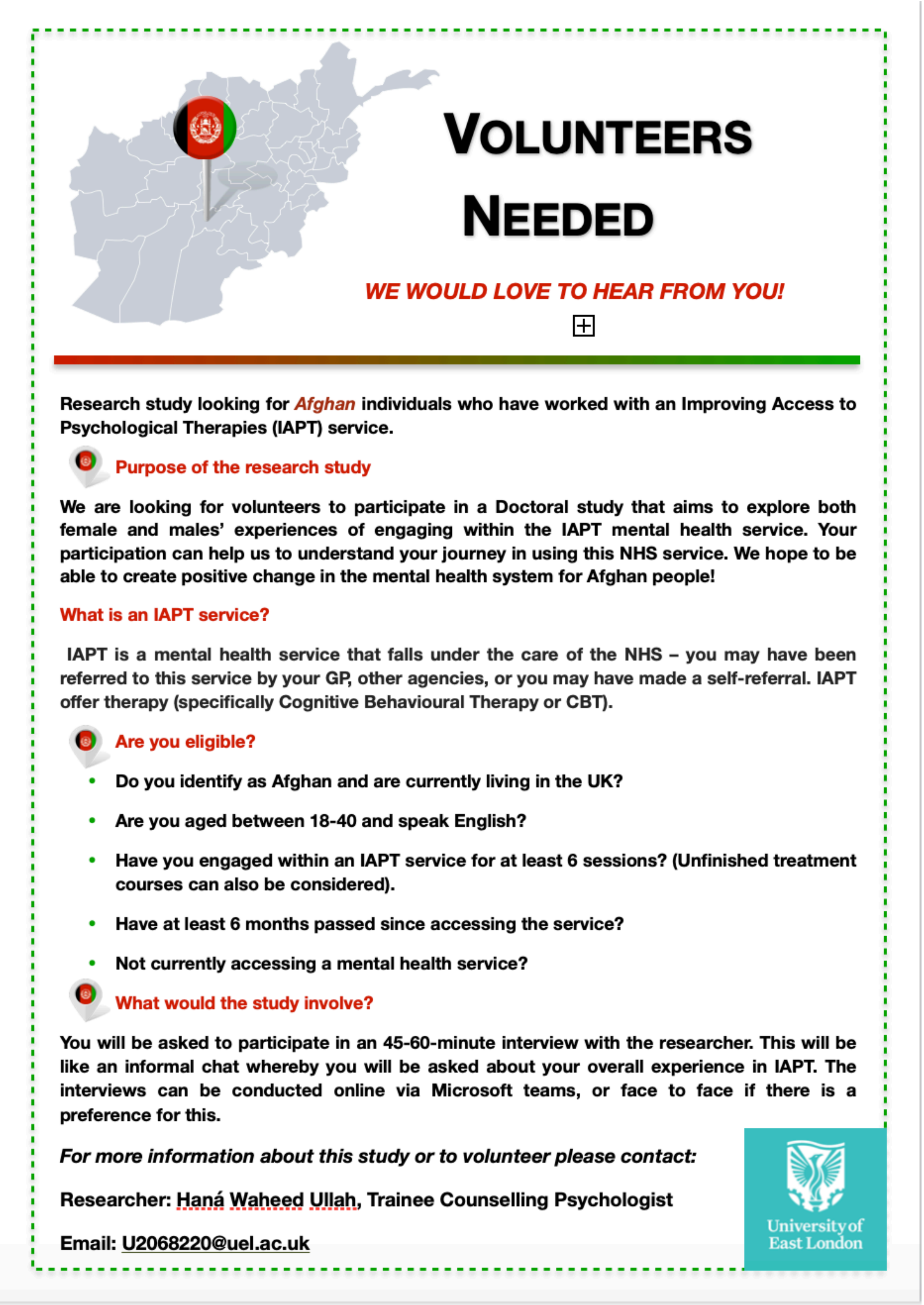
Overarching themes, themes and subthemes. Overarching themes are **<u>bold and underlined</u>**, *themes are* ***bold and italicised*** *and subthemes are italicised.*

Overarching theme	Themes	Subthemes
1. **The beginning – Accessing IAPT**	***1.1: Reaching out for help and the influence of family dynamics***	*1.1.1: Access and relationship with the GP*
	1.2: Assessment with IAPT to decipher treatment plan and the importance of creating a trusting environment	*1.2.1: Waiting*
2. **The Middle – engaging with therapy**	***2.1: The modality (telephone, video, face to face)***	
	2.2: The Manualised CBT technique	*2.2.1 Homework*

	2.3: Therapist characteristics	*2.3.1 Rapport and relational working*
	2.4 Cultural understanding and influence on therapy	*2.4.1. Why does culture matter? Fear of judgement* *2.4.2 Cultural competence – curiosity*
3. The end: Leaving IAPT	***3.1 Ending therapy and reflecting on the journey***	*3.1.1 Positives: A space to share* *3.1.2 Negatives: Shutting the door* *3.1.3 Suicidal ideation and self-harm* *3.1.4: Is the DSM one size fits all?*
	3.2: Considerations for the future: 'It could be very life changing'	*3.2.1: The importance of choice and shared decision making*

Appendix E

Research Advert



VOLUNTEERS NEEDED

WE WOULD LOVE TO HEAR FROM YOU!

Research study looking for *Afghan* individuals who have worked with an Improving Access to Psychological Therapies (IAPT) service.

Purpose of the research study

We are looking for volunteers to participate in a Doctoral study that aims to explore both female and males' experiences of engaging within the IAPT mental health service. Your participation can help us to understand your journey in using this NHS service. We hope to be able to create positive change in the mental health system for Afghan people!

What is an IAPT service?

IAPT is a mental health service that falls under the care of the NHS – you may have been referred to this service by your GP, other agencies, or you may have made a self-referral. IAPT offer therapy (specifically Cognitive Behavioural Therapy or CBT).

Are you eligible?

- **Do you identify as Afghan and are currently living in the UK?**
- **Are you aged between 18-40 and speak English?**
- **Have you engaged within an IAPT service for at least 6 sessions? (Unfinished treatment courses can also be considered).**
- **Have at least 6 months passed since accessing the service?**
- **Not currently accessing a mental health service?**

What would the study involve?

You will be asked to participate in an 45-60-minute interview with the researcher. This will be like an informal chat whereby you will be asked about your overall experience in IAPT. The interviews can be conducted online via Microsoft teams, or face to face if there is a preference for this.

For more information about this study or to volunteer please contact:

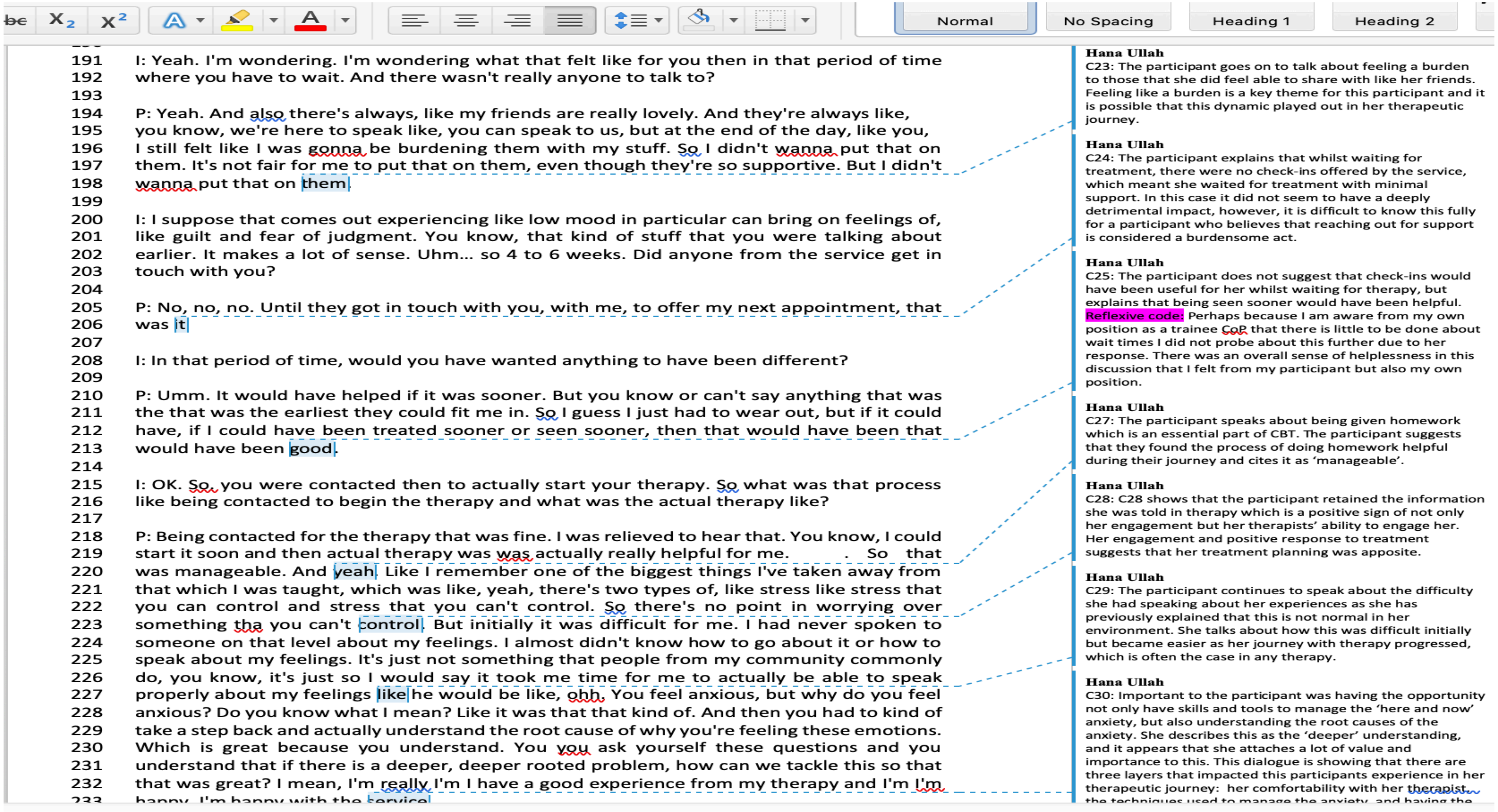
Researcher: Haná Waheed Ullah, Trainee Counselling Psychologist

Email: U2068220@uel.ac.uk

University of East London

Appendix F

Example of Initial Data Immersion Phase with Comments and Latent/Semantic Coding



I: Yeah. I'm wondering. I'm wondering what that felt like for you then in that period of time where you have to wait. And there wasn't really anyone to talk to?

P: Yeah. And also there's always, like my friends are really lovely. And they're always like, you know, we're here to speak like, you can speak to us, but at the end of the day, like you, I still felt like I was gonna be burdening them with my stuff. So I didn't wanna put that on them. It's not fair for me to put that on them, even though they're so supportive. But I didn't wanna put that on them.

I: I suppose that comes out experiencing like low mood in particular can bring on feelings of, like guilt and fear of judgment. You know, that kind of stuff that you were talking about earlier. It makes a lot of sense. Uhm... so 4 to 6 weeks. Did anyone from the service get in touch with you?

P: No, no, no. Until they got in touch with you, with me, to offer my next appointment, that was it.

I: In that period of time, would you have wanted anything to have been different?

P: Umm. It would have helped if it was sooner. But you know or can't say anything that was the that was the earliest they could fit me in. So I guess I just had to wear out, but if it could have, if I could have been treated sooner or seen sooner, then that would have been that would have been good.

I: OK. So, you were contacted then to actually start your therapy. So what was that process like being contacted to begin the therapy and what was the actual therapy like?

P: Being contacted for the therapy that was fine. I was relieved to hear that. You know, I could start it soon and then actual therapy was was actually really helpful for me. . So that was manageable. And yeah. Like I remember one of the biggest things I've taken away from that which I was taught, which was like, yeah, there's two types of, like stress like stress that you can control and stress that you can't control. So there's no point in worrying over something tha you can't control. But initially it was difficult for me. I had never spoken to someone on that level about my feelings. I almost didn't know how to go about it or how to speak about my feelings. It's just not something that people from my community commonly do, you know, it's just so I would say it took me time for me to actually be able to speak properly about my feelings like he would be like, ohh. You feel anxious, but why do you feel anxious? Do you know what I mean? Like it was that that kind of. And then you had to kind of take a step back and actually understand the root cause of why you're feeling these emotions. Which is great because you understand. You you ask yourself these questions and you understand that if there is a deeper, deeper rooted problem, how can we tackle this so that that was great? I mean, I'm really I'm I have a good experience from my therapy and I'm I'm happy. I'm happy with the service

Hana Ullah
C23: The participant goes on to talk about feeling a burden to those that she did feel able to share with like her friends. Feeling like a burden is a key theme for this participant and it is possible that this dynamic played out in her therapeutic journey.

Hana Ullah
C24: The participant explains that whilst waiting for treatment, there were no check-ins offered by the service, which meant she waited for treatment with minimal support. In this case it did not seem to have a deeply detrimental impact, however, it is difficult to know this fully for a participant who believes that reaching out for support is considered a burdensome act.

Hana Ullah
C25: The participant does not suggest that check-ins would have been useful for her whilst waiting for therapy, but explains that being seen sooner would have been helpful. Reflexive code: Perhaps because I am aware from my own position as a trainee CoP that there is little to be done about wait times I did not probe about this further due to her response. There was an overall sense of helplessness in this discussion that I felt from my participant but also my own position.

Hana Ullah
C27: The participant speaks about being given homework which is an essential part of CBT. The participant suggests that they found the process of doing homework helpful during their journey and cites it as 'manageable'.

Hana Ullah
C28: C28 shows that the participant retained the information she was told in therapy which is a positive sign of not only her engagement but her therapists' ability to engage her. Her engagement and positive response to treatment suggests that her treatment planning was apposite.

Hana Ullah
C29: The participant continues to speak about the difficulty she had speaking about her experiences as she has previously explained that this is not normal in her environment. She talks about how this was difficult initially but became easier as her journey with therapy progressed, which is often the case in any therapy.

Hana Ullah
C30: Important to the participant was having the opportunity not only have skills and tools to manage the 'here and now' anxiety, but also understanding the root causes of the anxiety. She describes this as the 'deeper' understanding, and it appears that she attaches a lot of value and importance to this. This dialogue is showing that there are three layers that impacted this participants experience in her therapeutic journey: her comfortability with her therapist, the techniques used to manage the anxiety, and having the

Appendix G

Initial Thoughts as a Result of Data Immersion

- Participants have a range of experiences some overlapping and some diametrically opposing. Participants who appeared to have more complex mental health difficulties tended to engage less well with the IAPT system.
- At the root of all distress is choice; participants varied in what ‘choice’ meant to them; i.e., some participants emphasised the importance of sharing protected characteristics with their therapist, where others wanted a degree of separation from their therapist.
- Cultural understandings were important to some, and this linked to a sense of belonging and also isolation within their own communities.
- Fear of judgment was a common theme amongst all participants.
- The therapeutic technique tended to have less importance placed on it in comparison to the relationship between therapist and participant.
- When difficulties were more complex, key factors seemed to be missed by the service (self-harm, suicidal ideation, flashbacks).
- When difficulties were more ‘straightforward’ participants engaged with treatment better and appeared to have a smoother journey (a beginning, middle and end).
- Longer wait times increased some participants distress and risk to self.
- Common themes related to treatment being ‘surface level’.

Appendix H

Table 3: List of finalised exhaustive codes used to recode data. These were commonly prevalent condensed codes.

1. Afghan culture and mental health	Identifies the experience of being Afghan and experiencing a mental health difficulty. This could relate to family, social circumstances, religion and stigma.
2. Anxiety	Identifies experiences during therapy that were anxiety provoking
3. Assessment	Identifies assessment processes like engagement with the assessment, helpfulness and overall access to assessment.
4. Being frowned upon	Connected to culture, this highlights areas where stigma was culturally present but not labelled as stigma.
5. CBT	Identifies experiences with the manualised CBT technique.
6. Choice	Identifies where choice was or was not offered in reference to therapist and treatment modality (or any aspect of treatment).

7. Community	Identifies how a sense of community (within the frame of Afghan culture) can impact one's mental health
8. Cultural context and impact	Identifies how individual cultural experiences impact the journey in its entirety, like from the point of accessing the service, engaging in therapy and ending.
9. Cultural curiosity	Identifies experiences of therapist's curiosity towards participants cultural experiences.
10. Cultural importance (access)	Identifies whether culture was considered when working with participants at the point of access and assessment. It is at this stage treatment will be decided for individuals, so this code highlighted whether cultural experiences were formulated into participants treatment plans.
11. Cultural perspectives and the therapist	This considers whether treatment therapist (whilst conducting CBT) were cognizant of individuals cultural perspectives
12. Cultural curiosity (asked)	This identifies whether therapists showed curiosity towards the participant in regard to their culture or other important aspects of their experience. The code within this is 'asked' to identify whether therapists asked about these issues.
13. Differences	This identifies differences and similarities between participant and therapist as this often impacted the relationship or the ability to relate to the therapist, which therefore impacted rapport building and overall engagement.

14. Religion and Islam	This code also falls under differences and considers how one's experience with religion may influence their mental health, and lack of speaking about this can impact treatment.
15. Dismissal	This identifies parts in the journey where the participant felt dismissed, overlooked or not heard in the treatment process.
16. Disorder specific issues	There were groups of data that related to trauma and depression that were not picked up on in therapy.
17. Empathy or lack of (empathy)	This identifies participants experiences with an empathetic therapist or lack of empathy, and then how this impacted engagement.
18. Endings	This identifies how treatment was ended (like abruptly, or as planned, or through disengagement).
19. Friends and family	This identifies the experience that participants had with support outside of IAPT such with friend and family. Often the experience was that the inside community were not accepting of mental health.
20. The beginning and the GP	This identifies both negative and positive experiences with the GP before entering IAPT.
21. Homework	This identifies a part of engagement with therapy, so both positive and negative experiences of utilising homework as a key component in CBT.

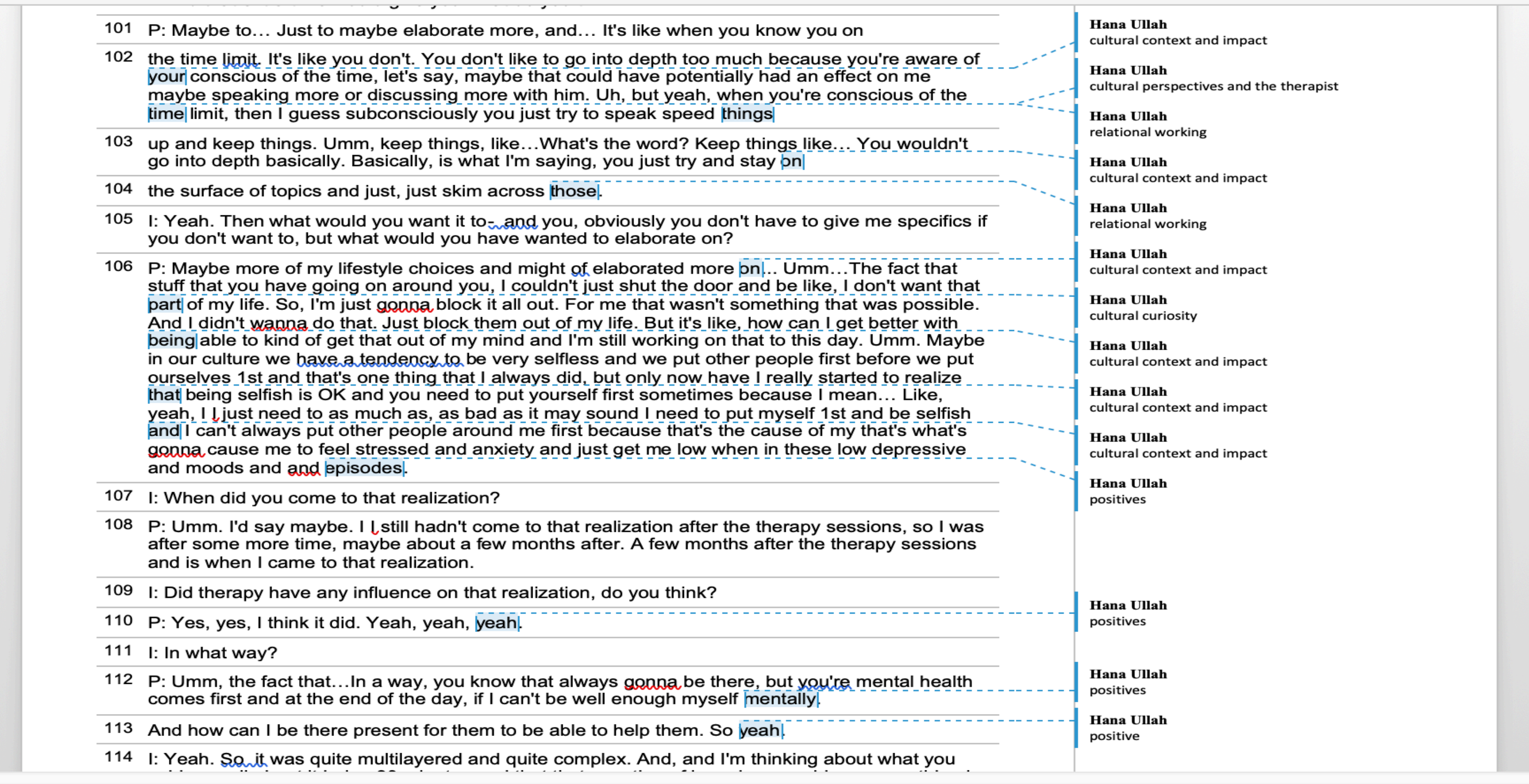
22. Judgement and culture	This identifies when participants felt judged by professionals, but in particular their therapist. This could also highlight a fear of judgement without evidence of judgement that existed before entering the service.
23. Lonely journey (alone)	This identifies experiences of loneliness whilst accessing therapy and how this can mirror the loneliness/isolation present when experiencing a mental health issue with a lack of a support network in the community or family. This was also contextualised by participants feeling like they had to manage things on their own. A key word for coding this was ‘alone’.
24. Male, female	This code identifies engagement of therapy in reference to therapist gender. It explores experiences with how gender made participants feel in their therapy.
25. Modality, telephone, video., face to face	This identifies experiences with the actual modality of treatment and how helpful or unhelpful the modality was in reference to engagement and how the participants felt during treatment.
26. Negatives	This identifies negatives in the treatment process from start to finish.
27. Positives	This identifies positives in the treatment process from start to finish.
28. Preference	This identifies whether participants were given a choice for preference in their treatment process; this mainly relates to whether the participants had a choice of the therapist they worked with and

	partially what was completed in therapy i.e., how much depth the participant was allowed to go into in reference to their experiences.
29. Referral (self/GP)	This identifies the type of referral people made to gain access to the service with this was a self-referral or a GP referral.
30. Relational working, relationships, rapport	This identifies the relationship building throughout accessing therapy but during the therapy course. There was an emphasis on rapport, trust and being able to relate to the other.
31. Similarities	This identified how similarities between participants and their therapists aided the treatment process.
32. Social anxiety	This identifies disorder specific issues and how these impacted the formulation and treatment process. It identified how social and cultural circumstances were sometimes being misdiagnosed as social anxiety. This identifies where there were there was focus on disorder like social anxiety, and how it did not necessarily capture the individuals experience but lead the treatment protocol.
33. Suicide and self-harm	This identified experiences with deliberate self-harm and suicidal ideation (both passive and concrete) as a result of waiting for treatment and finding it difficult to engage with treatment as a result of feeling misunderstood.

34. Surface level	Identifies experiences that were felt to be kept on the surface as opposed to having a deeper understanding of the difficulties.
35. The beginning and the GP	This identifies the relationship participants had with their GP and how this influenced access to therapy.
36. The technique (CBT)	This identifies the CBT techniques used during therapy, which can also include the issuing of homework.
37. Therapist skills, Listening, Sympathy/empathy	This identifies the therapist's individual skills and whether they had a positive or negative influence on therapy.
38. Toxicity in the afghan community.	This identifies the issues of toxicity in the Afghan community which further highlights the difficulties of experiencing a mental health issue in what is described as a toxic environment.
39. Understanding/understood	This identifies whether participants felt understood in their journey in general or from a cultural perspective.
40. Waiting for treatment (long, worse, wait)	This identifies wait times for treatment and how waiting had negative impacts on individual mental health.

Appendix I

Extracted Common Codes from a List of Exhaustive Codes and Assignment to New Transcripts with Clearer Line Numbers



101 P: Maybe to… Just to maybe elaborate more, and… It's like when you know you on

102 the time limit. It's like you don't. You don't like to go into depth too much because you're aware of your conscious of the time, let's say, maybe that could have potentially had an effect on me maybe speaking more or discussing more with him. Uh, but yeah, when you're conscious of the time limit, then I guess subconsciously you just try to speak speed things

103 up and keep things. Umm, keep things, like…What's the word? Keep things like… You wouldn't go into depth basically. Basically, is what I'm saying, you just try and stay on

104 the surface of topics and just, just skim across those.

105 I: Yeah. Then what would you want it to- and you, obviously you don't have to give me specifics if you don't want to, but what would you have wanted to elaborate on?

106 P: Maybe more of my lifestyle choices and might of elaborated more on… Umm…The fact that stuff that you have going on around you, I couldn't just shut the door and be like, I don't want that part of my life. So, I'm just gonna block it all out. For me that wasn't something that was possible. And I didn't wanna do that. Just block them out of my life. But it's like, how can I get better with being able to kind of get that out of my mind and I'm still working on that to this day. Umm. Maybe in our culture we have a tendency to be very selfless and we put other people first before we put ourselves 1st and that's one thing that I always did, but only now have I really started to realize that being selfish is OK and you need to put yourself first sometimes because I mean… Like, yeah, I I just need to as much as, as bad as it may sound I need to put myself 1st and be selfish and I can't always put other people around me first because that's the cause of my that's what's gonna cause me to feel stressed and anxiety and just get me low when in these low depressive and moods and and episodes.

107 I: When did you come to that realization?

108 P: Umm. I'd say maybe. I I still hadn't come to that realization after the therapy sessions, so I was after some more time, maybe about a few months after. A few months after the therapy sessions and is when I came to that realization.

109 I: Did therapy have any influence on that realization, do you think?

110 P: Yes, yes, I think it did. Yeah, yeah, yeah.

111 I: In what way?

112 P: Umm, the fact that…In a way, you know that always gonna be there, but you're mental health comes first and at the end of the day, if I can't be well enough myself mentally

113 And how can I be there present for them to be able to help them. So yeah.

114 I: Yeah. So, it was quite multilayered and quite complex. And, and I'm thinking about what you

Hana Ullah
cultural context and impact

Hana Ullah
cultural perspectives and the therapist

Hana Ullah
relational working

Hana Ullah
cultural context and impact

Hana Ullah
relational working

Hana Ullah
cultural context and impact

Hana Ullah
cultural curiosity

Hana Ullah
cultural context and impact

Hana Ullah
cultural context and impact

Hana Ullah
cultural context and impact

Hana Ullah
positives

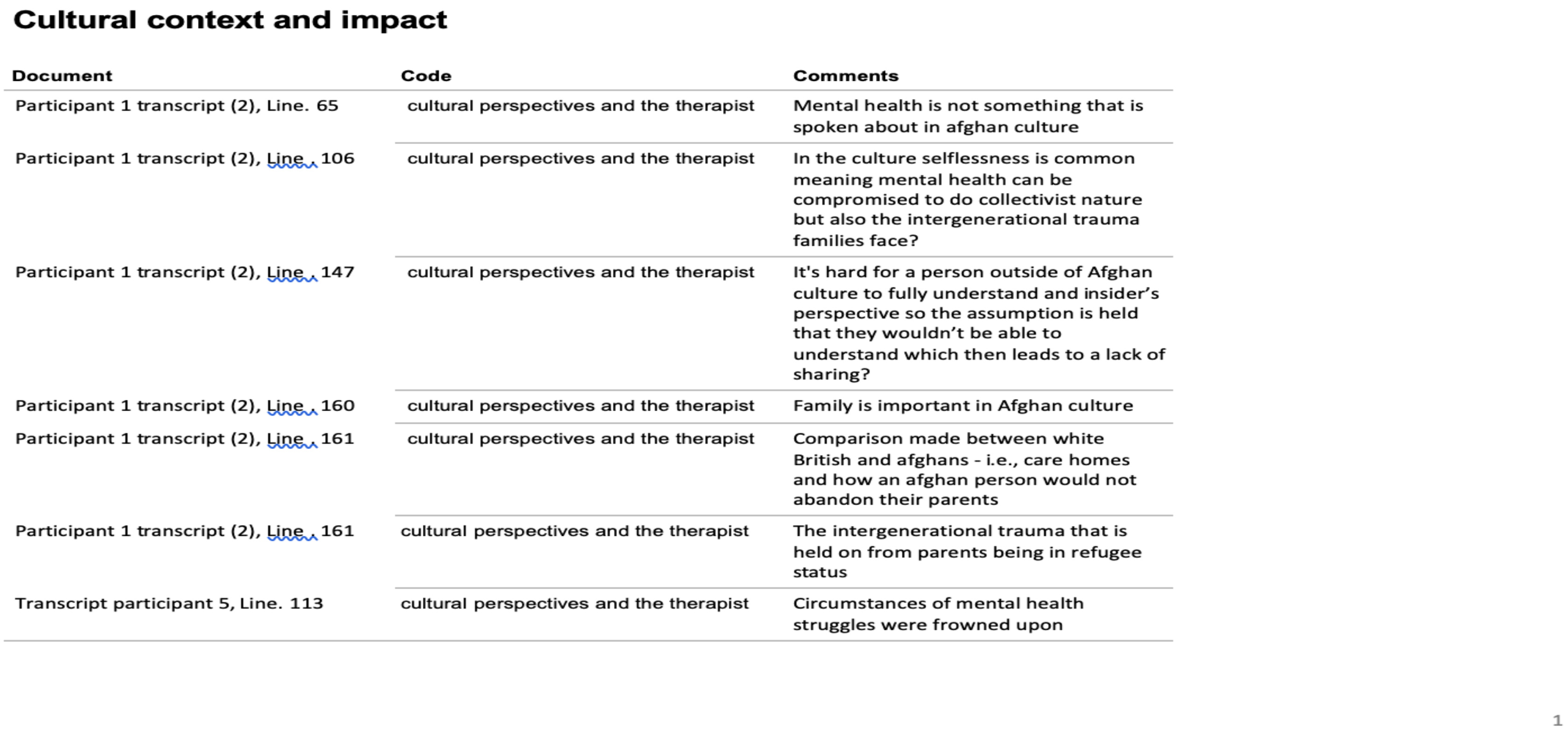
Hana Ullah
positives

Hana Ullah
positives

Hana Ullah
positive

Appendix J

Example of Collated Codes with Corresponding Line Numbers Adjacent to Participant Transcript



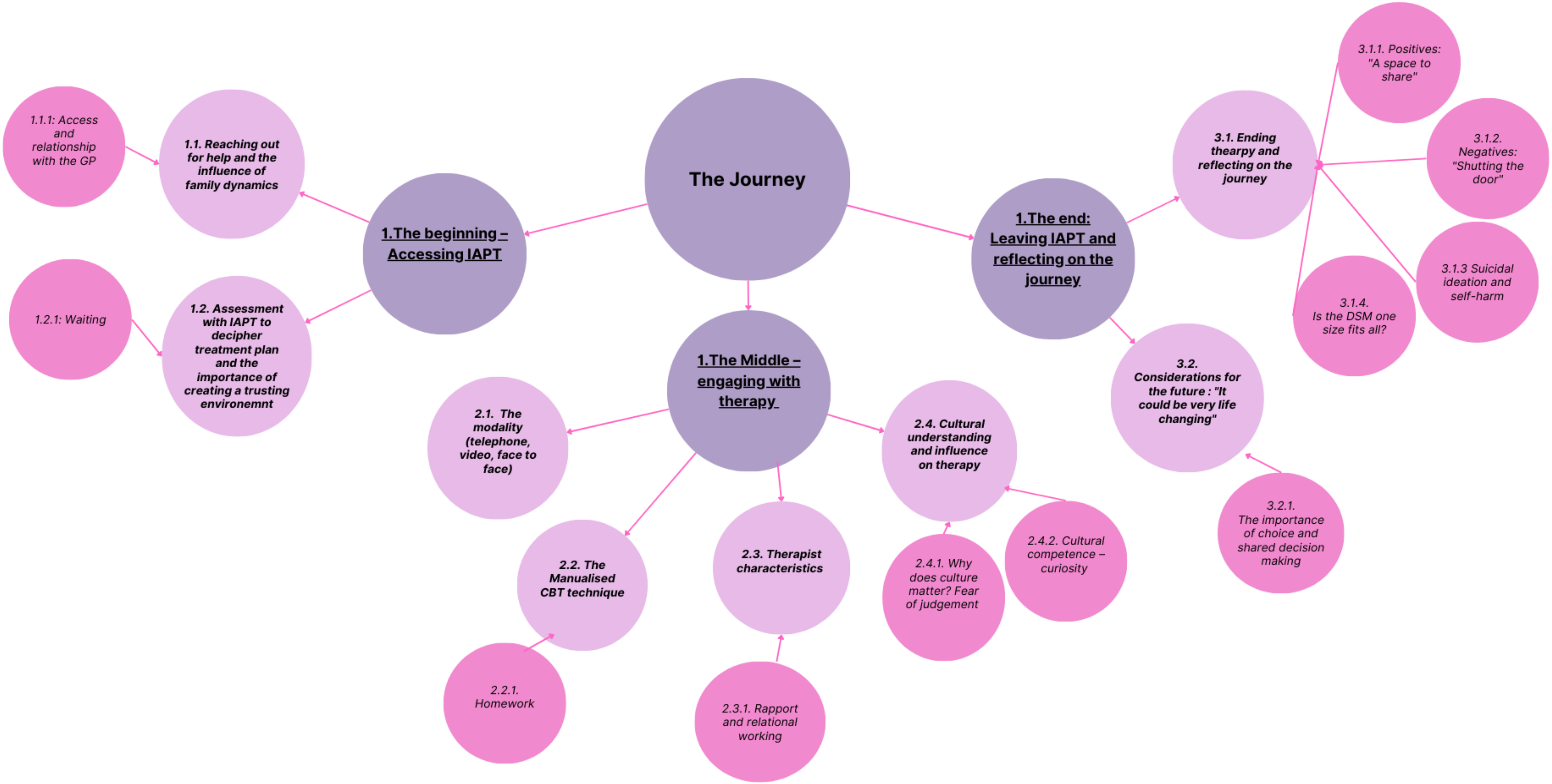
Cultural context and impact

Document	Code	Comments
Participant 1 transcript (2), Line. 65	cultural perspectives and the therapist	Mental health is not something that is spoken about in afghan culture
Participant 1 transcript (2), Line . 106	cultural perspectives and the therapist	In the culture selflessness is common meaning mental health can be compromised to do collectivist nature but also the intergenerational trauma families face?
Participant 1 transcript (2), Line . 147	cultural perspectives and the therapist	It's hard for a person outside of Afghan culture to fully understand and insider's perspective so the assumption is held that they wouldn't be able to understand which then leads to a lack of sharing?
Participant 1 transcript (2), Line . 160	cultural perspectives and the therapist	Family is important in Afghan culture
Participant 1 transcript (2), Line . 161	cultural perspectives and the therapist	Comparison made between white British and afghans - i.e., care homes and how an afghan person would not abandon their parents
Participant 1 transcript (2), Line . 161	cultural perspectives and the therapist	The intergenerational trauma that is held on from parents being in refugee status
Transcript participant 5, Line. 113	cultural perspectives and the therapist	Circumstances of mental health struggles were frowned upon

Appendix K (see below)

Figure 1

Mind map of initial creation of themes and relationships between subthemes


The Journey
1.The beginning – Accessing IAPT
1.1. Reaching out for help and the influence of family dynamics
1.1.1: Access and relationship with the GP
1.2. Assessment with IAPT to decipher treatment plan and the importance of creating a trusting environemnt
1.2.1: Waiting
1.The Middle – engaging with therapy
2.1. The modality (telephone, video, face to face)
2.2. The Manualised CBT technique
2.2.1. Homework
2.3. Therapist characteristics
2.3.1. Rapport and relational working
2.4. Cultural understanding and influence on therapy
2.4.1. Why does culture matter? Fear of judgement
2.4.2. Cultural competence – curiosity
1.The end: Leaving IAPT and reflecting on the journey
3.1. Ending thearpy and reflecting on the journey
3.1.1. Positives: "A space to share"
3.1.2. Negatives: "Shutting the door"
3.1.3 Suicidal ideation and self-harm
3.1.4. Is the DSM one size fits all?
3.2. Considerations for the future : "It could be very life changing"
3.2.1. The importance of choice and shared decision making