

ORIGINAL RESEARCH

'Not a cure, but helpful' – exploring the suitability of evidence-based psychological interventions to the needs of Black, Asian and Minority Ethnic (BAME) communities

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(Received 12 September 2022; revised 6 November 2022; accepted 18 November 2022)

Abstract

Individuals from Black, Asian and Minority Ethnic (BAME) groups experience profound disparities in accessing mental healthcare, show poorer treatment outcomes, and high attrition rates when compared to their White British counterparts. Despite the national rollout of Improving Access to Psychological Therapies (IAPT) services, research exploring service users' recovery narrative has been scarce. The aim of this study was to explore whether evidence-based psychological interventions are suitable to the needs of BAME communities. Semi-structured interviews were conducted with nine BAME service users who received evidence-based psychological treatment(s) from IAPT services. Reflexive thematic analysis (RTA) was used to analyse the data which included a six-phase process to produce a robust pattern-based analysis. Overall, three themes were generated. The first theme highlighted the importance of recognising cultural dissonance within therapy, which considered patient therapeutic expectations, therapeutic guilt, and conflicting cultural identities. The second theme identified the need for therapists to develop cultural competency. This included the importance of building therapeutic trust and exploration of patient culture within therapy. The final theme considered the road to recovery and highlighted challenges with therapeutic engagement and evaluations of therapeutic effectiveness. Overall, BAME service users felt that therapy was not a cure, but found it helpful. Clinical implications and future recommendations are discussed.

Key learning aims

- (1) To briefly introduce cross-cultural theoretical models that may assist mental health professionals to think critically about whether Western notions of therapy are suited to the needs of ethnic minority communities.
- (2) To highlight cultural challenges that may impede therapeutic success for BAME communities.
- (3) For IAPT services and practitioners to consider cultural competency training needs that may enhance service user therapeutic experiences and outcomes.
- (4) To encourage IAPT services to enhance knowledge about psychotherapy and mental health by promoting culturally sensitive psychoeducation in ethnic minority communities.

Keywords: Black; Asian and Minority Ethnic (BAME); common mental health disorders; Improving Access to Psychological Therapies (IAPT); mental health; psychotherapy

Introduction

The Office for National Statistics (2021) reported that there are over 67.1 million people living in England and Wales, of which approximately 15.2% identify as Black, Asian and Minority Ethnic (BAME) backgrounds. Despite the growth in ethnic minority populations, evidence suggests that there are disproportionate inequalities in mental health care and treatment (e.g. Fernando, 2012; Good and Hannah, 2015; Harwood *et al.*, 2021). The Improving Access to Psychological Therapies (IAPT) programme was launched in 2007 to tackle the impact common mental health disorders were having on individuals, the economy and society by increasing access to psychological therapies (Clark, 2011; Clark, 2018). A stepped-care approach was implemented which included low-intensity and high-intensity evidence-based psychological interventions such as guided self-help and cognitive behavioural therapy (CBT).

Psychotherapy is a product of the West, and tends to adopt the values, beliefs and principles of the dominant individualistic culture (Frese *et al.*, 2001; Laungani, 2007). Clinical trials examining the efficacy of evidence-based psychological interventions tend to include a homogenous set of participants (e.g. White, middle-class); therefore, when interventions are applied to 'real-world' clinical settings, seldom do they produce consistent findings (Gordis, 2014; Pawson and Tilley, 1997). These disparities become more salient in ethnic minority clinical populations served by IAPT services who show poorer recovery outcomes when compared with their White British counterparts (e.g. Baker, 2018; Harwood *et al.*, 2021; Moller *et al.*, 2019). Recovery is defined as the *subjective experience* of having gained control over one's life, in which hope, achievement and social connectedness are some of the direct benefits (Ryan and Pritchard, 2004). IAPT services grounds itself in producing numerical outcome data to quantify and evidence service success. Whilst empirically supported outcomes are useful for monitoring and planning, they often ignore the recovery narrative which is important to understand what works well, for who, and when (Christodoulou *et al.*, 2018; Williams, 2015).

Theoretical approaches such as individualism-collectivism (Hofstede, 1980; Hofstede, 2011; Triandis, 1995) and the self-construal theory (Markus and Kitayama, 1991) allude to cultural differences between those living in the West and those who originate from collectivist societies. Namely, the desire for individuals from collectivist societies to preserve cultural norms, values and traditions in order to maintain harmony and group cohesiveness (e.g. with family members, clans, tribes) over self-serving needs (Hofstede, 2011; Markus and Kitayama, 1991; Tse and Ng, 2014). These characteristics often clash with Western notions of therapy that insist on self-sufficiency, independence and autonomy (Al-Krenawi and Graham, 2000; Christopher, 2001; Fernando, 2012). These cultural conflicts can intensify for those brought up in the West as they tend to hold bi-cultural identities, thus increasing dissonance between cultural expectations and Western therapeutic practices (e.g. Allen and Bagozzi, 2001; Gushue and Constantine, 2003).

A qualitative meta-analysis exploring 'hard-to-reach' communities in the UK reported that factors such as expressions of mental illness, differing world-views, barriers to accessing mental health services, and psychological interventions not accounting for patient cultural needs disrupts therapeutic uptake and engagement (Lamb *et al.*, 2012). Ethnic minority caregivers echoed these concerns (Miller *et al.*, 2021) which together can increase scepticism about the credibility of psychotherapy and mental healthcare (Prajapati and Liebling, 2021; Sue, 2006). Beck and Naz (2019) highlight a number of fundamental issues that hinder therapeutic success in BAME communities who access IAPT services. This includes services not being able to facilitate or recognise distress across cultures, patient therapeutic fears, and poor treatment outcomes due to inadequate cultural adaptations. Whilst IAPT services aim to consider patient cultural needs, they seldom incorporate cultural specific factors such as patient idioms of distress, values or practices (Beck, 2016; Naz *et al.*, 2019).

Table 1. Service user demographics

Demographics			
Age (mean, SD)	37.33 (5.74)	Diagnosis	<i>n</i> (%)
Gender	<i>n</i> (%)	Depression	5 (55.6%)
Female	8 (88.9%)	GAD ¹	2 (22.2%)
Male	1 (11.1%)	MADD ²	1 (11.1%)
Ethnicity	<i>n</i> (%)	PTSD ³	1 (11.1%)
Pakistani	4 (44.4%)	Referral pathway	<i>n</i> (%)
Bangladeshi	1 (11.1%)	General practitioner	7 (77.8%)
Chinese	1 (11.1%)	Self-referral	2 (22%)
Arab	2 (22.2%)	Type of therapy	<i>n</i> (%)
Other	1 (11.1%)	Group CBT	2 (22.2%)
Religion	<i>n</i> (%)	CBT ⁴	5 (55.6%)
Muslim	6 (66.7%)	Counselling	2 (22.2%)
Other	2 (22.2%)	Recovery	<i>n</i> (%)
None	1 (11.1%)	Recovered	3 (33.3%)
		Not recovered	6 (66.7%)

¹Generalised anxiety disorder (GAD); ²mixed anxiety and depressive disorder (MADD); ³post-traumatic stress disorder; ⁴cognitive behavioural therapy.

Research exploring the recovery narrative of BAME service users has been scarce. In one study, Christodoulou and colleagues (2018) explored the experiences of Turkish-speaking service users offered guided self-help at an IAPT service in London. Results showed that the therapeutic expectations caused service users confusion and anxiety. In addition, service users had differing cultural experiences of distress, ambivalent help-seeking attitudes, limited self-efficacy, and problems with continuity. Often therapy sessions were too short to make real progress, which in turn, impeded the recovery process. In another study, Omylinska-Thurston and colleagues (2019) found that CBT did not meet the needs of service users. Participants reported difficulties in grasping CBT concepts, had negative perceptions of therapists, and found IAPT processes unhelpful. However, the population sample was majority White British, thus authors recommended further exploration in ethnic minority populations.

Given the inadequate recruitment of BAME groups in clinical trials and poorer treatment outcomes, this study aims to explore whether evidence-based psychological interventions offered by IAPT services are suitable to the needs of BAME communities. Exploring such needs are crucial for clinical practice, especially since ethnic minority communities can feel misunderstood or even mistreated by mental health service providers (Bristow *et al.*, 2011; Mclean *et al.*, 2003; Naz *et al.*, 2019) leading to increased therapeutic disengagement (Baker, 2018; Harwood *et al.*, 2021).

Method

Participants

Participants were recruited using purposive sampling via social media and word-of-mouth (Bricki and Green, 2002). Participants were not seeking or receiving treatment at the time of the study. The experiences are reflective of the course of treatment(s) participants received from an IAPT service. Participant demographics have been highlighted in Table 1. The mean age was 37.33 years ($SD=5.74$). The majority of participants were female. Most service users identified as Pakistani, followed by Arab, Bangladeshi, Chinese, and other ethnic groups. The most common religious orientation was Muslim. The majority of participants were referred to IAPT service by their general practitioner (GP). The most common therapy received was CBT, followed by

counselling and group CBT. Out of nine participants, three reported that they had recovered from therapy.

Design and procedure

Qualitative research methods were chosen as this allows for in-depth exploration of service user experiences and recovery narratives (Williams, 2015). Participants interested in the study were emailed the information sheet and consent form detailing the purpose of the study. Once agreed to participate, the author arranged for the interview to take place online (e.g., Zoom) or via telephone due to the study taking place during the global COVID-19 pandemic. The author developed the topic guide by careful consideration of existing literature, discussion with practitioners, and by brainstorming ideas that would enrich understanding of service user experiences and needs. The interview schedule consisted of 12 open-ended questions, including prompts where needed, to allow participants to discuss their lived experiences (Braun and Clarke, 2013). Topics relating to referral pathways, therapeutic engagement, therapists cultural competency and therapeutic effectiveness were considered core areas of interest (Beck and Naz, 2019; Good and Hannah, 2015). Questions included ‘*How well do you feel the therapy was tailored to your needs?*’ and ‘*How well was your therapist able to understand your cultural background, values, and beliefs?*’. The author was conscious of personal biases as someone from a BAME background, so took precautions to ask neutral questions that were not led by personal subjective experiences or knowledge (Pope & Mays, 2006). The author carried out all the interviews as part of her doctoral research. The interview process was interactive whereby the author weaved in and out of the topic guide to allow participants the opportunity to talk about what was important and meaningful to them. Interviews were audio-recorded and lasted between 30 minutes and 1 hour. All participants were debriefed verbally and sent a debrief sheet after the interview took place. Audio files were transcribed verbatim and anonymised. Participation was entirely voluntary and no payment or incentive was offered.

Analysis

Reflexive thematic analysis (RTA) was chosen as it is a flexible approach that does not confine to particular theoretical frameworks, philosophical positions, or ideologies (Braun and Clarke, 2013; Braun and Clarke, 2021a). RTA was considered the most useful analytical approach to explore service user perspectives by generating meaningful insights into their lived experiences (Braun and Clarke, 2006; Clarke and Braun, 2013). RTA involves reflexive engagement with the data, guided by a six-phase process to produce a robust pattern-based analysis (Braun and Clarke, 2006; Braun and Clarke, 2019). During the *data familiarisation* stage, the author immersed herself in the data by conducting the interviews, making notes, and thorough engagement with the transcripts. Notes about initial analytical observations and insights included participant feelings, discourse, and understanding of their world. The author also considered her positionality as someone from a BAME background and reflected on her assumptions, biases and subjective knowledge by keeping a reflexive diary. Next, the author *coded* the transcripts by using the ‘comments’ function in Microsoft Excel to create side margins to highlight the relevant extracts and codes (Byrne, 2021). To *generate initial themes*, topic areas were clustered according to their shared meaning. This included a number of themes and subthemes that were generated in the data and aligned to the research question (see Supplementary material for codebook extract). The author recursively *developed and reviewed themes* to ensure that they addressed the research question (Braun and Clarke, 2013). To *refine, define and name themes*, the author went back and forth between the data to ensure

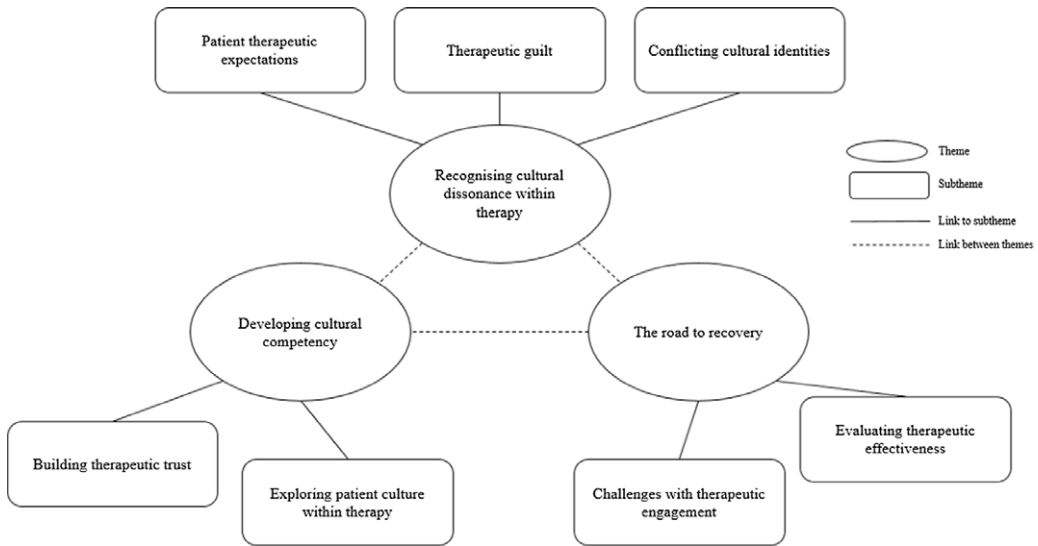


Figure 1. Thematic map of themes and subthemes.

that the data tells a ‘story’ that does not drift off topic (Braun and Clarke, 2019). To note, the author recognises the added benefits of multiple coders and research triangulation (Nowell *et al.*, 2017); however, inter-rater reliability is considered ‘*illogical, incoherent and ultimately meaningless*’ in RTA as it is impossible to avoid researcher bias and subjectivity of how the data is conceptualised and understood (Braun and Clarke, 2021a). Thus, the credibility of single coder analysis is not entirely diminished. Nonetheless, to minimise such concerns, the author shared findings with the doctoral research supervisory team and a clinical expert to review the credibility of the analysis. Following feedback, themes were further refined and defined. The thematic map is shown in Fig. 1. Finally, the report was *written up* to offer a narrative account of whether evidence-based psychological interventions meet the needs of BAME service users accessing IAPT services.

Results

Three over-arching themes were generated: (1) recognising cultural dissonance within therapy, (2) developing cultural competency, and (3) the road to recovery (see Fig. 1). Pseudonyms are used to preserve participant anonymity.

Recognising cultural dissonance within therapy

The first theme highlights the importance of recognising cultural dissonance within therapy and considers service user therapeutic expectations, therapeutic guilt, and conflicting cultural identities.

Therapeutic expectations: ‘How will I talk this problem away?’

The first subtheme considers service user experiences of accessing IAPT services and receiving therapy. Several service users felt apprehensive about therapy, often due to the lack of knowledge about mental health disorders, the purpose of therapy, and what to expect from

IAPT services. Service users opened up about feeling ‘anxious’, ‘afraid’, ‘uncomfortable’ and ‘nervous’ about attending their first therapy session. Often this was the first therapeutic encounter they had with mental health services and was a ‘big change’ from the traditional route of seeking help from their GP. Service users talked about having ‘no idea’ what they were signing up for. This resulted in a few service users dropping out of IAPT services because they were unable to explain the purpose of therapy to their families. For example, Zara (SU7) questioned ‘*how will I talk this problem away?*’ given the inherent reliance on the medical model within her culture.

Service users talked about disorders such as depression, anxiety and post-traumatic stress disorder being absent from their culture, which meant it was difficult to translate them ‘*back into the community or the mother tongue*’. Service users often lived in multi-generational households, which meant they found it difficult to explain their mental distress and therapeutic needs to older family members, who reinforced that they had ‘*no problem*’. For example, Bushra (SU6) talked about how mental distress was normalised as everyday problems and deterred her from seeking therapy:

‘You know, in my culture . . . these things, depression and anxiety, they don’t exist. Now they exist, but when I got it, it didn’t exist. It was like there’s nothing wrong with you, just shake it off . . .’

Therapeutic guilt: ‘You’re going against the way that you’re taught . . .’

This subtheme describes the therapeutic guilt service users experienced by engaging with therapy. Service users experienced dissonance between their cultural, familial and religious obligations and Western therapeutic expectations. This led to feelings of shame, guilt and entrapment. Service users often found therapy culturally insensitive and felt that White therapists in particular did not understand that they were bound by certain ‘*cultural expectations and values*’. Some service users talked about the negative consequences advice from therapists would have had on their lives. For example, Qadira (SU9) dropped out of therapy because she felt that her therapist did not understand that she was unable to disclose her personal issues to her family as it would have caused shame and embarrassment:

‘I think some of the advice that she was giving me . . . is just not possible for me to do in general as part of religious cultural limitations for me . . . I possibly would have lost my family, my parents, my siblings. I don’t think she realised that that side of it.’

For others such as Annie (SU4), being asked to involve her family in the recovery process led to immense guilt for not being able to deal with her own ‘*problems*’. Annie’s Chinese upbringing taught her to be resilient, and she felt that by revealing her concerns to her family would have been negative:

‘Yeah, we feel guilty that you’re going against the way that you’re taught to deal with your problems and a lot of that comes from how you’re raised and how your upbringing was, I think.’

Service users also talked about therapists not understanding the gravity of their religious teachings and obligations. Some service users felt ashamed that they had to seek therapy as they were taught that it was ‘*forbidden*’ to have negative thinking patterns. For example, Kalsoom (SU5) was often told by her family that if she had ‘*tawakkul*’ [faith] in God she would not have depression:

'It's almost like, well, if you believe in God, you shouldn't have depression. That was the information that was fed to us growing up...'

Conflicting cultural identities: 'I have a massive identity crisis'

This subtheme describes the cultural clash between Western therapeutic practices and service users' cultural identity. Some service users felt that by challenging their thoughts and behaviours, they were having to compromise their own identity. For example, Annie (SU4) felt that Western concepts such as 'self-compassion' went against the way she was 'taught to deal with your problems':

'... I guess I was getting really hesitant, but one of the things I said was it feels like I'm changing who I am by challenging these thoughts. I think to some extent I have a massive identity crisis... I'm incredibly hardworking and my parents have always believed in, like working really hard... I think that is partly a cultural thing. ... But I think one thing that she tried to get to was self-compassion and I found that really hard because it almost felt like slacking off.'

Some service users talked about the different 'personalities' and 'masks' they had to adopt and interchange due to varying cultural expectations. Most service users were British born, and had to juggle familial expectations to abide and serve elders (e.g. parents and older siblings) and the western notions of being independent and autonomous. Service users such as Khalid (SU1) felt that White therapists in particular had limited understanding about these challenges:

'Because even though they don't understand this at the moment, I have two masks on, one for when I leave the house, basically confident, strong, leader, not discriminated against. The other is for dealing with my issues... It was a good therapist, but he didn't understand the cultural barriers... I would say that there was partial cultural values, partial UK values and emotions in one. But he couldn't understand the concept that I had three different psychological personalities – one for home, one for work, and one for with friends.'

Developing cultural competency

The second theme considers the importance of developing cultural competency by building therapeutic trust and exploring patient culture within therapy.

Building therapeutic trust: 'I don't think she understood the middle ground...'

This subtheme describes concerns relating to confidentiality, cultural misinterpretations, and lack of trust in mental health services and professionals. Despite understanding that therapists were 'bound by confidentiality', service users felt that a key component of therapy was to build a 'safe space' where they could 'trust' the therapist. Given the sensitivity of their personal issues, service users worried that if anything was to 'come out' it would not be a 'positive thing' for them. Service users often opted for one-to-one therapy over group therapy formats for fear of being recognised by community members. Service users desired 'privacy' and wanted to discuss 'sensitive' and 'private' matters with the therapist alone. Khalsoom (SU5) discussed that this resulted in her dropping out of group therapy and re-referring for one-to-one sessions:

'I have to go back to my GP and be like, I can't do this, but [they] keep sending me to group therapy. It's not something that I can do. And it actually made my panic attack condition worse, my mental health worse.'

Service users also talked about the cultural misinterpretations by White therapists which led to them not wanting to continue with therapy or trust that their concerns would be fully understood. For example, Khalid (SU1) reported that his therapist misunderstood his cultural expressions as 'angry' and 'aggressive' which instantly instilled barriers within the session. Others such as Aisha (SU3) reported that her therapist's mannerisms, expressions and assumptions about her hijab [Muslim headscarf] were offensive and led to her dropping out of therapy:

'Yes, I wear a hijab. She spent like maybe two minutes looking at that and then very dismissively, you know, look at me, kind of like a really sorry way and really, like, squinting her eyes and nose... looking at my hijab. ... Instead of saying, tell me about yourself... it was like to tell me, why do you wear this? ... Then she obviously pointed towards my hijab and she said that, well, OK, is it is it like your dad or brother? ... And I was like, no, it's completely my choice. And she wouldn't accept it, that I would make that choice for myself.'

Some service users felt that due to Western thinking, White therapists misinterpreted everyday cultural barriers as 'extreme' incidents. For example, Qadira (SU9) reported that her therapist did not quite understand everyday cultural norms and misjudged them to be life threatening:

'... I do remember mentioning it [family pressures], but then I think she took the opposite extreme... I think it was more like honour killing. And I mean, it's nothing like that. I don't think she understood the middle ground, the family, where they just stop talking to you.'

Exploring patient culture within therapy: 'I wish that he'd made a little bit more effort...'

This subtheme considers the importance of exploring service user culture within therapy. Service users felt that 'social traumas' and everyday inequalities contributed to their mental distress so would have 'valued' therapists asking them about their 'culture', 'beliefs' and 'background'. Most service users felt that White therapists in particular were 'scared' to ask questions and 'couldn't easily relate because there were cultural differences'. For example, Annie (SU4) felt that exploration of her cultural values would have enhanced her therapeutic experience:

'I wish that he'd made a little bit more effort about what I value. That would have helped shape the programme as well, and help shape some of the tasks... but there wasn't very much conversation about it and how much my symptoms are impacting my day to day behaviour routine and say why that made some of the past more difficult.'

Service users appreciated therapists who were culturally sensitive and curious. A couple of service users preferred a therapist from a different religious and cultural background for fear of being 'criticised' or 'judged'. For example, Khalsoom (SU5) valued her White therapist taking the time to find out more about her culture. This made her feel extremely comfortable in the sessions and allowed her to open up about her concerns, which she struggled to do so in the past:

'I feel like it was because the lady I went to see wasn't of the same background as me, so she was really interested... and, you know, from that she picked up that I was talking about my

culture and my cultural practices. But she was really engaged in that and I felt that really helped me open up because she actively tried to get to know me.'

However, some service users preferred having a therapist who shared the same cultural background, although they felt this was not crucial to their care needs. Service users found it 'easier' to talk to therapists from similar cultures because they did not overtly have to explain factors such as their upbringing, religious obligations, familial and cultural pressures and barriers. For example, Bushra (SU6) felt that her BAME therapist 'just got it' and made her feel at ease during the therapy session:

'Like, if someone doesn't understand that [culture], they ask you question, why was this like this? She has a similar background of how I was brought up and, you know, the family rules and everything. But she kind of understood that as well. So it was quite, you know, nice.'

Cultural competency training was deemed important to understand cultural complexities. Service users felt that 'White, middle class' therapists 'seem to be getting no training around cultural competency and how to apply it to different cultures'. Service users felt that 'representation' was important and wondered if 'additional courses' were needed to enhance cultural competency. A couple of service users described the lack of training as 'systemic discrimination' and a 'pyramid scheme' that favoured White therapists in clinical roles and offered 'cheap labour' by using inexperienced psychological wellbeing practitioners (PWPs) over those who 'cared' about the profession. Aisha (SU3) was particularly vocal about this matter:

'This is actually robbing the system from people who actually care about the profession, people who actually care about somebody. . . . A degree got you into, you know, IAPT.'

The road to recovery

The final theme highlights the road to recovery by considering challenges with therapeutic engagement and service user evaluations of therapeutic effectiveness.

Challenges with therapeutic engagement: 'I don't know if it was tailored at all?'

This subtheme considers the challenges encountered during therapy and the implications that this had on service user therapeutic engagement. Service users felt that regularity (e.g. same therapist throughout course of treatment), option to choose type of therapy, and 'fostering an environment where people can actually talk about things' would have improved their experience. Most service users had disengaged from the service at least once, but did take up therapy when conditions got worse. The majority of service users reported that therapy was not 'tailored' to their needs and they were just 'going through the motions'. For example, Khalid (SU1) was particularly unhappy about therapy and felt that his therapist saw him as a 'number' rather than a 'person' in order to meet targets:

'It was not tailored to me as an individual, irrespective of culture. So the culture didn't even come into it . . . They see you as part of their targets, and they see you as a number to get you in and out to hit the target.'

There was a distinct difference between service users who received counselling or CBT. Service users who received CBT generally found it 'prescriptive' and a 'rigid set of tasks' where therapists went through the 'process' and completed 'forms and questionnaires'. Service users felt that therapy

was ‘*superficial*’ and therapists were too focused on trying to ‘*fix*’ their problem rather than getting to know their personal history. For example, Annie (SU4) recalled her therapeutic experience:

‘I just felt like he was like trying to stick me into a programme. I didn’t necessarily feel like that programme was right at the end of the day. And I guess it felt like frigid . . . it’s very much like bring your problem, let’s solve your problem.’

Service users reflected on homework tasks offered as part of CBT. They found homework ‘*unhelpful*’ and ‘*silly*’ and felt that therapists were following set ‘*programmes*’ without ‘*modifying*’ tasks to their individual needs. For example, Annie (SU4) reported:

‘I don’t know if it was tailored at all? You like come to a session and have homework printed out without meeting me. How do you know what homework you’re going to give me if we didn’t have the session?’

Others felt that the ‘*cultural connotations*’ attached to doing certain homework tasks were not considered by therapists. Khalsoom (SU5) felt that her therapist was dismissive of her cultural and familial boundaries:

‘A lot of parts, I was doing in private, so my family had no idea at all I was doing them . . . yeah, so it didn’t really look at my cultural side of things. They were just like, well, you need to work on these, you know, you need to be able to speak to your family . . . and it wasn’t something I was comfortable doing. So I think that would be more of a negative than a positive.’

However, some service users understood the importance of homework and the benefit it would have on their recovery process. For example, Khadija (SU2) talked about her initial apprehensions, but soon realised that to achieve wellness, she had to take control of her own situation:

‘. . . If you walk up to the session and think someone’s going to fix you, you’re not a machine. So I really have a lot of time for people who actually get on with doing the work. And I think that’s what makes a very big difference.’

Service users who received counselling valued being able to ‘*just talk*’ given the inherent stigma attached to mental health problems in their culture. Qadira (SU9) preferred just being able to ‘*let everything out*’ and felt that ‘*if it was more interactive or anything like that, I probably wouldn’t have not attended*’. However, for Zara (SU7), more practical ‘*advice*’ on how to manage her situation would have been beneficial. This resulted in her dropping out of therapy after one session:

‘But I prefer to get some maybe advice, like something that might make me be better . . . I’m just like free from the things I needed to say. But I’m the same, I have the same problem.’

Evaluating therapeutic effectiveness: ‘Not a cure, but helpful’

This subtheme describes service user evaluations of their recovery process and psychological therapies. Most service users described therapy as ‘*hit and miss*’ and could see the benefits of ‘*just talking*’ or using certain ‘*techniques*’ to ‘*get back into society*’. Whilst service users found therapy useful, they questioned the long-term benefits of therapy and felt that it did not help them recover from their mental distress. Service users reported that they had ‘*the same problem*’ and did not feel ‘*100 percent*’ following a course of treatment. A couple of service

users said they were ‘*looking for a cure*’, but this was not achieved through therapy. For example, Bushra (SU6) reflected on her therapeutic experience:

‘... I don’t think they can fix you. I think, you know, people need therapy. They need it in their lifetime again and again. I think, you know, to kind of get back into that kind of habit that they kind of teach you.’

Service users felt that a course of therapy was ‘*just too short*’ and would have preferred more sessions to help them overcome their issues. They understood service demands, but felt that it was a ‘*waste of time*’ if people were not recovering from their disorder or seeing the full ‘*benefit*’ of therapy. Most service users felt that therapy was ‘*momentary*’ and did not help resolve past traumas, issues or concerns. Aisha (SU3) was particularly vocal about this:

‘... You know, they need to focus on the past and the present for you to move forward. You are constantly stuck in today throughout the therapy ... I just like I’m seeking this to resolve past issues and how I ended up here and how to move forward from here, and none of that was addressed ever.’

Most service users said that they would recommend therapy to others and felt that everyone who needed it should ‘*try it at least once*’. For example, Bushra (SU6) felt that her therapeutic experience challenged her preconceptions of therapy and helped her move forward in the road to recovery. She felt that therapy was ‘*not a cure, but helpful*’ and recommended IAPT services to ‘*break down barriers*’ and ‘*misconceptions*’ of therapy to others:

‘... If someone said to me go for therapy, I would laugh at them, and say what’s talking going to do? You can talk to your family, your friends, you can talk to anybody. But I do think it does help because they’re like professionals. They know what to say ... I would recommend therapy, I think therapy does help.’

Discussion

The aim of this study was to explore whether evidence-based psychological interventions offered by IAPT services are suitable to the needs of BAME communities. Three themes were generated: (1) recognising cultural dissonance within therapy, (2) developing cultural competency, and (3) the road to recovery. Overall, service users felt that therapy was not a cure, but found it helpful. Critical areas of concern are discussed and recommendations are made to improve the therapeutic experiences and outcomes for BAME communities.

Recognising cultural dissonance within therapy

Recognising dissonance between cultural norms, values and expectations with Western concepts of mental health and therapy was deemed important. Western terminology for common mental health disorders was often unrecognised by family members or the wider community which prolonged access to care (e.g. Aggarwal *et al.*, 2016; Mohamed and Lowenthal, 2009; Prajapati and Liebling, 2021). Once services were accessed, service users were apprehensive about what to expect from therapy. The innate desire to put others first was synonymous to that observed in collectivist societies (Hofstede, 1980; Hofstede, 2011; Triandis, 1995) which led to feelings of guilt for seeking and engaging in therapy (Miller *et al.*, 2021). It was clear that psychoeducation was imperative, not only at an individual level, but for the wider community. Psychoeducation can help improve mental health outcomes for BAME communities (Jacob *et al.*, 2002; Horrell

et al., 2014), and thus a progressive model, which incorporates psychoeducation as *a priori* to therapy could enhance therapeutic engagement and outcomes (Boyd *et al.*, 2019). Moreover, to normalise mental health care, more community outreach is needed to make services more accessible and equitable for ethnic minority communities (Beck *et al.*, 2019; Jacobs and Pentaris, 2021; Lawton *et al.*, 2021; Memon *et al.*, 2016).

Given the interdependent nature of the self (Markus and Kityama, 1991), Western therapeutic notions of independence and self-sufficiency conflicted with cultural and familial norms and expectations (Jacobs and Pentaris, 2021; Loewenthal *et al.*, 2012; Mantovani *et al.*, 2017). Most service users were British born and tended to hold bi-cultural identities that enabled them to interchange between individualistic-collectivist patterns for living (e.g. Allen and Bagozzi, 2001; Gushue and Constantine, 2003). This was termed as wearing ‘masks’ or having different ‘personalities’. However, some service users felt that White therapists in particular did not understand the cultural clash and cultural boundaries during therapy which led to them dropping out (Bhullar *et al.*, 2012; Hong and Woody, 2007; Mofrad and Webster, 2012). Given the evolving nature of cultures and increasing globalisation, theoretical models and concepts should not be seen as gospel, but rather as guiding frameworks to help understand cultural differences (Cohen *et al.*, 2016; Triandis, 1995). Practitioners should tailor therapy to the individual needs of service users by considering their cultural identities, experiences, requirements, and expectations from therapy.

Developing cultural competency

Developing cultural competency is important for therapeutic success (e.g. Castillo and Guo, 2011; Fernando, 2010; Miller *et al.*, 2021; Sue, 1991; Sue, 2001). However, service users felt that it was first important to build trust within the therapeutic relationship. The inherent stigma attached to mental health disorders was apparent which led to service users worrying about confidentiality and their personal issues being let out into the community (e.g. Bristow *et al.*, 2011; Clement *et al.*, 2015; Jacobs and Pentaris, 2021). As a result, group therapy was the least preferred option. Service users valued therapists who asked them about their culture, beliefs and background, as this helped them to understand their circumstances better. Whilst therapists from similar cultural backgrounds were favoured, this was not deemed important for recovery (Naz *et al.*, 2019; Sue, 1991). Some service users preferred the option for a therapist from a different cultural and religious background for fear of being judged (Prajapati and Liebling, 2021). Therefore, IAPT services should consider patient choice when allocating therapists.

Given the inherent individualistic values systems of the West, service users felt that cultural competency training was particularly important for White therapists as they were the least likely to understand patient socio-cultural needs and requirements (Al-Krenawi and Graham, 2000; Fernando, 2012; Loewenthal, 2018). Service users talked about White therapists misjudging their tone of voice, religious garments and cultural norms which built up barriers within therapy. Research shows that cultural misinterpretations can have detrimental consequences for the individual and heighten the ‘circle of fear’ in mental health services (Prajapati and Liebling, 2021; Sainsbury Centre for Mental Health, 2007). Therefore, IAPT services should regularly evaluate and enhance cultural competency training needs for its workforce so that they can better serve BAME communities (Bassey and Melliush, 2012; Beck *et al.*, 2019).

The road to recovery

Service users discussed the challenges with therapeutic engagement and evaluated therapeutic effectiveness. Service users worried that therapy sessions were too short, not personalised, and

therapists were more concerned about meeting targets at the expense of their needs. Given increased service demands, the ‘McDonaldization’ of IAPT services has been under scrutiny with concerns over the quality of care for patients (Bassey and Melluish, 2012; Binnie, 2015). Service users recognised that therapy was not a short-term fix and would have valued longer sessions to feel the full benefit of therapy (Christodoulou *et al.*, 2018). Most service users reported that they did not recover following a course of treatment, but found therapy helpful and would recommend it to others. Given the high attrition rates in BAME communities (Baker, 2018; Harwood *et al.*, 2021), IAPT services should consider culturally sensitive and culturally responsive services to meet the needs of service users (Beck *et al.*, 2019; Beck and Naz, 2019).

CBT was the most common therapy offered, but service users questioned its authenticity. In line with previous research, patients found CBT prescriptive, rigid, and not tailored to their specific needs (Omylinska-Thurston *et al.*, 2019). Some service users found CBT situational and too focused on the present without consideration of past traumas. The need for therapists to consider the patient as a whole, which includes their cultural, religious, spiritual and social needs is imperative to boost the recovery process (Fenn and Byrne, 2013; Prajapati and Liebling, 2021). Similarly, service users felt that therapists did not consider their cultural boundaries and implications when setting homework tasks (Miller *et al.*, 2021; Prajapati and Liebling, 2021). Often, it was not easy for service users to disclose personal problems to their families or carry out tasks rooted in Western rhetoric (e.g. being independent and self-sufficient). Despite reservations, some service users understood the benefits of homework should they want to take control of their situation and improve their mental wellbeing. Those who received counselling valued being able to talk to someone about their concerns as this was uncommon within their communities (Cardemil and Battle, 2003). However, some service users felt that more practical advice was needed to help improve their lives. To minimise disengagement from therapy, IAPT services should consider patient choice of treatment options through informed and collaborative discussions (Marshall *et al.*, 2016).

Limitations

Despite data saturation being achieved after seven interviews (Braun and Clarke, 2021b), the sample size ($n=9$) was small and does not offer a comprehensive account of service users from different ethnic minority backgrounds, genders and age groups. This was due to the study taking place during the global pandemic which minimised recruitment options and availability (e.g. via IAPT services). Future research should consider such variations in order to capture the experiences of broader clinical populations (Jacobs and Pentaris, 2021; Mohamed and Lowenthal, 2009). Moreover, given that this study was a reflective account of service users’ past experiences, there is possibility of recall bias due to the length of time between receiving therapy and the interview (Althubaiti, 2016). To minimise this, future research should consider exploring service user experiences during a course of therapy to understand what works well and how services can be improved.

Conclusion

Exploring the recovery narrative of service users from BAME communities is imperative. The cultural clash between Western notions of therapy and service user cultural and familial expectations was evident. To better understand and serve the needs of ethnic minority populations, IAPT services need to increase cultural competency training for its workforce. Whilst most service users did not fully recover, they found therapy useful and would recommend it to others. It appears that there is a long way to go, yet not unachievable. Future research should consider inclusion of more diverse individuals to capture a broader

narrative of service user experiences and needs. Moreover, research should seek to explore whether IAPT practitioners are culturally competent to deal with the needs of BAME communities and identify training needs. Given the limited knowledge about mental healthcare, IAPT services should consider more community engagement by increasing psychoeducation as *a priori* to therapy.

Key practice points

- (1) To provide mental health professionals with theoretical models and concepts that may assist with understanding therapeutic differences across cultures.
- (2) To assist mental health professionals to reflect on their own cultural competency training needs and consider how to better serve BAME communities.
- (3) To encourage IAPT services and commissioning bodies to promote psychoeducation as *a priori* to therapy for both service users and the wider ethnic minority communities.

Further reading

Bassey, S., & Melliush, S. (2012). Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: a template analysis focus study. *Counselling Psychology Quarterly*, 25, 223–238.

Christodoulou, V., Fortune, L., Arslan, G., & Canan, K. (2018). Turkish-speaking service-user experience of guided self-help in an improving access to psychological therapies service: using discovery interviews to improve services. *Qualitative Report*, 23, 2205–2221.

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Supplementary material. To view supplementary material for this article, please visit <https://doi.org/10.1017/S1754470X22000599>

Data availability statement. The data that support the findings of this study are available from the corresponding author upon reasonable request.

Acknowledgements. This study was conducted as part of a fully funded doctoral research programme at Birmingham City University. The author would like to acknowledge and thank the supervisory team for their guidance during the course of studies and Dr Kate Cooper (University of Bath) for her expertise during the review of the study themes.

Author contributions. **Afsana Faheem:** Conceptualization (lead), Data curation (lead), Formal analysis (lead), Investigation (lead), Methodology (lead), Project administration (lead), Resources (lead), Validation (lead), Writing – original draft (lead), Writing – review & editing (lead).

Financial support. This study was part of the author's fully funded PhD at Birmingham City University. No other grant from any funding agency, commercial or not-for-profit sectors was received.

Conflicts of interest. The author declares none.

Ethical standards. Ethical considerations were reviewed in line with the British Psychological Society (BPS) code of conduct and those drawn from the British Association for Counselling and Psychotherapy (BABCP) Ethical Framework to inform best research practice. This study received approval from Birmingham City University Research Ethic Committee by an independent panel consisting of a team of academics in April 2017 (Ethics Code: 060/17 Cat A). The study was a service evaluation and did not require approval from the Health Research Authority (HRA). All participants provided signed informed consent and agreed for the results to be published.

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Cite this article: Faheem A. 'Not a cure, but helpful' – exploring the suitability of evidence-based psychological interventions to the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist*. <https://doi.org/10.1017/S1754470X22000599>