South Asian Indian patients' perspective of the Improving Access to Psychological Therapies (IAPT) cognitive behavioural therapy (CBT) interventions for depression in Primary Care: A Qualitative & Grounded Theory Analysis Study

Grace Johnson

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Grace Johnson

School of Health and Society

University of Salford, Salford, UK.

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A very short story;

A few years ago, at work, I was asked to see and give psychological therapy sessions to an elderly 68 year old woman from BAME community, whom at the time was experiencing depression and anxiety as a result of a relationship problem with her newly retired husband and was contemplating divorce; yes; divorce at 68. However, our journey lasted as short as this story in that a week later my Manager called me into her office and reported that, Mrs. Earle (anonymised) had asked that her referral be given to someone else; she had reported I was such a lovely young lady but that she had asked to be seen by "someone not so youthful", to put it in her own words. At this time, I was well into my 30's. Mrs Earle's case made me reflect on therapy processes and hence I engaged in self-dialogue to consider the factors that may have influenced her thoughts and actions in order to reach such decisions.

(G.Johnson, 2019)

CONTENTS

Part 1

Part 2

Part 1

Part 2

Part 1

Part 2

APPENDICES

LIST OF DIAGRAMS

LIST OF TABLES

LIST OF FIGURES

Acknowledgments

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Dedications

This thesis is dedicated to my mother Angeline Zihumo-Bungu; a selfless being and my daughter, Hannah who keeps my reality in check. It is also dedicated to all those who believe in equality and have pride in whom they are.

Thesis Abstract

Background

Mental Health is paramount to personal wellbeing, building relationships and making contributions to society, (Thornicroft, Rugerri & Goldberg, 2013). With the population of the United Kingdom constantly changing over the past decades, primary care services within the National Health Service (NHS) have experienced significant challenges in adapting and modifying services to meet a wide range of needs (Serrant-Green, 2014). Poorly targeted, inappropriate interventions and ineffective organisation and delivery of services impact negatively on those at the receiving end such as the BAME group of South Asian Indians (SAIs).

Study Aim

The focus of this study was to explore South Asian Indians' experiences of psychological therapies received in primary care when presenting with depression.

Methods

A Qualitative and Grounded theory analysis study was used, and a total of 7 South Asian Indian people participated in the study. Qualitative semi-structured interviews were conducted with the participants in the West Midlands who had experienced depression and had received CBT. Data was gathered and analysed using a Grounded theory (GT) approach (Charmaz, 2014; Corbin and Strauss, 2014; Glaser & Strauss, 1967).

Findings

Four unique findings emerged from the study. The critical findings in this Thesis indicate that first encounters are crucial as they determine service uptake and successful completion of treatment and dropout rates. For SAI's, dropping out of services was a result of patients feeling considerable progression in their condition that they no longer required services. Another significant finding demonstrates that for SAI's, accessing services can be a personal choice based on individual evaluations and perception whether the service would be beneficial. This means that SAI's would engage in psychological therapy presuming they were *"listened"* to and *"understood"* from their individual contexts.

The findings also evidence a new pedigree of patients experiencing depression who wish to be viewed as major stakeholders within IAPT decision making policies and suggested that co-production frameworks and approaches to healthcare be implemented so they may be actively involved in developing mental health policies, administration and delivering of care.

Conclusion

Research on the study topic of SAI and experiences of CBT psychological therapies when suffering from depression in UK Primary Care is limited. Therefore, having presented the unique findings, neither replicated from existing research, this study is original as no relevant studies which have assessed or explored SAI patients’ experiences of IAPT CBT psychological therapies for people with depression in UK Primary Care were identified in the literature to date. Key aspects from this thesis may also contribute to ongoing and necessary debates about healthcare inequities and inequalities, thereby informing policy changes and development.

CHAPTER 1: Background to Study

i. A Prologue to the Importance Mental Health Wellbeing

The World Health Organisation reported that emotional wellness is pivotal to the general prosperity of people, social orders, and nations, and that “mental health conditions contribute to poor health outcomes, premature death, human rights violations, and global and national economic loss” (WHO, 2018, p. 1). Mental health is a human right and according to Serrant-Green (2014), equity, health and care have always been embedded within a human rights framework in some way for generations, with The Equality Act 2010 making it illegal to discriminate directly or indirectly against people with mental health problems in public services such as the National Health Service (NHS). Around the contemporary world, health systems are also trying to improve access to evidence based psychological therapies for common mental health disorders such as depression and anxiety. Arguably, people of all ages experiencing mental health problems have been stigmatised and marginalised for decades. Generally, while the numbers of BAME communities in the United Kingdom (UK) has increased significantly in various urban areas, it is argued that there has not been any notable change within mental health services in a bid to adapt to any cultural needs of these groups, (CoDE, 2012). NHS England (2016) highlights that for decades in the UK, mental health services have been extremely underfunded with majority of people not receiving adequate or no input at all. Consequently, hundreds of thousands of lives have been put on hold or ruined, some resulting in tragic and avoidable fatalities.

Additionally, the last three and a half decades witnessed large numbers of people who have migrated across continents due to conflict, persecution, war or simply others looking for a better life. Therefore, Europe continues to be a continent of immigration and it is argued that the current meaning of mental health be explored. In the UK, migrants such as asylum seekers and refugees come with histories of pre-migration personal trauma which may require a psychological input. Serrant-Green (2014), reported that this change in population has brought significant challenges to individual healthcare professionals when determining, diagnosing, and managing healthcare needs around conditions and practices that may be typified in certain ethnic groups, but which they were not initially trained to deal with.

Moreover, as seen in the media and shared stories within clinical practice, many migrants experience and endure hardships during their passage to UK which causes significant emotional and physical distress. Examples in recent News are of refugees and migrants drowning in the Mediterranean Sea on-board overloaded illegal small boats bound for Europe (The Independent, 2019). Other migrants especially those from South Asian India who arrive as a result of marriage suffer other distresses related to loss as they have to leave their own home land to come to a foreign country (Charsley, Van Hear, Benson & Storer-Church, 2012). However, these distresses associated with loss, belonging and identity and many others do not end there as they may well continue to encounter and face many stressors in their newly found home of UK. Therefore, its argued that migration always requires psychological and social adjustments, and this can be done through giving psychological help (Gopalkrishnan, 2018; Bhui et al., 2015; Fernando 2010). The West Midlands region of the UK has a huge population of BAME of black afro-Caribbean and African origin as well as south Asian Bangladeshi, Indian and Pakistan all of whom may have migrated to UK for different reasons. Over the years the numbers of people in this region experiencing mental health difficulties has risen and according to NHS England (2016), one in four adults experiences at least one diagnosable mental health problem in any given year. Mental health problems are also believed to represent the largest single cause of disability in the UK with the cost to the economy estimated at £105 billion a year. However, there is no concrete statistical data regarding the numbers of SAI with common mental health problems such as depression in UK, with the Mental Health Foundation reporting that the statistics are inconsistent (Mental Health Foundation, 2019).

Arguably, Fernando (2010) points out how Western countries pride themselves on scientific sophistication and an advanced system of medical treatment in combating ill health although conversely, when looking at mental health the picture is significantly different. Fernando (2010) goes on to argue that western psychology is rooted in worldviews, attitudes and beliefs denoting western culture; to a very minimal extent if any, have they been influenced by non-European cultural traditions hence retaining the Eurocentric nature with a narrow and restrictive perspective. In agreement, Sloan (2000) states how the concept of psychology far from being neutral appears to serve a social, ideological and political interest which is of significance when we explore how the Improving Access to Psychological therapies Programme (IAPT UK) was commissioned in the United Kingdom in 2008 by Lord Layard, (Department of Health [DH], 2008). Layard argued that bad mental health costs the economy at least £70 billion in lost output and costing the economy £10 billion in extra physical healthcare due to mental illness, reporting that the key determinant factor of life satisfaction and of economic performance is mental health (Layard, 2015).

According to Layard, offering psychological therapies to people would enable them to have better mental health thus enabling them to get into employment, take less time off work, and return to employment after experiencing common mental health problems such as depression and anxiety. Being an economist with special interest in depression, Layard reported that by offering psychological therapies the net cost of providing these treatments would be zero due to the huge savings on disability benefits, crime, social services, and additional physical healthcare following receipt of therapy and treatment. However, what Layard (2015)'s postulation negated was the biopsychosocial factors that impact on one's mental health other than just economic factors whereby an individual patient may have social factors present that are associated with the depression and or anxiety. Psychological disorders have aetiologies that are largely multi-factorial, involving complex interactions between genetic and environmental factors.

Sloan (2000) argues that psychology privileges concepts and practices which appears to benefit dominant groupings in society at the expense of those who are marginalised as well as less powerful. Agreeably, Henman (2007) claims that significant factors that are detrimental to the health of minority groups may also be such things as discrimination, racism, or persecution by host population (in migration), as well as widespread unwillingness to recognise their health beliefs, practices, and expectations. The crucial question paused here is, how can an intervention be deemed effective among so many diverse cultures and belief systems? Evaluating western psychotherapy especially in relation to IAPT cognitive behavioural therapies illustrates that the aim of therapy is usually perceived in individualistic terms, that of one becoming self-reliant and independent through restructuring thoughts and behaviour. Contrary to this however, is the understanding that in some collective community cultures mainly those minority ones present in UK such as Black African and South Asian, becoming self-reliant and independent may be perceived as a sign of deviance or even illness (be-witched), (Chadda and Sinha Deb, 2013).

South Asian Indian society is collectivistic, with its community viewing social cohesion and interdependence as the norm. Unlike western societies where individualism is emphasised, the Indian society tends to be collectivistic where the family forms the focal point of its social structure. This means that unlike their western counterparts they are very much ingrained in caring for the collective members and suffer significant illness burden. Fernando (2010) discusses how the western cultures or westernised person may perceive a process of exorcism that is concerned with elimination of evil as sign of malevolence or some form of illness in the exorcist. This means the prevalent use of psychotropic drugs and electro-convulsive therapy may be viewed in the minority traditions as unethical or malevolent interference with spiritual experiences or beliefs. This is especially true of quite several African traditions whose lives and everyday rituals are associated with interceding with spiritual mediums through a person who is ‘possessed’. Hence this suggests that each intervention given to an individual must be based on their perception of illness rather than in terms of ethnocentric illness models.

In view of this, such cultural differences indicate how people in different cultures possess a range of integral constructs of self and others consequently impacting on their views and opinions on health and illness (Gopalkrishnan, 2018; Bhui et al., 2015; Fernando, 2010; Henman, 2007). Therefore, within South Asian cultures, the concept of self is defined relative to others, regarding fundamental concepts of belonginess, dependency, empathy, and reciprocity, (Memon et al., 2016; Rastogi et al., 2014; Chadda & Sinha Deb, 2013). Since South Asians consider personal space, autonomy, and privacy as secondary, applying Eurocentric psychotherapy models which predominantly focus on dynamic models, ego structure and individualism becomes challenging in the south Asian collectivistic context (Knaak et al., 2017; Roberts et al., 2016; Chaudhry et al., 2013; Fernando, 2010). However, a crucial point to make is that although a significant number of studies have shown the traditional Indian family as a better source for psychological support and more resilient to stress, caution needs to be exercised not to generalise.

Current healthcare provisions such as IAPT UK cognitive behavioural therapy is widely delivered as an intervention to all patients in Primary Care regardless of their belief system, race, culture neither ethnicity nor context. Therefore, this carries significant impact and results in negative and unhelpful outcomes concerning BAME's access to psychological services. These concerns will be discussed elsewhere in forthcoming chapters.

ii. "Black and Asian minority ethnics" (BAME/BME) explained

The terms BAME and BME are terms which are generally used interchangeably. BAME is a term long used in the UK to refer to black, Asian and minority ethnic people and according to Barrett (2018), the term evolved from *"political blackness",* a concept suggesting battles against discrimination in the 1970s by distinctive ethnic groups . However, the use of the term BAME is criticised due to its homogenisation of people from a variety of different ethnic and cultural backgrounds consequently recreating unequal power dynamics where White does not denote a visible marker of identity subsequently perceived a privileged identity. Subsequently, classificatory systems that employ broad categories, whether ethnic or racial, are subject to the criticisms based on their assumptions of and exaggerating homogeneity within each group based on pre-designated taxonomies (Bradby, 2003). Contrarily, ethnicity can be described as *'a dynamic and subjective definition of one's self in relation to a range of factors including language, geographical origin, skin colour, political preferences, and religious and cultural practices'* (Loue, 2006; cited in Beck, 2016, p.8). Ahmad and Brady (2007) argue that contemporary perceptions of ethnicity reveals it as a marker of identity, a tool for organising communities as well as a possible marker of disadvantage, discrimination, or privilege.

Historically, ethnic groups have often been defined based on skin colour, self-identity, country of birth and ancestral origin. Arguably, everyone belongs to an ethnic group hence for the purposes of this thesis the term ethnic minority will be defined to enable clarity and justification for using South Asian Indian as participants in this thesis.

In this thesis the working definition of Black and Asian ethnic minority has been influenced by the one in use within the Royal College of Psychiatrists [RCPsych] (2013) meaning, *'those with a cultural heritage distinct from the majority population'*.

The Royal College of Psychiatrists have also suggested that the terms *'race', 'ethnicity' and 'culture'* are often wrongly used interchangeably. For example, as a term, 'race' is understood and often used when describing a person's physical appearance; culture referring to shared features that bind individuals together into a community. However, the definition of ethnicity includes aspects of both race and culture and other characteristics such as traditions, language, religion, spirituality, upbringing, nationality, and ancestral place of origin. RCPsych (2013) also suggest that ethnicity should be understood in terms of personal expression of identity influenced by life experiences and place of habitation and ethnicity being a dynamic that changes over time. The Office for National Statistics [ONS] (2011) classifies BAME into the following 4 categories: Asian and South Asian (Indian, Pakistani, Bangladeshi) and Chinese and the Black and Black British (African, Caribbean).

Therefore, BAME groups in this instance are viewed as the following:

- Those people living in the United Kingdom who are designated as belonging to a non-white ethnic group ONS (2011).
- Those which represent distinct groups such as, Black African, and Afro Caribbean people and Asian people from India, Pakistan, Bangladesh, and Chinese
- And with their own identity recognised by themselves and by others.

Hence, it is important to note that the term *'ethnic minority'* is often used in the thesis to represent all racial and cultural minorities in order to clarify those service provision issues common to groups as diverse as the Chinese, Asian or Afro-Caribbean communities. However, common inferences such as that BAME have less healthy behaviors than white populations should be avoided because using the term does not mean that all ethnic minorities are homogenous and that solution to problems of accessibility and appropriateness of health services are singular for all groups as discussed earlier. Other factors such as histories, experiences of adversity, needs and perceptions may not be homogenous (Fernando, 2010; Sewell 2009; Bughra & Bahl, 1999).

iii. Intersectionality

Health disparities such as racism and sexism could be understood beyond independent systems of privilege and oppression. Instances where inequalities are placed across socio-demographic factors, are usually steered by social inequity, or social policies and practices consequently resulting in higher rates of disease in specific groups while shielding and privileging others (Bauer, 2014). The intention of applying an intersectional lens enables the examination of multilevel interactions, forces, factors, and power structures that influence individuals' lives and health (Hankivsky et al., 2017). According to Carstensen-Egwuom (2014), the notion of intersectionality has become a significant heuristic idea utilised by researchers when investigating human encounters based on various intersecting power relations. Intersectionality was first coined by black feminist scholar Kimberlé Williams Crenshaw in 1989 with the formulation of a theory which aimed to explore the oppression of women of "colour" within society; although the concept has broadened to encompass more aspects of social identity such as race, gender, sex, sexuality, class, ability, nationality, citizenship, religion and body type. Harvinsky (2017), argues that peoples' health and experiences of depression are shaped by various intersecting factors such as age, gender, social class, social environment, geography, life experiences, and other social determinants of health.

Based on the epistemological foundations of intersectionality, personal experiences may be used to challenge and extend pre-determined understandings of power, inequality, and difference as well as highlighting social relations of dominance that are underexplored in the everyday experience (Carstensen-Egwuom, 2014). Hence, social theories can be developed from empirically grounded concepts which may be based on a researcher's own subjectivity, their bodies, their tacit and implicit knowledge, and their positioning (ibid).Moreover, considering all intersectional positions within the research topic may give capacity to and yield new and interesting observations on the distribution of the burden of disease across social locations, (Harvinsky, 2017; Bauer, 2014). you need to expand here and discuss what this means for you and your study The substantial discernments that the idea of intersectionality postulates is the complexity of multiple axes of differentiation; economic, cultural, political, instituted by and productive of specific social and historical contexts (Carstensen-Egwuom, 2014). IAPT's CBT therapies evidence base negates and neglects ethnic and cultural differences which might serve to support archetypal, hegemonic power and systems of dominance that are still in play in today's modern societies and health systems (Cooper et al., 2012; Loewenthal et al.,2012). Cognitive Behavioural Therapy, as will be discussed in greater detail in Chapter 2 is founded in Eurocentric theoretical frameworks in the West, and I argue that its provision within NHS IAPT serves the interests of the hegemony, the dominant class. Consequently, this may create potential incongruence between the views of BAME and in this instance SAIs, and those of the professionals delivering the intervention. There is contention in providing dominant psychological treatments and interventions which may be inappropriate due to how these interventions seek to treat symptoms instead of considering individual contexts pertaining to their, culture, values, and beliefs. This may also include issues of social status, gender issues, perceived racism and prejudice experienced when seeking help within the healthcare sector. Thus, the continued provision on CBT therapies as the evidence base therapy to befit all ethnicities within NHS Primary Care can be perceived as hegemonic power that allows dominant structures to flourish and serving continued oppression and reinforcing dominant ideologies.

Arguably, intersectionality as a framework significantly delivers substantial and specific identification of inequalities especially when attempting to develop treatment strategies, guaranteeing that the results are relevant within specific communities to population health (Bauer, 2014). Consequently, I acknowledge intersecting social locations and structural power dynamics and refer to how social position and power may shape identities within society in the following section exploring my positionality.

iv. Positionality

According to Jacobson and Mustafa (2019), an individual's perspective and interpretation of their social world is impacted by where, when, and how they are socially located and in what society. Qualitative health research such as grounded theory aims to understand how people interpret and find meaning in their everyday lives, exploring social and political forces which shape everyday lived experiences as well as examining the role of power and social position in health-related phenomena (Centre for Critical Qualitative Research, 2018; Charmaz 2014; Aldiabat & Le Navenec, 2011).

Positionality is the idea that individual qualities, perspectives, and personal experiences impact how one comprehends the world; in this specific circumstance, sex, race, class, and different parts of personalities are markers of social and spatial positions and are not fixed, given characteristics (Garcia, 2014). Positionality challenges the concepts of value-free research maintaining that qualitative research cannot be divorced from being subjective; thus, it is fundamental to consider individual situations before taking part in research, particularly subjective exploration (Manohar, Liamputtong, Bhole & Arora, 2017; Garcia, 2014). Many factors influenced this research study such as personal events and experiences, professional experiences ,and my own values and beliefs for carrying out this specific research. Another factor was the awareness of post-positivism recognition that human values are an integral part of scientific enquiry. Postpositivist paradigms recognise the importance of human influence on knowledge development thus empowering researchers to use various approaches when exploring complex human phenomena (Tanlaka, Ewashen and King-Shier, 2019). This exploration is achieved by actively involving and capturing the unique viewpoints of stakeholder groups especially those of patients and their carers with respect in their capacity as experts by experience. Accordingly, post positivism positions truth as being necessitated by context, human action, and interaction in contrast to positivism, which situates truth as being rooted in an objective reality (Birks and Mills, 2015; Ritchie, Lewis, MacNaughton, Nicholls, & Ormston, 2013).

It was the breakdown of a relationship when I was studying for an undergraduate BSc. Honours degree in Sociology, back in the 90's that influenced this study. As I struggled with severe depression and very dark thoughts to the point of experiencing a near death experience, it was to a significant extent the help of my religion and support of my friends and family that I overcame my severe emotional distress. Within the societal construct and context in which I grew up, depression and psychology was something you heard only in books or social and mass media. Help was sought from “within” in that I looked support from within my immediate social network, a network made up of family, relatives, and close friends. Values and beliefs, I held then and some which I have proudly retained took precedence in trying to manage my difficulties even at so young and crucial an age of early adulthood. To come out and publicly accept, speak of, and seek help for depression would have been a shame on my family and I; the ridicule and stigma associated and attached with my difficulties then would perhaps have been the death of me. My religion and the non-judgemental listening, validation and acceptance, my position in suffering from depression and my experiences of the support from family and friends paved a way for my vocation. Thus today, I remain that very living example of someone who overcame depression neither by bio-medical, psychological nor pharmacological help but by the collective community with whom I lived.

Correspondingly, Carl Rogers’ (1951) early life experiences on his parents’ farm permeated his philosophy that personal growth is attainable even after the worst of experiences which came about after observing a potato seed grow in a very harsh farming environment. A crucial question remains though; what part did the health services play in my journey to recovery? Of course, I had attended counselling services offered at that time; all I can remember is that it did not resonate with me given that within the traditional African upbringing I had, depression, counselling or therapy was non-existent. Any personal difficulty encountered by an individual was expected to be managed within and by the family at large. I had also been previously prescribed medications that debilitated me instead of improving my symptoms. Could there have been some like me who had not benefitted from the very health system that was meant to help them, but unlike me had also been unfortunate not to have other forms of support to help them in their recovery journeys. Talking to another individual, a health worker, who was not part of my extended family about my personal problems was “foreign” to me and the process was neither appropriate nor befitted my needs based on my traditional cultural values and beliefs. Consequently, these experiences influenced my perceptions of why patients from BAME backgrounds especially in West Midlands did not fully access services. Reflections on my own experiences and professional practice led me to question whether their cultural backgrounds; values, beliefs, social constructs and political or economic constraints may not have been compatible with treatments and interventions being provided in Primary Care, constraints which are discussed in detail in later Chapters. Indeed, this ‘insider’ position was also noted by Hamby (2018), who argues that social scientists cannot exist outside of culture, nor their place in history since awareness of one’s place in the social-cultural context can constrain one from unintentionally reinforcing harmful hierarchies or social dynamics.

Positionality necessitates the acceptance or an appreciation of the influence of the individual. For example, I am a Black African British citizen, middle-class female, and a mother. As a Black British African Psychological professional working in a West Midlands City which is largely diverse and delivering treatment interventions predominantly BAME localities, matters regarding BAME mental health have always been part of my vocational life, thus of considerable interest to me. Due to my position as someone who has studied sociology and psychology all my life as well as being a Psychological professional of Black African heritage, my ethnic, academic, and professional positionality has ultimately influenced my research. Moreover, I grew up in a Southern African country that had been colonised by the British for nearly a century before fighting a liberation war and gaining independence in 1980. Although my formative years where in Southern Africa, as newly independent country, as native people, my family still faced racial oppression, segregation, discrimination, and endured prejudices in their own Motherland. Thus, as a BAME person I identify with all BAME and in this instance with South Asian Indian people from different communities and backgrounds based on their histories of oppression, racism, and discrimination. However, from an intersectionality perspective, my personal experiences of the world may differ from other people whom I may share identities with, as I may have a social advantage in one of them, and in this study as a professional in a position of “authority” and as researcher, researching “the other.” Contrarily, this does not mean I am not susceptible to or do not experience racial oppression by virtue of having academic and professional privilege, although that privilege may have been enabling and bear positive social impacts through implementing change or reshaping policies based on my research findings. Bauer (2014) argues that, most individuals occupy social positions that include both privileged and marginalised domains within health research processes and that, intersectionality serves a purpose in equipping and enabling researchers to understand these experiences and processes of privilege and marginalisation alongside their composite integrated occurrences. According to Carstensen-Egwuom, (2014), the conceivable recognition of a possibly privileged position, such as my own as a counsellor prior to gaining entrée in the research field could result in invaluable gains, which could be achieved through constant reflection on research processes and experiences and demonstrating how such a position is negotiated, questioned, or challenged.

Notably, positionality is significant in the context of my research because understanding our position in relation to the social position of our participants, enhances our understanding of the power relations within our research and gives opportunity to be reflexive about how to address this (Day, 2012). Drawing from the Greek myth of Chiron, Jung (1951) articulated that a disease of the soul was the best form of training for a healer, hence the phrase “the wounded healer”. This phrase signifies how I have also pursued this research with a vast knowledge of what it is to experience psychological distress, and acknowledge my own vulnerabilities because I had previously had an emotional validation of my feelings which helped develop my self-awareness and a deep sense of empathy, patience and compassion for myself and others.

Being of BAME heritage and working with predominantly BAME patients as well as my experiences of depression, I perceive myself a partial insider within this research since part of my identity is as a member of the BAME group with lived experience of depression, but I am not South Asian Indian. According to Greene (2014), an insider researcher is someone who shares common languages, themes, and experiences with their participants; hence, researching in a field in which one is a member is perceived to enhance complete acceptance from the participants resulting in increased trust and openness. Insider positionality is suggested to encompass the aspects of an insider researcher’s self or identity which is parallel to or intermutually similar with that of the participants (Taylor, 2011).Through the use reflective diaries (see Chapter 3), I managed to maintain constant analytic reflection upon the importance of academic knowledge and processes for social and political struggle and awareness of power dynamics on my privilege as the researcher. The use of reflective diaries also helped in maintaining objectivity, reflexivity, and authenticity since being an insider can present issues of bias and subjectivity based on the premise that insider researchers can struggle to distance themselves from the study topic (Greene, 2014; Taylor, 2011). Hence, positionality is important to recognise in the context of research design which will be discussed in greater detail in Chapter 3; Research Design.

However, due to the heterogeneity, variability, uniqueness of ethnicities as well as depressive illnesses, I considered myself to be an outsider to the research participants' stories because of my status as an academic and psychological practising professional. Moreover, that the way in which communication shapes interaction is significant and I do not speak any of the South Asian languages, my religious beliefs may differ along with cultural traditions and values which have influenced my position as an outsider in this research. Therefore, I have tried to engage with my position in a reflexive way which is highlighted throughout the thesis and especially consigned with reference to my methodological and analytical perspectives. In doing so, I include aspects of my positionality that reveal how I have influenced the analysis and highlight how this has enabled a deeper understanding of the phenomena. This view is reflected in Carstensen-Egwuom (2014) who reported that,

> *" if more of such "confessional" data is published, it can have a revealing effect. It can help to bring about a new recognition to the value and resourcefulness of subjective, personal thoughts and emotions in research." (Carstensen-Egwuom ,2014,p.270)*

Furthermore, through attending workshops, conferences, and becoming familiar with psychology and mental health literature, I have experienced many claims about the existence of a large body of evidence demonstrating the effectiveness of psychological therapies for a range of mental health problems. However, contrary to these claims there remains significant disparities regarding access to such treatments with inequality significantly demonstrated across several domains such which include ethnicity as well as language, (Kim & Mattila, 2011; DH, 2009). Findings from Kim and Mattila (2011) showed that language barriers can often lead to miscommunication with health care providers as well having a detrimental impact on understanding health care processes as well as understanding health information and treatment. Language was found to be imperative based on the fact that verbal communication is the basis of psychological interventions such as psychotherapy and the inability to communicate causes such barriers which may be significantly detrimental to mental health, (Fernando, 2010; DuBard & Gizice, 2008; Helman, 2007; Sentell, Shumway & Snowden, 2007.)

Furthermore, based on my experience as a Psychological Therapist whose practice is based in Primary care in West Midlands, I encounter people with common mental health disorders mainly depression daily and yet depression often sub optimally managed. This is evidenced in by minimum numbers reaching IAPT prescribed recovery thresholds, drop outs, with others experiencing numerous episodes and accessing services repeatedly although IAPT has reported positive results across the country (UK Government [GOV.UK], 2019; NHS Digital 2018; therapymeetsnumbers.com, 2018). According to official statistics published by NHS Digital in 2018, just under half (49.3 per cent) of those referrals finishing treatment for anxiety and depression in 2016-17 recovered, making it the highest rate of recovery since 2012-13 when figures were first recorded. Of the 525,000 referrals that finished treatment in the year having started as clinical cases of anxiety or depression, 259,000 (49.3 per cent) recovered. Recovery rates for patients from the white ethnic group were 50.2 per cent, 44.9 per cent for black or black British, and 44.2 per cent for Asian or Asian British.

Within current IAPT Services in primary care, services are under used, not accessed, and when accessed there are significant high dropout rates from ethnic minority groups such as Black African/Caribbean and South Asian people (used for the purposes of this study) compared to their white counterparts. This is despite there being an estimated 8 million BAMEs people, (ONS UK, 2011) and the West Midlands being one of the biggest multicultural cities in the UK. The reason for this may and has been suggested to be that; BAME patients do not always envisage primary-care interventions as an appropriate, meaningful and relevant response to depression, (Commander, 2004; Lawrence et al., 2006; Ahmed & Bhugra, 2007; Gater et al., 2009; Hussain & Cochrane, 2003).

In the West Midlands, I observed GPs referring large amounts of BAME people for psychological therapies with only a few patients accessing services. Moreover, there was a high rate of dropouts. This whole experience led me to reflect and re-evaluate my own way of working and my academic goals and desire to broadcast the real issues of how people's histories, culture, ethnicity, values and beliefs and the impact this has on informing help seeking behaviours amongst people from BAME groups. Since observing the patterns in IAPT between 2008-9, and from a socio-cultural perspective based on my Southern African upbringing I continuously reflected and questioned whether factors such as culture, values, beliefs, or the way people perceived their world informed decisions about health and illness.

Thus, based on my personal and socio-psychological background I continued to focus and concentrate on psychological therapies with reference to BAMEs with the hope of developing and finding multicultural ways of helping these groups of patients. Consequently, I began engaging some very few BAME health professionals I worked with in conversations and debates about why there may have been very few BAMEs accessing our services and significant numbers in dropouts. These conversations were predominantly imbedded on the principle that there was a crucial need in mental health/psychology to enable practitioners as service providers to understand people from BAME groups' cultural embedding if we were to understand their behaviours and interactions. I immersed myself into co-creating and developing psychological materials and groups targeted at BAME's such as finding appropriate rooms in the appropriate locations, language materials for mainly south Asian patients as well as actively involved in the supervision processes of the practitioners involved in the development of adapting CBT group treatment for BAME groups such as South Asian women's groups. These adapted treatments have consequently been recommended in the NICE Guidelines for working with South Asian Women in IAPT (NICE, 2018). This was and continues as a bid to get more BAMEs to access services as well as offering them interventions and treatments that may be more suitable, appropriate, and meaningful to their needs.

As a healthcare professional, maintaining an inquisitive interest in my clinical practices is one of the reasons to question why things I observed occurred. I started to imagine whether if things were done differently, health care that is currently being delivered could improve significantly. Thus, the enthusiasm I held regarding my profession resulted in the generation of questions to which answers were sought and I ended up immersing myself in research.

Professionally, performing health research with specific patient groups is currently perceived to be crucial with many countries featuring service user or patient involvement on their political agendas. Moreover, in mental health, there has been an influx of patients aspiring to introduce their lived experience and service use into the research arena in trying to improve the relevance and utility of what is being researched. Contemporarily, as echoed by scholars (Wallcraft, Schrank, & Michaela, 2009; Bradley, Curry and Devers, 2007, Carter & Thomas, 2005) research is increasingly becoming common in health services and a number of qualitative studies have been used in healthcare to study certain issues like physician-patient relationships, diffusion of innovations, quality improvement strategies, and novel interventions to improve care and for many other several reasons. Additionally, the recent interest in evidence-based health care intervention and treatments facilitates and gives reason to conduct clinical research in order to fulfil clinical guidelines for improving health care provision.

According to Marx Weber (1946), all research is contaminated to some extent by the values of the researcher and that, it is through these values that specific problems get identified and studied in particular ways. It is argued that factors such as beliefs, morals, religious, political, and personal and professional experiences may be the very reason for one to immerse themselves into researching specific topics. According to Nilsson (2014), what makes up a larger part of our knowledge of the world are our beliefs about objects, culture, history and future and these beliefs are used to predict, to explain, to create, to console or to entertain, for which some end up being constructed and labelled as theories. However, whatever the theory/theories, they are products of fertile minds endeavouring to find explanations for lived and observed phenomena.

v. Psychological therapy: a treatment for depression

At this point it is important to note that the term psychotherapy in this study is a collective term covering all psychological therapies and counselling approaches that address psychological difficulty (Gabbard, Beck & Holmes, 2007). Psychotherapy includes psychoanalysis and family/systemic psychotherapy, humanistic, integrative therapy, existential, rational emotive therapy, cognitive analytic therapy, and many others, including cognitive behavioural therapy which will be the focus of this study. The use of psychological therapies to manage depression in BAME groups has been of interest because it is an area that has been neglected in wider policy. There are gaps in and around issues of appropriateness, relevance and effectiveness of psychological interventions provided for BAME populations in primary care in the UK (Khan et al., 2019; Naz, et al., 2019; Naeem et al., 2015; Rathod, Kingdon, Rathod and Phiri; 2010; Fernando, 2010, Sewell, 2009; Ahmed & Bughra, 2007; Lawrence et al., 2006; Hussain & Cochrane, 2003; O'Connor & Nazroo, 2002). However, although a significant number of population surveys have clearly indicated the prevalence of depression in black and Asian minority ethnic groups (Naz, et al., 2019; Roberts et al., 2016; Williams, 2015; Evans et al., 2014; Gater et al., 2010), mental health services have continually failed to respond to their needs. Additionally, research exploring which patient variables may influence decisions surrounding access and psychological treatments has almost exclusively focused on GPs. However, it is argued here that there needs to be strategies for changing attitudes and practices to generate universal understanding of mental health directed at national and international levels.

Hence, there is a crucial need to carry out further research into mental health since studies of effectiveness of psychotherapy in BAME patients are limited considering most Randomized Controlled Trials (RCTs) have focused on establishing efficacy in mainly white patients. According to Woodhall et al., (2010) evidence indicates that people from minority ethnic groups are underrepresented in psychological well-being research; whereby there is a lack in numbers of members that are selected to represent a specific group of patients. Compared to their white counterparts, minority ethnic patients may be excluded due the challenges of working with culturally and linguistically diverse groups as well BAME people's fears and suspicions regarding questions about possible immigration status (ibid). Additionally, unwillingness to participate in mental health studies maybe due to stigma associated with mental health illness within BAME communities and histories of oppression and power struggles, where BAME people may not feel entitled or privileged enough to participate (Clark, 2018; Indome, 2018). Indeed, Roth and Fonagy (2005) argue that it is necessary to emphasise at the outset that empirical evidence is not absolute and needs to be considered within a relativist framework following an extensive review of psychological therapy outcomes within mental health services. There are some suggestions that researchers within the psychotherapeutic field need to be conscious of the dangers of imposing ethnically rooted cultural biases on definitions of needing treatment or a good outcome.Therefore, participation by BAME groups is needed to include those who are seldom heard (Bhugra & Ahmed, 2007; Elder & Holmes, 2002).

The challenge therefore in bridging the gap in treatment is to consider potential ways of developing interventions that are useful and appropriate to BAMEs, in order to improve the quality of health and social care. With this in mind, it can therefore be argued that when shaping health services in times when we live in an advanced and diverse era, there is a need to study how individuals from particular ethnicities such as BAME perceive and respond to ill health. Additionally, it is crucial to know what types of health care they may prefer and find appropriate and useful as well as knowing the cultural and social aspects of the society in which they dwell.

vi. Rationale for Study choice of Depression in South Asian Indians

Research suggests that cultural differences significantly has impact on health outcomes as well as ethnicity, nationality, race, religion, faith and culture and generational differences having influence on healthcare (Tobert, 2017). Although there is literature indicating the effectiveness of psychological therapies for depression and other common mental health problems, there remain remarkable disproportions regarding access and appropriateness of the treatments consequently leading to inequality giving reason for carrying out this study. Additionally, the most significant development in the 2010-2015 Parliament was the Health and Social Care Act 2012, which established ‘parity of esteem’ for mental health and physical health. In its true sense, ‘parity of esteem’ means access to NICE recommended services should be uniform regardless of the nature of the problem whether mental or physical. Prior, the NHS Equality and Diversity Council which was established in 2009 proclaimed their vision to deliver; better health and better care; reduced inequalities; more accessible services; more clinically effective services; and safer services with improved health and better patient experiences.

Furthermore, it can be argued that existing ethnic inequalities cannot be explained in terms of a variable disease burden. Indeed, there is an argument stating that people’s accounts or stories can be used to deepen the understanding of the constitution and impact of social structure or macro-context, (Lawton, 2003; Pierret, 2003) with factors such age, gender, socio-economic and ethnicity included. Thus, research needs to be carried out collecting data about the experiences and outcomes of mental health treatment in BAME groups amongst others. It is also concerning that there is a lack of research on ethnic variations in mental health service experience and outcomes as well as not being bench marked resulting in the unavailability for progress or performance to be measured against and this needs to be challenged and changed. According to the Guidance for Commissioners of people with mental health in 2014 and Guidance for Commissioning mental health services for vulnerable adult migrants 2015, there needs to be progress made in reducing health inequalities through the use of measurements from the perspectives of BAME service users, their carers and their families.

A significant number of population surveys have clearly indicated the prevalence of depression in black and minority ethnic groups of people (Gajwani, Parsons, Birchwood & Singh, 2016; Evans et al., 2014; NICE, 2014; Chadda & Sinha Deb, 2013; Bhattacharya, Cross & Bhugra, 2010; Furler et al., 2010; Fernando, 2009; Sewell, 2009; Ahmed & Bhugra, 2007; SCMH, 2006; NIMHE, 2004). Therefore, this makes the topic of managing depression in BAME groups to be of interest because it is an area that has been neglected in wider policy and practice debates. Moreover, help seeking by people from BAME groups for depressive problems in primary care is relatively under researched as shown in Chapter 2. Evans et al., (2014) claim that although use of primary care is high amongst BAME groups, under recognition of depression and consequent poor access to treatment of depression in BAME groups is a significant problem. Additionally, findings from a study of mental health services by the Sainsbury Mental Health Centre [SCMH] (2006) indicated a significant financial and economic gains if existing ethnic inequalities in mental health were reduced, giving justification to undertaking research focused on the specific needs of BAME to help inform policies on mental health provision on treatments. It was found that the average cost of mental health services for Black service users was 58% higher comparing to that of a white user (SCMH, 2006)

Carrying out this research could also serve to remind, highlight, and emphasise the legal obligation that commissioners and providers of mental health care should meet the principle of equality of care, which is a core value of the NHS, (DH, 2013). Moreover, the Equality Act (2010) and The Human Rights Act (1998) stipulate and require that health and social care services have a legal duty to offer services that are accessible and appropriate to all sectors of the community, irrespective of ethnic origin; therefore, meaning what is expected of public bodies such the NHS in terms of service provision are services that are non-discriminatory and respect the needs of diverse communities such as those of BAME.

A sense of accountability also has been a determining factor in carrying out this research since the scarce evidence available indicates that mental health organisations have so far not succeeded in meaningfully involving BAME service users. Often community leaders are engaged with rather than service users which often results in proxy participation resulting in a misconstrued understanding of BAME service users' lives and what treatment interventions maybe suited to their needs, Begum (2006). Additionally, from a health care perspective, there is an ethical duty to enquire and find out how local communities served perceive service provision as well their experience of it. Currently in the UK, this issue is quite popular with talk of values-based commissioning with its aims being those of establishing and safeguarding services supported and owned by service users and their carers or families, (RCPsych., 2013).

Respectively, there is limited research on the subjective experience of BAME patients who have received IAPT UK psychological therapies so far as well as their understanding of how services can be accessed and the meaning of receiving such services. Evidence based practice encourages health professionals to use the best available research evidence whilst considering the patient's characteristics as well as perspectives and values to inform care, but care packages often reflect the perceptions of the majority culture of what is appropriate, and therefore may not be suitable or relevant to BAME groups. Evidence shows oversights in misdiagnosis and significant disparities in assessing and treating as depression in ethnic groups (Kalathil, 2011). It is further argued that Eurocentric/Western psychotherapies geared to cultural needs in the West need to be *"rid of"* as a culture bound phenomenon that is unlikely to have much meaning as an indication of benefit in other cultures, with the principle of *'no decision without me'* (DH, 2012) made central to all commissioned treatments and services. Bowl (2007) argues that research has so far *"relied* *heavily on the perceptions of professionals, carers and community representatives"* and neglected to consult BAME service users themselves. This argument was based on findings from focus groups and interviews with South Asian and African Caribbean mental health service users to ascertain how current UK government initiatives such as Delivering Race and Equality in mental Health [DRE] (DH, 2005) might achieve significant improvement in services for BAME service users. It was found that socio-economic exclusion played a significant part in shaping black and SAI service users' experiences of mental health difficulties which presents a barrier in achieving a reduction in BAME hospital admissions, (Bowl, 2007a; Bowl, 2007b).

The issues of concern central to this project are as follows:
The mismanagement of depression potentially causes considerable harm and exacerbates difficulties for those experiencing it as it accounts for seven per cent of the health responsibility within the NHS. (NICE, 2011; Royal College of General Psychiatrists 2008; Layard 2005). Moreover, my own personal experiences of varying patterns of treatments resonates with the suggestions that currently in the psychotherapeutic field treatment is dominated by a universal application of therapeutic theories that could be irrelevant, meaningless, and ineffective to the patient, (Fernando, 2010; Rogers & Pilgrim, 2010). Furthermore, there are a significant lack of systematic reviews and meta-analyses that have determined the efficacy and effectiveness of the treatment of depression with NICE recommended psychological therapies on people from BAME communities (Sewell, 2009). Considering the vast demographic changes occurring worldwide, it is no longer justifiable or appropriate for psychotherapists to operate from Eurocentric assumptions. It is hoped that the research will help explore and question the generalisability of current approaches in psychological care provision. Therefore, specific focus is on the efficacy of the current NHS Programme of Improving Access to Psychological Therapies (2008) for BAME groups. Subsequently, there is a significant cause for concern based on feedback from BAME patients and through patient Forums and Service user experience surveys on this topic. This implies a crucial need for accurate evaluation and diagnoses of disorders within the bounds of culture for ethnic patient groups to have appropriate, meaningful, and effective treatment and interventions. Compounded by cultural and institutional exclusion, mental

health services in both hospital and community settings seemingly continue to be insensitive to the needs of BAME people hence the focus of this study.

Chapter 2: Reviewing existing Literature

Part 1

Introduction

This chapter explains the design and findings of a review of literature used to locate health care literature relating to South Asian Indians and their experiences of primary care psychological therapies for depression. It is acknowledged that scoping reviews maybe be conducted instead of systematic reviews where the purpose of the review is to identify knowledge gaps, scope a body of literature, clarify concepts or to investigate research conduct as suggested within Grounded Theory Approaches ((Mann et al., 2018; Strauss and Corbin, 2015; Charmaz, 2014; Dunne, 2011; Glaser & Strauss, 1967) . Moreover, according to Mann et al., (2018), scoping reviews are viewed as helpful precursors to systematic reviews which can be used to confirm the relevance of inclusion criteria and potential questions. This chapter also explores how the review was conducted and outlines the decisions made in determining the purpose, aims and justification of the literature review in line within a grounded theory analysis study.

A literature review was undertaken to explore any knowledge that was available regarding the subject area and based on current contexts on the BAME group of South Asian Indians and how they perceive psychological therapies in primary care for depression. This was done to help identify common perceptions and discover any key issues that could guide the study design. The other purpose for the review was to help establish a sense of the subject area through understanding correlated fundamental concepts on South Asian Indians and their experiences of psychological therapies for depression which could be of significance in later stages of theory development.

i. The Importance of Literature Reviews in Health and Social Care

There are many reasons for conducting literature reviews although this may be influenced by the researcher’s methodological approach and philosophical paradigms (Chilisa & Kaluwich, 2012). The usual aim of the literature review in qualitative research studies is to refine the research question, determine gaps in earlier research and identify a suitable design and data collection methods for a planned study. What makes reviews important is their ability to summarise the literature that is available on any specific topic, with its extent and magnitude, and enhances a Doctoral researcher's ability to think objectively (Randolph, 2009). Literature reviews are a powerful tool which helps to uncover new information and evidence, especially in healthcare-based research. According to Grant and Booth (2009), the comprehensive review of the literature enables scholars to refute pieces of information which could be significantly misleading. Moreover, they are significant in health and social care because they enable information and research to be viewed within individual contexts and set amid other similar information and research, with the effective outcome being systematically evaluated so that its impact can be evaluated systematically (Smith & Noble, 2016). Consequently, a comprehensive and thorough picture is given which otherwise could remain partially hidden whenever a single piece of research or other information is viewed in isolation.

Although reviews are typically undertaken to determine the extent of current knowledge and contextualise the subject area with contemporary research (Parahoo, 2014), in Grounded Theory they infer a different meaning as demonstrated in the next section.

ii. The use of Literature Reviews in Grounded Theory

In Grounded Theory (GT), it is understood that concepts grounded within the data are used to generate a theory. Typically, the theory is therefore generated from empirical data rather than from existing literature. In GT, published literature can be used to help provide a tentative insight into what is already known about a specific phenomenon with some arguing that it is both practical and imperative to research the theory during the early stages of the project thus avoiding any duplication of extant work (Dunne, 2011). However, conducting a literature review before data collection and analysis is sometimes discouraged in grounded theory because of the risk of introducing bias; hence, some argue that the researcher should be deterred from seeking theories that may emerge from data (Elliot & Higgins, 2012; Dunne, 2011). Arguably, this creates challenges as many researchers need to demonstrate adequate appraisal of the contemporary literature for ethical approval.

Glaser and Strauss (1967) suggests that performing a literature review prior to data collection and analysis could result in a theory which has been imposed upon by existing theories, therefore precluding it from being legitimately grounded in, and emerged from the data.

However, maintaining theoretical sensitivity through constant comparisons and continuous memo writing could be one way to stay true to and achieve a good, grounded theory (GT) study. Theoretical sensitivity is a fundamental concept of grounded theory which refers to the insight of the researcher into the research area and their ability to give meaning to data. It denotes how attuned the researcher is to the nuances and complexity of the participant's words and actions and their ability to separate out what is relevant and what is not (Strauss & Corbin, 1998), an initial rather than a comprehensive review should be undertaken to foster theoretical sensitivity in order to enhance theory development throughout the data collection and analysis process. There is a suggestion that the design and conduct of the research can be supported by scoping literature for a review hence providing an opportunity to generate a feel for the subject area. Indeed, Corbin (2008) claimed that an initial review of the literature can help the researcher to explore areas of interest, engage with their own assumptions and guide the early stages of the research process.

Hallberg (2010) discusses being aware of the fine line between avoiding the use of literature before commencing a study and being informed so that there is clear and focused direction. Moreover, in one of his articles, Suddaby (2006) wrote:

> *The reality of grounded theory research is always one of trying to achieve a practical middle ground between a theory-laden view of the world and an unfettered empiricism. A simple way to seize this middle ground is to pay attention to extant theory but constantly remind yourself that you are only human and that what you observe is a function of both who you are and what you hope to see.*
> *(Suddaby, 2006: 635)*

Theoretical sensitivity is encouraged by being broad minded, acquiring, and open to new or unanticipated interpretations of the data, as well as the development of skills where literature, data, and experience is combined and there is intentness to subtleties of meaning. Following on, Strauss and Corbin (2015) offer their own perspective and acknowledge that a researcher brings to the research both personal and professional experience, as well as knowledge acquired from literature that may include the area of inquiry. As previously discussed in Chapter 1, theoretical sensitivity consolidates with the concept of positionality and its potential influence on the research process. Arguably, researchers who position themselves as insiders due to shared ethnic identities and cultural commonalities with participants, easily gain the trust and establish good rapport with the research participants (Shariff, 2014; Bishop 2008). As previously discussed, as an insider based on my ethnicity as a BAME of African heritage with cultural value commonalities with SAIs, my positionality can influence researcher objectivity resulting in significant abilities to recognise not only the ties that bind me and my participants, but also the social differences that divide us (Manohar et al., 2017). Strauss and Corbin (2015) argue that literature read before data collection could not necessarily impede the emergence of the theory and advocated for engaging with the literature and to use it throughout the stages of the research.

Conversely, some readers, academics and researchers have interpreted the GT method to mean fieldwork before literature search. However, this is a misconception of the original premise put forward by Glaser & Strauss (1967), who encouraged researchers to *"use any material bearing in the area"*, and this is taken to include the writings of other authors, (Allan, 2003). Wilkinson (1998) argues that, other than providing a framework for establishing the importance of the study, a literature review is essential since it also sets a benchmark for comparing the results of a study with other findings. Strauss & Corbin (2008) assert that the use of literature marks a basis of professional knowledge and referred to it as "literature sensitivity". Strauss and Corbin identified many uses of engaging proactively with the literature from the beginning of the research process, where literature is interweaved throughout the process of evolved grounded theory which presents as another voice contributing to the researcher's theoretical reconstruction. Subsequently, the literature is viewed as a means to provide examples of similar phenomena that can aid in stimulating thinking about properties or dimensions which in turn can be used to examine the data presented, (Strauss & Corbin, 1998). The key message is that, reviewing relevant literature establishes current thinking in the area of health and social care provision, and perceptions the populations hold and how this consequently impacts on access to services; this being the precursor to this study having observed disconcerting patterns in attendance for sessions amongst SAI patients within my professional practice in a NHS IAPT Service.

According to NICE (2008), health care decisions for individual patients and for public policy should be informed by the best available research evidence. The use of the latest research and information about best practice is encouraged to ensure that decisions are demonstrably rooted in this knowledge (Lavis et al., 2005). Therefore, what informed my decision to undertake the initial literature review was the potential for this to help locate literature that could answer a clinically meaningful question as well as providing evidence to inform practice.

iii. Identification and Selection of Suitable Studies

According to Scotland (2012), it is impossible to engage in any form of research without committing to ontological and epistemological positions as it enables informed decisions to be made regarding the methodology to be chosen in seeking answers to the research question. Grix (2004) argues that different ontological and epistemological positions generally lead to different research approaches even when researching same phenomenon. According to Snape and Spencer (2003), the quality of the research product can be attained through acquiring an awareness of the philosophical underpinning of the research. More understanding and awareness is important in enabling improved comprehension of research, application of theory to practice, engagement in academic debate, and presentation of research findings (Scotland, 2012). More awareness helped clarify my own thoughts about the study and provided guidance in establishing a framework within which to present and analyse the findings. It is important to note that the process of data extraction and appraisal was achieved with the knowledge that theory developed by using a grounded theory methodology should be grounded in the data and not in the existing literature.

The review sought only to familiarise with the concepts around experiences of IAPT psychological therapies for SAIs and was undertaken to ensure a high-quality appraisal of key concepts (Charmaz, 2006).

An inclusion/exclusion criterion was developed for study eligibility (Table 1) to enable the boundaries of the review question to be clearly defined, that is, the BAME group of South Asian Indians' experiences and perceptions of accessing and psychological therapies for depression within NHS primary care. In order to establish the criteria each aspect of the research question was defined very clearly to clarify exactly the focus, and any variations that needed exploring were considered and key words established (Table 2). The criteria was determined by the elements of the question which was achieved by exploring the factors which would help meet the aims of the study such as participants, interventions, comparisons, outcomes, and study design known as PICOS as endorsed by Cochrane Collaboration (The Centre for Reviews & Dissemination, 2009). This would help locate articles which met the psychological, demographic, and geographic characteristics requirements of the research question and objectives, such as South Asian Indians within United Kingdom who have experienced depression and received CBT therapy. They were also common limiters applied to the criteria as follows:

- date range since IAPT was first commissioned in 2008
- language - the issue of language placed amongst the exclusion criteria due to the fact that as the Chief Investigator and lone researcher, I was not able to speak any of the South Asian languages.

However, it is advised that the criteria should not be limited in extent, as to exclude studies which may be fundamental to the review, although not too extensive to make the review process out of commission due to misinterpretation and misrepresentation (The Centre for Reviews & Dissemination, 2009).

The justification for the included literature was based on a need to develop *'a feel'* for the subject area as advocated by Charmaz (2014) and generate an awareness of the key issues, challenges and practices relating to psychological therapies for depression in primary care for BAME group of South Asian Indians. Engaging with the existing literature is believed to enhance the process by helping the researcher to identify what is important to the developing theory if the researcher *"maintains an attitude of scepticism"* (Strauss & Corbin, 1990, p.45), and not allow that scepticism to impose itself on the theory.

Included Studies	***Excluded Studies***
✓ ***Research that explored the perceptions of SAI patients with depression and their perceptions of therapy.*** ✓ ***Research that investigated the contextual factors of access, inequalities of access and barriers to services for SAI when experiencing depression.*** ✓ ***Research that addressed the relational dynamics that exist and affect interactions between SAI patients and healthcare professionals when experiencing depression.*** ✓ ***Research that explored current practices in collaborating with SAI in meeting their health-related needs when experiencing depression.*** ✓ ***Research that reported outcomes of treatment for SAI with depression in UK.*** ✓ ***Studies published within the last 10 years.***	- ***Research not published in the English language.*** - ***Research having children as participants.*** - ***Research exploring other biomedical and/or psychological outcome measures and not correlated to experiences of treatment and perceptions of psychological therapies.*** - ***Research completed outside UK.*** - ***Not published within the last 10 years.***

Table (1) Literature Review Inclusion/Exclusion Criteria

The inclusion/exclusion criteria helped ensure that the question was focused and prevented preconceptions from selection of studies as the criteria are defined before the literature search, and before the inclusion and exclusion of studies. The research designs were appraised, for example why specific samples and or demographics had been chosen such as inner-city female patients as well the choice of diagnostic instruments and operational definitions. The factors that informed inclusion or exclusion of studies were based on whether the research question was clearly defined in terms of population, interventions, comparators, outcomes and study designs, and initial sampling methods based on specific study inclusion/exclusion criteria, demographic statistics including age, gender, and race. Additionally, citation tracking was utilised for further literature search to explore what was relevant to the study which produced significant data and information on South Asian with depression and psychological therapies. According to Bakkalbasi, Bauer, Glover and Wang (2006) citation tracking is useful since it allows researchers to find the most influential articles for a specific topic.

Table 1 demonstrates the inclusion/exclusion criteria employed in this study. The decision on what to include when reviewing the literature was based on a literature search utilising keywords and phrases (Table 2) systematically on a few health and social care online databases as listed below.

There were seven key concepts under the search questions: *depression*, *South Asian Indian, cognitive behavioural therapy, counselling, United Kingdom, IAPT, Primary Care.* The chosen databases for a comprehensive literature search which helped identify all published studies relevant to the specific research questions were: PsychINFO, MEDLINE, AMED, BNI, CINAHL, EMBASE, HBE, HMIC.). These databases were chosen because they are known to generate a large .proportion of relevant studies (Aagaard, and Lund, Juhl 2016). Sources of literature were searched for studies published between 2009-2019. Various combinations of keywords using Boolean operators were adopted and the following key-word-string was adapted as the final search parameters (Table 2)

PSYCHOTHERAPY/ OR "BEHAVIOR THERAPY"/ OR "BRIEF PSYCHOTHERAPY"/ OR "COGNITIVE BEHAVIOR THERAPY"/ OR "CLIENT CENTERED THERAPY"/ OR "GROUP PSYCHOTHERAPY"/ OR "INDIVIDUAL PSYCHOTHERAPY"/ OR "INTEGRATIVE PSYCHOTHERAPY"/ OR "RATIONAL EMOTIVE BEHAVIOR THERAPY"/ OR "PSYCHOTHERAPEUTIC TECHNIQUES"/ OR "PSYCHOTHERAPEUTIC PROCESSES"/ **("transcultural counsel*" OR "transcultural cbt" OR "transcultural cognitive behavio*" OR "transcultural therap*" OR "transcultural psychotherap*" OR "transcultural iapt" OR "transcultural improving access to psychological").ti,ab(counselling OR psychotherapy OR "behavio* therapy" OR "cognitive behavio* therap*" OR cbt OR counseling).ti,ab**
AND
"CROSS CULTURAL COUNSELING"/ OR "MULTICULTURAL COUNSELING"/ OR COUNSELING/ OR "PSYCHOTHERAPEUTIC COUNSELING"/ (1 OR 2 OR 3 OR 4) **"PRIMARY HEALTH CARE"/"GENERAL PRACTITIONERS"/ OR "FAMILY MEDICINE"/ OR "FAMILY PHYSICIANS"/("general practitioner*" OR "family doctor*" OR "primary care").ti,ab OR (7 OR 8)**
AND

(iapt OR "improving access to psychological therap*").ti,ab "SOUTH ASIAN CULTURAL GROUPS"/ **(asian* OR gujerati* OR gujarati* OR punjabi* OR panjabi* OR hindi* OR urdu OR tamil* OR kannada* OR telugu* OR hindu* OR sikh* OR muslim* OR moslem* OR indian* OR bengali* OR bangladeshi*).ti,ab**
AND
(11 OR 12) (uk OR "united kingdom" OR britain OR british OR england OR british OR wales OR welsh OR scotland OR scottish OR ireland OR irish OR London OR Birmingham OR Manchester OR Sheffield OR Edinburgh OR Glasgow OR Cardiff OR leeds OR Belfast OR Liverpool OR leicester OR nhs OR "national health service").ti,ab (5 OR 10) (13 AND 14 AND 16)

Table (2) Keywords

The inclusion criteria of literature was initially intended only for studies that specifically explored only South Asian Indian people with experiences of depression and IAPT CBT in primary care. However, the review produced very limited results and was unable to attain significant literature on IAPT and CBT psychological therapies for SAI. The reasons for little or no literature IAPT focused research with SAI and BAME maybe due to the IAPT program being fairly recent having been commissioned in 2008 in England. Concurrently, Evans (2013) argues that, the IAPT programme is established on an economic model essentially relying on its running costs to be amassed through “recovery rates” and substantial numbers of patients returning to work. Consequently, this issue was resolved by including study populations that where from a BAME background such as Pakistanis and Black Afro-Caribbean and Black African, which provided a wider range of studies than would have otherwise been possible. Therefore, the inclusion criteria was extended to include studies that explored any South Asian and BAME experiences of CBT psychological therapies, such Pakistanis, Bangladeshis, Black Afro-Caribbean and Black African people. This was done with the awareness that BAME are not homogenous and are diverse on basis of ethnicity, nationality, age, religion, social and migration status, in addition to other factors of identity. Literature was also obtained by locating cited references using free resources such as Google Scholar and Google books.

Therefore, a total of 17 studies were included for review as illustrated in Diagram 1 below . Articles included a mixture of, qualitative, mixed methods, quantitative and randomised controlled trials. The studies included reported on psychological and mental health service use between BAME groups such as SAIs, Pakistanis, Bangladeshis, Black Afro-Caribbean, Black African and Whites. The studies explored issues regarding attitudes to mental health problems ,accessing and barriers to accessing mental health services, , the help-seeking process, stigma to mental illness and intervention preferences such as social networking and involvement of family. Among studies reviewed were those that investigated the effectiveness of CBT and culturally adapted CBT (CA CBT) as well as studies that examined outcomes resulting from adapting therapeutic techniques and addressing cultural issues in therapy. Studies from other countries were excluded due to the aims of the research question which sought to explore experiences of IAPT programme which is at the time of researching was exclusively rolled out only in the UK. Studies were excluded if they investigated psychological therapies for children or older people of 65 and to suit the requirements of the research question. Papers that were theoretical in nature such as meta-analysis and systematic reviews were excluded. This clearly highlights that the area of knowledge surrounding the experiences and perceptions of IAPT psychological therapies for SAIs with depression is under-explored given that IAPT is significantly a new concept. This confirms that SAIs' help seeking behaviours for IAPT psychological therapy within NHS Primary care has not been extensively examined. Hence the aims of this study is to explore patterns of accessing services and what SAIs may perceive as useful and appropriate psychological interventions when experiencing depression.

iv. Eligible Research studies & Literature Critical Appraisal

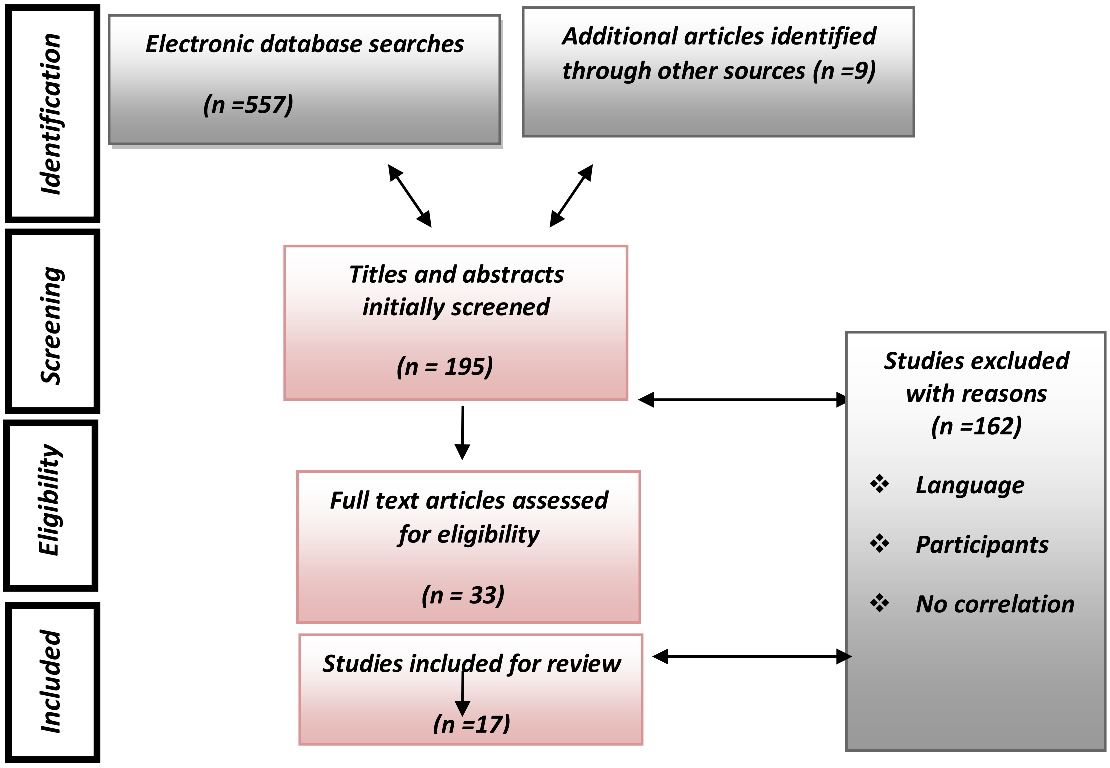


Diagram (1) Study Selection Flow Chart

Critical appraisal of literature means evaluating the literature retrieved in order to identify strength and weaknesses. The Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2014a) as illustrated with a few examples in Diagram 2, was utilised for qualitative papers as a guide to assess the quality of the studies and determine their appropriateness for inclusion. The CASP tool was utilised since it's argued to help develop evidence-based approaches in health and social care and aiming to enable individuals develop skills to find and make sense of research evidence, helping in transferring knowledge into practice, (Nadelson & Naldeson, 2014; Burls, 2009). Some key appraisal determinants were research design, method choice, and type of analysis with papers that were appraised as poor on research design, inappropriate in the choice of methods or lacking robust analysis being excluded. Other determinants were based on the type of studies identified, primarily qualitative research studies exploring the mental health of BAME groups using grounded theory study designs. Those studies with the population of interest such as South Asian Indians were crucial, as well as the health outcomes and effectiveness. Data type including primary data and the language of publication was also fundamental. Data such as information gathered from research interviews extracted from sample population such as participants' vignettes, responses to survey or questionnaires, and data from focus groups. The language of publication was important in that as the Chief and only investigator I only speak English and therefore would not be able to appraise any data published in any languages that would be foreign to me . However, the majority of the studies demonstrated strength through their use of highly trained and experienced mental health staff to undertake the interviews in other languages such as Punjabi and Urdu including a thorough scrutiny of documents and tapes. Data collection by people who spoke a similar language as the participants without the use of interpreters allowed rich data to be collected (Cormier, 2018; Merry et al., 2011).

Predicated on the grounded theory methodology, there was awareness that my assumptions and previously acquired knowledge should not be prioritised over any data including reviewed literature, but to engage with it in a critical manner (Charmaz, 2014; Thornberg, 2012). There was also an awareness of my position as an insider and outsider based on my role as a BAME, Psychological Practitioner and an academic researcher and what implications my positionality would have on the research process.

The initial search process explored for research in relation to South Asian Indian patients and the perspectives of primary care psychological therapies. The search included identifying what epistemologies may have underpinned any studies on South Asian Indian patients and their perspectives of primary care psychological therapies. Furthermore, the search also included if any of the studies on South Asian Indian patients in primary care had measured effectiveness of psychological therapies. This enabled me as a researcher to identify any knowledge gaps as well as informing their study design and earn methodological insights (Dunne, 2011). Correspondingly, this also enables the researcher to identify areas that are not extensively reviewed as well as identifying the size and nature of an evidence base to determine feasibility for future research activity (Elliot & Higgins, 2012; Dunne, 2011).

To ensure a comprehensive understanding of how South Asian Indian perceive psychological therapies for depression and other common mental health disorders, papers were included if they discussed the prevalence of depressive disorders, access to treatment, lack of diverse treatment options and perceptions of/on help seeking behaviours. The type, appropriateness and justification for methodology choice were fundamental as well as relevance to phenomena under study in determining whether a detailed discussion and justification of philosophical underpinning had been given. An illustration with a few chosen key studies can be seen in Diagram 2 below; CASP Table of Analysis.

Screening Questions >>>>>>	*Aims Of Research*	*Methodology*	*Research Design*	*Recruitment of Participants*	*Data Collection*	*Researcher Role awareness & relationship with participants*	*Ethical Considerations*	*Data Analysis*	*Findings*	*Research Relevance*
Memon et al., (2016)	Dominant aim highlighted throughout study – To determine perceived barriers to accessing mental health services among BAMEs to inform the development of effective and culturally acceptable services to improve equity in healthcare -Prevalence of depressive disorders.	Qualitative Focus groups	-Populous City - Networking with community Groups Assessed Access to treatment, lack of diverse treatment options.	-Inclusion /exclusion criteria – Age 18-67 -Gender; Males Females -Purposive sampling	- Anonymous self-administrated questionnaire	Training - Regular Reliability & Consensus Meetings	Anonymisation -Consent after full explanation of study. -Ethical Approval sought	-Thematic Analysis - NVivo qualitative data analysis software. -To minimise bias, another researcher independently read the scripts	-Written Reports -Use of participants quotes. Results generalised and not focused on any particular ethnic or service-user subgroup	-Depression prevalent in BAMEs -Issues of access, barriers , experiences of treatment -Findings relevant to inform the development, commissioning, and delivery of effective and culturally acceptable mental health service and to improve access to the service. Limitation acknowledged

Loewenthal et al., (2012)	Dominant aim; To investigate the feasibility of achieving Improving Access to Psychological Therapies (IAPT) for people from Black, Asian and Minority Ethnic (BAME) communities living in the UK, with specific reference to Bengali, Urdu, Tamil and Somali speaking communities	Qualitative Focus groups	Cosmopolitan/ diverse City Networking with community Groups -Community Development Work	-Inclusion /exclusion criteria – Age 40 and above -Gender; Males Females -Purposive sampling -Bengali, Urdu, Tamil and Somali speaking communities - Community associations with which the NHS Trust. -Posters were also placed in community buildings to advertise the study.	- Open ended Focus Groups using topic guides -Vignettes followed by questions/probes were chosen as the appropriate method of enabling sharing of experiences within the focus groups. - Respondent validation interviews conducted on an individual basis -Use of community appropriate language	Reflective diaries Group supervision Meetings	-Consent after full explanation of study.	-Thematic Analysis Transcribing and translating into English	-Thematic presented report writing -Use of participants quotes.	-Depression prevalent in BAMEs -Issues of access, barriers , experiences of treatment -Cultural, language and religious barriers factors in seeking mental health support. -Results present as implications for IAPT in creating culturally sensitive psychological programmes.

Khan et al., (2019)	Dominant aim; To develop and test the feasibility and acceptability of a culturally-adapted, CBT-based, manual-assisted intervention in British Pakistani mothers experiencing depression.	Qualitative - Mixed-method feasibility study	Non-controlled pre-post feasibility study design Cosmopolitan/ diverse Inner City Statistical Methods -Use of non-parametric tests	-Inclusion /exclusion criteria – Age 18 and above -Gender; Females -Sampling from previous cohort study -Ethnicity; Pakistani	- In depth Qualitative interviews- digitally recorded -Clinical interview schedule -Questions from team discussed/previous literature topic guides -Trained Bilingual researchers -Use of community appropriate language	None mentioned.	-Consent after full explanation of study. - Ethics sought and granted	Framework Analysis	-Thematic excel spreadsheets and theoretical table. -Transcribed verbatim -Written report -Use of participants quotes.	- A culturally-adapted CBT-based group intervention (was acceptable. Improvements were reported in depression and health-related quality of life. Understanding of depression' in physical terms. Factors contributing to depression were marital disharmony, lack of social support, and financial difficulties. lack of availability of culturally sensitive interventions and the limited cultural sensitivity of NHS staff was also reported.

Diagram (2) – CASP Table of Analysis

v. Overview of the Methodologies

The literature search produced studies such as cross-sectional population surveys, quantitative approaches, interpretive analysis, and qualitative grounded theory within constructivist paradigm approaches. Studies identified demonstrated a range of data collection methods such as theoretical sampling and negative case analysis, use of semi–structured interviews with Bi/Multi Lingual interviewers with initial topic guides from previous research which changed as interviews evolved as well as the use of Field diaries (Kapadia, Brooks, Nazroo & Tranmer, 2017; Bhattacharya et al., 2010; Gater et al., 2010; Lawrence et al., 2006). In terms of data analysis many studies used grounded theory and described coding, constant comparison, and categories/sub-categories. Other studies detail data analysis methods such as axial coding constant comparison and memos. The findings of the research and subject relevance to the impending study also formed the basis for screening, with reference to prevalence of depression in SAIs and BAME, Primary Care treatment and patient experience stories synonymous with current contexts informing towards healthcare policies and implications on service provision. Studies mentioning researcher role awareness and reflexivity and relationship with participants including training, regular reliability and consensus meetings were found to be favourable.

The research designs were appraised, for example why specific samples and or demographics had been chosen such as inner-city female patients as well the choice of diagnostic instruments and operational definitions. The factors that informed inclusion or exclusion of studies were based on whether the research question was clearly defined in terms of population, interventions, comparators, outcomes and study designs, and initial sampling methods based on specific study inclusion/exclusion criteria, demographic statistics including age, gender, and race. Additionally, citation tracking was utilised for further literature search to explore what was relevant to the study which produced significant data and information on South Asian with depression and psychological therapies. According to Bakkalbasi, Bauer, Glover and Wang (2006) citation tracking is useful since it allows researchers to find the most influential articles for a specific topic.

In conclusion it is important to note that the fundamental purpose of the literature review was based on a practical basis due to a need to acquire ethical approval to access the research arena, i.e. participants who were NHS patients. There was also a need to demonstrate theoretical understanding and an expectation to demonstrate a rationale and justification for undertaking the study as part of the GT research approach (Strauss & Corbin, 2015; Thornberg, 2012; Charmaz, 1990). What follows is a summary of key papers and literature obtained on the subject of depression as a major problem, the issue of access and inequalities to accessing services, barriers to services, as well as IAPT psychological therapies i.e. cognitive behavioural therapy (CBT) as an intervention and its effectiveness. Moreover, it is also important to note that available literature that explores IAPT was mainly statistic oriented since the IAPT programme is predominantly goal and target driven as discussed in Part 2, Section ii. of this Chapter.

Part 2.

Depression: a common mental health problem in primary care.

i. The problem of Depression and Accessing services

It is important to note that there is a significant lack of literature on depression in South Asian Indians, its management and effectiveness of the treatment delivered within IAPT UK. As discussed in the preceding section, the IAPT programme has been operational over the last 11 years and the majority of research on the programme has evaluated statistics based on issues of access and recovery for all patients rather than focusing on specific ethnicities. However, Mental health disorders such as depression and anxiety are widespread and have an estimated combined prevalence varying between countries but over 10/% in most Western countries, (Kessler & Wang 2008;WHO, 2004). Moreover, depression usually leads to significant morbidity and mortality and huge medical and societal costs as supported by O'Neil et al., (2016), who claim that depression is a risk factor for heart disease, diabetes, metabolic syndrome, and suicide rates within the South Asian community being higher than among other populations. The World Health Organization predicted that by 2020, depression will be the second most important cause of disability after ischemic heart disease worldwide (WHO, 2015; WHO, 2008; WHO, 2007).

Regardless of depression (See symptoms in Table 3) presenting as one of the most commonly encountered chronic conditions in primary care (Coventry et al., 2011; NICE 2011; Eshun & Gurung 2009; Royal College of General Psychiatrists 2008; WHO 2010; Saver et al 2007; Lawrence et al., 2006; Layard 2005), there remains difficulties and challenges with under diagnosis and undertreating. Around 20% of the population of England have a mental health problem, and the societal and economic costs of poor mental health are estimated at 105bn a year.

Inability to sleep, early morning waking, oversleeping, or needing too much sleep
Persistent sadness, anxious or low mood
Feelings of hopelessness, pessimism
Feelings of guilt, worthlessness, helplessness
Decreased energy, fatigue
Appetite changes/weight gain or loss
Loss of interest or pleasure in hobbies and activities
Difficulty in concentrating
Restlessness and irritability
Suicidal ideation/self-harm

Table (3) Symptoms of Depression

Moreover, in the UK, an estimated two million people a year encounter mental health services although many of those needing support do not access it through the NHS, (Dormon, 2015). According to The Royal College of Psychiatrists (RCPsych, 2014), one in five people become depressed at some point in their lives (Diagram 3), and it is reported that depression can last for a few months with the person getting better, but only for the depression to return again. It is also usual to recover from depression, but it is also common for the depression to return. Episodes can last several months or even longer in some instances.

Pan, Liu, and Kreps (2018) reported that care for depression is usually flawed regardless of the patient having been diagnosed and for some individuals major depression can result in severe impairments that interfere with or limit one’s ability to carry out major life activities. Flaws and deficits in depression care could be due to a number of factors including lack of resources, inaccurate assessments, misdiagnosis, and stigma (WHO, 2018). From a professional practice perspective, access for BAME may have been impeded by these factors as well as reports from patients' feedback about lacking socio-economic resources such as transport fares that leads to difficulties in appointments attendance. However, research on the IAPT programme by Clark, (2018), Gyani, Shafran, Layard and Clark (2013) and Clark (2011) has not focused on the afore mentioned specific issues but has centred on economical evaluations associated with targets and other statistical processes. Therefore, this research is timely in that the existing UK national statistics and information on BAME and IAPT psychological treatment and interventions, effectiveness and appropriateness is lacking, incomplete or unlikely to be representative of the true picture, of which this research aims to explore.

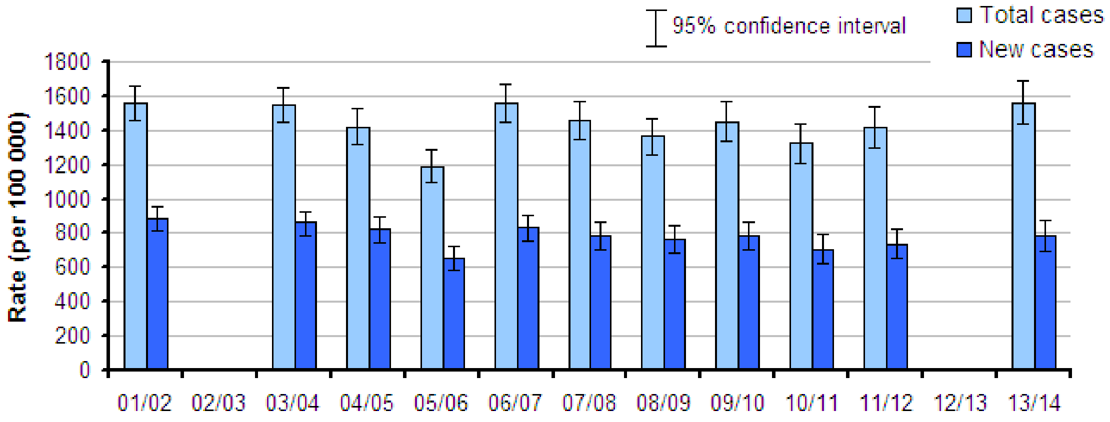


Diagram (3) UK Depression Statistics

Research suggests that most population surveys have produced conflicting results concerning the prevalence of depressive disorders in ethnic minority groups in western countries, but most European studies found higher prevalence of depression in ethnic minority groups compared to white Europeans (Bhughra & Bahl, 1999; Bhugra & Mastrogianni, 2004; Gater et al., 2010; Bhattacharya et al., 2010; Evans et al., 2014).

People from BAME groups have a different experience of depression from that of the population as a whole. This is supported by Furler et al., (2010) who argues that despite the clinical manifestations of depression being universal among all populations, the origins of depressive symptoms vary widely across cultures. For south Asian Indian depression can be triggered by certain factors such as behaviour deficits resulting from the inability to balance conflicting family hierarchy, gender, roles, and high academic standards, (Naz, 2019; Shramko ,2019; Mann, 2017). Elsewhere research suggests that in a community that valorises endurance, stoicism is the ionised mode of existence where there is social pressure of conforming to a model minority stereotype living up to certain social positions (Elias, 2015).

The South Asian Indians often view psychological distress and disorders as either violation of some moral or religious principle or even spirit possession. Literature shows that mental disorders are often considered God’s will or past karma as was well as beliefs surrounding witchcraft consequently causing a delay in seeking help and accessing services for professional input, (Naz, 2019; Tavkar et al., 2008). Several studies also suggest that individuals with depression tend to endorse somatic ailments such as headaches, backaches, weakness, and dizziness, (Julian, 2016; Tavkar, 2008). As a result, help tends to be sought from mainstream healthcare professionals, found as more appealing as compared to mental health services.

Conversely, from a cognitive perspective, depression happens where and when thoughts have become irrational with thoughts being founded on ones’ values and belief systems, Beck, (1976). According to Dattilio and Bahudur (2005), what may cause depression is the cultural conflict due to, a continual struggle in keeping up and striking a balance with the dominant individualistic culture and the parent collectivistic culture based on values and beliefs entrenched in their collectivistic cultural orientation. Consequently, this may trigger stress, unhelpful thought processes, cognitive distortions and hence impacting on the ability to make decisions and the result being major depressive illness. Evidently, help seeking behavior in SAI patient groups remains a challenge in managing depression. Therefore, poor outcomes for depression may be due to lack of access to appropriate and meaningful services, whether because they are unavailable or because they are not recognised as needing such services.

Although there is widespread talk about the availability of services for people with depression and access having increased since 2010, BAMEs and certain areas of the country with high numbers of SAI are still lagging and experiencing poorer service and outcomes

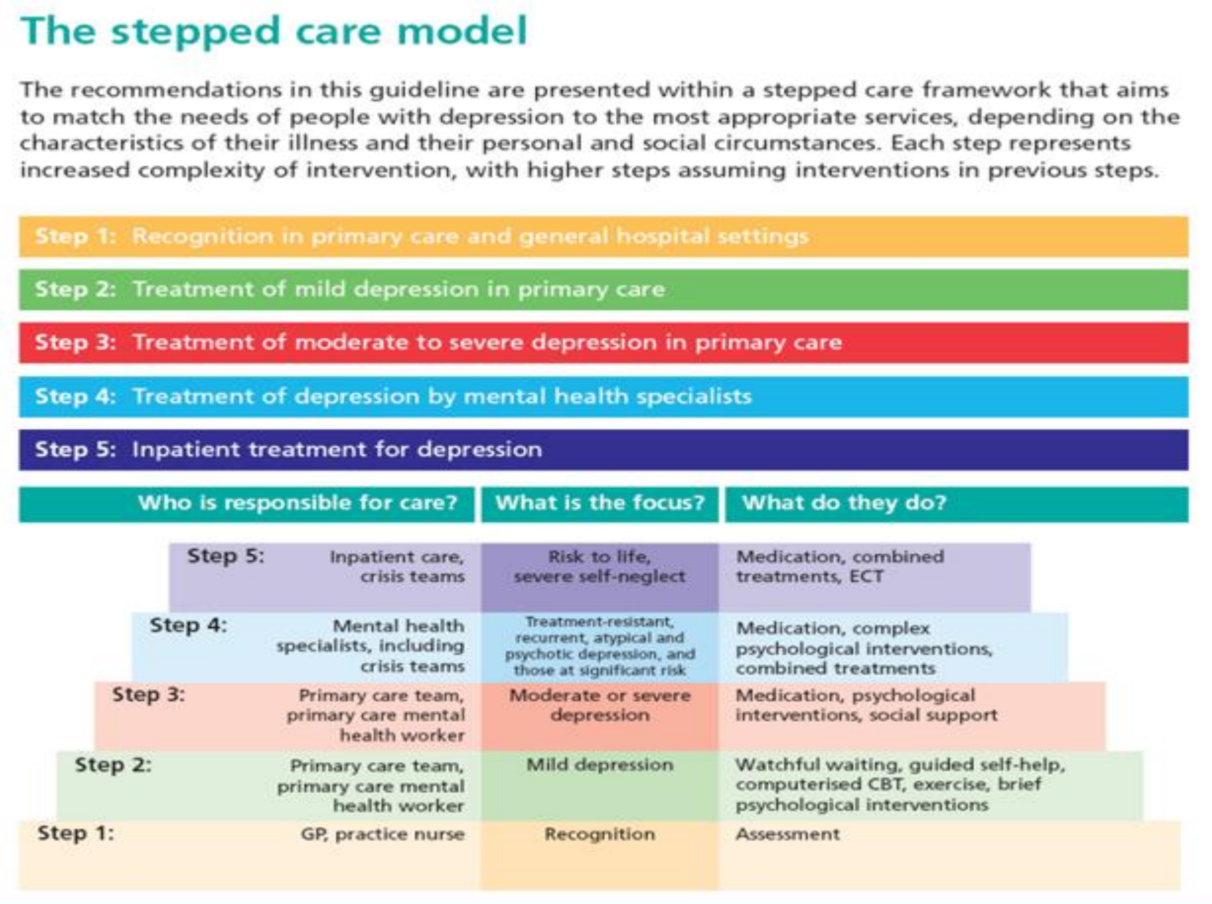
(GOV.UK, 2019; NHS Digital 2018; therapymeetsnumbers.com, 2018). Literature has shown that people from BAME groups tend to have poorer health, a shorter life expectancy and have more difficulty in accessing health care than most of the population, (IAPT, 2018). Greene, Pugh, and Roberts (2008) argue that a delay in accessing treatment can potentially result in higher rates of hospital admission and more complex and intrusive interventions, including compulsory detention and seclusion.

Thus, depression is an area of particular concern for the minority communities in the UK, and ensuring that people's access to psychological therapies is not hindered by their ethnicity, culture or faith is one of the leading priorities outlined in Delivering race equality in mental health care's action plan, (DH, 2005; NIMHE, 2005). This leads to the next section which summarises treatments for depression currently being offered within primary care in England.

ii. Improving Access to psychological Therapies (IAPT) UK

Improving Access to Psychological Therapies (IAPT) is a United Kingdom initiative to improve access to psychological therapies. IAPT was developed in 2008, following a UK Department of Health White paper commitment in "Our Health, Our Care, and Our Say" (DH, 2005). This paper was a result of the economic evaluations by Professor Lord Richard Layard and Labour Party policy, (Layard, 2006). Pilot work was undertaken in Newham and Doncaster (Clark et al., 2009), and the national implementation plan was published in early 2008 (DH, 2008). Roll-out to at least 20 sites in 2008/9 was agreed in the first year, with full roll-out to follow in the subsequent years. The aim of the project was to increase the provision of evidence-based treatments for common mental health problems mainly anxiety and depression by primary care organisations. IAPT supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE www.nice.org.uk) guidelines for people suffering from depression and anxiety disorders in UK. Additionally, it was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication, which traditionally had been the only treatment available.

The programme also collects anonymised data from services nationally to identify trends, mental health needs and to monitor recovery rates throughout England. Below is a diagram that outlines the IAPT Stepped-Care Model/Pathway, Diagram (4). Within stepped care, the progression of patients from step 1 interventions through to a higher step intervention is based on a mixture of increased need and past experience of treatment. As the NICE Depression Guidelines outline, it is expected that many patients will have had access to lower step treatments prior to receiving treatments from higher treatment steps. For example, many patients with moderate/severe depression will benefit from brief psychological interventions and this may reduce the burden on more intensive treatment on the patient and the service providers and commissioners, (DH, 2008)



The stepped care model

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.

Step 1: Recognition in primary care and general hospital settings

Step 2: Treatment of mild depression in primary care

Step 3: Treatment of moderate to severe depression in primary care

Step 4: Treatment of depression by mental health specialists

Step 5: Inpatient treatment for depression

	Who is responsible for care?	What is the focus?	What do they do?
Step 5:	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4:	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3:	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2:	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1:	GP, practice nurse	Recognition	Assessment

***Diagram (4) A Stepped Care Model* – (*https://www.england.nhs.uk/mental-health/adults/iapt/*)**

iii. A Model of Cognitive Behavioural Therapy

IAPT uses evidence-based psychological therapies to help those experiencing depression get better through the use of cognitive behaviour therapy (CBT), (see Diagram 5). CBT is a therapy which has demonstrated to be a significant approach to help treat common mental health problems and physical health conditions in adults, young people and children, and is recommended as a treatment for common mental health disorders such as depression (NICE, 2011). CBT is based on the cognitive model of mental illness initially developed by Beck (1976). As a model, CBT hypothesises that people's emotions and behaviours are influenced by their perceptions of events, and not a situation in and of itself that determines people's feelings but rather the way in which they perceive a situation (Beck, 1976). Thus, modern CBT refers to a family of interventions that combine a variety of cognitive, behavioral, and emotion-focused techniques, (Hoffman, 2011). When depressed, patients are excessively negative in their interpretations of events (Beck, 1976). Beck's approach initially focused on research into and the treatment of depression, but in the last and recent decades CBT has been applied to an ever-increasing number of areas including other common mental disorders such as anxiety (Clark and Beck, 2010), According to Beck (1976), there are three levels of cognition namely, core beliefs, dysfunctional assumptions and negative automatic thoughts. Core beliefs, or schemas, which are deeply held beliefs about self, others, and the world, are generally learned early in life having been influenced by childhood experiences and seen as absolute. The cognitive triad of negative core beliefs relate to the self, for example, *'I'm useless'*, the world/others, *'the world is unfair*', and the future, *'things will never work out for me'*. Alternatively, people adopt dysfunctional assumptions that are inflexible conditional 'rules for living' which may be unrealistic and therefore maladaptive. One example could be where people may live by the rule that 'I would rather not to try than risk failing'. The third cognition of negative automatic thoughts (NATs) as they are commonly known are involuntarily activated in certain situations and centre on themes of negativity, low self-esteem, and uselessness, especially in depression.

Modern CBT does not claim that a person's emotional problems are simply created in her head but that the impact of adverse events, for example, an road traffic accident whilst driving, can be greatly exacerbated by the person's unhelpful thoughts and beliefs that interfere with her ability to cope constructively with such events. Therefore, when delivering CBT, the therapist and client work together in changing the client's behaviours, or their thinking patterns, or both. This is done by equipping them with the tools to change their maladaptive cognitive and behavioural patterns, (Diagram 5, Five Areas Model).

According to Neenan and Dryden (2015), establishing alternative perspectives underscores the CBT principle that there is always more than one way of viewing things, regardless of their unpleasant nature.

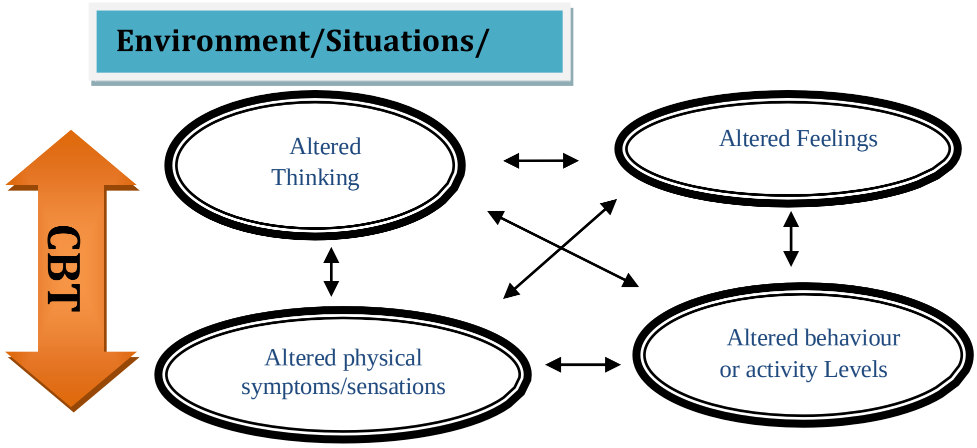


Diagram (5) - CBT 5 Areas Model

Predominantly, CBT is problem-oriented emphasising mainly on the present in comparison to some other forms of talking therapy as it focuses on ‘here and now’ problems and difficulties. Rather than making the causes of distress or symptoms in the past its focal point, CBT explores different ways to improve a patient’s current state of mind. Within the NHS, CBT can be offered in individual sessions with a therapist or as part of a group although the number of CBT sessions you need depends on the difficulty being experienced, British Association for behavioural and cognitive psychotherapies (BABCP 2015; NICE, 2011). On Average this will be between 6 and 12 weekly sessions lasting between 30 and 60 minutes each.

Evidence shows that CBT is comparable in effectiveness to antidepressants, interpersonal or psychodynamic approaches for depression as well as been shown to effectively manage severe and chronic depression especially when coupled with antidepressants, (Beltman, Voshaar and Speckens, 2010; Pampallona, Bollini, Tibaldi, Kulpenick & Munizza, 2004). Despite the reported effectiveness of CBT some authors have refuted its effectiveness and suggest that he strong effects in some studies may be an overestimation due to a publication bias, (Cuijpers, Smit, Bohlmeijer, Hollon, & Andersson, 2010).

However, there is an acknowledgement within CBT that there may be behaviours that potentially cannot be controlled through rational thought, but are rather as a result of early life experiences or are predisposed by certain external and/or internal stimuli. A useful example in this instance would be someone experiencing difficulties in the relationship and interpreting this as a case of being “bewitched thus unlucky” without looking at the factual reasons (e.g. promiscuous behaviour by the other party) why their relationship may not be working. Unlike the long-established psychoanalysis where therapist seek unconscious meaning behind behaviours and then diagnose the patient, CBT is problem focused and action oriented where the therapist’ role is to help patients identify specific strategies to help manage the problems (Schacter, Gilbert & Wegner 2016).

Noteworthy, in the case of South Asian Indians, CBT being Eurocentric may not take in account some endo-cultural issues that may come up at the beginning of therapy treatments thereby posing a threat to therapy outcomes. This is so as people from collectivist societies tend to be less open and secretive about ongoing personal difficulties especially when their opinions, views and lived experiences do not align with the conventional wisdom and that of the family, Chadda & Sinha Deb, (2013). It is also of importance to note that different cultures have established values and norms that governs individuals’ social interactions, roles and responsibilities having been determined by the culture they conform to; hence different cultures have their own values and beliefs about health and health care. Even as professionals whose views and meanings of life events have been constructed by our own ethnic and cultural backgrounds, we carry our own beliefs and values regarding health ad illness and unique to each individual professional.

Spector (1996) wrote:

> *“We have to find way of caring for the client that matches that client’s perception of the health problem and its treatment. In many situations, this is not difficult; in other situations, it seems impossible. With the passage of time, a pattern emerges; for the healthcare provider, the needs most difficult to meet are those of people whose belief systems are most different from the ‘mainstream’ health care provider culture”.* (Spector 1996, in Holland & Hogg, 2018).

However, it is important to note that regardless of certain cultural groups having common beliefs and values, not everyone in that group may have the same attitudes and assumption about illness and health especially since beliefs are also determined by socio-economic levels and other attributes.

There is evidence that shows that religion and spirituality can be valuable concepts in responding to and recovering from common mental health disorders such as depression and anxiety, (Morgan, 2017). National guidelines recommend a holistic approach to managing mental health difficulties and care provided, emphasising social and psychological determinants of mental wellbeing although there is no mention of spirituality and religion within their guidelines despite a growing evidence base over recent years showing their significance to many suffering from depression and anxiety. Additionally, Peng, Huang, Chen and Lu (2009), report that psychotherapies, including cognitive behavioural therapy, is viewed as effective treatment for depression, but its efficacy in older people is not well defined.

However, against the glorification of CBT by the National Institute of Clinical Excellence and in the UK Press, and its potentially transformational impact in managing depression; this is partially not factual which the scoping review revealed and is discussed next.

iv. Cross Cultural views in understanding depression

Cross-cultural differences in levels and rates of depression have been reported quite extensively with cultural variations comparisons between western and non-western cultural groups and those among western industrialised nations, (Bredstrom, 2019; Crasnow & Superson, 2012). Due to forced and voluntary migration, economic globalisation, and technological advances there has been an emergent of issues related to cross-cultural interactions, one such being common mental health difficulties mainly depression. Other factors that have been investigated as reasons for variations in levels of depression include cultural depiction of one’s self, perceptions about mind – body relations, and expressions and regulations of one’s emotions. Worldwide increases in population growth and mobility have resulted in a society that is increasingly multicultural in nature (Memon et. al., 2016; Bhattacharya et al., 2010; Eshun & Gurung, 2009; Buckner, Castro, Holm-Denoma, & Joiner, 2007). Overall, epidemiological, clinical, and other studies suggest that cultural factors can impact significantly on mental health and, in the last half century there have also been several debates on cultural influences on mood disorders such as depression.

Depression is a term that carries both lay and clinical meanings. In the clinical context, the Diagnostic and Statistical Manual of Mental Disorders-V (2013) distinguishes two main types of mood disorders, major depression being one of them. As previously outlined, depression is characterized by depressed mood, loss of interest or pleasure in most activities, appetite and sleep disturbance, lack of energy, difficulties in concentration, low self-esteem and decrease in self-confidence, feelings of guilt and recurring suicidal ideation (ICD 10 –WHO, 2010). Disputably and according to NIMH, (2007) depression in certain instances, cultures or ethnic groups could be somatic in presentation with aches, pains or cramps that are persistent regardless of appropriate medical intervention. Mahsood et al., (2015) reported that the language of distress used by South Asians differ from that on which structured diagnoses are made and may lead to underestimate of distress. According to Rout & Rout, (2010) and Ahmed & Bhugra, (2007) the “western” classification of depression is not entirely satisfactory for use in non-Western cultures; with the term “depression” being absent from the language of many cultures, is used rarely in others or construed differently.

The majority of research reports that the origins of mental wellness and mental illness stem from early life experiences with a combination of factors such personality, trauma, poverty and emotional deprivation making people vulnerable to mental health difficulties such as depression (Manthorpe & Moriarty, 2009; Ahmed & Bhugra 2007). Rout and Rout (2010) conducted qualitative research to explore the manifestations of psycho-social stress and mental health in the lives of British South Asian women. Using purposive sampling a total of 34 British South Asian young women, aged 16-29 years living in North-West of England were interviewed using semi-structured, in-depth interviews and thematic analysed. Three themes emerged from their findings suggesting that the outcomes of psycho-social stress in young British South Asian women manifest themselves psychologically, physically, and through negative behavioural practices with the most occurring themes being depression and self-harm.

Concurringly, it is also suggested that second generation women from South Asian Indian communities, of foreign-born parents may be significantly susceptible to cultural value conflict and high maternal control resulting in depression (Roberts, Mann & Montgomery, 2016; Inman, Devdas, Spektor & Pendse, 2014). Within the SAI communities, there is an expectation on women to balance their immigration and its intrinsic “freedom” through the maintenance of and upholding gendered patriarchal values, evident through their dedication to their home and spousal responsibilities, to such a degree conserving and securing family honour, (Roberts et.al., 2016).

Moreover, within South Asian communities in the UK, poor physical health, socioeconomic adversity, interpersonal and family problems were found to be the major risk factors for depressive disorders (Memon et al., 2016; Inman et al., 2014; Bhattacharya et al., 2010). In a community-based tri-ethnic cohort study of White European, South Asian and African and Black Caribbean individuals living in north-west London and using the 10-item Geriatric Depression Scale interviewer-administered during a clinic visit, Williams et al., (2015) found that compared with White Europeans, South Asian and Black Caribbean participants were significantly more likely to have depression. Mitigating circumstances such as poor physical health resulted in higher prevalence of depressive symptoms among South Asian people, with significantly higher prevalence in Black Afro-Caribbean due to socioeconomic disadvantage.

Furthermore, acculturation adds another dimension to the influence of cultural factors on the development of mental health problems such as depression. Compelling evidence in multicultural literature document that BAME groups are particularly vulnerable to psychological distress (Bredstrom 2019, Chaudhry, Husain, Tomenson & Creed, 2012). This is reported to be due to significant differences in cultural norms, values, and discrepancies between the expectations of their culture of origin and the new culture following migration for whatever reasons. Separation from families, language difficulties, experiences of discrimination, shift in social status, and lack of financial and social resources can be the predisposing factors, (Bhattacharya et al., 2010; Eshun & Gurung, 2009; Ahmed & Bhugra, 2007).

Another example of how adverse life events, social disadvantage, and difficulties with acculturation impact negatively on BAME communities' mental health is noted in Chaudhry et al., (2012) cross-sectional and prospective cohort study of 18- to 65-year-old Pakistani women in UK. The study highlighted that depression was associated with older age, social isolation and significant difficulties pertaining to health and close relationships. Chaudhry et al., (2012) used questionnaires to determine the relative importance of life events, chronic social difficulties, and acculturation in a population-based sample of British Pakistani women. The Schedule for Clinical Assessment in Neuropsychiatry for diagnosis, the Life Events and Difficulties Schedule for social stress and an acculturation questionnaire was also utilised and data were analysed using SPSS and at follow-up. Depression was found to be associated with severity of depression at baseline as well as less acculturation in relation to use of the English language.

Conjointly, studies of different conceptual models of depression have found that people from White/Western backgrounds are more likely to follow a bio-psychiatric model and expect depression to require professional treatment (Meer & Mir, 2014; Greene et al., 2008). Although a lack of awareness and information about mental health problems within some BAME groups maybe a factor, evidence suggests that many BAME patients and their carers are dissatisfied with mainstream services which they often perceive as misunderstanding and/or misrepresenting their situation (Moller et al., 2016; Meer & Mir, 2014; Rathod et al., 2010; Gater et al., 2008).

Accordingly, personality factors may also lead to multiple mental health problems. Eysenck 1990 in (Pervin, 1999, pp. 224-276) noted that there is sufficient evidence to show that personality factors and stress can lead to feelings of helplessness and hopelessness and finally depression. Socio-politically, a range of patient, practitioner and structural and organisational factors are believed to collectively or independently constrain optimal management of depression in primary care. Explanations for the widespread under recognition of depression and its mismanagement in primary care maybe due to a number of factors but most importantly, that "western" classifications of depressions are not entirely satisfactory for use in non-western cultures (Fernando & Keating, 2009; Ahmed & Bhugra, 2007). Moreover, the term depression is believed to be absent from the languages of many cultures, is barely used in others or understood differently. The DSM (V) (2013) suggests a cultural formulation as a supplement to the multi-axial assessment but others argue that it very much corresponds with western ideas of illness which makes it quite complex to transfer it to other cultures (Bredstrom, 2019; Crasnow & Superson, 2012, Kirmayer, 2001).

The concept of mental health whether depression or any other common mental health problem is understood to be complicated especially where health provision in targeted at a multicultural society. Therefore, Fernando & Keating (2009) advocate for the simplification of this complexity by viewing mental health as being on a continuum divided into “eastern” and “western” traditions. Under recognition might stem from perceptions about depression that consequently shape attributional styles and relegate depression as a normal response to difficult life situations (Coventry et al., 2011; Eshun & Gurung, 2009; Lawrence et al., 2006).

v. Inequalities in accessing Services

It is argued that social and economic factors such as the unequal distribution of wealth and resources can be another factor affecting BAME accessing psychological therapy services. Though dated, The Black report of 1982 found significant health disparities in the United Kingdom with the results indicating outright correlations between income, poor social status and ill health and higher mortality rates with numbers rising in contemporary UK. Evidence suggests that BAME usually get sectioned and hospitalised under the Mental Health Act 1983 as opposed to majority whites who get offered psychological interventions instead, (Care Quality Commissioning, 2015; Fernando & Keating, 2008). Research shows that depression is under diagnosed in primary care all over the world, particularly in ethnic minority groups mainly due to unsatisfactory “Western” definitions of depression, different explanatory models between patient and doctor, linguistic barriers and variations in presentation ((Gajwani et al., 2016; Fernando & Keating, 2008)

Although a significant number of population surveys indicate that depression is widespread in BAME groups of people, mental health services have continually failed to respond to their needs (Evans et al., 2014; Gater et al., 2009; O’Connor & Nazroo 2002). According to the

Office of National Statistics (ONS) UK Census in 2011, there are an estimated 11 million people from BAMEs groups and research suggests these groups have a high prevalence of depression, (Cooper, Spiers & Livingston, 2013; Gater et al., 2009). However, help seeking behavior in BAME patient groups remains a challenge especially due to stigma, shame, taboo, cultural perceptions of mental health difficulties and other various factors, (Meer & Mir, 2014; Fernando, 2010: Rathod, Kingdon, Phiri & Gobbi, 2010).

In a comparative quantitative study by Syeda et al., (2012), South Asian Indians living in India, prefer to seek help from family members rather than other sources compared to SAIs in UK who prefer to ask a friend for help. With a particular focus on how beliefs about counselling impacted on help-seeking behaviours for psychological distress for second generation British South Asian women, a thematic analysis study by Moller et al., (2016) found that stereotyping was the main deterrent factor. Similarly, other factors that could influence decisions to seek and access health could be a tacit understanding of the material, psychological and social costs of engagement by patients, costs of which may be significantly higher in deprived, marginalised and minority groups of people, where resources are scarce on an individual basis as well as high levels of stigma still incomparably attached to mental health difficulties, (Lamb, Bower, Rogers, Dowrick & Gask, 2012).

Further research to gain an in-depth understanding of mental illness and stigma in its social and cultural context and its meanings to participants, Knifton (2012) conducted qualitative community participatory based research with focus groups of Pakistani, Indian and Chinese heritage communities in Scotland, UK. Using purposive sampling across all ages, faiths, and genders, Knifton (2012) asked participants questions regarding beliefs about mental illness and its causes, stigma, and discrimination in communities. Knifton's, findings indicated variations within and between communities about perceived causes and meanings associated with mental illness and stigma although across and within the three communities, mental health stigma and its consequences were extremely and deeply embedded.

The stigma and associated challenges of mental health in BAME is an important subject. Other research has used qualitative methods to understand and address the problems facing ethnic minorities with regard to accessing mental health services. Arday (2018) explored this issue within a university context and conducted unstructured focus group and semi-structured individual interviews to explore lived experiences of negotiating mental illness as BME students within higher education. Using convenience sampling and thematic analysis, the paper suggested that BMEs experience overt discrimination and a lack of access to culturally appropriate services that are cognisant of the racialised plights faced by BME individuals. The findings also highlighted the need for information to be made available in languages that BMEs would understand regarding their illnesses and ways of seeking professional treatment.To a greater extent, population surveys have produced conflicting results concerning the prevalence of depressive disorders in ethnic minority groups in western countries, but most European studies found higher prevalence of depression in ethnic minority groups compared to white Europeans (Evans et al., 2014; Bhattacharya et al., 2010; Gater et al., 2009). In the UK, there have been significant higher rates of depression in African Caribbean women than white European men and women in a community sample from Manchester (Eshun & Gurung, 2009). Concurrently, it seems that people from minority groups have higher prevalence rates than the dominant group (Evans et al., 2014; Bhattacharya et al., 2010; Bhugra & Mastrogianni, 2004).

Depression is a contested concept because different cultures express and interpret depression in different ways ranging from somatic, interpersonal, cognitive processed and existential-affective, (Freeman et al., 2016; Fernando 2010). Despite this, biomedical and social research provides compelling evidence for strong and consistent links between ethnicity, gender, deprivation, and poor mental health (Evans et al., 2014; Greene et al., 2008). People from BAME groups are more likely to experience inequality and social exclusion, as well as direct racial discrimination, poverty, unemployment, and insecure housing. In the UK, statistics indicate that poverty rates and prevalence of depression for BAME groups are much higher in inner London, the north of England, and the Midlands than elsewhere (Evans et al., 2014; Bhattacharya et al., 2010; Eshun & Gurung 2009; Gater et al., 2009; Greene et al., 2008; Ahmed & Bhugra 2007; Buckner et al., 2007; Lawrence et al., 2006; Fernando 2003; Hussain & Cochrane 2003).

The prevalence of depression amongst BAME groups has been reported elsewhere. For example, Edge and Mackian's, (2010)'s qualitative study where they used in depth interviews from a purposive sample of twelve Black Caribbean women with peri-natal depression in the North of England. The aim was to examine prevalence and psychosocial risks for perinatal depression among the ethnic group as well as exploring these women's approaches to help-seeking. Using thematic analysis, findings indicated that social and structural factors proved a barrier to accessing services for the Caribbean women. Staff attitudes, the fear of psychiatric labelling, and stigmatisation by professionals had a significant negative impact on the women's willingness to seek help for psychological distress. Other structural issues were also highlighted as barriers to seeking help which included limited availability of culturally competent therapists, long waiting times and inadequate childcare.

Factors related to barriers in accessing mental health care have been of central concern to those researching help seeking behaviours in BAME communities. Respectively, in their nested qualitative study, Masood et al., (2015) aimed to identify barriers faced by British South Asian women in accessing a culturally-adapted intervention for post-natal depression. Masood et al., (2015) conducted in-depth interviews which formed part of an exploratory randomized controlled trial (RCT) to test the feasibility and acceptability of the culturally adapted psychological intervention. Using thematical analysis, the findings indicated that, the inability to read and understand handouts written in English and the carrying out of between-session work due to personal and domestic commitments were significant barriers to accessing intervention. Having a culturally-sensitive facilitator, childcare and transport support were also among the factors that would make services more accessible.

Similarly, some of the barriers to patients accessing treatment related to an inability, reluctance, or unwillingness to understand or configure depression as a mental health problem (Lamb et al., 2012). Other factors such as institutional racism and the use of racial stereotyping have been argued to negatively influence clinical encounters and outcomes (Naz, Gregory & Bahu, 2019; Memon et al., 2016; Edge & MacKian, 2010; Fernando 2010; Rogers & Pilgrim 2010). Consequently, this has generated deeply-entrenched mistrust within these communities; even among those without first-hand experience of services, hence a powerful barrier to accessing care and treatment (Evans et al., 2014; Memon et al., 2012; Bhattacharya et al., 2010; Edge & MacKian 2010; Fernando, 2010; Keating, 2009; Ahmed & Bhugra, 2006).

Moreover, organisational based barriers such as the lack of minority ethnic health professionals both at local and national levels and unhelpful professional attitudes can also be an impeding factor to accessing services for BAME. Betancourt, Alexander, Green, Carillo, and Park (2005) argue that due to the lack of diversity at the policy making level structural policies, procedures and delivery systems have been designed and delivered to diverse populations with the expectation to suit and meet the needs of those of minority ethnicities in need of services. Elsewhere, it is argued that what hinders access for people from BAME groups is the lack of multiple points of entry into specialist mental health services. (Salway et al., 2016; Fountain 2010; Moffat, Sass, Mckenzie & Bhui, 2009). Initially, the main pathway to access in IAPT was via GP Referrals but within practice in West Midlands IAPT, Services have over the past few years introduced self-referrals.

The UK's National Institute of Clinical Excellence has highlighted and acknowledged the need to improve the mental health wellbeing of BAME and offers specific guidance on innovative ways to engage with people from BAME to improve access to psychological therapies (NICE, 2017). There has been key messages presented acknowledging specific issues and concerns that can be explored through targeted initiatives. Evidently, in a qualitative study of mental health and wellbeing of BAME groups residing in Brighton & Hove, Memon et al., (2012) examined the level and quality of mental health services being accessed by people from BAME groups. Using focus groups and community surveys, the main objective was to improve access and quality of treatment from existing services. , Memon et al., findings indicated universal experiences of racism, poverty, poor education, and acculturation difficulties within BAME communities as the barriers to healthy mental health wellbeing. Stigma, isolation, and negative attitudes from professionals were also among other barriers.

It is suggested that stigma and shame which has a complex characterisation and includes discrimination, rejection and loss of personal power has influenced this mistrust (Memon et al., 2016). The concept of "double stigma" has also been hypothesised in various literatures, wherein people from BAME groups with mental health problems such as depression suffer discrimination not only because of their ethnic background but also because of their mental health problems, (Staiger et al., 2018; Ciftci, Jones & Corrigan, 2012). Double stigma refers to a situation when two highly stigmatised conditions occur in the same individual at the same time (Turan et al., 2019). Over and above the prejudice and discrimination BAME communities usually experience from dominant groups within society, those with mental illness experience stigma and discrimination from their own communities. As a result, BAME people may delay or avoid treatment with consequent deleterious effects to their health in an effort to avoid public and self-stigma, shame, as well as interactions with services which don't understand fully their needs as well as offering what BAME may find appropriate treatment/ interventions to their problems.

This aspect has been explored further by Memon et al., (2016), who undertook a qualitative study to inform the development of effective and culturally acceptable services to improve equity in healthcare in Southeast England. The aim was to determine perceived barriers to accessing mental health services among people from BAME communities. Using focus groups males and females over 18 years of age were recruited to 2 focus groups and interviews were carried out in a discussion format and data were analysed using thematic analysis. Memon et al., (2016) results indicated that personal and environmental factors, as well as relationship between service user and healthcare provider as the main determinants to accessing services. Amongst other barriers to seeking help, especially for participants who had spent formative years in their native country was the incapacity to recognise symptoms of mental health problems and reluctance to accept a mental illness diagnosis. Other deterrent factors and barriers perceived to be negatively impacting and acerbating individuals mental health difficulties were the interminable waiting times for assessments and treatment intervention.

Moreover, a popular belief within South Asian Indian communities is that suffering of any kind produces hope which is essential to life therefore, most individuals will not attend the GP or hospitals until their symptoms become severe (Edge & MacKian, 2010; Eshun & Gurung 2009; Tavkar, 2008). There is a strong belief in family and religion which are perceived as the central source of help. Those who seek help from others outside the family tend to be perceived as self-serving and a disregard for the family. The issue of communication poses as a barrier in terms of language, cultural expression, and cultural beliefs of illness (Elias, 2015; Memon et al., 2012; Buckner et al., 2007; Hussain & Cochrane, 2004).

My professional practice as Psychological therapist provided an emic perspective of other factors that may impact on access to services by BAME, such as the changing concept of cultural competence due to the constantly growing numbers in ethnic and diverse populations in UK. According to earlier studies, a lack of sensitivity by health professionals to patients and the communities they dwell in such as, cultural beliefs, practices, expectation, and backgrounds can be a deterring factor when accessing services, (Staiger et al., 2018; Moller et al., 2016). Gender based beliefs such as having a female therapist for an Asian male patient has resulted in a significant number of male patients dropping out of services due to family-based values and beliefs regarding receiving help from a female. My professional experience has revealed how beliefs based on age or religion of the Professional, especially the young helping the older seemed to be shaming and frowned upon within some Asian and black ethnic communities. This appeared to be based on their beliefs regarding respect for the elderly and no first name calling basis (Coventry et al., 2011;Fernando, 2010). Sensitivity to enhance access to services for BAME also consists of doing away with structural barriers which include provision of interpreters as well as the provision of sufficiently translated health education materials and appropriate appointment days, dates and times suited and centred around the person’s values, beliefs and needs. Anecdotal evidence from my professional observations and reported feedback from patients attending therapy sessions reinforces this perspective, that a proportionate number of South Asian patients of Muslim faith prefer not to attend appointments on a Friday afternoon as some of the times coincide with attending mosque or prayer times.

It is also understood that other barriers to accessing services are the silence about past histories and experiences of trauma (Knaak, Mantler & Szeto, 2017), as they suggest that when patients present at clinics, they may need to communicate their histories and migration timeline. Additionally, Meer & Mir (2014) suggest that cultural values governing communication norms and culturally based affective responses to mental disorders (for example, unwillingness to report psychological problems and taking them out in the public domain) among Asian immigrants may be related to low utilisation rates and access to mental health services.

As a result, it is argued that, ethnocentric attitudes of medical and mental health professionals where eastern cultures are perceived as repressive, patriarchal and inferior to western ideals have the potential to impact on treatment pathways (Rathod et al., 2010; Gater et al., 2008; Ahmed & Bhugra, 2007; Kohn et al., 2003) for example; the provision of services such as IAPT in UK whose prescribed models are generalized therefore at risk of being culturally insensitive, inappropriate and meaningless to BAME patient groups and hence ineffective.

vi. Evidence Base for CBT treatment effectiveness

The scoping review revealed minimal evaluations of the effectiveness of psychological therapies for SAI when suffering with depression in UK within the IAPT Programme as afore mentioned in Part 1 of this Chapter. There was a lack of sufficient evidence on outcomes and effectiveness of IAPT CBT where ethnicity was considered, i.e. within BAMEs. Accordingly, Naeem et al., (2015) conducted a series of qualitative projects, underpinned by ethnographic approaches as well as randomised controlled trials with South Asian Pakistanis where people suffering from depression where interviewed regarding, symptoms, issues of access and barriers to access, referral processes, attribution styles and acceptability of psychological therapies. The extent to which CBT was consistent with personal, religious, family, social and cultural values was explored with information gathered from the qualitative studies collated to develop an adaptation framework that guided the CBT adaptation process (ibid.) Findings indicated a number of issues which needed to be considered when working with South Asian Pakistanis such as, awareness of culture and religion, assessment of a person's level of acculturation, importance of involving family, language needs, engagement and therapy processes, with patients not wanting to be treated as equals within therapy and expectations of being treated sensitively by practitioners, (ibid).

This inequality was also highlighted in a quantitative comparative study by Syeda et al., (2012) who compared attitudes towards ‘Western’ counselling and counselling services of Indians living in the UK for more than 10 years between British citizens and Indians living in India. Following completion of a 12-item attitude questionnaire, based on the Likert scale rating including with statements ,and questions on awareness of counselling services, and its significance and sources for seeking help and finding information about counselling; results indicated that Indians in the UK found Western counselling more favourable compared to White British and the Indians in India. However, gender differences were found with Indian men finding western counselling more favourable than Indian women in the UK.

Similarly, using interpretative phenomenology analysis, Tarabi et al., (2018) explored the experiences of individual CBT among second generation Muslim men receiving CBT in the UK. Individual face-to-face semi-structured interviews were conducted with Muslim men who had received 10 and 16 sessions of individual CBT. Results indicated that to a significant extent CBT was effective in managing difficulties as well as helpful in learning new tools and skills overcome problems with participants reporting the process of therapy as *“enlightening”.* However, certain aspects of CBT were found distressing, challenging or difficult especially the language and difficulties with terminologies used, as well as cognitive processes of challenging of negative thoughts, with some participants finding ad referring to CBT as daunting and intimidating.

The disparities and dilemmas with wide variation in the pathways and general patterns of use and psychological/mental health services uptake within BAME communities and issues of efficacy and equity continues to require further exploration. Fernando (2010) argues that, Eurocentric/Western psychological therapies such as CBT are geared towards cultural needs in the west of which therapy is mainly individualized and usually focused on the patient gaining insights and cognitive understanding. Moreover, Lamb et al., (2012) reported many groups with high levels of mental distress face disadvantages because care is usually not made available to them at the appropriate and crucial time. Lamb et al., (2012) state that the interactional relationships with the relevant professional may be the very factor that deters help seeking or diverts it into forms that do not necessarily address their needs.

Fernando (2009); Walsh and Cross (2013) argue that these need to be “rid of” as a culture bound phenomenon that is unlikely to have much meaning as an indication of benefit in other cultures.

Identifying the experiences and understanding the needs of potential service users is fundamental when designing appropriate interventions to improve access to psychological therapies. In a qualitative study exploring the perceptions, strategies, and needs of older people with depression von Faber et al., (2016) reported that, people who suffer from depression found using several cognitive, social, or practical coping strategies as beneficial. Although most participants reported to manage their problems sufficiently, some reported a need for professional help with others being ambivalent about seeking and receiving treatment. Respectively, Lawrence et al., (2006) reported that people with depression preferred psychological treatment to medical treatment and only seek professional help if they considered the depression severe.

The benefits of engaging in social groups when experiencing depression has been reported by Gater et al., (2010), who carried out a randomized controlled trial with British Pakistani women to determine the efficacy social groups as therapeutic intervention for depression. Results indicated that participants who received social group intervention improved significantly compared to those who received antidepressant medication only. Gater et al., (2010) recommended a combined medical and social approach to tackle persistent depressive disorders in this group and general measures to increase more social support combined with educational facilities to empower women from this ethnic group. Training General Practitioners (GPs) in overcoming communication difficulties and challenging popular stereotypical views, assumptions and behaviours were also recommended. This provides valuable insights into the importance of incorporating culture and ethnic values

when offering psychological interventions to South Asian people; hence offering significant support to arguments by those who encourage the process of multicultural practices. However, studies such as Gater et al., (2010) can be criticised for their excessively narrow subject focus, with a rigid concentration on the social model of depression instead of broadening it to other models such as psychological, biological, or pharmacological.

Fernando (2010) suggests that the justification for focusing on a social model could be rooted in the continuing failure of the aim of Western psychology, which is often conceptualised in terms of the person becoming self-reliant and independent whereas in other cultures these qualities may be viewed as a sign of deviance or even illness.

Similarly, in a study by Williams et al., (2015) to investigate the extent to which exposure to other recognised risk factors for depression might potentially account for any prevalence differences, findings indicated that, South Asian and Black Caribbean participants were significantly more likely to have depressive symptoms compared to White British. Williams et al., (2015) highlighted the importance of understanding the reasons for these ethnic differences in order to identify opportunities for interventions and address inequalities.

There are also suggestions that treatment and supportive services for people from BAME groups are often based upon inaccurate assumptions and prejudicial stereotypes including, for example, "aggressive black men", as policy makers and service providers fail to understand the cultural and social circumstances of people from BAME groups and thus their reluctance to seek help. Inter-group stereotyping when experiencing depression is reported to result in social isolation, rejection from friends, and family, with the majority of people avoiding social interaction with people with mental disorder (West, Hewstone & Lolliot, 2014). According to Major, Mendes, and Dovidio, (2013), the intergroup processes, have a negative impact since they contribute to health disparities which result in contrasting encounters and experiences of mental health problems, variations in health behaviours, and disparate quality of health care experiences by its members. Furthermore, the reports into institutional racism in public services and a number of enquiries into the deaths of black men with mental health difficulties in police or health custody, incorporated with existing fear and apprehension of mental health problems, could prove to be a major deterrent to service access for people from BAME groups. One such death is that of David "Rocky" Bennett who died in custody following a restraint whilst he was in a mental health hospital in Norwich, England (Keating, 2007; DH, 2005; Sainsbury Centre for Mental Health, 2002)., The inquest into Bennet, a black man of Afro Caribbean heritage's death indicated that his racial, cultural or social needs were inadequately attended to. Sashidaran (2003) reports on the lack of capacity and commitment by health policy makers such as the Department of health to address issues of racism and long-established patterns of ethnic inequalities within mental health services in UK.

Hence, in order to manage stigma and have knowledgeable understanding of depression and other common mental health disorders, people from BAME communities require considerable mental health literacy and practical support. Tailoring services to meet specific needs, tackling stigma, racial and intergroup stereotypes, cultural naivety as well as institutional racism which present as barriers to service access can provide valuable evidence that may facilitate change and assist in transforming mental health services and improved access for people from BAME communities.

vii. Psychological therapies as an Intervention

There are numerous arguments that health care systems are a mixture of care activities dictated by the social, political, and economic contexts of a culture or society (Bhattacharya et al., 2010; Fernando, 2010; Seeley, 2000; Bhughra & Bahl, 1999). Moreover, Commissioners for NHS services in the UK have been made aware of the standard that regardless of their ethnic background, everyone who uses mental health services should have equitable access to effective interventions, and equitable experiences and outcomes. In the UK, reducing health inequalities is an important government target and the Five Year Forward View by NHS England (2016) highlights the need to improve the levels and quality of service received by BAME patients. The government's commitment to achieving parity of esteem between mental and physical health is laudable and according to McInnes (2014), the evidence on which it is based cannot be disputed. The rates of morbidity and economic burden of common mental health disorders and mental illness on the UK expenditure has been dubbed by the Mental Health Foundation (2016) as an inequality so huge beyond justification. However, according to Keating, Robertson and Kotecha (2003) and Royal College of Psychiatrists (2018), ethnic minorities for the most part have been left behind in recent initiatives to develop an evidence-based platform.

Similarly, research studies such as Roberts et al., (2016) have reported oversights in misdiagnosis and significant disparities in assessing and treating mental health issues such as depression across cultures and ethnic groups. According to Gajwani et al., (2016) and

Sewell (2009), this implies a crucial need for accurate evaluation and diagnoses of psychological disorders within the bounds of culture for ethnic patient groups to have appropriate and effective treatment and interventions. Roberts et al., (2016) suggest the powerful nature of traditions and culture on the lives, mental and physical health of South Asian Indian therefore consideration is needed when planning treatment interventions. Moreover, in UK primary care, the provision of integrated and effective treatment for depression is hindered by logistical challenges associated with time limited consultations, the separation of mental health services from General Practitioners (GPs), and poor access to psychological services. Given these structural constraints, patients' subjectivity, and opportunities for collaborative approaches to managing depression potentially recede in the face of abbreviated consultations that centre on logistics and disposal (Coventry et al., 2010).

Arguably, despite the drive for national standards and approaches, patterns of treatment vary across the UK NHS. It has been reported that the psychotherapeutic field treatment is dominated by a universal application of therapeutic theories that can be irrelevant, meaningless, and ineffective to the patient, Fernando 2010; Rogers & Pilgrim 2010). Historically, in mental health services, psychological therapy provision had been reported to be "patchy", uncoordinated, idiosyncratic, potentially unsafe, and not fully integrated into management systems, (DH 2004). Since 2008, The Department of Health has allocated substantial funds and commissioned services for Improving Access to Psychological Therapies (IAPT), but so far the currently delivered therapies are rooted in Euro-centrism and Western views of the person, for example CBT (Fernando, 2010; Rathod et al., 2010; Sewell, 2009) and in UK primary care, CBT is perceived as evidence based effective treatment for depression (Turkington et. al, 2006). However, the emphasis on evidence and standardization within IAPT that leads to a focus on measurement could be a potential factor in perpetuating the inequalities that BAME people encounter. IAPT's use of the Minimum Data Set (MDS) such as the Patient Health Questionnaire (PHQ-9), and Generalised Anxiety Disorder (GAD-7) to measure symptoms of these common mental health disorders. Therefore, it is argued that the preoccupation with measurements disguises significant evidence about the causes of distress not being just physiological or biological but being social and political.

Hence, the requirements for racially inclusive and culturally competent practice in psychological therapies are argued to comprise of: professionals skilled in exploring racial and cultural identity; understanding that life events with racial elements are a social reality which may also have internal representation; to understanding the primitive feelings that may accompany racial encounters and conflicts; and to notice and incorporate expression of culture and race in therapeutic work (Bhui & Morgan, 2007) .

Contemporary debates within health and social care contexts in relation to BAME patient groups focus on the efficacy of the current NHS IAPT on BAME patients. The second phase of IAPT was marked by the publication of “Talking Therapies a Four-Year Plan of Action”, (2011). Conjointly, the White Papers on the future of the National Health Service (NHS) provided frameworks within which Service delivery can be improved and specific emphasis on Primary Care services to take into consideration the needs of BAMEs, (DH, 2012). Furthermore, NICE guidelines recommend that depressed patients receive individual psychological interventions such as CBT as first line treatment, with group therapies being an option for people who prefer this (Cramer et al., 2011). However, it could be disputed that groups can also be problematic since there is a potential for multicultural groups to mimic intercultural conflicts of the larger society such as racism and stereotyping. Concurrently, cultural concerns, beliefs, taboos, and stigmas may further inhibit the sharing of personal information with a group of people of different or similar genders or backgrounds (Hole, 2007; Hays 2001 in Eshun & Gurung, 2009). Fernando (2010) contends that Eurocentric/western psychotherapies are geared to cultural needs in the west of which therapy is mainly individualized and usually focused on the patient gaining insights and cognitive understanding. Seemingly, there is also a lack of systematic reviews and meta-analyses to determine the efficacy and effectiveness of the treatment of depression with NICE recommended psychological therapies on people from BAME communities (Sewell, 2009).

viii. Controversies surrounding IAPT CBT treatments as Evidence Base

To monitor the extent to which the NICE guidelines for depression in adults were being implemented and delivered by IAPT, two National Audits were undertaken in 2011 and 2013, NICE (2018). Since 2014, NHS Digital, (2018) published annual reports showing variation in outcomes in IAPT services. Over the course of more than a decade and ahead of its 3rd guideline, data indicated that access rates increased to around 1million patients per year entering treatment, and waiting times decreased so that for over 90% of IAPT patients access to treatment is less than 6 weeks. Although this is undoubtedly a great achievement, it does not indicate the actual numbers of BAME, in this instance, South Asian Indian that accessed services, entered treatment, and effectively recovered from depression.

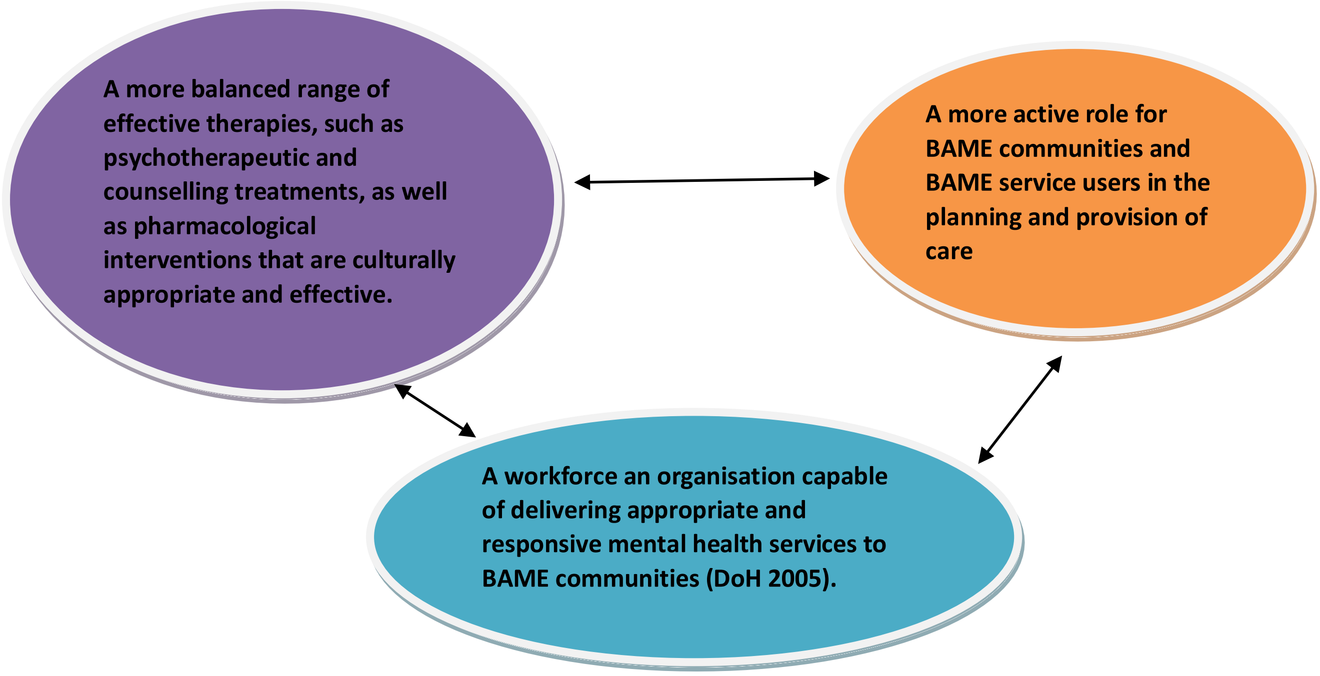
Using qualitative, quantitative, and mixed methods to investigate the feasibility of achieving Improving Access to Psychological Therapies (IAPT) for people from BAME communities living in the UK, Loewenthal et al., (2012) carried out focus groups with Bengali, Urdu, Tamil and Somali speaking communities. The communities were engaged to explore how they conceptualise and experience and responses to mental health issues. Approaching their data using thematic analysis, findings suggested that Bengali, Urdu, Tamil, and Somalis inadequately understood common conceptualisations about mental health issues and lacked knowledge on how to seek support when experiencing common mental health problems such as depression. The development of culturally sensitive primary care and GP services with ease of access and flexibility were indicated as essential. The findings also highlighted the need to explore cultural and religious factors that implicitly affect access and referral to psychological therapy treatment an interventions such as IAPT. Moreover, there has been perceivable analysis of the IAPT program in that the IAPT program is predicated on an evidence base for those populations wherein the interventions have been assessed. However, it has been argued that the evidence based psychological therapies such as CBT does exclude validation from a scope of various ethnicities, for instance ethnic minority populaces, (Williams, 2015; Griffiths et al., 2013).

Agreeably, IAPT may not the place where "all" people with common mental health problems and emotional distress can or will be treated. Moreover, Wallcraft et al., (2009) argue that although in theory increasing the availability of services and supports with demonstrated “effectiveness” is essential, there are some concerns that privileging select approaches/ interventions such as CBT through dissemination and funding initiatives limits service user choice by narrowing the range of available services. Service users who gave feedback on evidence-based practice described it as paternalistic, following a top down medical model that may not be congruent with the recovery vision articulated by patients (Wallcraft et al., 2009). According to Marzili (2002), the research base appears to support the status quo since it predominantly reports on recovery rates through evaluating symptoms, recidivism, and treatment outcomes rather than the promotion of wellness outcomes such as empowerment, self-efficacy, meaning in life and hope.

Interestingly, CBT as already established is a structured problem focused, goal-oriented approach aimed at modifying thoughts, assumptions, beliefs and behaviours in order to influence disturbing emotions and habits. How then would a talking therapy provided by professional be translated for example to black women who feel a deep cultural connection to “being strong” rooted in the histories of enduring longstanding oppression and slavery (Burr & Chapman 2004; Edge & Rogers 2005). As a result people from BAME groups engage in self-management mechanisms based on the interpretation of individual narratives as well as wider collective ones which mainly relate to concepts of power, struggle and oppression as well as resilience, being able to overcome and mastery (Shramko et al., 2019; Arday, 2018;Fuertes, Brady-Amoon, Thind and Chang, 2015).

Importantly, expectations about health may be held by an individual both about themselves and their own health status or quality of life and about health care services and systems; therefore, these expectations have a major influence on satisfaction with those services. Arguably, ethnicity plays an important role in people’s expectations because these are influenced by people’s understanding of the world and the social and political contexts in which they are located (June et al., 2010; Moriarty, 2008). Correspondingly, what is viewed as mind and body in western psychology is conceptualised in set ways as entities and tested objectively with mainly medical tests and tools. However, the eastern view is the indivisibility of the human life that compromises mind, body, spiritual, and other entities of human life as a “whole” (Fernando & Keating 2009). It’s noteworthy, according to (Kirmayer

2007) that western diagnostic and conceptual frameworks may be culturally determined, and that cultural communities may have ways knowledge bases that may not necessarily rely on the nature of observational and experimental measures and methods that characterise evidence-based practice. Thus, health care systems include patterns of beliefs about causes of illness, norms governing choice and evaluations of treatment, and so individuals' responses to illness and treatments, their carers and society at large and social institutions relating to them are all interconnected (Bhughra & Bahl 1999).



A more balanced range of effective therapies, such as psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.

A more active role for BAME communities and BAME service users in the planning and provision of care

A workforce an organisation capable of delivering appropriate and responsive mental health services to BAME communities (DoH 2005).

Diagram (6) Shaping Services for BAME

According to the NICE BAME Positive Practice Guide, isolation is believed to be a key component of depression. Its goes on to emphasise that it is therefore fundamental that IAPT Services work to include people from BAME communities and cultural groups so that they are able to access psychological therapies and are not isolated further from such services (DH, 2009). How these services could be shaped as propounded by the Department of Health (2005) is illustrated in Diagrammatic Form (Diagram 6). This is discussed further in Chapter 6 which explores implications and recommendations for service provision.

ix. Cultural Sensitivity and Culturally adapted CBT

Within the limited research currently available, attributable evidence has raised questions about the effectiveness and equitability of CBT which is rooted in Eurocentric Western culture. Significantly, health is seen as an individual sense of well-being as opposed to the eastern cultures where illness is perceived as disharmonies within a whole or collective (Louie 2018; Sinha and Chauhan, 2013; Fernando, 2010). My personal, academic, professional, and everyday life experiences have highlighted the notion that African tradition's concept of health is more social than biological. On the other hand, South Asian tradition such as Indians place significant emphasis on the harmony between a person and their collective group as indicative of health, (Louie 2018; Sinha and Chauhan, 2013; Fernando, 2010; Eshun & Gurung, 2009).

In Muslim cultures specifically Malaysia, an individual is perceived to experience mental illness as a result of abandoning or neglecting Islamic values, principles, and practices, with the experience of positive mental health understood to be achieved though religious practices which could purify thoughts and actions (Khan et al.,2010). Moreover, it is understood that some South Asians and other African and Eastern cultures are well known for believing in back magic and witchcraft as a cause of poor mental health (Naeem et al., 2015; Fernando, 2010). This is recognised globally, for example, Miranda et al., (2004) reported that cultural differences potentially could make psychotherapeutic interventions differently effective for minorities with Eurocentric modalities perceived as potentially harmful or even oppressive to diverse populations (Wendt, Gone & Nagata, 2015). A definitive example is that of "depression" for which there is no specific word that means the same in South Asian languages of Punjabi, Urdu, and Hindi (DH, 2009). CBT, a western approach, also encompasses a lot about distorted cognitions and cognitive restructuring, therefore, what may be referred to as "distorted cognitions" in the west, may well be or become functional and adaptive in a different culture. Davis (1990) asserts that there is a dilemma of trying to reconcile attempts to discover a language and principles that can be endorsed as true for all people considering populations around the world are highly heterogeneous in personal and cultural make up, beliefs, language, and customs.

Challenges associated with heterogeneity was reported elsewhere, for example Rathod et al., (2010) found that a common problem reported by white therapists delivering CBT was the belief that therapy is the same for everyone. The therapists argued that they would follow the same format for a BAME patient as they would for a white patient. However, this presents a problem since delivering interventions delivered to White patients in the same mode for individuals from BAME communities means inappropriately and inadequately attending to cultural or social needs, and may be inconsistent with some BAME people's beliefs of self and collective, especially those from South Asia (Kapadia et al., 2017; Memon et al., 2016; Lavender et al., 2006). South Asian Indian and other BAME communities give significant value and meaning to family as opposed to the western ideals of individualisms as noted and referenced earlier (Knaak et al., 2017; Fernando 2010; Sewell 2009). One of the suggestions by Ratho et al., (2010) is the need for service and treatment providers to understand the fundamental world and life views in different cultures which in turn impacts lifestyle choices and perceptions of illness. Subsequently, this would in turn arbitrate whether a therapy like CBT would be acceptable and suitable to whomever it is delivered to.

Historically, in the UK, the Voluntary Sector have always been the ones to provide culturally appropriate services for BAME groups and not necessarily the statutory agencies consequently making health provision inequitable. Black Voluntary sector organisations have historically filled the gaps in mainstream provision with initiatives such as Servol Community Trust in Birmingham, The Afro-Caribbean Mental Health Project in Brixton, and Advocacy Project in Liverpool, (Fernando & Keating, 2009; Lawrence et al., 2006; Jennings 1997). Thus, evidence suggests that cultural appropriateness entails services that are based on culturally aware practices, which move beyond having posters of BAME people and ethnic décor in waiting rooms (Cooper, Spiers, & Livingston, 2013; Collins & Arthur 2010; Furler et al., 2010).

However, since CBT is underpinned by individualistic values, others have suggested that CBT needs to be adapted to meet the needs of patients from collectivistic cultures such as SAIs., (Beck & Naz, 2019; Beck, 2016; Naeem et al., 2015; Hinton & Patel, 2017). According to Hinton & Patel (2017), in order for CBT to be adapted and culturally sensitivity must be adhered to when engaging with minority ethnic groups who suffer from depression, as well as a need to comprehend the way culture shapes health illness beliefs, experiences and help seeking behaviours. Beck (2016) suggests that, what constitutes culturally sensitive CBT is CBT that is adapted to suit any individual be it white patients or those of minority cultures, and where the discussion touches on ethnicity and cultural issues. Culturally adapted CBT on the other hand is argued to be that which is specifically adapted for people from specific ethnic backgrounds suffering from a specific disorder, where practitioners adopt culture specific linguistics such as metaphors, symbols, idioms without deviating from the basic principles of CBT (ibid, 2016). Therefore, therapy that is culturally adapted should consist of cultural values and practices, with consideration of the individual patient's acculturative and socio-economic status, gender, migration history and experiences of oppression (Beck & Naz, 2019; Naz et al., 2019; Beck, 2016; Naeem et al., 2015; Hinton & Patel, 2017; Rathod et.al, 2010).

Although it is acknowledged that cultural adaption cannot solely enhance outcomes, certain emerging frameworks have been proposed within the field of psychotherapy aimed at improving access to services and acceptability of psychological interventions for BAME such as SAIs. Concomitantly, Khan et al., (2019), argue that adjustments should be executed inside CBT for it to be viable for South Asian women. In their mixed method research to develop and test the feasibility and acceptability of a culturally-adapted CBT-based, manual-assisted intervention in British Pakistani mothers experiencing maternal depression, (ibid.) reported that CBT was perceived as appropriate if consideration was given to specific aspects. These aspects included CBT language, which was adjusted to a familiar South Asian language, socially fitting and culturally suitable at home tasks, metaphors and utilising socially suitable stories such as folklore when explaining the Activating, Beliefs and Consequences (ABC) model of CBT.

Encompassing debates regarding improving access to psychological therapies and appropriate treatment interventions for BAME communities have been ongoing without any resolution or advanced developments to date. According to Stone et al., (2018), when culturally adapting interventions such as CBT, there is a need to consider the lived experiences of patients and their specific world views and convictions about wellbeing, as well as recognising that being members of ethnic minority communities poses a risk factor for common mental health disorders such as depression as a result of marginalisation, poverty and discrimination. In order for access to psychological therapies to improve within the BAME communities there needs to be advancement in delivering culturally competent psychological therapies with treatment modalities reshaped, diversified, and transformed to meet the specific needs of these groups of people. There is a need to recognise that due to cultural differences between the majority White and minority ethnicities such as SAIs, the effectiveness of certain psychotherapeutic interventions can be perceived futile due to Eurocentric modalities being rooted in Western ideologies which maybe inconsistent with BAME populations' values and beliefs. BAME people's experiences of migration, racism, prejudice and discrimination, economic disadvantages and issues of language needs to be taken into context when adapting treatment interventions.

Critiquing the Reviewed Literature

The objective of perusing literature was to establish the availability of existing knowledge in order to determine any research gaps and map further exploration. As previously discussed in **Section ii**. of this Chapter, the review confirmed an absence of papers that specifically explored South Asians' perspectives of IAPT CBT therapies when experiencing depression in UK. There were a limited number of studies that examined the perspectives of psychological and mental health interventions, issues of access and barriers to services in the UK, within South Asian Indian, Pakistani, and other BAME groups such as Black Afro Caribbean and Black African communities. Utilising GT methods to support the review has helped to appreciate key concepts in the literature and confirmed the lack of studies on IAPT since implementation in England in 2008. Interestingly, the majority of the papers published focused on statistical reporting of National IAPT overall outcomes which did not provide evidence or insight into issues of access and efficacy of IAPT CBT interventions for SAIs. The absence of research is concerning since it results in a disservice to patients as well as presenting an impediment to improving and delivery of equitable and effective care services

However, to the extent that the majority of the research is exploratory, results offer insights into the importance of recognising barriers and treating depression using different treatment modalities in ways that would encourage BAMEs to seek and access treatment.

Studies presented in the review can be commended for having chosen qualitative and mixed methods such as focus groups, and community based participatory studies since findings and explanations that emerge are genuinely new knowledge used for the development of new theories about phenomena (Charmaz, 2014; Aldiabat & Navenec, 2011; Corbin & Strauss, 2008). The use of focus groups and community based participatory research can also be commended since the co-production of information guarantees and results in considerable health care improvements (Jull, Giles, Graham, 2017 Yaraghi, Du, Sharman, Gopal & Ramesh, 2015; Bovaird & Loeffler, 2013; Jakab, 2011). The use of grounded theory and thematic analysis is perceived suitable for the investigation of complex multifaceted phenomena and useful when exploring socially related issues, particularly when investigating social problems and/or situations to which people must adapt, (Chapman, Hadfield & Chapman, 2015; Charmaz, 2014; Corbin & Strauss, 2014; Aldiabat & Navenec, 2011). Although there is clear demonstration of data analysis processes using systematically coding, themes, retrieving of concepts and constant comparison, authors can be criticised for neither explaining grounded theory nor their reasons for choosing this theoretical perspective. There is also a failure to describe the difficulties that can be potentially encountered in applying analytical processes so to inform the reader of the realities of the approach.

Chapter Summary

The review has helped establish an insight into understanding issues of access, help seeking behaviours, barriers, and perceptions of BAME and SAI's experiencing of accessing psychological therapy in primary care, as well as enhancing my understanding of positionality and the wider hidden mechanisms of power and oppression. Conducting the review has helped generate meaning and understanding about the treatment needs of South Asian Indian patients with depression, as well as providing an insight into IAPT CBT therapies and its compatibility with patients from BAME and South Asian cultures. Completing the review has also helped highlight the importance of putting BAME people' s migration histories and socio-economic, cultural and experiences of racism, discrimination and political struggle into context when delivering care. The need to address the afore mentioned factors when delivering CBT in order to deliver culturally competent therapy

and reduce inequalities in mental health provision for BAME service users is also emphasised. The main concepts identified illustrated the challenges faced by BAME people such as SAIs accessing IAPT and highlighted need to explicate the experience of BAME further. This has helped construct a picture surrounding choices and decisions made by SAIs when faced by depression in primary care.
Thus, the aim of this research study in exploring SAIs perspectives of IAPT psychological therapies when experiencing depression is to explore what the IAPT Program benefactors would perhaps have overlooked around interventions for SAIs in Primary Care. Additionally, the review has highlighted the gap in research surrounding specific experiences of SAIs when receiving IAPT CBT therapies for depression in UK Primary care. The review also failed to produce crucial literature relating to patient drop out issues within IAPT in Primary Care subsequently highlighting a crucial gap which needs to be explored. Arguably, this gives voice to the aims of this research study which is to explore and understand SAIs patients' experiences and perceptions of IAPT psychological therapies in Primary care when they are experiencing depression.

Furthermore, the review has presented an influential resource in guiding the decision making around methodological processes such as the grounded theory designs and processes of data collection, its analysis and reporting techniques associated with studies that are qualitative in nature. Grounded theory methods necessitate understanding, helps develop, and supports researchers to utilise real world knowledge about health concerns. Consequently, conducting the scoping review also helped in highlighting specific areas of concerns around the research question which enabled the shaping of topic guides and interview questions surrounding phenomena being studied as evidently discussed in the ensuing Chapter which outlines the research study design.

Chapter 3: Study Design:

Introduction

This chapter describes the underpinning ontology, epistemology, methodology and subsequent research design employed in this study. An account of the study design used to gather, analyse, and synthesise data influenced by the constructivist grounded theory method of Charmaz, (2014) is explicated following an initial justification for choice of methodology and concluded by an ethical statement explaining how the research process was initiated.

The literature review highlighted the limited adequacy in currently available research aiming at exploring the experiences of depression and IAPT psychological therapies in South Asian Indian people which highlighted the need for further exploratory research. This is echoed by INVOLVE (2012) and The National Survivor User Network (2013), which advise the need for high quality research and service development with insights gained from patients who have direct personal experience of study topic. Similarly, Staniszewska et al., (2017) assert that patient and public involvement in health and social care research is increasingly important, helping to ensure that the research focuses on issues relevant to patients and other healthcare service users.

However, Gale Heath, Cameron, Rashid, and Redwood (2013) suggest that quantitative methods as opposed to qualitative methods are used to describe and measure levels of occurrences based on numbers and calculations. Arguably, quantitative approaches involve the investigation of data in terms of causes and strength of relationships, which would not be suitable for aims of research that seeks to explore experience, Barbour (2008). Other reasons for adopting a qualitative approach relate to current understanding about service user and provider experiences which might be difficult to obtain using surveys and other quantitative research methods. Furthermore, existing quantitative research instruments may not be suited to the context where they are to be applied (Foley & Timonen, 2015) such as those seeking to elicit rather than test meaning. Qualitative research helps researchers in health and social care services to understand how social practices and patterns in health care are created and what meaning these practices have for people within specific and/or varied contexts (Lincoln & Guba, 1985). Hence, for the purposes of this study, qualitative methods are congruous with the research aims.

The following section discusses the ontological and epistemological values which underpinned this study.

Part 1

i. Epistemological & Ontological Values

"A study is shaped by the researcher's guiding principles associated with a paradigm or world view, which encompasses ontological, epistemological and methodological assumptions". (Denzin & Lincoln, 2011).

Birks and Mills, (2015) and Guba and Lincoln (2005) claim that what influences and informs methodological frameworks and consequently channelling how research is shaped in gathering and analysing data are the ontologies and epistemologies that underpin the study. Relativist ontology formed the basis of this study as discussed in Chapter 1 (Background to the study), based on my personal experiences, personal views, values and beliefs as a Black African British Citizen and also based on my vocation as a psychological therapist in primary care offering treatment for depression where the majority of sufferers are from South Asian ethnicities. According to Denzin & Lincoln, (2011) relativist ontology is the belief that reality is a finite subjective experience, and nothing exists outside of our thoughts, thus, reality is human experience and human experience is reality. They suggest that the purpose of science from relativist ontology is to understand the subjective experience of reality and multiple truths, and as a BAME individual, psychological professional and researcher, I perceive my traditional collectivistic Southern African culture to have similarities akin to the South Asian Indian culture; thus, I possess to a significant extent some cultural knowledge to accurately interpret and validate the experiences of SAIs in this study. There is an awareness that my diverse and different positions, roles, and identities are intricately and inextricably embedded in the process and outcomes of this health research.

The epistemological assumption of this grounded theory approach study is derived from symbolic interactionism (S.I) which explores the processes of interaction between people's social roles and behaviours (Deutscher, 2004; Greenwood, 2004). Hence there is a resemblance that resonates with the CBT model as discussed in Chapter 2. Accordingly, Clark (1995) states, *'at the very heart of the CBT model is the view that the human mind is not a passive receptacle of environmental and biological influences and sensations, but rather that individuals are actively involved in constructing their reality'* (Clark, 1995: 156). In order to understand a person's emotional response to life events, it is important to discover the meaning he attaches to these events: his subjective construction of reality. Questioning the nature of reality is a fundamental feature of such an inquiry, as the theoretical approaches underpinning social research call into question how reality is perceived and how meaning is shared (Ritchie et al., 2013).

i. (a)Foundations & History of Symbolic Interactionism

Although symbolic interactionism is also the basis for qualitative studies, it has however traditionally been viewed as one perspective underpinning qualitative research. With its intellectual heritage that spans over a long time, symbolic interactionism is rooted in social psychology. George Herbert Mead (1863-1931), a social psychologist laid the foundations of S.I. in the 1900s from the Chicago sociological tradition having been influenced by American Pragmatism, in particular, the views of John Dewey (1859-1952). Additionally, problems arising out of industrialisation and urbanisation of the early 20th century stimulated scholars of the era to develop a distinct theoretical perspective for systematic study of human social behaviour. This was consequently labelled symbolic interactionism (S.I), after his death by his student Blumer (1900-86) and later developed into what is known as the classical or Chicago school of interactionism (Benzies and Allen 2001). It is important to note that there are two most prominent variants of symbolic interactionism the other being the Iowa school of thought.

i. (b) The Nature of Symbolic Interactionism and its relevance to the Study

Symbolic interactionism is described here as a theory and approach for the study of individuals' social and psychological action and or interaction in search of portraying and understanding the process of meaning making. Schwandt (1989 and 1996 cited in Denzin & Lincoln, 2011), claims that the goal of this tradition is to understand individuals' point of views of their lived experiences in a complex world. Respectively, conceptualising human behaviour in its context helps researchers to examine behaviour in relation to the social circumstances, rules, laws, and conditions that govern the shared meanings of objects and affect human behaviour (Aldiabat & Le Navenec, 2011). One of the most important tenets in S.I. is that; research questions focus on how individuals interpret meanings and act in particular contexts, for it is these contexts that constrain behaviours (Charon & Cahill, 2004) for example; depression vs. stigma, stereotypes, shame, culture, values, beliefs – consequently impacting on access to services.

S.I. encourages a focus on understanding the connection between the shared meanings and human health behaviours (Denzin & Lincoln, 2011; Edge and Mackian, 2010; Scott, 2004). Applying S.I. to South Asian Indians' perceptions of depression, treatment and factors presenting as barriers to accessing services will provide the opportunity to explore their experiences and understand the challenges and enables. The research will examine the interrelationships between individuals, their social contexts and the wider structural societal forces which shape their lives, for example: political contexts such as healthcare policies, decision making within primary care NHS and psychological services i.e. IAPT; a service whose evidence base is very Eurocentric. Consequently, it may be these contexts that influence some factors such as help seeking behaviours. Furthermore, biomedical approaches to healthcare offer limited solutions to psychosocial challenges and psychological treatments which can result in de-contextualization of causes and meanings in their social contexts, from which most experiences of depression emanate (Rogers & Pilgrim, 2010).

This study focuses on human group behaviour and conduct (Strauss & Corbin, 2008; Charmaz, 2006; McCann & Clark, 2003; Patton, 2002), in this instance, exploring and listening to the stories of SAI people's experience of depression, help seeking behaviours and its treatment. Non–measurable factors used such as metaphors or symbols due to cultural influences, norms, values, or ideologies of BAMEs may be the most significant, could be better understood using a qualitative methodology. The following section outlines the development of a qualitative design and its appropriateness for this study.

ii. Qualitative Approaches

It is acknowledged that healthcare is about people and people overall being more complex than the subjects of the natural sciences Pope and Mays, (2013). There are significant questions about how humans interact and interpret that very interaction process of which health researchers may need to understand before any attempts in quantifying behaviours or events (de Sales, 2003).

Customarily, the province of qualitative research explores the world of individuals' experiences and their socially constructed realities. A patient's experience is obtained using detailed interviewing and rich descriptions of the social world as well as participant observation by the researcher, Hallberg (2006). Patients tell stories about their healthcare experiences which in turn are often used as a way of shaping practice whilst providing a source of knowledge. The exploration of experiences may also provide opportunities to patients and benefit them in making meaning of specific situations encountered during their healthcare journeys. Subsequently, the aim of this study was to explore South Asian Indians' experiences of talking/psychological therapies received in primary care when presenting with depression as well as exploring the current psychological care provision and the processes involving accessing such care.

Hence, the method chosen for this study is qualitative methodology with a grounded theory approach. Although it is well understood that qualitative methods are not quantitative, these methods are hereby defined as a way of collecting, analysing and interpreting data on phenomena that are not easily reduced to numbers. Health is also argued here to be a phenomenon which is viewed as substantially qualitative in nature since beliefs and experiences of health are better understood and explored qualitatively, unlike quantitative methods which are more appropriate for testing the effect of an intervention or a treatment (Carter & Thomas, 2005). Qualitative approaches will help understand the perspectives of a group of patients such as South Asian Indians, on issues such as help seeking behaviours for common mental health problems. Qualitative research enables phenomena to be studied in their natural settings to try and make sense of, or interpret, phenomena in terms of the meanings people bring to them (Ritchie et al., 2013; Silverman, 2013).

Unlike quantitative methodology which is an approach to science that seeks a single reality through manipulating, measuring and specifying relationships between specific variables in order to test hypotheses about causal laws qualitative methods are argued to be most appropriate when studying groups of people and their behaviour (Barbour 2008; Henwood & Pidgeon, 1992; Richardson, 1996). Predicated from this paradigm, the worldview that qualitative research allows into personal experiences, provides appropriate methodologies to understand South Asian Indians patient groups' help seeking behaviour and perceptions surrounding accessing IAPT therapies through GP referrals or self-referrals and their perceptions regarding the actual talking therapy such as CBT and its effectiveness with reference to their needs, context, values and beliefs was sought and explored. It is argued that qualitative research focuses on understanding the meaning of experience, actions, and events as these are interpreted through the eyes of the specific participants within research inclusive of the researcher (Pope & Mays, 2013; Richardson, 1996). Qualitative research aims to understand processes involved, processes such as sensitivity to the complexities of behaviour and meaning on the contexts where they naturally occur. It is argued here that rather than accept the concepts and explanations commonly shared in everyday life, qualitative research requires in-depth and exploratory questions about the essence of social phenomena (Lamont & White, 2005).

Moreover, qualitative methods are especially useful when conducting research in primary care and within GP practices as practices are aligned with the social world as opposed to the world of investigative natural science. As human beings we are mostly interested in viewing people as social beings rather than just as physiological systems as well as in the meaning of social events (Umberson & Montez, 2010). Seeking and exploring questions that can help describe experiences of seeking help and accessing psychological services within the GP Practice will help reveal patients' subjective experiences. A qualitative approach provides a holistic and less reductionist in its approach to problems which fits well within general practice environments and their nature of everyday work, (Carter & Thomas, 2005), and in this instance, where people come and seek nationally prescribed treatments such as IAPT CBT for common mental health problems such as depression. Trafimow (2014) asserts that qualitative research is unashamedly subjective which is an advantage in that it increases the descriptive richness, paves way for illuminating insights, and allowing full play for the intuitive attributes of the researcher. Equally, Bradley, Curry and Devers (2007) suggest that qualitative inquiry can improve the explanation of complex, real-world phenomena pertinent to health services research.

It is argued that what makes qualitative research is certain essential elements which are commonly agreed to give qualitative research its distinctive character (Denzin & Lincoln, 2011). These elements include research with aims that are directed at providing in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, perspectives, and histories (See Appendix 6). Additional elements include: research that has small samples chosen through purposive sampling on the basis of significant criteria (Appendix 4), specific methods of collecting data, usually involving a collaborative, interactive and developmental relationship between the researcher and research participants allowing emergent issues to be explored (See Appendix 7) and data which are very detailed, informative and extensive in nature (see Appendix 6). Specific ways of analysing data which is open to emergent concepts and ideas that may produce detailed description and classification is another fundamental element including identifiable patterns of association, and research that develops typologies, explanations, and outputs which usually focus on the interpretation of social meaning through mapping and representing the social world of research participants (Pope & Mays, 2013; Seale 2012; Denzin & Lincoln 2011;).

Nevertheless, qualitative methods have been criticised by Pandey and Patnaik (2014) as lacking rigour and they argue that, where there is no rigour research turns into fiction therefore useless and ineffective. Qualitative research is seen as limited because it does not measure or manipulate leading to the perception that it lacks reliability and validity, hence Lincoln and Guba (1985) argue that the term transferability and dependability are more aligned to the qualitative approach. Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts with other respondents which can be achieved through thick description as a way of achieving external validity (Lincoln and Guba, 1985). This means that researchers can demonstrate transferability through providing a detailed description of the enquiry and stating how participants were selected, i.e., purposively. Li (2004) argues that thick description enables judgments about how well the research context fits other contexts because without it, it would be difficult for the targeted audience to determine the authenticity and trueness of the overall findings.

To address issues of dependability, Lincoln and Guba (1985) highlight the need for an *"inquiry audit"* as one measure which may enhance the dependability of qualitative research. As demonstrated in this thesis this is achieved through describing in detail how data is collected, how categories are derived, and detailing the whole research process and justification to support choices made. Hence, qualitative research needs to illustrate whether the findings, interpretations and conclusions are supported by the data, therefore allowing others to challenge the process and findings of a study (Cohen, Manion, & Morrison**,** 2011; Li, 2004; Lincoln & Guba, 1985).

Indeed, Trafimow (2014) claims that what is fundamental at the theoretical level is relations between abstract and unobservable constructs rather than causation, which is where qualitative methodologies have an advantage over quantitative approaches. Equally, Bradley et al., (2007) argue that qualitative methods provide a sophisticated approach to specifying the complexity rather than simple dichotomous characterisations of interventions (of treatment versus interventions) common in quantitative research. Whereas quantitative researchers determine correlation and coefficients at the empirical level and not the theoretical level, the limits for numbers in qualitative research is determined when one reaches a point at which one seems to have exhausted the problem or when additional data collection seems to reveal no new information or insight, (Charmaz, 2014; Strauss and Corbin, 2008; McNeil, 2008). In grounded theory this is known as theoretical saturation which will be discussed in relation to this research and the justification for the qualitative method and influences of grounded theory is explored and justified in the following section.

iii. A Grounded Theory Framework

The methodology for this study is qualitative influenced by a grounded theory approach (GT) (Charmaz, 2014; Corbin & Strauss 2008; Glaser & Strauss 1967). Grounded theory is a qualitative methodology used to inductively separate clinical issues of importance by creating meaning about those issues by analysing and the emergence of theory. Grounded theory perspective was considered to be appropriate for this study as compared to other methodologies such as phenomenology and discourse analysis; the reason being that the aim of this research study was to generate understanding and meaning about SAIs perspectives of psychological therapy when experiencing depression in Primary Care. Unlike phenomenologists, grounded theorists seek to include all data sources that might contribute to theory development (Holloway & Wheeler, 2013). Conversely, phenomenology seeks to understand phenomenon through the specific human experience of the phenomenon so to better understand that experience of being in that particular *'life-world'*. Phenomenology serves to understand a person's experiences rather than to provide causal explanation of those experiences. Unlike grounded theory, the process of phenomenological research, therefore, does not *'break down'* the experience under study; rather, it provides descriptions that are rich and full and interpretations that exactly describe what it means to be a person in their particular world. The focus of the phenomenological researcher is therefore to understand the experience of the phenomena, rather than parts of that experience, Smith (2018).

Other methodologies include discourse analysis although in comparison to grounded theory and embedded in the constructivism–structuralism traditions, discourse analysis's key emphasis is on the use of language in social context, (Forrester 2010; Salkind, 2010; Chandler, 2002). According to Starks and Brown Trinidad (2007), discourse analysis focuses on combining attention to the linguistic detail of discourses with in-depth analysis of the context in which these discourses are produced. Contrary to grounded theory which focuses on developing explanatory theory of basic social processes, discourse analysis seeks to understand the way people utilise language to create and enact identities and activities, Gee (2011). According to Strübing (2007) it is important for one to understand theoretical discourses that surround a methodology in order to justify the research conclusions formed). Therefore, the next section of this Chapter looks at the evolution of grounded theory as well as its processes.

iii. (a) Origins of Grounded Theory

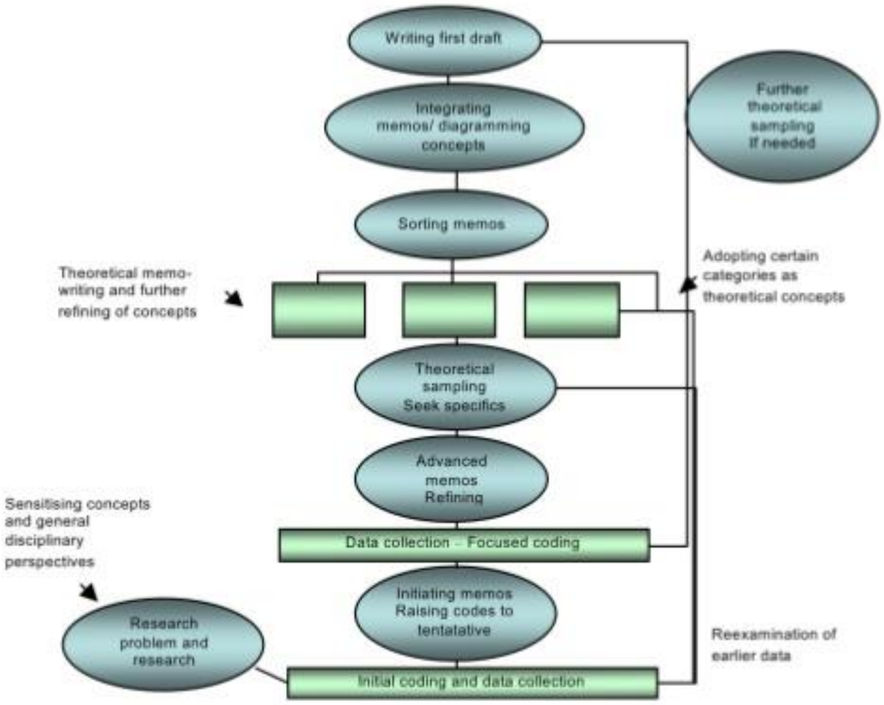
Grounded theory originated in the 1960s as a result of Barney Glaser and Anselm Strauss's (1916-1996) sociological research studies on the theme of dying in hospitals (Charmaz, 2014; Strauss & Corbin, 2008). Through joint efforts, they designed a method that enabled researchers to generate a substantive theory grounded in empirical data using systematic ways. The goal was to discover a theory that would fit the data and would work in the real world (Glaser & Strauss, 1967). Concurrently, GT has bifurcated roots in the rigorous positivist tradition that Glaser grew up with as well as the Chicago School of field research and its empirical traditions. This put together evolved as a tool which combined Glaser's deductive attitude to data analysis, with Strauss' inductive methods with the objective being developing theory from data. In addition to generating theory from data, Glaser and Strauss stressed that existing theories could be modified or further developed (Glaser & Strauss, 1967). Grounded theory challenged the then-dominant logico-deductive way of theorizing because, rather than develop a theory and then systematically seek out evidence to verify it, researchers using grounded theory set out to gather data and then systematically develop the theory derived directly from the data (Dey, 1999). This implies that in grounded theory the focus is not based on testing hypotheses taken from existing theoretical frameworks, but rather develops a new 'theory' grounded in empirical data collected in the field. By its very nature, these data are deliberately privileged above any existing theoretical concepts due to the reality of the data (Dunne, 2011).

This study has been influenced by Charmaz's constructivist grounded theory. Whilst there are a few iterations and interpretations of GT, Charmaz's GT was appropriate because it enables meaning to be revealed and analysed. In this thesis participants' experiences of IAPT psychological therapies for depression is explored through telling their stories within the context of their own culture, values, beliefs and many other factors or phenomena.

iii. (b) Charmaz's Influences on Grounded Theory

According to Charmaz, (2006), grounded theorists adopt a few strategies to focus their data gathering and analysing and there is a qualitative process flow to building a grounded theory. This process is illustrated in the Diagram (7).

Qualitative process-flow to build grounded theory.



Source: Adapted from Charmaz, 2006

Diagram (7) – ***Building a Grounded Theory*** (Adapted from Charmaz, 2006)

Charmaz (2014) has over more of a decade presented a grounded theory rooted within constructivism and which others can view as an approach between positivism and post modernism. Within constructivism social realities are perceived as multiple and simultaneous as opposed to a one and only *“real reality”*. Humans are influenced by history and cultural context which consequently shape their views of the world, the forces of creation as well as the meaning of truth (Nilsson, 2014). Charmaz (2008) also asserts that,

> *“Consistent with Marx, I assume that people make their worlds but do not make them as they please. Rather, worlds are constructed under particular historical and social conditions that shape our views, actions, and collective practices”*.
> (Charmaz, 2008, p.409*)*

This may be relevant when considering the South Asian Indians perspectives who may not access health and social care services based on their early lived cultural experiences that influenced their decision to seek help for mental health or/and physical health problems (Roberts et al., 2016; Rathod et al., 2010). This is illustrated in the work of Bhugra and

Mastrogianni, (2003) and Parker, Gladstone and Chee (2001) who reported how *"minority ethnic"* patients reported the absence of the word depression in their culture and upbringing, as well its manifestations which sometimes posed a barrier to seeking help or accessing services.

Combined with explicitness and flexibility, grounded theory offers systematic analytical strategies to collecting and analysing data to develop theoretical analyses (Charmaz, 2014). From an epistemological perspective, constructivism accentuates the subjective interrelationship between the researcher and participant, and the co-construction of meaning (Charmaz, 2008; Hallberg et al., 2006; Mills et al., 2006). Hence researchers as human beings form part of the research process as opposed to being just objective observers, (Guba & Lincoln, 2005) whereby their values should be acknowledged not only by themselves but also by their readers as an inevitable part of the outcome. Thus, when explicating meaning about SAI groups of their experiences, this is important because it provides an explanation of various concepts consequently helping in arriving at conclusions such as patterns of help seeking behaviours.

Charmaz's fundamental tenets of GT as illustrated in Diagram (8) include minimising preconceived ideas about the research problem and the data; using simultaneous data collection and analysis to inform each other; remaining open to varied explanations and or understandings of the data and focusing data analysis to construct middle range theories. These strategies are used to initiate early analytic thinking through the researcher interacting with the data. Grounded theory strategies provide an opportunity for the researcher to venture beyond classic induction thereby building several checks and continuous refinements into qualitative inquiry (Charmaz 2014; Charmaz, 2008). This is achieved through a constant process of successive analytic and data collection phases of research with each one informed by the other towards theoretical sensitivity. Strauss and Corbin (2015) describe theoretical sensitivity as a multidimensional concept where a researcher displays insight into the research area and how they adapt to the nuances and complexity of the participants' words and actions and being able to reconstruct meaning from the data generated with the participant. Charmaz (2006) argues that sensitivity is attained through stopping and thinking anew, considering multiple vantage points, comparing, following leads, and building on ideas. This enables participants' stories to be interpreted within the participants' world contexts. In order to enhance researcher sensitivity, the researcher is encouraged to read the literature, open coding, category building, reflecting in memos followed by doubling back on data collection once further lines of inquiry are opened up (Hoare, Mills and Francis, 2012).

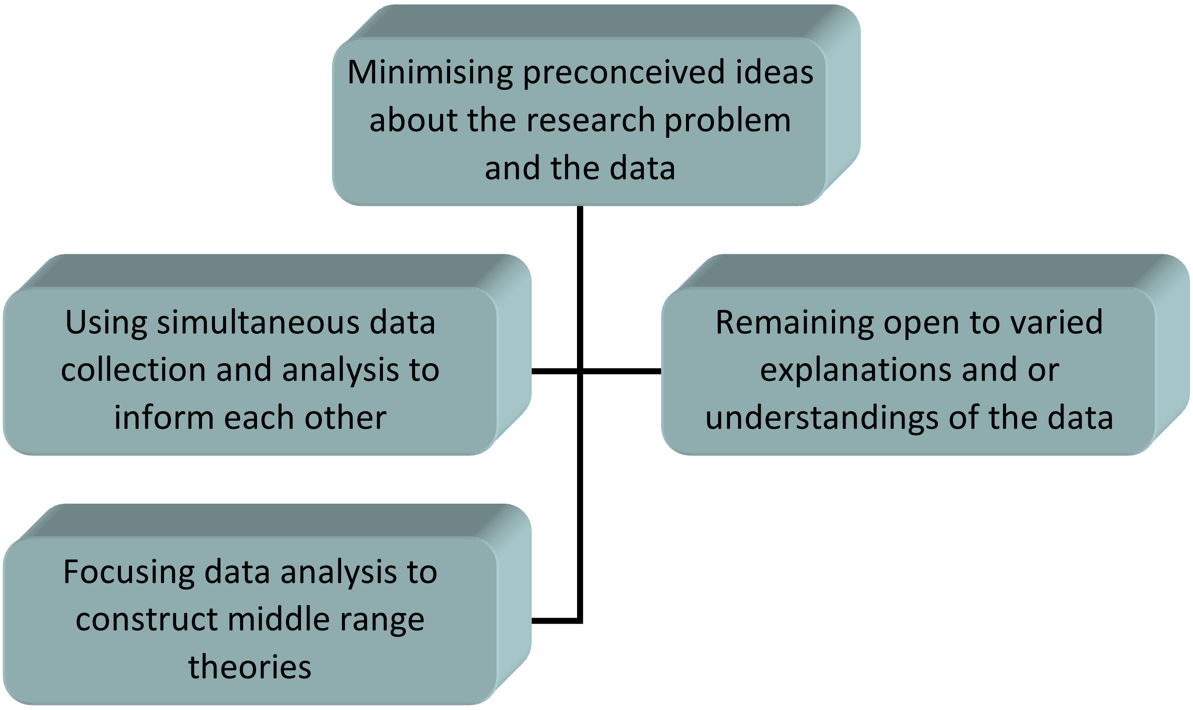


Diagram (8) Charmaz's Fundamental tenets of Grounded theory (2008)

It is understood that looking first at the data from the lived experience of the participants, the research can from the initial stage listen to the stories and how they construct their worlds in order to generate meaning and understanding. Initial data can provide leads that can be followed upon at later stages and incorporated in further interviews to gain more data and categories that would be constantly compared to existing ones hence adhering to the constant comparison tenet of grounded theory approach. The strength of a grounded theory approach is also embedded in its potential to develop theoretical sensitivity, meaning, and deeper understanding about the subject, which is developed through the researcher's relationship with the participant. An assertion put forward by (Charmaz, 2014) is that theoretical sensitivity is achieved by exploring life from multiple angles with the intention of following leads for the development of further ideas; and this is achieved through seeing possibilities, the establishment of connections and the art of being inquisitive.

Charmaz, (2014) encouraged researchers to adopt a reflexive position and try to understand *"how"* and sometimes *"why"* participants construct meanings and actions in particular situations which will be discussed at length in later sections of this Chapter. Through reflexivity, there is recognition that as an individual, with a particular background and social identity, the researcher will inevitably influence the research process and should be subject to the same critical analysis and scrutiny as the research itself, (Byrant & Charmaz, 2007; Charmaz, 2007). Therefore, despite Charmaz beliefs about minimising preconceived ideas about the research problem and data, there is an acknowledgment that each person brings a past to the present and will surely bring preconceived knowledge and ideas to their research.

Furthermore, Charmaz (1990) claims that*,*

> *"Rather than reflecting a tubulu rasa, grounded theorists bring to their studies the general perspectives of their disciplines, their own philosophical, theoretical, substantive, and methodological proclivities, their particular research interests, and their biographies."* (Charmaz, 1990, p. 1170)

Grounded theory research enables the researcher to enter the world we are studying and need to learn from the inside (Charmaz, 2004). Learning from the inside, to gain an "emic" perspective means learning from the participant experiences of their IAPT therapeutic journeys from the time they recognised they were depressed to the time they completed their talking therapy sessions. It enables perspectives of what mattered most to them and what meanings they placed on each and every experience, which can be analysed in meaningful ways. However, combining emic and etic approaches results in extensive views of a culture or community thus enabling researchers to examine more than one aspect of one culture. Findings are therefore meaningful and could be used as data to influence health and social care policy and ultimately reshape or develop better services for South Asian Indians and perhaps others alike, i.e. BAME.

Grounded theory is relevant to phenomena being studied, i.e. exploration of perceptions of psychological treatment received and needs of South Asian Indians because there is the recognition of the importance of social, interactional processes that relate to the aspects of knowing that, meaning the more theoretical explanations of a situation or phenomenon. Grounded theory is able to investigate the actualities in the real world and analyses the data with no preconceived hypothesis (Jeon, 2004). Using in depth interviews helps acquire a greater understanding if the experiences of help seeking and treatment received for South Asian Indians receiving IAPT psychological therapy in primary care.

Theory generated in this thesis will explain the influences, conditions, contexts, and consequences of the processes that happen within psychological interactions between patients from South Asian Indian groups and practitioners within primary care. GT is suitable because it seeks to understand meanings people give to experiences and, how these are influenced by factors such as their cultural contexts as afore discussed, organisational, psychological, economical, socio-politico or other situations. This is relevant because according to Roberts et al., (2015), Chadda and Sinha Deb (2013) and Sashidaran (2003), South Asian Indians have been known to attend work rather than attend a psychological appointment due to the hierarchy of priorities where economical gain for the good of the collective (others) supersedes psychological wellbeing. GT can provide a useful method since its objective is to provide explanations of events as they occur in the reality of the participants (McCann & Clark 2003). Therefore, a GT methodology affords a systematic approach to generate a theory that illuminates human behaviour as a social process among actors in their interactional context (Charmaz, 2014).

To sum up, this section looked at the philosophical and theoretical perspectives of GT as well as ontological and epistemological foundations. Charmaz's constructivist perspective and the fundamental tenets were discussed and its relevance to the research question. Theoretical sensitivity and researcher reflexivity were explored and their importance when constructing a grounded theory. The following section explicates the research design and processes in line with the GT approach.

iv. Reflexivity in Grounded Theory

Although there is a unanimous agreement that a theory developed through GT should be grounded in the data and not in the existing literature, constructivists argue that avoiding the researcher's influential role in the research process is rather impossible (Charmaz 2014). Thus, constructivist paradigm maintains that research is a product of the values of researchers and cannot be separated from them (Mertens, 2014). According to Carstensen-Egwuom (2014), being reflexive entails;

> *“continuous attention and reflection upon the social practices of positioning and differentiation in the field (including the positioning of the researcher), as well as analytic reflection upon the importance of academic knowledge and processes for social and political struggles”.* (Carstensen-Egwuom, 2014, p. 265).

Consequently, from my position, engagement with literature became an issue of sensitisation that could stimulate theoretical sensitivity as suggested by Strauss and Corbin (1998). Concurrently, Charmaz (2014), argued that the researcher cannot be separated from data collection and analysis since they are both the product of shared experiences and relationships with participants and other sources of data. Consequently, the end product, the “grounded theory” is perceived to be the product from the researcher’s ability to analyse observed material and collected data, during the research process (Charmaz, 1990).

Reflexivity was demonstrated from the initial phases of my research journey and the research process through recognising and being aware of my intersectional positioning with reference to social class, gender, ethnicity and profession, (being a Black British-African, middle class, female psychological therapist and academic). Maintaining an awareness of certain *“privileged”* positions before entering the research field may be crucial as suggested by Carstensen-Egwuom (2014), who argues that adopting a reflexive stance upon experiences during the research process helps in demonstrating how such a position is negotiated, questioned, or challenged.

From an intersectional perspective and when practicing reflexivity, power issues often come into play, and attention needs to be paid to *“blind spots”* of power and dominance (Carstensen-Egwuom, 2014). Therefore, reflexivity was demonstrated through keeping diaries, and memos (discussed in **Part 2(i)** of this Chapter**)**, with detailed description of how I managed to establish rapport and relationships during the research process and summarising how the research arena was infiltrated and how data and information was collected using co-productive methods (Figure 1; Example of reflective note).

Reflection following Priya's interview.

Priya identified with me due to cultural likeness and being "the other half", calling "us", myself and her, minorities. This makes me think of the societal hierarchies and I feel she was already feeling comfortable being with me before we commenced the questioned and answer session. This makes me think of myself as a practitioner in terms of the importance of being aware of some things we may take for granted such as the "identity" of the practitioner within therapy processes and whether attending therapy is based on identification; I must follow up on this in the next interviews. When I reflect on therapy dynamics, I arrive at the understanding that what I may perceive as effective within a therapy setting may not necessarily be what works for a patient. How that therapy could be made more appropriate and useful to a patient is based on what the factors she reported and why that would be so important to her in her journey to wellbeing. At the same time, I think this is something I expected to hear due to the similarities with my culture of origin. On Priya mentioning resources, I think of how I, friends, and relatives alike from my ethnicity have chosen to miss a Doctor's appointment to working "a shift" (nursing) due to the financial demands from family abroad. I think this would be an important point to focus on in my next interview.

Figure (1), Reflection following Priya's interview

In the above reflective note, Priya positions herself as someone who shares the same identity as a BAME individual and with such a tone of conversation, I immediately felt accepted positively acknowledged in my positioning as a BAME individual and my position as an explorative researcher.

According to Karnieli-Miller, Strier and Pessach (2009), qualitative interviews entail an asymmetrical power relation between the researcher and the participant since qualitative inquiry promotes and seeks the participants' equal participation in the research process, unlike quantitative measures whereby the researcher carries absolute authority. Through utilising an informal "chit chat" with participants at the initial meeting point and before entering the recorded phase of the interview, my main aim was to generate a compassionate and nonthreatening environment. In adopting this stance, I hoped to establish an atmosphere of empathy driven by anti-authoritative, and non-hierarchical aspects in thereby establishing balanced power relations (Indome, 2018; Carstensen-Egwuom, 2014; Karnieli-Miller, 2009).

Attempting to be reflexive from a grounded theory perspective presents intense dilemmas for the researcher especially when attempting to put prior knowledge aside when starting a new study; thus, researchers should attempt to not fall victim and be consciously directed by earlier theories and concepts in interpretations and conclusions of the data (Hallberg, 2010). Furthermore, Giles, King & de Lacy (2013) argue that acknowledging the influence of prior knowledge reflexively, prior undertaking of a literature review can lead to an amplified grounded theory research. Strauss and Corbin (1990) recommend not dissociating from the literature, but rather to engage with it and use it during the whole research process. Moreover, Charmaz (2014) argues that the researcher cannot be relegated from data collection and analysis as they are *"created from shared experiences and relationships with participants and other sources of data"* (Charmaz, 2014, p.239). From a constructivist point of view, the resulting theory *"depends on the researcher's view; it does not and cannot stand outside of it"* (ibid.). Therefore, the result is not of a detached or disassociated researcher, but rather, *"results from these researchers' commitment to analyse what they actually observe in the field or in their data"* (Charmaz, 1990, p.1162). According to Ramalho, Adams, Huggard and Hoare (2015), the basis of this means, a theory cannot be grounded in the data by an active passivity that allows its emergence, but rather by a proactive focus on the data, acknowledging that it is not the research methodology that aims to discover a theory despite the researcher, but it is the researcher who aims to construct a theory through the methodology.

Fundamentally, theoretical sensitivity is heightened by reflexivity, and refining concepts can demonstrate how meaning is constructed as the beginning line for interpretation and analysis (Charmaz, 2014). According to Carolan (2003) one enters the research arena laden with information and the researcher’s responsibility is to make transparently and reflexively explicit the processes of interpretation within the act of meaning making.

The literature read can help develop researcher sensitivity as well as enhancing the analytic process. Therefore, a researcher is encouraged to be reflexive throughout and manage the influence of previous knowledge and engage with the existing literature to enhance the analytic process and using existing literature can help identify what is important to the developing theory. Reflexivity was therefore demonstrated by the use of memos and where issues of positionality were also explored and reflected upon, as discussed in **Part 2(i)** of this Chapter.

v. Research Design

According to McCann & Clark, (2003), selecting an appropriate research method is one of the most critical challenges presented to a Doctoral researcher, and any researcher that adopts a grounded theory approach needs to consider which version of GT they will use to inform their data collection and analysis; either classical or Strauss and Corbin. The informed lesson here and what is important is that GT is presented as a method of choice as it is rigorous and systematic, yet also permitting flexibility and freedom. It is also presented and recommended as suitable for the investigation of complex multifaceted phenomena, and is well equipped to explore socially related issues, particularly when investigating social problems and/or situations to which people must adapt, (Charmaz, 2014; Aldiabat & Navenec, 2011; Corbin & Strauss, 2008).

The constructivist world view of Charmaz is common in health and social care since it is imperative for health care staff to understand the subjective experience of each patient. As a result, the GT approach has been applied by health and social care researchers in multiple healthcare settings, often with the overarching purpose of understanding experiences and social behaviours as well as describing processes to enhance patient care. With the current health care policies and their focus on evidence-based care, using GT gives significant opportunities for health care researchers to construct relevant theoretical perspectives while guiding and informing health and social care practice, (Higginbottom & Lauridsen, 2014)

Consequently, GT is perceived as particularly useful and relevant to approaches to health care promotion and provision and development of services; with emergent theories generated being applied in management and treatment of depression in South Asian Indians and BAMEs alike within primary care, consequently resulting in enablement to approach existing problems in different ways. Credibly, there is a widespread use of GT in the fields of qualitative research, spanning from the study of software development processes (Coleman & O’Connor, 2007), to research on relational identity in intercultural friendships, (Sias et al., 2008; Lee, 2007), and studies on beer consumption, Pettigrew (2002). In all these instances, GT is considered suitable in this instance since social interaction is at the heart of caring processes in health and social care settings, (Aldiabat & Le Navenec, 2011).

The aim of this thesis relates to the GT paradigm which is to explore, explain and understand in detail as opposed to predict and control in order to generalize. Grounded theory is an approach for generating theory that is grounded in and systematically derived from data, (Charmaz, 2014; Strauss & Corbin, 2008; Glaser & Strauss, 1967). It is argued that, *"data do not provide a window on reality but instead the discovered reality arises from the interactive process and its temporal, cultural and structural contexts",* (Charmaz, 2000, p. 524). The argument advances this, stating that GT places an emphasis on the comparative method of constant concurrent data collection and analysis with the aim of developing a solid grounded theory that describes, explains, interprets, and predicts the phenomenon if interest. Subsequently, the use of the qualitative methodology of grounded theory capacitates the exploration of the appurtenant, implied questions within the study as to why, how, where, when, under what conditions, and with what consequences the phenomenon unfolds. The main objectives of the study are summarised in Table 4.

- **To generate meaning and understanding about the treatment needs of South Asian Indian patients with depression from IAPT psychological therapies through patients' stories of experience.**
- **To generate an understanding of IAPT psychological therapies; e.g. Cognitive Behavioural Therapy (CBT), its appropriateness and compatibility with patients from BAME South Asian Indian cultures.**
- **To understand South Asian Indian patients views about and what works for them.**
- **To explore and generate meaning about how SAIs access psychological services/the accessibility of psychological therapies.**

Table (4) Study Objectives

In this research participants experiences in terms of IAPT psychological therapies for depression is explored through telling their stories within the context of their individual culture, values, beliefs and many other factors or phenomena. Questions are asked about factors that influence seeking help in terms of predisposing factors, precipitating factors, triggers, and impact from their own individual perceptions, (Appendix 6; Interview Guide).

When GT emerged in the 1960's, it was an approach that was viewed as revolutionary since it challenged the dominant quantitative model in social science research both in terms of its artificial divisions between theory and research, and in the inferior role assigned to qualitative research (Charmaz, 2014; Denzin & Lincoln, 2005; Seale, 2004). The two Sociologists' discovery of GT is argued to have resulted from their efforts to improve the theory/ research gap that had not been bridged by studies using logical deductive reasoning as a method of inquiry. Conversely, according to Johnson, Long, & White, (2001), p.245; the development of grounded theory was a response to this criticism, an attempt *"to make scientific"* that which had commonly been accused of being *"mere journalism"* or even *"fiction".* Consequently, GT could be argued to have been designed to provide an alternative to the verification research tradition prevalent in Sociology at the time (Glaser & Strauss, 1967). Others argue that grounded theory paved a way of challenging the status quo in social research given that existent studies were dominated by the testing of "grand theory" as well as being deductive in nature (McGhee et al., 2007). In essence, GT can therefore be viewed as a reaction to external forces, in this case the hegemony of quantitative research methods during that particular time period.

However, GT method has been modified over periods of times within which it exists by new ideas encountered in the world of research. Although this study especially focuses on Charmaz's grounded theory processes, it also in some parts refers to Strauss and Glaser; therefore, it is fundamental to briefly summarise what resembled the original GT of Glaser and Strauss.

Glaser and Strauss' grounded theory comprises several unique methodological elements which provide practical guidelines that facilitate the rigorous construction of theories relating to social processes from raw data. The main features include theoretical sampling, the constant comparison method, coding and categorising, memo writing, and theory generation, all of which occur simultaneously throughout the whole study. Other characteristics of GT are the processes of induction, deduction, and verification with induction compelling researchers to access the field with neither cynical nor preconceived assumptions from literature or elsewhere. Whilst constant comparison and theoretical sampling simultaneously are seen as essential characteristics of data collection and analysis in grounded theory studies, open mindedness, contingencies of time and resources is therefore encouraged as well as some flexibility and adaptability in order for the theory to emerge from data (Charmaz, 2014; Strauss & Corbin, 2008; Glaser & Strauss, 1967). Jeon,

(2004) asserts that, the fundamentals in a situation whereby procedural modifications may be required has to find the researcher being readily prepared to give detailed descriptions of decisions made and actions taken, meaning there has to be an audit trail of the research process. However, provisional hypotheses can be constructed after initial data collection of which further data collection then empirically verifies the hypotheses (Charmaz, 2014; Strauss & Corbin, 2008; Payne, 2007).

Moreover, and to a certain extent, there is a contention and some confusion over what constitutes theory in GT. This confusion is brought about due to the fact that; although as a research method grounded theory is often heralded as revolutionary in the history of the qualitative traditions, it is however the most frequently discussed, debated, and disputed of the research methods. Arguably, one of the most provocative controversies surrounding GT constitutes a methodological split between its co-originators, Glaser, and Strauss. Essentially, among the several critics was Kathy Charmaz (1939 to present date) who argued that Glaser's grounded theory was based on positivistic ideals about objectivity, neutrality, reproducibility, and an underlying assumption that a true reality exists that can be reproduced without being influenced by the researcher.

Essentially discovering theory from data suggested that a set of social or psychological relationships exist objectively in the world. An interesting comment made by Strauss & Corbin, is that; "the form in which the theory is presented does not make it a theory; rather the fact that it explains or predicts something makes it a theory" (Strauss & Corbin, 2008).

Consequently, this division established the on-going contention between the Glaserian and Straussian versions of grounded theory (Birks & Mills 2011; Dunne 2011; Richards & Morse 2007; Walker & Myrick 2006). Therefore, the differences between the two can be summarised by stating that Glaser's approach to GT emanates from being purely purist relying on an open attitude to the research enterprise. Glaser defends his position by arguing that,

> *"Keep in mind that preconceived concepts do not have to be forgotten. They are just to be suspended for the GT research so the researcher is open to the emergent. Why let them get in the way? Sure, they may have legitimate power as sanctified by the literature, but this power must be ignored or resisted. Otherwise it will take over and*

> *stop the generation and subsequent power of a classical substantive GT with fit and relevance that works in explaining what is going on"*, (Glaser, 2012, p.2).

For Glaser, the researcher ought to be professionally naïve in order for theory generation to be free from compromise by researchers' prejudices but emerging directly from data.

Contrarily, Strauss and later Strauss and Corbin and Charmaz's GT approach has pragmatic characteristics, outlining a more structured attitude to theory building which stipulates the use of a set of analytical tools and guiding principles. Charmaz's approach to GT encourages the researcher to apply existing insights and experience to the subject matter where appropriate (Denzin & Lincoln 2011; Martin & Gynnild, 2011; Charmaz, 2014; Kelsey, 2003).

Having discussed and explored the main aims and objectives of this study, the next section details the sampling approach adopted in line with qualitative and GT perspectives.

v. (a) The Sampling Approach

Although deciding on the size of the sample is an essential component of quantitative research, when using a GT approach, the researcher does not decide on the sample size before the study begins. Participants are not selected based on their representativeness but rather due to their expert knowledge of the phenomenon under study. According to Charmaz (2014) the very act of seeking related data to develop an emerging theory is referred to as 'theoretical sampling'. As initial data are collected and analysed, further consideration is given about which participants to recruit, sample size, settings and the type of data to be further collected is based on the emerging theory, (Charmaz, 2014; Strauss & Corbin 2008; Glaser 1978). Samples in qualitative research are usually small in order to support the depth of analysis that is essential to qualitative inquiry, and are selected based on the capacity to provide richly-textured information relevant to the phenomenon under investigation (Vasileiou, Barnett, Thorpe & Young, 2018). Contrary to quantitative research of which statistics-based rules require precise sample sizes, qualitative sample sizes are determined by the methodological, theoretical, epistemological, and ideological pluralism that characterises qualitative inquiry (Gergen, Josselson & Freeman, 2015; Baker & Edwards, 2012). The suggestion is that that the more in-depth valuable data is collected from each person, the fewer participants are needed. Based on the individual and in-depth qualitative interviews Gergen et al., (2015) suggest researchers use smaller samples due to the complex task associated with analysing qualitative data.

However, it is important to note that the researcher does make preliminary sampling at the beginning of a study and decides on the criteria and methods of recruitment of participants as well as the setting (McCann & Clark, 2003). In this study initial sampling was first employed based on the research participants who covered the full range of specific characteristics the study aimed to examine as evidenced in some examples of the criterion such as ethnicity (SAI) and age (18-65 as per the original IAPT specifications). The moment when key concepts of data collected has reached saturation point and it seems no new data is emerging, the researcher can then perceive the sampling to be complete, (Smith & Biley 1997). Saturation here entails a point whereby the researcher has gathered all the data and does not need to continue since there will not be any more useful data to collect to top up on the existing data. Since saturation is a contentious issue amongst scholars, as its been argued that proving that one has reached saturation is difficult, the researcher here focused on developing and presenting well informed categories constituting significant depth.

The main advantage of theoretical sampling is that it strengthens the rigour of the study if the study attempts to generate the theory in the research area and helps in shaping the process of data collection and analysis (Barbour, 2008). Breckenridge and Jones (2009) argue that theoretical sampling helps develop and refine theory that is ‘grounded’ in data.Theoretical sampling is argued to be significantly flexible since it allows the researcher to make shifts in plans and emphasize early in the research process so that the data gathered reflects what is occurring in the field, (Barbour 2008; Coyne, 1997).

v. (b) Inclusion & Exclusion Criteria

Participants in qualitative health care research tend to be key stakeholders who have first-hand experiences of and insights into the particular phenomenon under study, and it is important to treat them as experts based on their experience (Mansell, 2010; Clements, Rapley & Cummins, 1999). The participants’ experience of phenomena under study is integral to the sampling strategy which influenced the development of the inclusion and exclusion criteria. Hence, the inclusion criteria included male or female of ages 18-65 years. Exclusion of people above 65 years was based on the argument that, deciding whether an elderly patient over the age of 65 suffers from depression or dementia is often difficult due to the fact that the two conditions co-exist in a significant proportion of cases, (DiNapoli et al., 2015; McSweeney et al., 2012; Kales, Chen, Blow, Welsh and Mellow, 2005). The inclusion criteria were also influenced by the Commissioning of IAPT (2011) which originally targeted adults of working age but in 2010 was opened to adults of all ages. To meet the criteria, a participant would have to be able to communicate effectively in English and also have received one or more sessions from an IAPT psychological therapy service in primary care since within IAPT one encounter or session can be classified as a treatment session.

People with co-morbid disorders, psychotic illness, or alcohol dependence were also excluded if these factors were clear at the outset or at assessment stage. Table 5 shows the Inclusion/Exclusion Criteria adopted for the study.

INCLUSION	**EXCLUSION**
✓ Gender: Male or female of ages 18-65 years	- **Disability: Learning Disabilities or Cognitive Difficulties**
✓ Ethnicity: Be **South Asian Indian in race and ethnicity**	- **Language: Inability to speak English.**
✓ Language: **communicate effectively in English**	- **Currently reporting to be experiencing depression.**
✓ Treatment: have completed psychological therapy **4 weeks prior to satisfy the criteria**	- **Comorbid Disorders: psychotic illness, alcohol dependence, receiving further psychological therapy**
✓ Other Care: Not **registered with a community mental health team and be under the care of a Psychiatrist**.	

Table (5) Inclusion/Exclusion Criteria.

Participants also had to satisfy the criteria of being South Asian Indian in race and ethnicity as reported on the equal opportunities Form at initial registration with their GP, (see Appendix 4, Participant Flyer). Participants need to have completed their treatment at for least 4 weeks prior to allow for significant time to reflect on their difficulties and therapy or recovery processes. Participants were excluded if there were registered with a community mental health team and be under the care of a Psychiatrist as this would imply receipt of help from secondary services which would impact on the aims of the study.

vi. Data Collection Methods

Qualitative data tools were used to elicit information and gather large amounts of data from participants. This included in depth individual interviews which is explored in this section of the thesis.

vi. (a) Use of Interviews

Charmaz (1990) argues that GT allows the researcher to explore unique experiences. The aim of this study was to explore the experiences of SAI regarding depression and IAPT psychological therapies in primary care. In-depth interviews are claimed to be especially helpful and relevant in health care related research since they help uncover the subjective domain, the world of feelings, perceptions, values, morals, and experiences, (Smith & Biley, 1997). Despite their advantages, critics such as Boyce & Neale (2006) have suggested that in-depth interviews are less efficient in terms of time and cost because the researcher must conduct a large number of sessions to attain different perspectives. However, this relates more to a positivist, reductionist perspective that seeks to find associations between phenomena rather than gain meaning and depth where, knowledge is based on natural phenomena and their properties and relations. In-depth interviews are also argued to be weak since they are prone to bias due to participants' stake in the study or for several other reasons. Moreover, there may also be errors in interpretation, recording and a deviation from the agreed questions guides or themes (McCann & Clark, 2003; Patton, 2002).

Charmaz (1990) suggests that, questions should be framed around experiences, thoughts, feelings, which can be captured using a range of methods that involve talking, listening, or observing the phenomena. Hence, to capture the experience of BAME groups, in-depth face-to-face interview were used using open-ended questions because these provide an opportunity to gather rich and meaningful data about the participants experiences (See Appendix 2 & 3, Interview Guides). From an intersectionality perspective, there was recognition that although I employed individual interviews, this process gave voice to the individual that formed a representative of a greater community, therefore leaving them in the middle ground as neither community nor individuals; thus demonstrating their multiple positionalities at micro and macro levels within society. Arguably, this subjective and meaning-laden approach may also lead to the discovery and emergence of new theories and a respondent's logic, thinking process and frame of reference can also be revealed (Boyce & Neale, 2006). It is important that the participants' unique experience is captured hence an audio recorder was used to record in-depth interviews and were transcribed verbatim. This is considered to be integral to the analysis and interpretation of verbal data, (Warren & Williams, 2008; Halcomb & Davidson, 2006; Wengraff, 2001).

vi. (b) Interview Questions Development

Interviews were used as a conversation in which the interview was adapted to manage the flow of the discussion and also based on the participants' needs. Charmaz (1990) argues that a detailed interview guide is not always necessary since the first question is considered as something that may influence the whole interview. The type and the quality of the material the researcher obtains is influenced by how one frames, paces, and manages the interview questions. Charmaz, (1990) suggests that questions which touch on people's experiences of illness and how the illness may impact on their lives should be included. Charmaz (2006) advises that questions be developed through exploring the interviewer's topic and to generate meaning and understanding, and key question used where those that fitted the participant's experience. These questions related to processes in individual experiences, thoughts, feelings, and actions of SAIs when experiencing depression and processes of seeking and receiving treatment thus facilitating the exploration of multiple issues yet highlighting the fundamental features of the phenomenon under exploration.

A number of appropriate subject areas were developed by generating a matrix constituting the research study topic and its key concepts. This assisted in visualising the interview questions in relation to the research study topic based on the experiences of depression and thoughts on seeking help, accessing services and treatment received as well as preferences and any points to be considered by providers when providing health services. Interview questions were also developed based on professional practice and experience as well as existing literature. However, it is importance to note that some questions changed and emerged from the conversations as the interviews evolved with participants.

Charmaz argues that,

> *"The informational questions bring the respondent further into the interview and establish chronology, types of events, degrees of awareness, cast of participants, and the like. If a researcher has established rapport, he or she can bring in reflective and feeling questions. When trust and ease come more slowly, then sequencing them carefully works better",* (Charmaz, 1990, p 1167).

vi. (c) Interview Schedule Pilot

Following recommendations from the NHS Research Review Panel, interview schedules, guides and questions were "piloted" on patients from SAI background who were currently having treatment and were not going to take part in the study. One of the important stages in a research project is a pilot study which is conducted to identify potential problem areas and deficiencies in the research instruments and protocol prior to implementation during the full study. An important factor was to ensure that the interview schedule items reliably and specifically addressed the research questions. The pilot also tested whether the schedule was conceivable, clear, and appropriate for the target population, and presented in a consistent manner, (Leon, Davis & Kraemer, 2011; Hassan, Schattner & Mazza, 2006). Participant information statements and consent forms were also tested for comprehension.

There is a risk of errors in interpretation, recording and a deviation from the agreed questions guides or themes, (Boyce & Neale, 2006; McCann & Clark, 2003; Patton, 2002). This is echoed by (Davis, 1990), who asserts interviewing participants from different cultures may be problematic in the participant's understanding of certain words so interviewers should avoid use of jargon. Concurrently, some words have different meanings for ethnic people and so it is important to ensure the language used is appropriate for the target audience. There can be dilemmas of trying to reconcile attempts to discover a language and principles that can be endorsed as true for all people, (Kuhadja, Thorn, Gaskins, Day & Cabill, 2011; Davis, 1990;). This is arguably so due to the fact that populations around the world are highly heterogeneous in personal and cultural make up, beliefs, language, and customs. Hence, the interview schedule was developed with service users to guide and later piloted to ensure clarity and direct the conversation toward the topics and issues under exploration. This enhanced the robustness of the methods.

Therefore, question guides were developed following discussions from professional and Service User steering groups, as well as from questions based on patient experience questionnaires which are usually utilised within psychotherapy services to gather feedback on service user experiences. This was undertaken to ensure that the questions were meaningful and used a lay language. As seen in Appendix 6 & 7 (Interview Guides), an example of the questions was: *"what prompted you to seek help?" and "tell me about your experience of the therapy sessions you had".* The construction and makeup of the interview guides enabled the participant to reflect through the use of open-ended questions which were free from abbreviation and jargon. The objective of using laymen's language was to try and gather the person's perception of their experiences of difficulties and treatment as opposed to placing illness rhetoric on them, as demonstrated in Appendix 7**.**

The location of the interview was carefully considered as it is recognised that there may be conflicting roles, for example, research role vs. professional practitioner role (Cohen, Manion & Morrison, 2000).

vi. (d) Methodological Rigour: Transparency of Researcher/Reliability

Previous knowledge, practice or experience of phenomena being studied is agued to have an impact and inevitably influences the data collected and results within a study (Chenail, 2011; Poggenpoel & Myburgh, 2003). Although a pilot study is the usual procedure in which the researchers normally try out their tools for the proposed study to see if these tools would perform as expected, these are not universal or practical for all studies. Therefore, a technique whereby the researcher/interviewer themselves is interviewed is perceived as a useful initial step to create interview protocols that help to generate the information proposed and to assess potential researcher biases. The interviewing the interviewer approach is also understood to help the investigator around the following issues; identifying personal feelings arising during the questioning; developing greater appreciation for the challenge of sharing all one knows about a topic; making overt perspectives that might bias the researcher in the study. This was achieved with the help of a fellow colleague employed within the psychological field and possessed significant knowledge in research methods. Hence, within the interviewing the researcher/interviewer technique, the researcher assumes the position of the research participant thereby helping them gain perspective in what it feels like to be interviewed, Chenail (2011).

Additionally, interviewing the interviewer may also help the interviewer learn the value of patience in the interviewing process, gaining an appreciation of feelings of being and not being heard; appreciating the vulnerability of the participant and identify a priori assumptions about the participants, (Chenail, 2011; Seal, 1999). This is also important especially in situations where the researcher has a strong affinity for the participants being studied or is a member of the population itself. As a BAME, psychological therapist, and researcher with extensive knowledge and experience in the research topic, the experience of being interviewed by my colleague made me more aware of the multiple positions I was assuming within the process. However, this prior experience provided guidance within the process since Charmaz (2006) claims that background assumptions and disciplinary perspectives facilitates great attention to possibilities within the data collection process. This awareness enhanced my ability to follow up on different ideas and concepts although retaining an open-minded approach and remaining focused on participants' narratives.

It is important to note that no major changes were made to the interview questions and topic guides following piloting as feedback received indicated that all the information and questions were relatively transparent, coherent, and understandable.

The following details the ethics processes and procedures employed for transparency of the research study.

vii.Ethical Statement

vii. (a) Risk analysis

Ethical issues in human subjects' research have received increasing attention over the last 50 years where contemporary ethical guidelines for medical research have been largely influenced by case histories of medical abuse and atrocity (Bowker, 2011). What is believed to be the main ethical hazard of research with human subjects is when a researcher uses participants for purpose that are not participants' own. Moreover, it is widely understood that The Nuremberg Code, which outlines 10 basic principles for the treatment of human subjects, and the subsequent Declarations of Geneva and Helsinki, were framed largely in response to the actions of Nazi doctors and scientists (Fisher 2006). Research ethics are essential in that they are based on concern that whereas the community needs knowledge, the patient or volunteer needs protection, (Carter & Thomas, 2005).

Contrary to the goal of biomedical research which is carried out to advance knowledge about the effectiveness of particular medical interventions, psychological research's goal is to allow participants to act as informants representing themselves and/or their communities regarding specific treatments or interventions. Moreover, it is not the case that therapeutic interventions are offered in exchange for participating in psychological research; since the risk of harm to participants whether minimal or great is usually weighed against the benefit to the research community; and there are a few specific guidelines concerning the results to the lives of the participants (Bowker, 2011). Concurringly, Silverman (2013) argues that the rich and detailed character of much qualitative research can mean intimate engagement with the public and private lives of individuals which has to be kept confidential.

According to (Mental Capacity Act 2005; DH 2003) the primary concern of the researcher should be the safety of the research participant. Therefore, a risk analysis approach was adopted, and the research was continually monitored as it proceeded (Long & Johnson 2007; Cohen et al. 2000). However, Bowker (2011) argues that ethically, it is not satisfactory to simply state risk be kept at a minimum in practice and theory both. He goes on to question the ambiguity of the ethical standard of risk since it seemingly ignores many other risks of research and or everyday life. What is advocated here is to for researchers to define contextualise, and weighing risk based on the participant's good, ideal outcome and the best-case scenario for each individual participant.

According to Higginbottom & Serrant-Green (2005), researchers often lack the expertise to conduct research with minority ethnic communities since they may not have the insight into cultural norms and values of specific groups. Taylor (2000) also argues that in research ethics, sensitivity to cultural and social diversity in the treatment of participants and concerning them is viewed as paramount. Accordingly, acting within these recommendations, reflexivity was exercised concerning the impact of differences in values and social or cultural experience on the research and transparency about any effects in collecting, processing, and reporting outcomes. Prior to the study, the researcher attended workshops and seminars focusing on working with multi-cultures as well as courses on equality and diversity and attending local community initiatives.

Ethically, there is mention of competence in the designing, planning and conduct of research which is necessary to safeguard the wellbeing of participants. This is also to ensure that the investment of time and effort made by participants results in meaningful and valid contributions to knowledge, DOH (2004). Acquiring sufficient research training was paramount so to design and implement a study through thorough exploration of ethical dilemmas which was achieved through liaising and communicating with the Research and development Department of the Hospital trusts affiliated with.

vii. (b) Ethical Approval

Ethical approval was received for proceeding with this study through the Salford University Ethics Committee as well as the NHS Health Research Authority and NHS Local Research Network for West Midlands.

vii. (c) Confidentiality

Informed consent was obtained from each participant after they received a full explanation both verbally and in writing regarding the study’s purpose, the information gathering process, time commitment of participants, assurances of anonymity and confidentiality (Appendix 3; Consent Form). Participants’ dignity and privacy was safeguarded through ensuring personal information given was kept confidential. The study was explained extensively, and participants were informed that they had the right to withdraw at any time for whatever reason without prejudice. Participants were also informed that the tape recorded interviews would only be identified with a number and pseudonym in order to be transcribed and for the purpose of data analysis and that no names or places would be used in the final transcription and would be withheld in the completed Thesis. There was no risk with confidential breaches concerning external transcriptions since it was made clear and agreed in interviews that, no actual names of participants, medical professionals or carers and relatives should be mentioned at any point.

vii. (d) Data Protection

The participants were informed that the right of access to the data provided by participants was restricted to the researcher and Supervisors. The participants were also informed that field notes and interview transcripts were kept under lock and key at the researcher's place of work and that the findings of the study will be submitted as a Thesis and possibly in peer reviewed journals on completion of the study.

In keeping with the Data Protection Act (1998) and the new General Data Protection Regulation (2018), research data was securely stored on encrypted tape recorders, memory sticks, secured wallets and locked cabinets within my place of work, an NHS Service where practitioners have individual lockable cabinets. Best practice for protecting privacy are constantly evolving and measures were taken to protect data from malicious software, log in monitoring, and data back up plans and finely shredding and proper disposal of paper. Arrangements were put in place for the disposal of materials after a period of up to 3 years and audio tapes were destroyed after transcription and analyses had been completed**,** (Caldicott Guidelines, 2006).

vii. (e) Safeguarding vulnerable participants

Mental health patients who take part as participants in research need to be safeguarded and treated with sensitivity due to the nature of their unique difficulties. Participants were asked to share their experiences of psychological therapy treatment for their difficulties with depression. In consideration of the sensitive nature of the subject topic, there was an awareness of the possibility that some participants would experience some level of distress or discomfort whilst reflecting on their lived experiences. Additionally, participants were required to have the mental capacity to make the decision to consent through being able to display that they understand the study sufficiently to give informed consent.

As a result of this awareness, a contingency plan was put in place as follows:

a. Participants were informed prior to the interview of the right to withdraw without prejudice.

b. Participants were informed prior to the interview that any information they had provided would not be used unless they had explicitly consented to.

c. Participants were informed that debriefing was available to anyone who requested it.

d. Participants were informed that should they need further therapy or help of any kind; the researcher would signpost them or refer them to appropriate or relevant services.

Hence, participants having agreed to take part prior to the interview date, where asked *"checking in"* questions Diagram (9) on the day of their interview as part of risk assessment and practising safeguarding.

~Is there anything that may affect your taking part today?

~Is there anything that may affect your ability to understand and consent to taking part in this research?

~Are you happy to take part in the research interview today?

Diagram (9) Participant Checking in Questions

Dyer and Bloch (1987) argue that, despite good reasons for safeguards, there is need to remember the therapeutic goal of increased autonomy whilst applying the safeguards as being overly protective may work against the best interests of the patient.

viii.Recruitment of Research Participants

Participants were recruited from West Midlands GPs since it is the is the location where I am professionally based and therefore am aware of current psychological care service provisions and processes. Therefore, participants from South Asian Indian communities were recruited from 2 sites within Primary Care GP Centres; a location the researcher works and familiar with and an area that has been noted to have a significant concentration of

BAMEs ONS (2011), especially South Asian Indians, Pakistanis, Bangladeshi and Afro Caribbean communities although there is a lack of studies in this particular location. The ONS (2011) classifies BAME into the following 4 categories: Asian and South Asian (Indian, Pakistani, Bangladeshi) and Chinese and the Black and Black British (African, Caribbean). South Asian Indians were chosen due to there being dominant in population terms than any other groups. Those seen in Psychiatric Services were excluded since the focus of the study was based within Primary Care.

Contrary to sampling strategies for quantitative methods and based on probability theory, purposive sampling was employed, and participants were chosen based on their expert knowledge of the phenomenon under investigation (experience of depression and having received therapy). Charmaz (2006) and Patton (2002) suggest that purposive sampling is the identification and selection of 'information-rich' cases related to the phenomenon of interest. However, recruiting participants was difficult as some of those identified were not willing to participate whilst others struggled to make themselves available for interviews. Bernard (2006) argues that, other than their expert knowledge, participants need to be available, willing to share experiences and opinions in an articulate, expressive, and reflective manner. In this study, participants were identified by the researcher based on meeting the criteria and appropriateness for inclusion. Hence, theoretically sampling sites, as opposed to participant selection was employed and this facilitated the collection of in-depth data narratives through patient's stories.

Furthermore, in GT it is difficult to predict the exact number of people to be recruited. This is often dictated by the process of theoretical sampling discussed in previous section. 7 SAI people participated in the study although 10 participants had been recruited in the first instance, with 3 cancelling their interviews thus withdrawing from the study. Recruiting participants presented challenges where no one came forward following the display of posters and flyers in GP Surgeries and Medical Centres as well as GP handing out flyers to prospective participants (Appendix 4). The next stage was searching GP databases to identify patients who met the inclusion criteria for the study and following this process Participant Invitation Letters and Prospective participant Information Sheet (Appendix 1 & Appendix 2) were sent out to those identified. In total, 70 Letters were sent out and out of the seventy 27 people indicated their interest although upon further follow up only 10 managed to be recruited. Considerable barriers to participation of BAME in clinical research have been identified for both researchers and participants according to George, Duran and Norris (2014), whose systematic review found that applying recruitment approaches initially developed for White participants and failing to culturally and linguistically adapt recruitment materials is problematic. Based on the collectivistic nature including families and communities in a dialogue around research participation is advocated since most decisions are made through conferring and deliberating with the family and or community involvement, benefits and cost, for which decisions to participate in research are frequently not independent of (Salman, Nguyen, Lee and Cooksey-James, 2015; Norris, 2014). Others have cited barriers due to psychosocial issues such as mistrust, fear, and lack of confidence to practical concerns including childcare, schedule conflicts, lack of transportation Clark et.al.,(2019).

Upon reflection, there is an awareness that as a BAME person, I could identify with the psycho-social issues which might present as barriers as I have been contacted on numerous occasion to participate in research by my local Orthopaedic Hospital at which I am a patient but have not participated due to some of the reasons in the preceding paragraph. Despite my position as a learned academic and experienced practitioner, I have refused to participate in research despite my awareness of the benefits to Clinical services my participation would prove. However, this failure on my part due to logistic reasons such as time, schedule clashes and childcare responsibilities having both parents living abroad that childcare has always been a challenge to me but also prioritising *"extra work/second job"* so to be able to help the very family *"back home"* financially, of which participating in The Orthopaedic Hospital's research would clearly be a significant inconvenience resulting in relevant financial loss.

However, identifying solutions for overcoming barriers that resonate with BAME participants should be a critical condition for research studies for example, where issues of trust could be alleviated through involving patients to help design research studies from the onset making the process more patient centric, as well as engaging and partnering with community leaders and community-based organisations to effectively propagate information about clinical research with the emphasis on the valuable role of research participation (Clark et al., 2019).

Demographic details were also collected to present a general profile sample as evidenced in the Interview Guide (Appendix 6). Table (6) provides information about the people who participated in the study.

Participants ***(P = Patient)***	**Gender**	**Age**	**Occupation**
1	***Female*** ***(Priya)***	***44***	***Self Employed***
2	***Female*** ***(Kully)***	***22***	***Unemployed Graduate***
3	***Female*** ***(Bindi)***	***65***	***Retiree***
4	***Male*** ***(Ravi)***	***45***	***Employed***
5	***Female*** ***(Ranjit)***	***50***	***Unemployed***
6	***Male*** ***(Davi)***	***42***	***Unemployed***
7	***Female*** ***(Bal)***	***35***	***Employed***

Table (6) Participant Demographics

viii. (a) Sample Recruitment

The people interviewed were aged between 22 and 65 years old. Initially flyers (Appendix 4, Research Flyer) were distributed to GPs and also posted around 20 Surgeries, with an advert about the study placed in a circulated Monthly Newsletter for Sandwell & West Birmingham Clinical Commissioning Groups. GPs were also asked to identify those meeting the criteria and ask them to contact the researcher as indicated in the flyer. At the same time a database from the Research Sites approved by the Health Research Authority (HRA) was searched for those people who met the criteria and appropriate HRA approved information prospective participant letters were sent to them, (Appendix 2).

Due to fewer numbers of people making contact to indicate interest in the study, follow up telephone calls were made to those who had initially been sent letters. At this point, interview dates were agreed with those who indicated interest and prospective participants were reassured that they could make contact at any point on the telephone number and e-mail address provided should they have any questions or concerns about the study. Consent forms were given before commencement of the interview where a signature was required following a verbal explanation of the study and an indication that they understood the nature of the study. Two copies of consent forms where completed which bore the researcher's signature and the participant's, (Appendix 3, Consent Form), and all participants were made aware of their rights to withdraw from the study at any time.

Five females and two males were invited to interview. All the participants met the inclusion criteria, and none withdrew from the study at the time of the interview. The sample was made up of a mixed range of adults reflecting diverse lifestyles as well as mental health problems; all with different predisposing and precipitating factors for their illnesses and reasons for accessing health services.

Interviews were conducted in a soundproof clinical room at the two HRA approved research sites with confidentiality being maintained prior and after the interviews. For safety assurance, lone researchers' policies were adhered to as recommended by The University of Salford. In order to provide a descriptive analysis of the sample, participant age, sex and employment status were recorded. Interviews last between 50-60 minutes and were recorded using an NHS Olympus encrypted recorder and data were stored securely on another NHS encrypted memory stick, with access restricted only to the researcher in adherence to the Data Protection Act (2018) and the HRA UK Policy Framework for Health and Social Care Research. Filed notes were entered into a journal based on observable interactions which took place onsite but not recorded on tape. All information on paper such as consent forms were kept in a locked cabinet at one of the approved NHS Sites. As explored in the next section, participants' identities were protected by using a researcher generated pseudonym. Interviews were transcribed by a professional transcription service and additionally, the transcription was proofed and checked for accuracy by the researcher who listened to the interview tapes against the transcript copies.

viii. (b) Participant snapshots *(Names are pseudonyms)*

This section describes the participants' characteristics whose identities were protected by using a researcher generated pseudonym in adherence to research ethical frameworks, specifically, confidentiality. A brief description of each participant is given to help contextualise their experiences of depression and the impact it had on their lives. The majority of participants had not recovered from depression following treatment based on the IAPT outcome measures and this is further explored in the Findings Chapter where participants' excerpts describe experiences which may have influenced and affected recovery outcomes in negative ways.

It is important to note that recovery from depression and anxiety according to IAPT policies is measured in terms of outcome measures/minimum data sets as discussed in Chapter 2. A minimum score of 9 on a PHQ-9, with a minimum of 7 on the GAD-7 according to IAPT, signifies recovery for clinical and statistical purposes. However, patients may report and demonstrate significant recovery (observable change in presentation in sessions) regardless of what the final score that counts to their "recovery" might be. This will again be highlighted in Chapter 6.

Participant 1: (Priya*)*

*Child minding gave her so much joy and fulfilment before depression struck. Priya, 44, was a married mother of 3 beautiful children. She had been seen for psychological therapy for 3 sessions on a fortnightly basis. Her primary diagnosis was depression after giving birth to child that had multiple physical health conditions. Although she reported that she benefitted significantly from therapy, Priya did not complete her CBT treatment as she dropped out of therapy. Based on the IAPT outcome measures and minimum data sets *** ***(PHQ-9: 13 & GAD-7: 19),*** *she had not recovered from depression.*

Participant 2; (Kully)

*Kully was a 22-year-old graduate and unemployed at the time of interview. She reported to come from a very large extended family where grew up being close to her cousins most of whom were of the same age range. She had been seen for psychological therapy for 5 sessions on a fortnightly basis. The predisposing factors for depression were University final exams pressure and cultural expectations on achieving highly whereby she was expected to acquire employment upon graduation followed by marriage. Kully dropped out of CBT treatment after attending 5 out of 9 sessions and based on the IAPT outcome measures and minimum data sets *****(PHQ-9: 6 & GAD-7: 7),*** *she had recovered from depression.*

Participant 3; (Bindi)

*Bindi reported that she had been a "happy go lucky bubbly" person before she experienced depression. She had worked at one of the largest chocolate making factory in the world during her younger days. Bindi was a retired 65-year-old woman who had been seen for psychological therapy for 10 sessions on a fortnightly basis. The primary diagnosis was depression and predisposing and precipitating factors were family problems. She completed psychological therapy treatment but based on the IAPT outcome measures and minimum data sets *** ***(PHQ-9: 17 & GAD-7: 14),*** *she had not recovered from depression.*

Participant 4; (Ravi)

*As a professional in a high-flying job with a stay at home wife and 3 children, Ravi presented as quite uneasy during the interview. He reported to feel an intelligent person like him should not have needed the services of a mental health professional. Ravi was a middle-aged male 45 years of age who had been seen for psychological therapy for 8 sessions on a variable basis. The primary diagnosis was depression and predisposing and precipitating factors were marital problems. He completed psychological therapy treatment but based on the IAPT outcome measures and minimum data sets *** ***(PHQ-9: 12 & GAD-7: 10),*** *he had not recovered from depression.*

Participant 5; (Ranjit)

*Ranjit had been in and out of therapy attending a few sessions and dropping out. She had accessed services on 5 occasions and had dropped out on all occasions after 1 or 2 sessions. Previously, she had been seen in a Counselling Service that specialises in helping Asian people. At the time of the interview Ranjit, 50, was unemployed but looking for a volunteer job as she had previously worked as an Administration Assistant. She had problems with her relationships, problems conceiving as well as miscarrying which had been the case for many years. Her primary diagnosis was depression and predisposing and precipitating factors where childhood abuse and marital breakdown/relationship difficulties and a failure to conceive. At drop out on the 5th occasion of accessing psychological therapy treatment and based on the outcome measures and minimum data sets *** ***(PHQ-9: 16 & GAD-7: 11),*** *she had not recovered from depression.*

Participant 6; (Davi)

*Davi spoke with a lot of anger and frustration regarding the fact he could not get a suitable job. Although he lived on his own, he had 4 siblings with whom he shared good relationships. Davi had been seen for psychological therapy for 3 non consecutive sessions due to non-attendance of therapy workshop sessions, eventually dropping out after the 3rd session. The primary diagnosis was depression and predisposing and precipitating factor was the breakdown of relationship between him and his partner. At drop out these was the outcome from the outcome measures and minimum data sets *** ***(PHQ-9: 5 & GAD-7: 5).***

Note: Davi's scores show that he was not in "caseness"/ a case for depression according to IAPT patient access criteria although he reported depression as the problem at assessment stage.

Participant 7: (Bal)

Bal was a 35-year-old Health Administrator who lived with her partner of 17 years and had a son. She reported that her parents' marriage had broken when she was a young girl although she still maintained very close relationships with both mother and father and her half siblings. Bal had been seen for psychological therapy for 3 sessions as these where the maximum number of sessions offered. The primary diagnosis was depression and *predisposing and precipitating factor was a termination of pregnancy. At completion of treatment and based on the IAPT outcome measures and minimum data sets *** ***(PHQ-9; 20 & GAD-7; 17),*** *she had not recovered from depression.*

Part 2

Data Analysis

Charmaz, (2008) suggests *"enacting 21st-Century constructionist principles"* as a process within GT approach were data analysis involves the researcher as an actor in the process, whereby methodological and analytic strategies are improvised through the duration of the research process. In order to generate or discover theory, the researcher assumes the role of an actor whose role involves intervening, manipulating, acting on, conceptualising, and uses specific techniques to generate data into theory (Walker & Myrick, 2011). Strauss & Corbin (2008), claim that analysis is the interplay between the researcher and data.

Following on, Charmaz (2014) also suggests that, when starting with data from the participants' lived experience; the researcher is given an opportunity from the start to attend to how these participants construct their worlds and helps map out the researcher's approach to data collection and analysis. Hence, literal transcription of the interview tape recordings was carried out by the researcher following professional transcription, in accordance with the suggestions by Charmaz (2014) and Strauss and Corbin (2008).

When using a grounded theory approach everything relevant to the general topic area is considered data. Once the research begins, every future step is determined by what is being discovered in the data. Therefore, each interview was transcribed verbatim while assigning an identifiable code to each transcript. Key phrases or words and experiments with meanings were identified, a process known as open coding, through which concepts are identified and their properties and dimensions are discovered in data. This was followed by axial coding where subcategories were created and associating these with properties and dimensions where a total of 5 categories emerged. Finally, selective coding followed in which the researcher attempted to integrate and refine the theory by using categories and their associations with subcategories. Diagram (10) below shows the GT process to analysis as informed by Charmaz (2014).

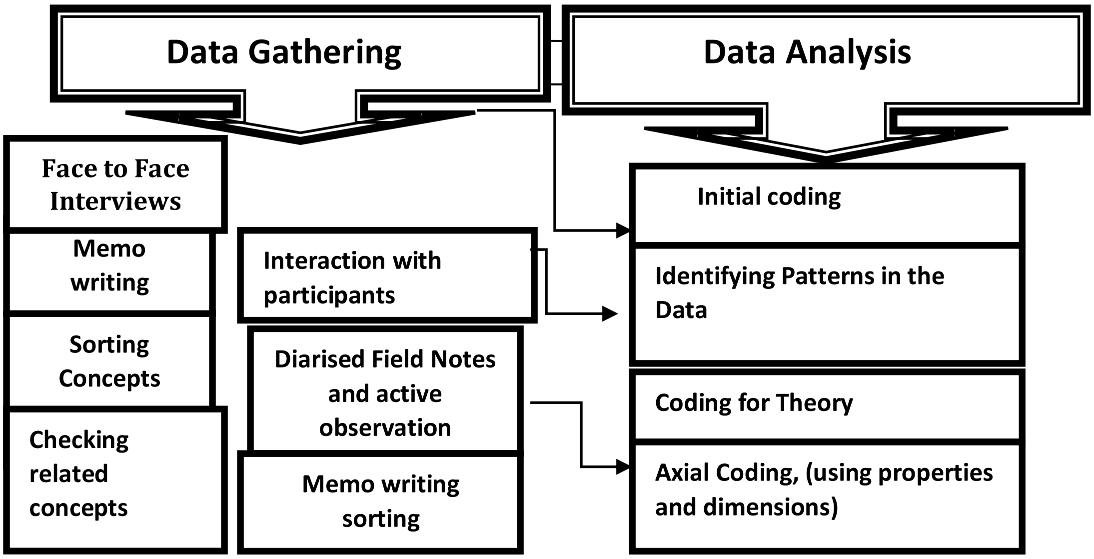


Diagram (10) Stages of Grounded Theory Approach to Analysis

However, critiques of grounded theory such as Thomas & James (2006) argue that it is impossible to free oneself of preconceptions in the collection and analysis of data in the way that is suggested by Glaser and Strauss (1967). Thomas & James (2006) perceived GT as very formulaic in nature and its lack of compatibility in opinion and action with open and creative interpretation, which should be the hallmark of qualitative inquiry.

i. Memos

Although many perceive the writing of memos as business communications to state policies procedures and proposals, the writing of theoretical memos is the core stage in the process of generating GT. Memo writing was adhered to throughout the data gathering and analysis stages in this study which served a reminder for the researcher to elaborate processes, assumptions and actions covered by codes or categories as suggested by Charmaz, (2006). Moreover, as one of the founding fathers of GT, Glaser argues (2012) that, if a researcher skips the stage of memoing by proceeding directly to sorting or writing up after coding, this cannot be seen as doing grounded theory. Ultimately, a research journal was kept throughout the research and memos produced eventually used to trace back through the researcher's thought and decision-making processes throughout the whole study. The journal also helped in highlighting some of the categories that emerged during the interviewing stages of the study and assisted in retaining an overview of the data/study. Writing memos is also believed to help the researcher enhance their analytical and reflective skills as well as help them retain and elaborate thoughts and striking ideas consequently helping in the development of theoretical codes, (Bohm 2004; Jeon 2004). Charmaz (2006) echoes this by suggesting the writing of memos or informal analytic notes which facilitates the research process through increasing the researcher's familiarity with the data; helping the process by which ideas are consolidated together with the researcher's ability to make comparisons between the data. Additionally, Glaser and Strauss both acknowledge that the researcher will not enter the field free from ideas.

Hence, throughout the study, case based, and conceptual memos were written. This was completed following each interview in form of a reflection based on information gathered from the interview. The memos comprised of the researchers' interpretation of information given and impressions formed about the participants' experiences. These memos allowed the researcher to systematically explore some of their pre-existing ideas relating to the information gathered in interviews.

Below (Figure 2, is Memo 1 written following Priya's interview and illustrates how Priya's comments influenced the analysis.

Memo #1- Exploring Priya's interview (Snapshot)

Loss of identity is believed to be a result of illness and one is defined by illness. Status is more important, and illness is defined as something only shared among close family. Illness is shameful. There is an expectation on family. Seeking help is perceived positively. Priya did not know about depression. Gender issues were important in when seeking help. Treatment choice offered her hope. She indicates preference of individual rather than group therapy and significance of language and ethnicity of practitioner is revered. Services were felt to be lacking in advertisement. There was a notion of right help at the right place and providing resource to enable access to services.

Figure (2) Memo #1- Exploring Priya's interview

Heath & Cowley (2004) claim that discovery is at the heart of both researchers' ideas as one enters the field open to realising new meaning and, via cycles of data gathering and analysis, progressively focuses on a core problem around which other factors will be integrated. Thus, memos were perceived as necessary tools for capturing the idea as well as for abstraction and theory development, which evolved throughout the research (Holton, 2010; Charmaz, 2006; Glaser, 1978). Therefore, developing ideas with complete conceptual freedom can be argued to be the basic goal of memoing, of which memos are perceived in economic terms as bankable in order to be sorted at later stages and help integrate the overall theory.

ii. Codifying & Categorising

"Any researcher who wishes to become proficient at doing qualitative analysis must learn to code well and easily. The excellence of the research rests in large part on the excellence of the coding".
(Anselm L. Strauss, Qualitative Analysis for Social Scientists, 1987, p. 27)

Saldana, (2005) claims that, where there is qualitative inquiry, there is a need to meticulously pay attention to the language being spoken and exhibited as well as deep reflection on emerging patterns and meanings behind human experiences. In GT, coding is the process of analysing the data and this process initially commenced with reading the transcripts of the interviews several times. Thereafter line by line coding took place which consisted of identifying and labelling the key concepts in each transcription such as words or phrases. Of central concern at both of these stages, according to Charmaz (2008) and Strauss and Corbin (2008), was clear definition of the codes including the processes they described and the assumptions implicit within themselves. The intent of coding was to conceptualise the data through analysing it and identifying patterns within it since coding is the very core process that initiates the development of theory through the conceptual abstraction of data and its reintegration as theory takes place (Charmaz 2014; Holton 2010).

Strauss' coding divides the process into three levels known as open, axial and selective coding and according to Lofland (2006), what gets coded when studying human experiences is units of social organisation where social life happens at four coordinates, namely; "the intersection of one or more actors [participants] engaging in one or more activities (behaviours) at a particular time in a specific place" (p. 121, emphasis in original). These aspects as evident within this thesis included cultural practices, encounters, roles, social and personal relationships, and organisations amongst an exhaustive list. Moreover, Lofland (2006) encouraged examining how participant agency interacts and interplays with structures and processes, as well as causes and consequences observed in the data apart from solely focusing on the magnitude and frequency of social life outlined previously.

iii. Open, Focused, Axial and Theoretical Coding, Theoretical sensitivity, and Theoretical Saturation

iii (a) Open coding

Open coding entailed fragmenting data which began with line by line, open coding of data and comparing incidents to each other in the data.

As Charmaz (2006) suggests, data was coded and labelled in every way possible bearing a set of questions in mind such as:

- “What is the issue here? What phenomenon is being addressed?”
- What persons are involved?” Interactional interplay.
- “What category does this incident indicate?”
- “What is actually happening in the data?”
- When? How Long? Where? How much? How strongly?”
- “What is the main concerns being faced by the participants?”
-

Old school ways of printing out copies of the transcripts was adopted and different colour STABILO highlighters (incomplete example in Table (7) were used with each specific colour representing specific meaning and or label, Charmaz (2006). Manual coding was used since my data sets were relatively small and also as a way of reducing costs since my research project was personally funded. Additionally, the decision to code manually was also based on the assumption that automated software such as NVIVO are not always able to detect nuances of meaning of a text in certain instances where a person would be able to.

Yellow →	**Helpfulness?what?}-useful?how?}effectiveness**
Grey →	**Community?who?-collectiveness; culture?tradition?**
Red →	**What?}Fear of being judged:- stigma? Shame?**
Purple →	**Someone?who?they,helper-Practitioners/family**
Lime →	**What?Feeling,symptoms,Expression,of?what}depression?**

Table (7) An illustration of Line Coding using colours

Line by line coding was used as a way of translating participants’ narratives. Several labels which cemented participants’ experience were identified and I was aware I had to stay focused and grounded in participants’ narratives which helped in extracting meaning from the data rather than meaning being imposed on data, (see Table 8 below). Charmaz (2014) claims that, pure labels are allowed to emerge when one stays grounded within participants’ narratives.

As suggested by Strauss and Corbin (2008) when I became more familiar with the data and the concepts and categories being identified, coding was done by sentence even by paragraph since there was no need to revert to line by line coding once new concepts or categories were identified.

*__Ravi;__ “I did not find it helpful (what?)**(impact/effect)**. This was a group session with loads of people there(who?) **(involving many)** I think it was just the whole process. It made me feel more down (how?)**(“affect/feeling” and impact)**. The questions she asked me. Like I was saying to you before, you know when you have a rapport **(relationship/effect)** with someone (who)**(professionals as someone/ other people)**like my GP, when someone’s known you from very young they know what kind of individual you are; when something happens they know all about you**(knowing**; it was not for me**(impact/effect). When people** don’t know you **(knowing)** they don’t know what’s going through your head **(affect/feeling)**. Only you as an individual know what’s going on for you **(not being understood)** and unless **(conditional)** you have been through the same rigmarole only then would you understand **(validate/acknowledge)**. When you go and see people**(professionals as other people)** they only give you little advice **(quantity/amount/effect)** and that’s not what I am looking for. To other people **(professionals as other people)** you are just a number and I am an individual not a 1 or 2.”*

*__Ranjit;__ I didn’t find Asian Family Counselling helpful **(impact/effect)** I think it made me feel more depressed **(“affect/feeling” and impact)**. It was just too close to home**(involving many)**. I feel there would be more freedom**(feeling)** if it wasn’t someone **(professionals as other people)** from my own background. Like I am not being judged**(feeling/perceptions),** things like that. That I have had sex outside of marriage or that I was happy to live with someone and not get married.”*

Table (8) An example of Line by Line Open Coding and Data Comparison

During the entire process reflexivity forced me to concentrate on the data and avoid undue influence by preconceived beliefs about the field of enquiry because, as a practitioner researcher there was a risk of decreasing the degree of trustworthiness and dependability due to previous or on-going experience with similar patient groups. Figure (3) illustrates how I exercised reflexivity through reflecting on the interviews process and narratives and my own thoughts and perspectives that emerged following the process.

<u>Reflection Following Bal's interview</u>

Clearly Bal did not want to be stereotyped as just another BAME with a meant l health difficulty. Reflecting on previous encounters in sessions, Bal 's concerns sounded familiar to those of my many SAI & BAME patients whom soon after coming into session have asked about whether coming to see a therapist meant they had a mental illness and if they would be committed to a psychiatric hospital. I remembered the "bad attitude" I have received from a considerable number of BAME patients whom upon entering the clinic room and seeing a Black face have behaved in a passive aggressive manner towards me. I had a recollection of a few sessions where patients asked me if I lived around the same area as the GP Surgery where I worked, that which was their local community. Apart from reading Literature and from seminars and workshops, my colleagues from BAME communities and I shared similar conversations previously. Considering the most of my participants have talked about this, shame stigma, assumptions made by patients about the professionals, colour/race/ethnicity and where the practitioners lives appear to be a significant factors influencing access to services. I find it concerning that one would perceive seeking and talking about a problem to a professional as exposing oneself. To patients a problem is "their business" and a professional is "a stranger". Such perceptions around the helper and help seeker dynamics had never crossed my mind.

Figure (3) Reflection Following Bal's interview

Based on my position as an insider and outsider, there was an awareness of the possibility that my personal subjections and interpretation would to some extent impact on the coding process. Moreover, during coding I searched for a core category that was central to other categories, in order to be able to generate theory that explains changes and dimensions in behavioural patterns as presented in Table 8, (an example of Line by Line coding). These categories represented the key issue in the participants' pattern of behaviour under investigation and experiences of treatment which consequently affected the whole process of seeking help.

Therefore selective/focused coding began after I identified potential core variables and it is through selective coding that categories were integrated and developed into the theory. Strauss and Corbin (2008) define selective coding as the process of selecting the central or core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development.

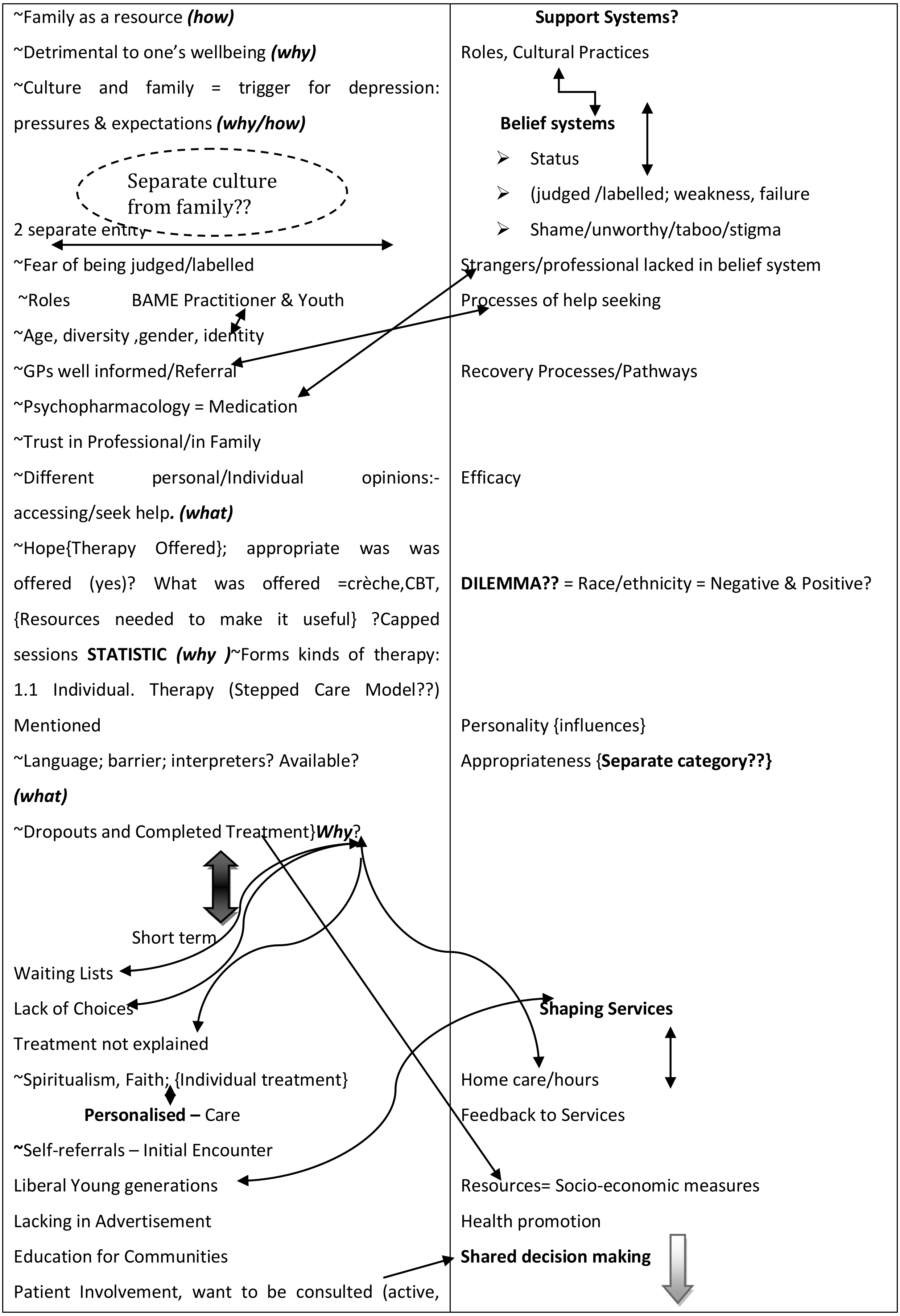
iii (b) Focused Coding

Thus, the construction demonstrated in axial coding continued in focused coding, with coding focusing on one category at a time until I felt ready to choose the core and then focused analysis on integration, (Walker & Myrick, 2006; Heath & Cowley, 2004). Charmaz refers to focused coding as an iterative process where one sifts through labels and codes developed in the initial phase to identify the most prevalent, salient, and frequent themes which could be refined to a higher level of abstraction. This process was achieved through revisiting the interview transcripts perused thoroughly and compared against early labels and categories identified in the initial coding phase. My aim was to identify a core or overarching category. Arguably, the imperative idea was to develop a storyline around which everything was encompassed and in this case experience of depression, help seeking, therapy seeking and outcome. After putting categories into sequence, the process of uncovering a considerable group or formation of consequences of various conditions took place and this consequently gave participants stories specificity. Hence this mapping formed the basis of the theory.

It is therefore argued that focusing on the core and other related categories, subsequent data collection can go very quickly with only a minimal field notes to be captured and analysed.

iii (c) Axial Coding and Theoretical Coding

Axial coding was implemented to enable putting the fractured data back together in new ways "by making connections between a category and its subcategory", Strauss and Corbin (2008). Thus, concepts were elevated to provisional categories which arose through a process of constant comparative analysis, grouping and clustering concepts alongside each other in higher order and with more abstract concepts, (Holloway & Wheeler, 2013; Corbin & Strauss, 2014). This connection was accomplished through the use of a coding paradigm, which focused on three aspects of the phenomenon: the conditions or situations in which phenomenon occurred; the actions or interactions of the people in response to what was happening in the situations; and, the consequences or results of the action taken or inaction (Corbin & Strauss 2014). This process facilitated complete engagement with participants' social constructs and world views without imposing my own. During axial coding, I worked towards understanding how categories were related to each other thereby forming subcategories. The purpose was to delineate and extricate relationships on which the axis of the category was being focused as demonstrated in Diagram 11, (An Example of Axial Coding).



~Family as a resource ***(how)***	**Support Systems?**
~Detrimental to one's wellbeing ***(why)***	Roles, Cultural Practices
~Culture and family = trigger for depression: pressures & expectations ***(why/how)***	**Belief systems**
	➢ Status
Separate culture from family??	➢ (judged /labelled; weakness, failure
2 separate entity	➢ Shame/unworthy/taboo/stigma
~Fear of being judged/labelled	Strangers/professional lacked in belief system
~Roles BAME Practitioner & Youth	Processes of help seeking
~Age, diversity ,gender, identity	
~GPs well informed/Referral	Recovery Processes/Pathways
~Psychopharmacology = Medication	
~Trust in Professional/in Family	
~Different personal/Individual opinions:- accessing/seek help**.** ***(what)***	Efficacy
~Hope{Therapy Offered}; appropriate was was offered (yes)? What was offered =crèche,CBT, {Resources needed to make it useful} ?Capped sessions **STATISTIC** ***(why)***~Forms kinds of therapy: 1.1 Individual. Therapy (Stepped Care Model??) Mentioned	**DILEMMA??** = Race/ethnicity = Negative & Positive? Personality {influences}
~Language; barrier; interpreters? Available? ***(what)***	Appropriateness {**Separate category??}**
~Dropouts and Completed Treatment}***Why***?	
Short term	
Waiting Lists	
Lack of Choices	**Shaping Services**
Treatment not explained	
~Spiritualism, Faith; {Individual treatment}	Home care/hours
Personalised – Care	Feedback to Services
~Self-referrals – Initial Encounter	
Liberal Young generations	Resources= Socio-economic measures
Lacking in Advertisement	Health promotion
Education for Communities	**Shared decision making**
Patient Involvement, want to be consulted (active,	

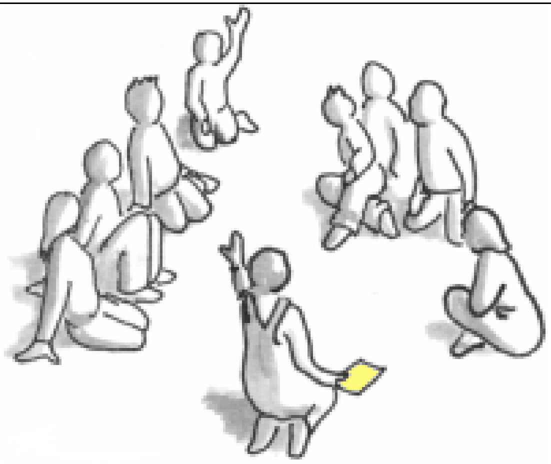
meaningful participation, research) SAI reflected in Policy. Care given. ***How?***	

Diagram (11) An Example of Axial Coding of Categories

The phenomenon signified by the axial category is, for example, an event or a fact. The actions of an individual as well as interactions between different people revolve around the phenomenon. Questions such as: what do my data refer to; with what, are the actions and interactions in the data actually concerned, make easier the choice of axial category. What helps shape the developing of phenomenon are the causes and causal conditions, (Bohm, 2004). Similar to open coding, axial coding is usually applied to short textual portions, to larger segments or the whole text. For theory to be formed or emerge, I related categories and concepts in terms of their formal and content aspects, (Bohm, 2004). Furthermore, consequences of actions are often indicated by means of expressions such as ‘as a result of’, ‘and so’, ‘with the result that’, ‘the consequence was’, ‘consequently’, (Brown et al., 2002).

Hence in this in this thesis, depression (cause) makes people seek/not seek psychological help (phenomenon). It is important to note that actions and interactions (therapy encounter) lead to particular consequences (stay in therapy or dropping out). Strauss and Corbin (2008) recommend that researchers be extra cautious when applying the coding paradigm to linguistic peculiarities in the data. Key words such as ‘because’, ‘since’, or ‘owing to’ are fundamental and should be considered as indicators of causal conditions. Therefore, once a concept was identified, its attributes were explored in depth, and its characteristics dimensionalised in terms of their strength or weakness.

Consequently, this helped the saturation of the selected categories that formed the basis of the emerging theory without collecting a lot of additional material that could have been irrelevant to the developing grounded theory, (Holton, 2010).

iii (d) Theoretical Sensitivity

Coding continued to be carried out in a reflective manner as suggested by Strauss and Corbin (2008) and Charmaz (2014); who argue that coding reflectively presents the researchers much like investigative reporters, asking the questions; what, when, why, how and with what result or consequence. Concurringly, the benefits of reflective coding when answering these questions weaves the loose array of concepts and categories unravelled and sorted in open coding back together into a pattern (Wilson-Scott, 2004). Being reflexive facilitated theoretical sensitivity. This meant that I theoretically and conceptually thought about the data from a distance, while simultaneously maintaining a close level of sensitivity and understanding about the process and my involvement within that process. Moreover, it also helped in providing meaningful insights into participants' societal constructs and worldviews as illustrated in Davi and Ranjit's interviews in Figure 4.

Reflection following Davi and Ranjit's interviews

Contrary to my prior belief, Davi and Ranjit's narratives have shifted my thoughts about SAI and family and leaves me to think that although family is important it may not be paramount to everyone. I sensed anger in Davi's voice and presentation when he talked about services in particular and how he implied that some of my questions must have been based on assumptions I held about SAI. Indeed, I held thoughts and beliefs based on my everyday experiences and encounters not only as a practitioner but as a friend to numerous people from SAI backgrounds so had this informed some of the questions I was asking. I wanted at one moment to find out what Davi's "anger" was about but I felt afraid that we would end up going off topic, although after we had completed the interview I regretted not having followed up on his "anger" as this may have given me valuable information. Perhaps I should contact him again and follow up on this which I could do as long as my NHS Research Passport is still valid? After following on a question about preference in practitioner based on race and ethnicity, he asked me interesting questions like, "if that mattered would I be speaking to you right now." It appears the first meeting is very a crucial point within the whole therapy process. Patients do not want to be seen as just a "statistic" of which being asked to complete minimum data set (MDS) such as PHQ9 and GAD7 reinforces this belief. Thus I arrive at an understanding about the importance of how we present and interact with patients and how some patients may feel health professionals don't view them as individuals with feelings to whom they owe a duty but as numbers coming through the door so to tick a box. Therefore, is there something as professional we could do to reassure patients and explain outcome measures in ways they understand and informing them of the importance of certain processes in health delivery? Seeking help as a personal choice not influenced by family or culture is certainly interesting and does not sound too familiar to me and must find out more in my next interview.

Figure (4) Reflection following Davi and Ranjit's interviews

For GT Founders, Glaser and Strauss (1967), it is essential that as researchers progress through the cyclical process of data collection and analysis, they 'are sufficiently theoretically sensitive'. The benefit of developing theoretical sensitivity to a wide range of integrating codes as used across a wide range of disciplines increases a researchers' ability to see their emergent categories fit to a developing theory. It 'allows one to develop a theory that is grounded, conceptually dense, and well integrated' (Strauss and Corbin, 2008).

Moreover, as illustrated by (Birks and Mills, 2011; Strauss and Corbin, 2008), theoretical sensitivity about patients' experiences was developed through reading literature, working in a mental health institutions and through my own related personal experiences, as well as through the process of data collection and self-awareness. Agreeably, Holton (2008) argues that two things that are required of the researcher in order to be theoretically sensitive are analytical temperament and competence. Holton (2008) suggests that analytical temperament helps the researcher to maintain analytic distance from the data, tolerate regression and confusion, as well as "facilitate a trust in the power of preconscious processing for conceptual emergence".

Strauss and Corbin (2008) also suggest that in order to achieve theoretical sensitivity researchers should use a set of definitive analytic tools such as; questioning; analysis of a word, phrases, or sentences, making close-in and far out comparisons and waving the red flag. These tools are believed to "increase sensitivity, when the researcher identifies bias to some extent, and helps them overcome analytic blocks" (Strauss & Corbin 2008). As illustrated in Figure 3 following Davi and Ranjit's interview where I recognised that what informed some of the questions I was asking was perhaps previously held thoughts and beliefs based on my everyday experiences and encounters not only as a practitioner but as a friend to numerous people from SAI backgrounds.

iii (e) Theoretical Saturation

The stage where no new theoretical insights can be derived from analysis and where new data no longer generates original codes is referred to as saturation hence signifying the completion of data collection (Glaser and Strauss, 1967). Although theoretical saturation is generally understood to fill gaps and generate integrated theory, Dey (1999) refutes the claim that saturation signifies the end of the research since this denotes that the process of propagating and developing categories, subcategories and their dimensions is exhaustive. Charmaz (2006) also acknowledged that there remains some controversy regarding the definition and conceptualisation of data saturation. Adiabat and Le Navenec (2018) also argue that a number of definitive unaddressed methodological issues could be the reason why a researcher may no longer be able to identify new data, as opposed to the continuation of data gathering.

From a constructivist perspective, saturation in this thesis was achieved through code saturation, (Hennink, Kaiser, and Marconi, 2016) after I felt I had 'heard everything' from participants and there was nothing different or new codes emerging. Additionally, time constraints such as University and NHS Research passport deadlines and limited resources such as financial constraints associated with transcribing due to my research studies being personally funded also influenced the process of data saturation (Adiabat & Le Navenec, 2018). Its suggested that, in order to facilitate substantive data saturation, data collection should be longer for greater assimilation of occurrences and to enable rapport with participants; from an emic and etic perspectives, substantial time for interviews is required in order for the researcher to fully understand the reality, meaning of experience and psychosocial processes from the participants' viewpoints (Adiabat & Le Navenec, 2018).

Consequently, a total of five main categories were constructed from the coded data as explicated in the ensuing Chapter. These categories put together including sub dimensions shape the study and expound the narratives shared by the patient regarding their overall experience of psychological therapy treatment and depression.

Chapter Summary

In summary, this chapter outlined the methodology and methods applied in this study. Epistemological and ontological stances were discussed and theoretical concepts pertaining to grounded theory were also elucidated. Charmaz' constructivist approach to grounded theory influenced the study design based on the aims of exploratory nature of the research study question. In-depth interviews were planned, and questions were developed from previous discussions with professionals, Service Users and prior knowledge gained from existing literature. Drawing on Charmaz and Strauss and Corbin's suggestions on coding, open, focussed, theoretical, and axial coding processes were employed. Constant comparison analysis was considered appropriate to support theoretical sensitivity and saturation of data. Ethical approval was sought and adhered to in line with University requisites and NHS research governance processes.

Chapter 4: FINDINGS & DISCUSSION

Introduction

This Chapter details the categories that emerged using the methods and design which were explained and discussed in Chapter 4. As elucidated in Part 2 of Chapter 4, this was achieved through coding, a constant comparison of codes and re-categorising and simultaneously paying meticulous attention to language and deep reflection on the emerging patterns and meanings of human experience. The emergent categories and sub dimensions discussed here derived from a process of thorough and going backwards and forward the analytical coding hierarchy exhaustively, with insights developing through manual indexing, sorting and memo writing as suggested by Charmaz (2014). Hence, what is commentated in the 1st Part of the Chapter is an overview of the SAI's experiences of living with depression and their experiences of the illness and treatment received.

The 2nd Part of this Chapter explores the key aspects and main findings of the research which highlight that, although several factors such as culture, traditional values and beliefs act as barrier to services, for some SAI participants accessing services was a personal choice that was not entirely prescribed by these factors. It also explores the findings in relation to how they can inform in order to reshape and further develop health policies and therefore transfer into current clinical practices.

Part 1: Emergent Categories from Data

Through data analysis, 5 categories emerged which highlighted and gave insights into SAIs' experiences of depression and IAPT psychological therapies in primary care. Excerpts taken directly from participants' narratives were used to provide a true representation of their experiences. Hence, in terms of their health and health seeking behaviours, there is evidence that South Asian Indians are significantly influenced by their history and a cultural context which weighs substantially on them when shaping the view of the world and behaviours and action that follows. Findings in this Chapter are presented on an emergent category basis in diagrammatic form and through use of participants’ excerpts with a description of their narratives. The five categories that emerged and discussed here are:

- ✓ Definition of illness
- ✓ Social Structure
- ✓ Therapy Processes
- ✓ Recovery Processes
- ✓ Service Development

i. Category 1 (with subcategories & sub dimensions): Definition of Illness

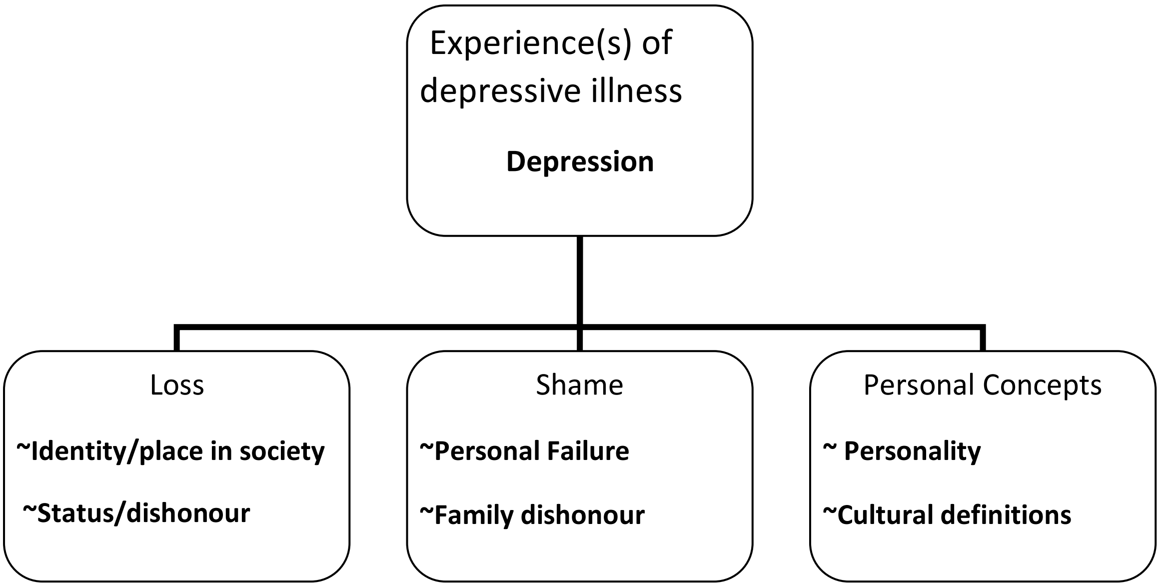


Figure (5) Category 1 - Definition of Illness

The first emergent category of patient’s experience of depression and psychological therapy is experience of depressive illness which is discussed in greater detail below in relation to its subcategories and sub dimensions. This category comprises loss as a sub-category described by participants when experiencing depression in relation to identity, status, and honour as sub dimensions. Shame is another subcategory with personal failure and family dishonour as sub dimensions. Personal concepts of depressive illness are the final subcategory within this emergent category with personality and cultural definitions of illness as sub dimensions.

Loss: Identity/place in society and status/dishonour;

Participants talked about how they felt they had become their own community's "laughingstock" due to not living up to the community's expectations. These expectations were around parenthood, career wise, as well as marital relationships as unmarried woman/women. The following quote illustrates this point;

> ***Priya,*** *"at the time I thought it was just me and it was my fault I was feeling this way; I felt stupid and silly that I was tearful all the time and could not look after the baby as a mother should."*

It was reported that when someone is ill in SAI community, the experience made the participants feel as if they had lost their place within that society/community. Participants reported that within SAI communities an individual gets defined by their illness and that the community focused more on status.

> ***Davi,*** *"Every day I used to cry, imagine a man crying, so embarrassing. You must understand, my relationship had broken down and I was out of a job and if you do not have a job you are nothing amongst my people. Everything was negative, and it felt like it was the end of the world."*

Participants reported that without a job one would be a "nobody" and status within the community is extremely important and if one did not have that they would be at the bottom of their own community hierarchy.

> ***Kully,*** *"I finished Uni and had frustrations of not getting a job. Every time I came to the Doctor, I said no I cannot work, I felt like a nobody".*

Participants reported a fear of being labelled and self-identity is important although it perpetuated depression where one felt they were not progressing in life or be a in a certain position as expected within that community. Status was reported as paramount so not to be looked down upon or be an outcast.

Shame: Personal failure and family dishonour;

Louie (2018) claims 2500 years ago Confucius advocated the need for Asian individuals to submit to the greater good of the collective group with doing so meaning honouring the self and others within a collective thereby acquiring stability and harmony.

According to Sinha and Chauhan (2013), SAI shame carries a connotation that the person is judged worthless or blameworthy**.** The participants expressed their feelings of hopelessness and feeling that they believed they had disgraced themselves and their families by being failures as a result of the depressive illness. The following quotes from participants illustrate this.

> ***Priya,****"I was basically feeling sad and feeling I was good for nobody as I was just lying there doing nothing and I couldn't even get up to help myself and do things and get up and make milk for the baby. The house was a tip. It was going to be interpreted as weak. I was feeling low in self-esteem and useless. You feel like you are a lost soul."*
>
> ***Ravi,*** *"You know with Asians there is a bit of stigma. They don't understand why you would want to go online or to see a Doctor about how you are feeling".*

Participants describe being scorned by the people whom they believed had close and strong relations with; that this resulted in shame and disgrace that was associated with the depression and consequently feeling a sense of helplessness within them and their situations.

> ***Bal,*** *"I had low self-esteem; I could not get up and help myself"*

> ***Ravi,*** *"I was afraid to say I had depression because of the people and friends around me."*

Being out of a job after graduating was reported to be a trigger for depression due to pressures and expectations from this social community group family, and culture was perceived as a source of depression as reported by Kully as she expressed feeling shunned by family:

> ***Kully,*** *"The thing was though I have grown up and never seen this like dark side of the family. It felt like we always loved each other and everyone has always been nice to each other then all of a sudden bam, like oh this person is talking about me here that I thought I was close to and saying things about me just because I was not in a job it was like letting everybody down."*

Personal Concepts: Personality and Cultural definitions;

'Culture' is an abstraction, reflecting the total way of life of a society and denoting shared patterns of beliefs, feeling and behavior and the basic values and concepts that members of a group carry in their minds as guides for conduct (Gautam & Jain, 2010).

However, in this instance, participants explained how being part of and adhering to some traditional cultures, values and beliefs did not impact on the way they perceive their illness; where one explains not being aware of depression or what it was, but being alert to certain symptoms such as constantly feeling tired and tearfulness. Therefore, rather than perceiving the problem as a mental health problem it was depression was presented as a physical illness as indicated in the following:

> **Priya,** *"I could not stop crying, I could not control it. So, I did not know this was part of the depression that was getting to me. I did not really know what the word depression was. "All I said was I didn't feel any good and I needed to go and see the Doctor."*

> **Bindi,** *"I had not heard of depression and I did not understand how I was feeling. I did not have a bath for a long time. Do you know I used to work at the chocolate factory and used to be full of confidence, but it all went?"*

Other participants described an unresponsive and independent decision, which were not affiliated to any cultural prerequisites or impositions to seek help from the GP.

> **Davi,** *"Going to the GP to ask help was my personal choice and my culture had nothing to do with it. If it's helpful for some individuals then fine but I am saying I think everybody is an individual and you know we all have individual characteristics, you know some people are happy to go and share their issues and they find some comfort, relief and benefit from that. I have to be really close to someone to actually share my inner feelings and it is got nothing to do with my race or that I am male. It's just my character basically."*

> **Ravi**, *"Because I know many people of my race that would happily go and speak to strangers."*

These examples illustrate how depression is perceived as life changing. Some participants did not perceive culture to be relevant when seeking help although individuals remained still quite depended on family. The data indicates that, if one were liberal and open minded to Western ideas and values the bigger the chance, they would access psychological help. Moreover, the participants believed depression was about the self, resulting in a feeling of loss of control over their lives as which they expressed as a loss that brings about change and transforming a life in a negative way, at the same time reshaping social relationship and limiting them. One became ostracised and felt like an outcast therefore precipitating a difficulty in finding continuity of the self when experiencing depression based on the repeated loss of control, autonomy, and self-respect.

> **Kully,** *"You don't know my people. Seriously, my cousins stopped ringing me. It's hard to believe isn't it that just because I didn't have a job none of them wanted to know me."*

It is important to note that participants who were born in UK and therefore significantly acculturated to the life and western culture reported that the word depression or what depression symptoms are was not quite familiar.

An example of another Memo compiled after an interview with Davi is given here expounding some of the concepts within the next category linked to other categories already analysed and some yet to be explored in the ensuing sections. The notion of independent and uninfluenced personal choices to seeking help can be observed in Figure 6; Memo # 6, following Davi's narrative.

Family is important in everyday general life, but mostly when in crisis. GP is always first point of contact. Conforming to culture is good at times it is not always everything that is prescribed within that culture that's beneficial or helpful. Although GP referred to a psychological service straight away there is a feeling that speaking to a "stranger" (professionals are referred to as strangers) does not help since they would be strangers and would lack understanding of them and their difficulties. Services received were not appropriate, neither useful nor helpful and this is neither connected to race, ethnicity nor culture of the practitioner. Services were rated based on initial encounter with the practitioner. Medication alongside psychological therapy is the norm. The knowledge the sessions would be capped at a certain number is seen as a deterrent factor. There is feeling of being just a "statistic", a "number" within the therapy process. Accessing services was a personal choice not prescribed nor restricted by any socio-cultural factors. Culture was seen as not relevant when seeking help although individuals remained still quite depended on family. Acculturation to Western ideals made one perceive psychological help differently from the rest. Feedback to services via the use of Patient experience questionnaires (PEQ) was seen as essential. Treatment was also desirable if it was tailor made and personalised for individual needs.

Figure (6) Memo #6 - (Exploring Davi's narrative

ii. Category 2 (with sub dimensions): Social Structure

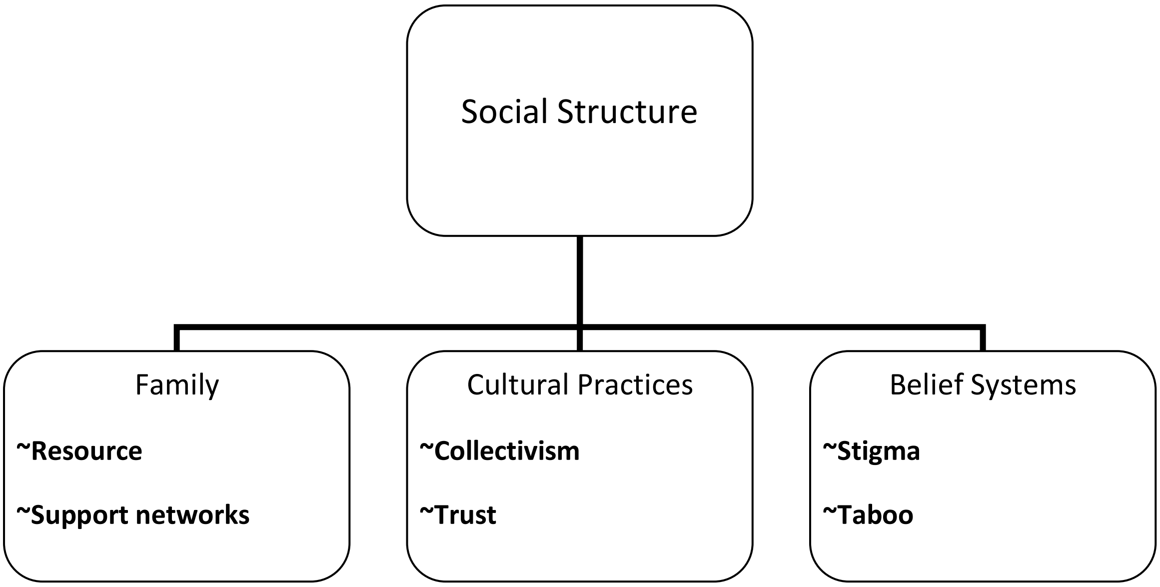


Figure (7) Category 2 - Social Structure

The second emergent category of patient's experience of depression and psychological therapy is social structure, here defined as the set of norms, values, behaviours, and characteristics which are socially recognised. Details about the subcategories and sub dimensions through participants own quotes are included below to illustrate this. This category comprises of family as a sub-category described by participants when experiencing depression and how it is perceived as a resource and source of support network therefore recognised as its sub dimensions. Cultural practices are another category comprising collectivism and trust as sub dimensions. Belief systems of depressive illness are the final subcategory within this second emergent category having stigma and taboo as sub dimensions.

Family: Resource & Support networks;

SAIs bestow prodigious value on the family as a unit with each individual having a specific role and position in the family hierarchy determined by age, gender, and social class, and where each person is expected to function within that role as well as submit to the larger needs of the collective (Sinha and Chauhan, 2013; Gautam & Jain, 2010).

Participants reported the dilemma and difficulties of having family as a resource and form of support but at the same time not getting the support from the very people who are meant to give it. However, the participants in this thesis appeared to have partial and divided feelings regarding the family where some participants reported that the involvement of family generally whether ill or not, is seen as a good thing and family is considered a resource for the person to rely on when not well.

> ***Priya***, *"Nobody came. Imagine you are like surrounded, literary surrounded by family and you did not find them helpful at all. My mother in law would not help, she gave excuses and did not like the fact I was getting attention in the house because of the baby. My mom did not want to come and help; she lives in* [redacted] **(a city within the West Midlands but erased for confidentiality purposes)** *and she felt if she came there would be a little bit of family friction".*

> ***Kully,*** *"so you felt like you could not talk to people you know, but imagine you are surrounded by family. It felt like it was the end of the world, I just wanted to die."*

> ***Bal***, *"I did not have family support."*

Contrarily, Davi and Ranjit state:

> ***Davi,*** *"Family can be very supportive when things are not going too well."*

> ***Ranjit,*** *"Your family are the most important people to you and they are sometimes very helpful but now I am without family just because I made them look bad because I left home and started living with a man before I was married."*

The participants described family as important in everyday general life, but mostly when in crisis. There is a reported expectation on family to help but if there is no support offered the difficulty could exacerbate. The participants reported a strong belief and expectation that before any other intervention, professional or otherwise, help should come from relatives.

Cultural Practices: Collectivism and Trust;

Distinctly, there are differing views regarding living, believing, and belonging and having faith in the extended family. However, participants reported that trusting in family and religion gives comfort as indicated below.

> ***Bindi**, "Having family helps big time, family support really helps and the love they give you gives you hope and happiness".*

From the participants' reports, illness was defined differently as something that was to be shared only among close family and not strangers.

> ***Priya**, "If you have people like your brother, sister and mother who listen to you better, when they listen to you it's a part of counselling it uplifts you; but because I didn't have any family next to me I was a completely lost soul."*

Significantly, the lack of trust and no support was perceived by participants as a maintenance factor which perpetuated the depression consequently resulting into the withdrawal from the collective by others due to mistrust and feelings of being failed by their community.

> ***Ranjit,** "They didn't help anyway, and I kept to myself, but it affected me."*

> ***Ravi,** "I still trust God and pray. I am a very religious person. I found it easy to speak to God to sort of get some signs from him; he puts you in the right path."*

> ***Priya,** "My mother in law started doing the drama because I was unwell. It is a family thing. You know the Asian family it is very hard to understand. You can't please the family; we can't do what we want to do".*

However, there was also a general feeling reported by participants that although conforming to culture is good, at times is not always everything that is prescribed within that culture that is beneficial or helpful.

Belief Systems: Stigma and Taboo;

The participants reported to perceive depression as something shameful and therefore described negatively as something that should not be discussed outside the family circle. Talking about depression within the tightly knit community was also considered by participants as not helpful. Some parts of the narratives are presented here:

> ***Priya,** "I couldn't explain how I was feeling to my mother in law".*

> ***Ravi,*** *"On the one hand you don't want to have a practitioner who is from an Asian background because trust me those people talk. I am not sure if having too many people from the Indian community in the same room works because you are guarded all the time thinking I must be careful what I say otherwise it may reach my family or friends and the like then that would affect your whole family and cause an embarrassment."*

> ***Bal,*** *"You don't share your business with anybody since they have their perceptions about Black and Asian people".*

Within their community and their social world, the participants described being ill as shameful. The participants reported difficult experiences with depression especially if triggered by a sensitive subject such as termination of pregnancy (TOP) which was frowned upon leaving others ostracized by family. This cultural stigma and personality were described by participants as something that interfered in the way that people made choices about accessing services since privacy was perceived to be paramount, rather than *"talking your business"* to "*strangers*". As a result, people were reluctant and skeptical about seeking help.

iii. Category 3 (with sub dimensions): Therapy Processes

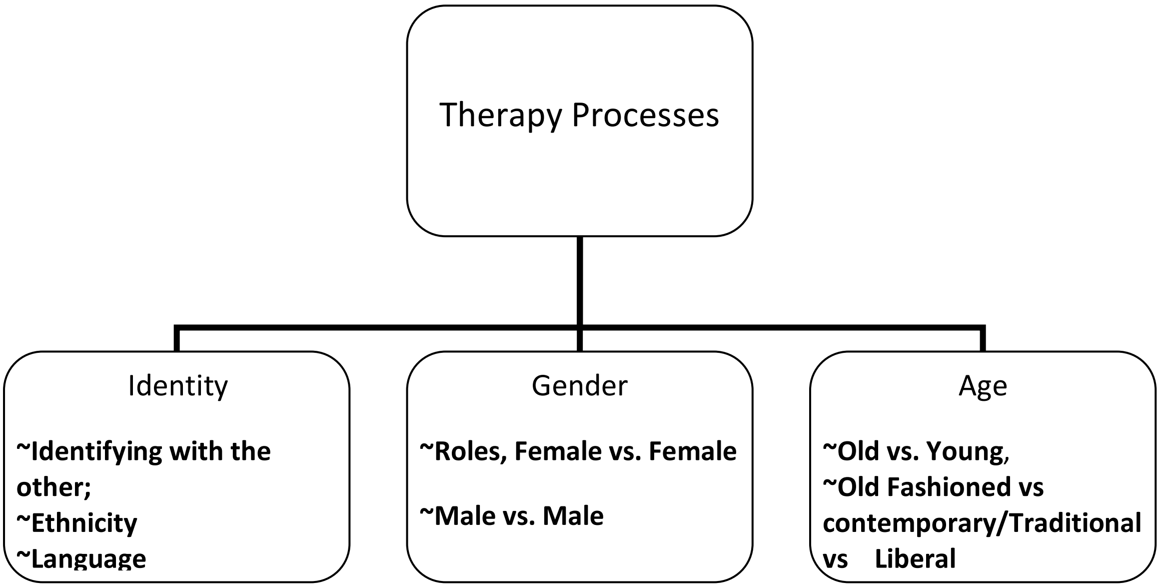


Figure (8) Category 3 - Therapy Processes

The third constructed category of patient's experience of depression and psychological therapy is entitled therapy processes also seen in the above 2 Memos. This comprises of subcategories such as identity in relation to identifying with the other within the therapeutic encounter and related to ethnicity and language. Gender in terms of gender roles within therapy is also discussed and here understood as is a social role encompassing a range of behaviours and attitudes that are generally considered acceptable, appropriate, or desirable for people based on their actual or perceived sex or sexuality. Age as a subcategory is also within this emergent category in relation to perceptions held about healthcare delivery and the age group of those delivering the help. Hence the sub dimensions effectively titled; old versus young; old fashioned versus current; traditional versus open minded.

Identity: Ethnicity and Language

Here participants described their feelings regarding the ethnicity/colour/race/culture of the professionals they came into contact with whether they felt they were listened to or "heard". Participants talked about their anxieties regarding their ability to speak and understand English and how this would impact on their experience for seeking and receiving help.

> ***Priya,*** *"I was not opening up so much; I had been thinking that maybe my English was not very good. The group was mixed there were Asian and white people. I said no to interpreter. I just could not speak, I thought if I speak how what are they going to say and are they going to take it. I was quite sacred. Maybe I was a bit worried my English was not right because there were some English people there. I thought if I said something stupid, they would not want to talk to me. And I was feeling all this funny feeling the anxiety was coming you know. It was kind of holding me back."*

> ***Ravi,*** *"The practitioner was English, and I don't know if she could understand in terms of cultural issues that you may bring to therapy. I did speak about culture and family; I am not sure if she could relate to it. The papers they gave us, I am not sure others understood although I did."*

> ***Bindi, "****You can see I am an old woman. How am I to understand all the paper they gave us was in English? English is not my first language, I was born in India, I speak Punjabi."* (although her English was quite perfect*).*

Participants reported that interpreters should not only be in individual sessions but group sessions as well because though others can understand English, in therapy, there are certain words and vocabulary beyond others grasp. There was a general feeling that session materials such as handouts and interactive learning could be better off explained in familiar native language such as Punjabi dialect especially within Group sessions where there was often significant numbers of SAIs. Language is seen as a potential barrier during the entire experience of depression and getting treatment since patients generally feel excluded if not quite understanding therapy session concepts. Contrarily, to their narratives regarding a reluctance to be seen by a SAI practitioner for confidential reasons and for fear of their problems being exposed to their communities, there is a belief that an Asian practitioner would be more sensitive to Asian family issues, or a black practitioner would identify more with them. This can be observed in my reflection following Priya's interview in Chapter 3; Part. 1(iv), Figure 1, where Priya makes a statement when meeting me (Black British African researcher) at the initial encounter immediately referring to me and her as *"the other half",* calling *"us",* myself, and her*, "minorities".*

Roles: Males vs. Female, Males vs. Males

With reference to roles, participants described feelings and thoughts on preference of professionals surrounding gender/sex.

> ***Priya,** "I was a bit scared even to say anything. I think men do not understand ladies' feelings, what you are going through internally. They only understand you got a headache or tummy ache but not in terms of your feelings internally. It is like a woman thing. Women can understand better. Even I prefer to see a woman doctor than a male doctor. I was not sure if my doctor would understand me (but then he did)."*

> **Bal,** "*Yeah it feels more comfortable talking to a woman than a man."*

> ***Ranjit,** "Men don't understand, women do especially because they are mothers.*

> ***Bindi,** "I think men don't understand."*

> ***Davi,*** *"I saw a woman from a West Indian Background and basically I didn't find the love. It is how she came across to me. I did not get that feel good factor, so I knew from early on that I would not be going back again."*

> ***Kully;*** *"There were male nurses as well I was surprised and there were ever so nice knowing what the patients were going through, and they were down to earth, and I felt I could talk to a man because it is about who you feel comfortable in front of the professional to open up."*

Women practitioners are believed to understand better due to their more patient-centered communication. It is important to note that what is observed here are gender-linked patterns of communication and gender-linked conversational differences in doctors and patients. Due to their feminine nature, female practitioners are seen to be emotionally responsive, more likely to express empathy, legitimation, concern, and reassurance when patients express the need for that. There is belief that female doctors provide an opportunity to the patient thus allowing them to tell their story.

Age: Old vs. Young; Old Fashioned vs current/Traditional vs Open minded

When working in a cross-cultural environment, it is important to understand the context in which different cultures view age and seniority. Confucian-orientated societies teach 'filial piety', seva (selfless service), dharma (duty) in the South Asian context which means respect for the elderly is quintessential (Sharma and Kemp, 2012). Age was discussed by participants as a continuous battle between the conventional and conservative elderly and the young who are acculturated into the contemporary world whether regarding education, career and in this instance health.

> ***Kully,*** "*I feel like at age 21 we should be expected to know what we want to do. Personally, for me I feel like we should be given more freedom. For me, I'd allowed the conventional society to dictate my life and do what's always been done, but that doesn't necessarily mean it's right."*

> ***Bal,*** *"If you don't agree with what they say you are not supposed to argue with them or have a different opinion from them. It is considered as rude and seen as if you have no respect for them. So, you are always supposed to take that adult perspective. I always risked getting told off."*

Respect for the elder’s perspectives and ways of life was described as being paramount and could be a potential barrier to accessing services.

Here as is with the cultural tradition and norms, participants reported that adults cannot take advice from a “younger” person because of the belief that wisdom comes with age; therefore, this poses as a barrier as help would not be sought if a practitioner was deemed “too young”. The young, recognised depression amongst the older generation but they did not seek help as a result of the above issues.

Parents are portrayed as backward thinking and family, and extended family made decisions for them. Within the narratives, parents are reported to have expectations, many which define the social status of the person within the collective hierarchy since each member within the family is regarded as having a distinct but complementary role to play and one’s self-concept exists in relation to others (Gautam & Jain, 2010).

Before exploring the next categories, a Memo, (Figure 9) is presented below explicating several afore mentioned and ensuing categories. In this Memo there are codes highlighting recovery journeys and which factors impacted on treatment choices as well as the efficacy and effectiveness of interventions received.

Memo #7- Analysing Bal’s narrative

Family is important although sometimes not be able to help in certain situations. Depression is perceived as life changing having been triggered by a TOP. Difficult experience with depression; trigger; TOP within a culture that stigmatises and frowns upon this Bal reports that without social support networks a person’s experience of depression can be very difficult. Support groups with others who may have had similar experience would have been helpful in that they would identify with others. Cultural stigma and personality interfered in choices about accessing services. To Bal, privacy and not talking to strangers about “your business” was paramount. Professionals make judgements about the person that deterred them from accessing and seeking help. Bal reports that seeing a practitioner from the same cultural background would mean “exposing yourself and therefore not helpful. She views Caucasian Practitioners as unable to give appropriate help due to cultural differences.

Figure (9) Memo #7 - Analysing Bal’s narrative

iv. Category 4 (with sub dimensions): Recovery Processes

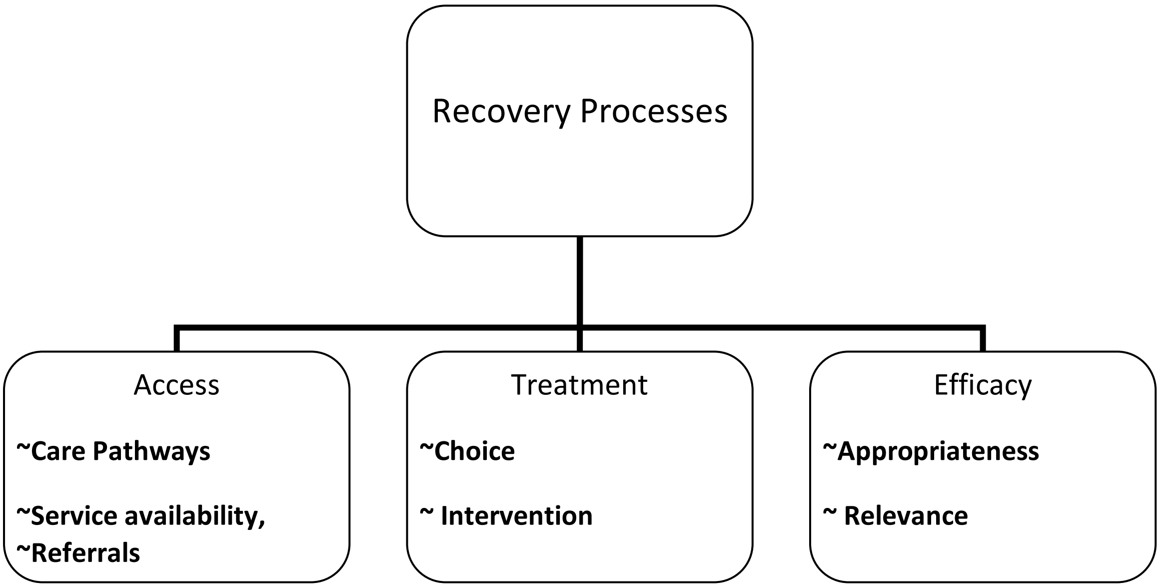


Figure (10) Category 4 - Recovery Processes

The fourth emergent category of patient's experience of depression and psychological therapy is entitled recovery processes. This encompasses subcategories namely access regarding sub dimensions related to care pathways, service availability and referrals. Treatment with reference to treatment choices and interventions within therapy is also discussed. Efficacy is the final subcategory which will be discussed in relation to the appropriateness and relevance of treatment services. A further discussion follows in relation to this category and its subcategories and sub dimensions.

Access: Care Pathways, service availability and Referrals

The participants described access in general and the ease of access to services and experiences of the entire process from when someone decides to seek help, where to seek help and how to seek help. These experiences where described as being positive or negative and the importance of the first encounter is also highlighted by the participants as this next excerpts illustrate.

> ***Priya,*** *"Doctor referred me straight to the counselling. He knew straight away it was depression".*

However, Priya reports how she had not been aware of services previously. She stated;

> ***Priya,*** *"They were not very helpful as they never gave me help after losing baby first time. They never had a meeting to say what you would like. I was not aware of any services."*

> ***Kully,****"I was just tired, and I had to go to the NHS for help."*

> ***Bindi,*** *"After being referred I had to wait sometime before I started seeing a counsellor."* **(By counsellor they are referring to a therapist as counsellor is common term used by lay/patients)**

> ***Davi,*** *"I am not one of those people that would go and spill my whole life to people I don't know."*

> ***Ranjit,*** *"Generally people actually do not know what is out there for them that is right until somebody actually effectively says. But overall, when you eventually get the help that help was very useful in being relevant to your needs."*

> ***Davi,*** *"I just saw some random GP since my GP had retired and I had rapport with my old GP. She was just doing her job; they advised you that is their role. I do not know if it was helpful. I was not in the right frame of mind. I just needed someone from a professional perspective to just give me their advice and she gave me."*

Accessing services was narrated as a personal choice not prescribed nor restricted by any socio-cultural factors such as family, beliefs, norms, or values. Culture was seen as not relevant when seeking help although individuals remain still quite depended on family. It appeared like if one were liberal and open minded to Western ideas and values, the more likely they would access psychological help. Participants reported that GPs were aware of a different range of the services available to refer patients to, since most patients were often referred at the first instance. Concurrently, there was also another issue regarding resenting being stereotyped as another BAME and who was simply a *"number and a statistic",* evidenced in his excerpt in Category 4 Recovery Processes; Appropriateness and Relevance.

Treatment: Choice and Intervention

The way in which choice about the treatment and intervention was offered was highlighted. Participants reported on their experience factors that influenced decision making when considering whether or not to seek treatment and if treatment were sought what intervention would be suitable for their needs.

> ***Kully,*** *"There was no wasting time, I went to the Doctor and he referred me to the 'Agency' (***name of Service removed and replaced with Agency for confidentiality purposes).** *I was offered CBT and I already knew that it was about changing the way you think. I was given morning appointments as those were what I preferred so I couldn't sleep in as much which was part of the depression."*

> ***Priya,*** *"The GP did not mention anything about psychological help the first time I visited them. I was offered anti-depressants and I was not sure I wanted any medication. I was not happy about medication because you learn about side effects. GPs should also explain a bit more about where they are referring you to."*

> ***Bindi,*** *"People put their faith in the professional. No, nothing was really explained, especially if you don't know anything about CBT."*

> ***Ranjit,*** **(on a second visit to GP)***:"No other options were given. I think what he did was basically referring me to the counsellor and said see how you feel and then you can come back to me."*

> ***Kully,*** **(after multiple visits back to GP and a further referral had been made to Perinatal Depression Team):** *"She prescribed me a dose of Sertraline or Citalopram, I think. Still I was not feeling good so from 50 dose she changed it maybe to a 100."*

> ***Davi,*** *"Yes it was the doctor who told me about the service and sent me to this centre for like a session, I went once, and I never went again. To be honest I found it a bit of waste of time."* **(describing his initial meeting). He describes attending a centre for an assessment session where he was then asked to attend group therapy sessions).** *"How it happened is that I went to the GP looking for a magic pill. The GP, she prescribed some tablets for the depression, but I didn't take them because I have a close friend who's been through similar sort of positions and she advised not to take them because you can get addicted to them."*

For all participants, the normal route to seek help or access services was through the GP. Seeking help was perceived by the participants to be a positive experience whereby GP would usually be able to notice depression and its symptoms instantly. Moreover, participants reported that GPs tended to offer psycho-pharmacological help alongside referring to talking therapy services. However, the participants felt that there was a lack of treatment choices offered although having some form of knowledge in psychology would guide one to seek and accept help without reservation.

Additionally, being open minded and liberal in thinking, questioning, and opposing cultural traditions and being open to new things increased the likelihood of agreeing to a further referral a psychological service by the GP. Participants reported that culturally there was a belief that professionals know best so those referred normally accept what the GPs offer.

The findings indicated that there was an apparent disconnection with the discontinuity of care in cases of seeing different GPs and not one's usual doctor, as well as seeing Locum doctors which presented as a barrier to seeking help. Participants explained that a crucial issue was that treatment is on most occasions not explained and although it may be temporarily helpful there is a feeling that services could offer more choices. It was suggested by some participants that service practitioners should offer home visits, and this would see the rise in access to services by SAI since home offers a comfort zone when experiencing depression.

> ***Bindi,*** *"I think the people have to come to my house, see, when I am depressed, I don't feel like coming out of the house or do anything .Who can help me if I can't go to GP. Even some of my friends want help but they are too depressed to go out."*

> ***Ranjit,*** *"I asked the doctor if these people could come and see me at home. He said no. I got stressed more because some days I couldn't get up to even shower, so I was upset when the doctor said I had to go to the surgery if I wanted to be seen." So, then what happens to the people who are frightened to go outside? They should just suffer?"*

The participants also suggested that waiting too long was a barrier to accessing services which resulted in some giving up on services and dropping out.

Efficacy: Appropriateness and relevance;

The efficacy and appropriateness of the treatment was disclosed by the participants, in particular, the gains of receiving therapy and the impact of treatment are explored here through participants' experiences of receiving psychological sessions as well as evaluating the benefits of a given treatment.

> ***Kully,*** *"For me it was ok as I already had some sort of background in psychology. Yes, I think it helped."*

> ***Priya,*** *"I think its Caroline (***anonymised)** *the lady's name was. Oh, she is a lovely lady. She came down from the Women's and explained she was part of the depression Team and I was crying and felt comfortable with her and she made me do a questionnaire. She said there was help in some place and that I should come there but although I drive, I said I can't come all the way there."* **(This was a further referral to a post-natal depression group).** *They said we will help you with your child there's crèche. When I went to the first session, I thought actually this is not bad because it was different from counselling. They picked me up and dropped me back off and so I thought to myself why not. I felt good and felt a little hope inside me that I would come out of this depression. So, it helped because we were talking to each other and then everybody had a turn to say something. I wanted to come out of this depression."*

> ***Bal,*** *"It was good because it helped us to talk."*

> ***Priya,*** *"Well they were supportive, they could understand. The thing is because there were a lot of Asian people there is as well but, in my group, they were not Asian actually. But there were more white people. But they I think I saw some Asian people on the other side maybe the other treatment room. But yeah, I think their understanding about the family pressure was good because they must have had experience with the other patients, because every time I said something, they had an answer to it. If there was not that understanding, I would have stopped at first session because it's about the understanding of the culture needs."*

> ***Bindi,*** *"That counselling has really helped me. I would not be here today if it were not for it. God help me because going to Temple and praying sometimes gives you hope you know. If I did not have God and the "Agency"* **(name of Service removed and replaced with 'Agency' for confidentiality purposes).** *I don't think I would be here talking like this."*

> ***Priya,*** *"I used to cry and cry. Now I said, "No," because I think when you go to Temple and Church, they talk nice things. Being religious will help that little bit, part of your living style, is*

> *they uplift you little bit by giving you some nice, like, a model of the day, for example, or a thought of the day. I'm thankful to the team that they've helped me, and I'm thankful to God that he helped me, as well."*

Within this category faith and spiritualism was recognised by the participants as equally as effective as psychological treatment. Conversely, some participants feel that faith and spiritualism is helpful although it is not regarded as significant, influential, or relevant within sessions/therapy. There was a consensus feeling among the participants that treatment could be more tailored to patient needs with interventions that incorporate cultural values and beliefs.

Treatment choice was recognised as offering hope and perceived as appropriate. Receiving Group CBT and other services such as crèche/nursery considered a bonus otherwise attending therapy sessions would be difficult as well as being a maintaining factor of the depression.

One the other hand, other participants shared differing narratives regarding their experiences of therapy and stated that the mode of treatment offered and given was not what they expected and therefore therapy sessions were deemed neither significant nor helpful. Consequently, there were a considerable number of dropouts citing inappropriateness to needs and unhelpfulness of treatment as the main reason.

> ***Davi,*** *"I did not find it helpful. This was a group session with loads of people there. I think it was just the whole process. The questions she asked me. Like I was saying to you before, you know when you have a rapport with someone like my GP, when someone's known you from very young they know what kind of individual you are; when something happens they know all about you; it was not for me. When people do not know you, they do not know what going through your head. Only you as an individual know what is going on for you and unless you have been through the same rigmarole only then would you understand. To other people you are just a number and I am an individual not a 1 or 2."*

> ***Ranjit,*** *"I didn't find this Asian "Agency" Service helpful,* (**name of Service removed and replaced with 'Agency' for confidentiality purposes).** *I think it made me feel more depressed. It was just too close to home. I feel there would be more freedom if it were not someone from my own background. Like I am not being judged or no one will know, and my family would look bad, things like that. That I have had sex outside of marriage or that I was happy to live with someone and not get married."*

To the participants, being referred further by the GP to an Asian Service for therapy was perceived to be "too close to home." There was a sense that if one is referred to a service where practitioners are of the same culture or ethnicity and race the more likely they would feel judged also especially based on the nature of the presenting issue. The findings indicated that for some participants the reason for drop out was not always that the service was not helpful but that sometimes one felt that they had improved and there was no need for further treatment.

> ***Kully,*** *"Because I had done psychology in College it was kind of easy for me to understand. Everything seemed to be going well for me since starting to see someone so after a while I stopped going for sessions because I did not see point to go back."*

> ***Ranjit,*** *"I thought I was feeling better and so I did not go back to see the woman from the other Agency not the Asian Agency (***names of Services removed and replaced with 'Agency' for confidentiality purposes)***. I was able to do things again although not much, but I would not spend a whole day in bed wearing my pyjamas or crying all the time. Looking back, I should have continued with the therapy because maybe I would feel even better."*

Participants described rating services based on the initial encounter with the practitioner and these encounters were perceived to be crucial points within the whole therapy process as Ravi and Davi explain in their narratives thereby concluding this section:

> ***Ravi,*** *"I kept going for sessions because as a professional I know the importance of doing these things. At the same time, the therapist I had seemed such a nice person from the beginning and she always smiled and showed she understood my predicament. I felt completely at home with her and always looked forward to our sessions."*

> ***Davi,*** *"After the assessment I didn't think I would even give it a shot, but I attended 3 sessions. The woman made me feel uncomfortable and she sounded as if she was not sure what she was doing. When you go and see people, they only give you little advice and that is not what I am looking for, so I stopped going."*

v. Category 5 (with sub dimensions): Service Development

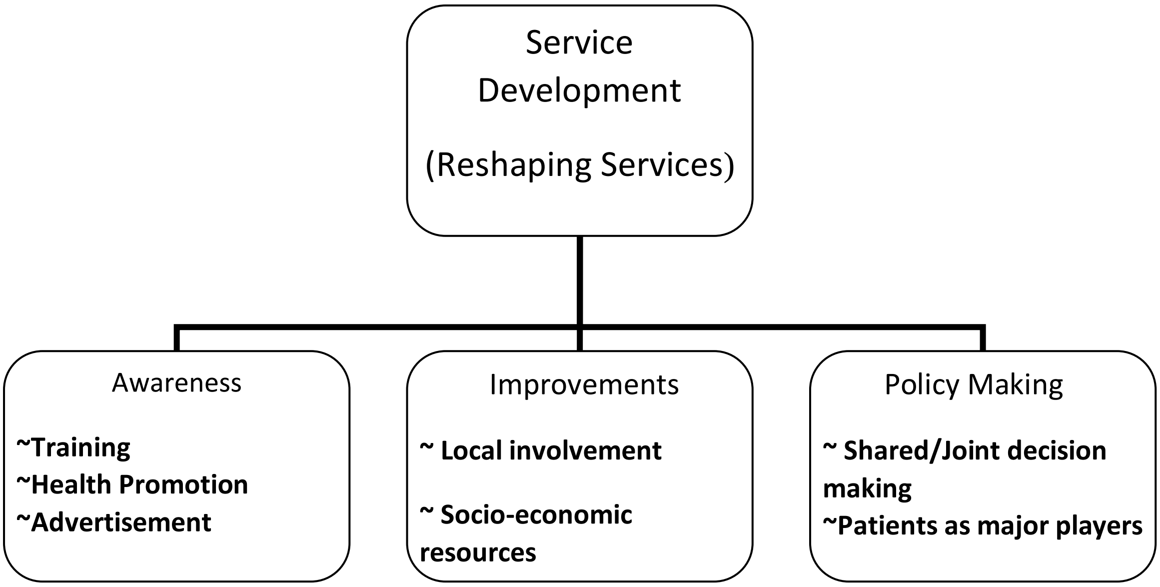


Figure (11) Category 5 - Service Development

The final category reflecting concepts delineated from patient narratives and illustrated in memos and interview reflections as cited previously, follows as the fifth constructed category of patient's experience of depression and psychological therapy titled service development. This was with special reference to reshaping of services based on patient feedback about current service delivery. This category has awareness as one its subcategories tying in sub dimensions such as health promotion and advertisement. Improvement in terms of redesigning and shifting the face of healthcare delivery and service jointly with patients at local level is also discussed, as well as specific factors such as socio-economic resourcing. Policy making concludes the category of reshaping services by exploring thoroughly its sub dimensions of shared decision making about health care service delivery using an evidence base in order to make evidence based policies, as well as that of utilising and creating roles for patients as major stakeholders to speed the process of reform.

Awareness: Training, Health Promotion, and advertisement;

Health promotion and the way in which this was advertised were discussed by the participants who advised on improvements.

Some suggested what services could do in order to make communities of what is available for their needs as well as raising awareness about depression to local communities. The following excerpts illustrate this.

> ***Kully,****"Generally people do not know what's actually out there until somebody says. Sometimes your world revolves so much inside you do not know you can seek help from the outside. They need to advertise more, not just within the GP Surgeries, Libraries, Temples, Mosque or Church. This would give people awareness. We need the right help at the right time."*

> ***Ranjit,*** *"Services should be readily available. People should come to your house, it's the comfort."*

The participants recommended that services be more advertised, offer better hours as well as have more diversity. The participants suggested that multicultural training be mandatory and on the curriculum for practitioner since participants perceived that professionals made judgements about patients which deterred them from accessing and seeking help.

> ***Priya,*** *"The improvement could be, I think they need to advertise a bit more. Not only just in the surgeries or only through the doctor, but libraries, maybe; children's centres. Sometimes it's just seeking the right help."*

> ***Kully,*** *"The therapists could perhaps learn how to work with people who are Indian because although I found everything quite ok I think it's good when someone you are talking to knows a bit more about where you are coming from."*

> ***Ravi,*** *"As a professional, it's always good that employees are given the right tools for their job. Some help around working with Asian people might be a good starting point."*

Services were felt to be lacking in advertisement around SAI since everything revolved around the collective group/community and many were not aware what help is available. Participants suggested educating people around Temples and places of religious gathering since they were believed to be informative.

Improvements: Local involvement and socio-economic resources;

Based on their experience participants suggested what would be needed and what resources needed to be in place in order to improve services within their communities.

> **Bindi,** *"It was good because they offered me a taxi, so it did not have any affect me financially."*

> **Priya,** *"They offered me crèche and if they hadn't then sorry that would not have been for me. I would just suffer in silence."*

> **Ravi,** *"Having professionals who speak a patient's language might be helpful as I have noticed people struggling when I have attended Group therapy sessions in the past."*

> **Davi,** *"Speaking to elders, going around the Gurdwara may help NHS understand and know more about our people."*

A shared acknowledgement and perceptions are voiced across participants implying that, without social support networks a person's experience of depression can be very difficult. Participants argued that support groups with others who may have had similar experience would perhaps have been helpful in that they would identify with others.

Feedback to services through the use of patient experience questionnaires (PEQ) was perceived by participants as essential for service evaluation and improvement. Findings also indicate that treatment was also desirable if it was tailor made and personalised for individual needs rather than "one size fitting all". In his narrative Davi states:

> **Ravi,** *"I was given a questionnaire at the first encounter to measure how I found the meeting. That is useful I think because at least they get to know what we think about their service. Actually, that was very good, I give them that and they should keep doing that. Maybe their service can then get better with all that information."*

> **Davi,** *"You obviously can't paint everybody with the same brush. Maybe give feedback forms at the end and you have to make sure the person understands that what their completing is not only going to benefit them but others and that it's a way of improving the NHS."*

> ***Bal,** "Just because something works for someone doesn't mean it is going to work for me so there has to be some kind of variety with this talking treatment. You might be surprised because many people might come along."*

There was a notion of right help at the right place and providing resource such as fares to appointments, children caring facilities whilst one was being seen in sessions was described as a fundamental factor, one that would increase access.

Policy Making: Shared/Joint decision making and Patients as major players;

Participants rallied for a change in the current state of affairs. Participants talked about the need for services that are not just handed down to them but services in which locals were considered the major stakeholders and play the biggest part in making policies and decisions about shaping services.

> ***Ranjit,** "Well it's a combined effort isn't.? For anything to work, so patients should have a say."*
>
> ***Davi;** "Things really have to change. Not just making changes for the sake of making changes, but to make the experience better."*
>
> ***Ravi,"**I think it's important, it's like at work if you don't involve all stakeholders you don't get everyone's opinion. Patients are also stakeholders which I think a lot of people forget."*

The knowledge that sessions are capped at a certain number and that this decision is made by the practitioner based on prescribed service policies was perceived by participants as a significant deterrent factor to accessing services and consequently triggered issues of power within the therapy process. Participants described feelings of being treated like a "statistic", a "number" within the therapy process. To participants, being asked to complete minimum data set (MDS) such as PHQ9 and GAD7 reinforced this perception. This is an overlapping concept as explicated and observed in participants' narratives in Category 4 (Recovery Processes) under efficacy, appropriateness, and relevance.

Moreover, the participants reported that the inability to involve patients in decision making regarding whom they could see, and where they ended up seeing a practitioner from the same cultural background is a critical issue which participants suggested be considered by service providers, since talking to a practitioner from one's own ethnicity means *"exposing yourself and therefore not helpful."* This presents a double bind dilemma where there are conflicting views and perceptions, with one negating the other as observed in Categories 2 and 3 and 4, where participants explained the benefits of seeing someone from their cultural background who would understand them better. The same notion is also implicit in Category 5 under sub-dimensions of Awareness: Training, Health Promotion and Advertisement; where participants suggest that employers offer multicultural training to employee (practitioners) so they can have better knowledge about SAI people and their situations. Here, participants also suggested that local communities ought to be consulted regarding fundamental issues around ethnicity and race in terms of provision of practitioners since there was popular view that a Caucasian practitioner would not be able to give appropriate help due to cultural differences.

The participants recommended that systems be put in place for services to flourish and be considered effective co-production and co-designing is essential and paramount. It was suggested by participants that policy makers involve local communities to become co-designers and co-producers of care when it comes to decision and policy making about healthcare provisions. This was due to the evidence that there was shared decision making within the SAI collective about any important matters (general) therefore, it was regarded as imperative that family, friends, and carers be involved in the decision-making processes of care provision within health and social care. Participants suggested more involvement of patients in research as active participants.

Summary

From exploring their narratives, it is unequivocal that, South Asian Indians viewed the world around them and the society they live in and placing extreme and extensive value around self-concepts, family, power, fear of being judge, pride, and cultural and societal hierarchies amongst a few. Based on their experiences of services, individual therapy was preferred over group therapy due to fear of opening up and being judged by their counterparts or others from different ethnicities. Despite the GP referring to a psychological service straight away, participants described feeling that speaking to a *"stranger",* (practitioners) did not help since they were not acquainted and would lack understanding of them and their difficulties. However, participants reported that sharing feelings with family was not an option since it was felt family would isolate them, evidencing stigma and shame. Services received were considered helpful by some participants although other participants found them neither as beneficial nor appropriate, due to factors such as failure to establish good rapport, ethnicity, language, overview of interventions at the assessment stage of the therapy process and initial impressions of the practitioner among many factors.

The next Part discusses the thesis findings in greater context and the implications they may have for practice and future research.

Part 2: Discussion

According to popular perceptions such as those noted by Keynejad (2008) and Patel (2003) people from BAME communities such as SAI disengage from psychological therapy treatment due to criticisms for being culturally incompetent. However, the findings in this thesis revealed that although some of the participants cited culturally competence among other reasons noted in the ensuing discussion, dropout is a result of either not being happy with the service at the first encounter, or that individuals may feel they have considerably progressed in their condition and therefore no longer require services.

According to WHO (2017), worldwide mental health problems are commonly stigmatised and globally, an estimated 322 million people were affected by depression in 2015. In the UK, there is evidence that this is more prevalent in some BAME communities including South Asian communities, where mental health problems persist as a taboo issue, (Bhui et al., 2015; Bhui, 2013; Buckner et al., 2007; Bhugra & Mastrogianni, 2004). Discouraging factors such as feelings of shame and denial affect early engagement with mental health services, which consequently lead to poorer outcomes, such as inpatient admissions and longer hospital stays. There is a reluctance to visit GPs which reflects in comparatively low referral rates for further treatment from BAME populations. Religious preferences associated with service provision are often misconceived or overlooked, as are cultural expectations of gender roles therefore branding services as culturally insensitive (Chadda & Sinha-Deb, 2013; Cooper et al., 2013; Conrad, 2005; Comino et al., 2001).

Hence, the ensuing discussion explores the thesis' findings with reference to how the SAI culture and other factors such as the nature of their collective backgrounds, language/communication barriers, age, beliefs, and values are problems in themselves besides being overlooked by service providers and policy makers.

i. The impact of culture

Clinical care for depression in primary care negotiates a path between contrasting views of depression as a universal natural phenomenon and as a socially constructed category (Furler et al., 2010). Therefore, beliefs around mental health problems may help explain why there are significant disparities in the rates of formal mental health service use among BAME such as South Asian Indians. Moreover, culture shapes the experience and expression of emotional distress and social problems in various ways; hence, it is crucial to consider the cultural meaning of symptoms and explore the social context of distress in order to accurately diagnose and treat patients from diverse backgrounds, (López and Guarnaccia, 2000; Kirmayer, 1989). Commonly, treatment and supportive services are often based upon inaccurate assumptions and prejudicial stereotypes (DRE/DH, 2005) as policymakers and service providers fail to understand the cultural and social circumstances of BAME communities, which also reflect the findings in this thesis.

Based on evidence from the literature and echoed in this thesis, people from BAME groups describe that sometimes, conforming to culture is good at times as confirmed by participants in the social structure category of emergent theories. This suggests that culture frames notions of normality, shaping beliefs and responses to experience of illness (Lupton, 2003). Additionally, the health professionals' own culture shapes expectations of encounters with patients and clinical practice (Harmsen et al., 2003)

In view of my own culture as a BAME/Black African researcher and practitioner, there is an alertness and awareness of issues around gender and age preference especially when working with SAI older/elderly males and females. There are various similarities in my African culture and SAI culture regarding 'respect' for the elderly around first name calling as well as the elderly preferring to be seen by someone older than them or someone whom they regard old enough to be giving advice, following the worldwide common saying/notion of 'the older, the wiser.' Therefore, culture plays an important role in shaping the doctor-patient relationship, in which different values, beliefs, and preferences can create problems for effective depression care (Furler et al., 2010)

When studying phenomena within SAI communities it is important to acknowledge how culture can shape the expression and recognition of mental health problems. This was illustrated in research by Yip (2012) which suggests that Confucian ideologies and collectivist tradition influences and discourages open displays of emotions so to maintain social and familial harmony or to avoid exposure of personal weakness. Having a mental illness signifies a lack of control thereby affecting an individual's capacity to perform social roles adequately consequently resulting in feelings of losing control over self-definition. Moreover, seeking help from external or mainstream resources is considered shameful and loathsome among SAIs, hence, this can ameliorate or influence whether a person seeks help despite their cultural influences (Tavkar, Ayer & Hansen., 2008) This is reflected in the thesis by Kully's narrative of feeling like a *"nobody"* because the depression made her feel unable engage in employment, yet the inability to acquire employment had been the initial trigger of the depression.

"Saving face" which is the ability to preserve the public appearance of the patient and family for the sake of community propriety is thought to be paramount to SAIs (Fernando, 2010; Samuel, 2009; Gilbert J., Gibert P., & Sanghera 2004). Since mental illness is stigmatising (Kapadia et al., 2017; Karasz et al., 2016; Memon et al, 2016), a public display of emotional difficulties reflects poorly on family lineage and can influence decisions made by others regarding marriages, social networking and other business matters within the community (Fernando, 2010; Furler et al., 2010; Kramer, Wang, Kwong, Lee, & Chung, 2002; Chew-Graham, Bashir, Chantler, Burman & Batsleer, 2002). Therefore, expressing psychological distress is commonly displayed in a somatic manner than mentally so to maintain the individual and the family's integrity with traditional professional concepts of mental health regarded as dissonant with individuals' self-concepts and culturally unacceptable (Eshun & Gurung, 2009; Bowl, 2007; Edge & Rogers, 2005).

Indeed, female participants in this study expressed how their main difficulties with depression had been triggered by failure to acquire marital relationships and how beliefs around co-habitant previous relationships outside marriage had impacted on their possibilities of getting married. In her interview, Ranjit explained encountering difficulties in her relationships as well as an inability to conceive and that her family had dissociated from her. Ranjit's family had not offered support based on the fact that she had previously been in a co-habitant relationship outside marriage, a concept that was perceived as shameful in her culture. Other participants, for example Priya, described about how being told she had depression and referred for treatment made her feel like a failure as a mother or female figure especially within the context of their cultures where seeking help is viewed as a sign of weakness. These findings are similar to others such as Gater et al., (2010), Greene et al., (2008) and Gilbert et al., (2004), which indicates that individuals may keep problems within the immediate family and not utilise health services, since the disclosure of a mental health reflects on the individual as weak and on the family as a failure. Males reported unemployment as the main trigger of the depression as well as difficulties with finding self-employment (business), were previous they had been quite successful business people. Davi stated*, "I was out of a job and if you don't have a job you are nothing amongst my people."*

Moreover, the findings indicated that the patients would likely not attend further treatment if there was discontinuity of care. This is evident in Davi's interview vignette which discusses his relationship with a GP with whom he had a historical relationship compared to sharing personal distress with practitioners he had no previous encounters, therefore felt would not *"understand".* Participants in this thesis reported feeling uncomfortable when they were made to see different healthcare practitioners as the patients were very *"private"* and did not intend for their *"business"* to become *"public"* which presented as a barrier to seeking help as supported by other studies (Bhui, 2013; Bhattacharya, 2010; Ahmed & Bhugra, 2007; Bowl, 2007) According to WHO (2017), there is a need for continued care for many individuals with depression with or without medication for varying periods of time. There needs to be continuity of medication, change in life styles, stress reduction and other rehabilitation components in order to make recovery possible and improve mental health wellbeing within this patient group.

According to Thornicroft (2006) culture may influence how people access mental health care in that decisions and actions are sometimes influenced by the people closest to us, which lie in the social aspect of help seeking behaviours. However, findings in this thesis show that coming to see a health professional for some was an individual and personal choice not dictated by any cultural norms and values. In his interview, Davi came across as somewhat confident within himself and able to make decisions based on his own personal choices and preferences. He described how he reached the decision to see the GP for his difficulties, and claims that, *"seeking help from the GP was my personal choice and my culture had nothing to do with it."* Davi stated that he believed some SAI people are still significantly individual at making decisions regarding their wellbeing in comparison to the usual collectivist nature. Davi also recognises that if there is a need to seek help from a professional one should do so regardless of what culture prescribes and that this should be based on individual choices and at the same time depending on a strong sense of the self or personal characteristics. Contrarily, Davi's beliefs about autonomous decision making differ from most SAI people who choose familial obligation to cultural loyalty versus independence which would allow for individual choices, (Leung et al., 2011).

The thesis findings also indicate that most people sought help with significant hesitation and lacked in motivation to do so based on the collective attitudes towards seeking help for mental health difficulties such as depression. (Ranjit's narrative indicated her reluctance to seek help for fear of being looked down upon by her family although Ravi acknowledged that he knew a few of his *"people"* who would go and seek help for depression without any fears or negative perceptions regarding the process. Therefore, this indicates that self-awareness may be lacking in most, and especially for those least acculturated who are still struggling to balance their traditional expectations with wanting to fit into their SAI community, (Bhat, 2015; Coward & Sidhu, 2008). Hence, only those with personal desire may access services.

These findings and the literature suggest that individuals are not forthcoming regarding issues of psychological states such as depression due to fears of cultural and social stigma and shame. This is a significant influencing factor which is discussed further in this chapter.

ii. Family "Collective" influence

In the West, individualism is emphasized, and independence, autonomy, self-reliance, and personal achievement are valued. In contrast, SAI communities are collectivist, emphasising family cohesion, conformity, solidarity, and cooperation, with interdependence and group priorities valued over those of the individual, Yamagishi et al., (2008). There is compelling evidence that in comparison to other BAME groups of people, SAI networks were more likely to consist of a high number of relatives rather than friends (Chadda & Sinha-Deb 2013; Zagelbaum et al., 2011; Tavkar et al., 2008). SAI are reported to have minimal social interaction with people who are not SAI and those who are not part of their family or community. Traditionally, Asians place great value on the family as a unit which was also reflected in this thesis through participants reporting and expressing the fundamental value of family. There is a notion of *"izzat"* which denotes personal and family status widely characterised as a pervasive feature of family life (Gilbert et al., 2004). Usually, family and friends within the community are perceived as the essential remedy for prevailing problems although at times they would be the source of the problem. Indeed, in-depth interviews with SAI women who had lived in Canada for at least two years found that many of the women reported acculturative stress due to intergenerational conflict at home, which was correlated with depression and ability to cope (Samuel 2009). This conflict was reflected in Kully's narrative during which she described how at 21years of age the younger generation are expected to know what they want to do with their lives. Kully went on to express a need for freedom and independence and that although she had always conformed to her collectivist society it did not mean that way of living was always right.

According to Leung et al., (2011), SAI rarely seek professional help for mental health–related issues, instead, depending on religion or other trusted sources of support such as social networks or family. Similarly, Chadda & Sinha Deb (2013) argue that seeking help from others outside the family may even be perceived as self-serving and a disregard for the family, especially due to the stigma associated with mental health difficulties; this means the participants would avoid or delay seeking help for fear of being ostracised. Within native SAI positions and roles are assigned and clearly defined to an individual within the family hierarchy, all determined by age, gender, and social class (Memon, et al., 2016; Rathod et al., 2010; Bhugra & Mastrogianni, 2004). Given these prescribed roles each individual is therefore expected to function within that role, submitting to the larger needs of the family even if it means neglecting their health. According to Kramer et al., (2002), mutual obligations and shame are the mechanisms that help to reinforce societal expectations and proper behaviour. Another imperative factor is negative attitudes to mental health problems evident within this collective paradigm and existing social support networks. Similar findings were observed in this thesis where participants such as Bindi describes how *“having family helps big time”,* and how the support from the family is valuable which gives one *“hope and happiness.”* Kully on the other hand talks about how despite the fact she had a *“lot of family”* around her and yet she could not openly discuss her difficulties with the depression for fear of being judged.

Furthermore, members of collectivist societies are more likely to keep personal problems to themselves, and only seek professional mental health services as a last resort, as seeking outside help may be seen as a failure of the family to solve the problem (Chadda & Sinha-Deb, 2013; Zagelbaum et al., 2011). Ranjit’s description of how she kept the depression to herself and not finding the family helpful is significant evidence showing the lengths people take to conceal their illness because of the fear it would impact negatively on the family. Ranjit’s scepticism about psychological therapies continued as she shared her thoughts about attending group sessions and not feeling comfortable for fear she was exposing the family to outsiders therefore subjecting her family to ridicule and shame as shown in Ranjit’s interview excerpts (see Category 4; Recovery Processes under efficacy, appropriateness and relevance) . Accordingly, Conrad & Pacquiao, (2005) contend that group therapy may not be acceptable to many Asian Indians who do not find it acceptable to share family problems with others since sharing this information may be viewed as shameful, and stigmatising for the family. Yamagishi et al., (2008) argue that most groups from the SAI communities are generally known for success, resilience, and diligence therefore in such a context, there is strong pressure to outwardly project these characteristics and not admit to "mental weakness." Therefore, based on these attestations it can be argued that it is not always everything that is prescribed within a culture that is beneficial or necessarily helpful, although on the other hand indicating family as crucial in the help seeking and therapy process.

iii. Stigma, stereotypes & labels

Due to fears of social stigma and shame individuals are not forthcoming regarding issues of psychological states such as depression which has been evident in the participant interviews and thesis findings. South Asian Indian communities typically value conformity to norms therefore it is not surprising that anything viewed as outside of the norm, including mental illnesses would be devalued and thus subject to stigmatisation, Abdullah & Brown (2011). Goffman's (1963) initial conceptualisation of stigma refers to it as *"an attribute that is deeply discrediting" that reduces someone "from a whole and usual person to a tainted, discounted one"* (p. 3). Therefore, individuals stigmatised are perceived as having a *'spoiled identity'.* There is evidence that there was a fear especially related to mental health diagnosis; a fear of being perceived as mentally ill patients from BAME. This is for example reflected in Bal's narrative when she talks about not willing to "*share"* her *"business"* with professionals whom she refers to as *"anybody"* since she believes they hold certain perceptions about BAME people.

According to Abdullah & Brown (2011), stigma is inextricably bound to culture because the behaviours and beliefs that are valued and the standards favoured are based on norms that are influenced by culture. This means beliefs about what it means to be mentally healthy versus mentally ill are culturally informed, as is the stigmatising beliefs about those with mental illness. Elsewhere research has shown that perceived discrimination in the healthcare settings can have a negative impact on adherence and service utilisation (Misra & Hunte, 2016).

Although stigma is believed to be common in the structural framework of society (Feldman & Crandall, 2007), Charmaz (1990) claims that suffering can present 'existential problems of identity and continuity of self', and that the self-concept is derived from diverse attributes, made up from an individual’s sentiments and values. Indeed, the participants in the thesis described how being open about having depression would tarnish their self-image as “good mothers” and expose themselves and their self-identity and be viewed as “weak” rather than the successful business people they had been in the past. Concurringly, others perceived not finding a job as a failure in their career lives and how falling pregnant outside marriage and terminating a pregnancy as the ultimate failure of womanhood as indicated in Bal’s narrative. Moreover, the stereotype that minority ethnic people such as those from SAI communities are the “model minority” also generates some advantages for this minority group, but it also produces blind spots and false negatives (Bach, Pham, Schrag, Tate, & Hargraves, 2004). What this means is that due to the high achieving and high expectations seen in SAI groups societal constructs are formed such that SAI are perceived not to have psycho-social problems, do not experience poverty due hardworking, and are perseverant, and it constitutes a powerful typecast to ‘idealistic self-concepts.’ Potentially, these stereotypes could serve as a deterrent to mental health care, and place significant dilemma at the centre of their need to seek help for preventable and treatable mental health disorders in order to befit the ‘model minority’ label (Shields et al., 2005).

As evident in participants’ excerpts in Category 2: Social Constructs under Belief Systems: Stigma and Taboo, Priya made clear her reluctance to seek and access services for fear of her mother in law perceiving her an incompetent mother as well as Ravi who feared becoming a subject of gossip by practitioners especially those who were SAIs. Under Category 2 and 4, Social Structure and therapy Processes respectively, findings in this thesis also show that experiences of therapy varied with most patients preferring individual than group sessions for fear of making their life story public hence humiliate and bruise one’s self identity. This is reflected in Ravi’s description of feeling uncomfortable receiving therapy with other SAI in case they went and shared information with relatives.

As mentioned elsewhere, (Memon et al., 2016; Roberts et al., 2015; Kapadia et el., 2017); that BAME people do not access services for fear of being committed or taken into secondary or tertiary care, none of the narratives in this thesis indicated fear regarding being detained or sectioned under the Mental Health Act 1983. There is also a belief among the general public who perceive those with mental disorders as frightening, unpredictable, and strange which often leads to the view that being mentally unwell is abnormal and out of the ordinary societal norms hence labelling and avoidance (Corrigan, 2004). Consequently, those who are unwell will continually avoid seeking help leading to health inequities primarily through the pathway of stigma, discrimination, and exclusion from accessing resources needed to be healthy. Owen, Thomas and Rodolfa (2013) found that BAME clients perceived higher self-stigma than White clients. Accordingly, Cheng, Kwan and Sevig (2013) used an ethnically diverse sample of African American, Asian American, and Latino college students to explore the stigma of seeking help. They found that higher levels of perceived racial/ethnic discrimination related to higher levels of perceived social stigma for seeking help which suggests that ethnic minorities such as SAIs experience an idealised self that is unattainable, hence there is guilt and shame from all quarters which may or may not be real. This is a notion that is synonymous with that of being a ‘model minority’ image which is damaging since it creates social pressures to achieve which are based on detrimental assumptions and inaccuracies (Bach et al., 2004)

Furthermore, and according to Lamb et al., (2011), what made an individual perceive a medical diagnosis as a way of labelling were their lived experiences of discrimination and stigma in day-to-day life. Stigmatisation is understood to occur on multiple levels throughout the healthcare sector, including structural such as investment of resources, quality of care standards, organizational culture as well as interpersonal, such as patient–provider interactions, discriminatory behaviours, and negative attitudes (Corrigan et al., 2014, Livingston, 2013). This however impacts on access to services for hard to reach or minority ethnic groups such as SAI. According to Baruth & Manning (2006), a practitioner’s lack of cultural self-awareness which refers to acknowledging one’s own cultural beliefs, attitudes, and values as well as an awareness of personal biases and faulty assumptions about other groups has negative consequences regarding access to services. Sue and Sue (2016) claim that the inability to recognise one’s biased views and stereotypical beliefs about other groups will probably result in ineffective services and significant rates of client dropout. Therefore, this means practitioners need to be culturally aware and able to recognise when they conceptualise a client’s case based on prejudice or stereotypical beliefs about a particular group of people for therapy to be more effective and increased access rates.

iv. Language & Communication

Language and communication are particularly relevant in depression care since working across cultural differences is commonplace in primary care where dialogue is crucial to the therapeutic encounter. According to Sue & Sue, (2016), counseling and talking therapy is a process of interpersonal interaction which means communication is paramount to the entire process; hence the information transmitted requires accurate and precise interpretation. Therefore, where information is inaccurately processed, the counseling process and outcomes can be negatively influenced (Baruth & Manning, 2006; Ponterotto, Casas, Suzuki, & Alexander 2001). From a symbolic interactionism perspective, the basis of any language is the use of symbols that reflect the meanings that we endow physical and social objects with (Blumer, 1969). Therefore, in any social setting in which communication takes place, there is an exchange of these symbols, meaning, we look for clues in interpreting the behaviour and intentions of others (Denzin & Lincoln, 2011; Edge and Mackian, 2010; Scott, 2004).

Communication being a two-way process is an interpretative process involving a negotiation between the parties concerned (Lehn & Gibson, 2011; Jeon, 2004) and evidenced below by the responses within this study, language in terms of expression and terminology, specifically the knowledge of English is a crucial guiding component to accessing care for SAI.

In this thesis, participant Priya whose first language was Punjabi clearly describes her difficulties during the entire help seeking process and she recalls how she struggled with *"opening up"* because she believed her English was *"not very good".* She goes on to claim that this was *"holding"* her *"back"* although having initially been offered an interpreter but declined. Priya describes the process as daunting and reported to have felt *"quite sacred" and* wondered how others would perceive her if she spoke therefore found herself *"unable to speak".* Priya described what she perceived as an inability to speak English would result in her being excluded hence triggering anxiety and a reluctance to fully participate within the therapeutic process. This shows that a lack of language or differences in communication skills often emerges as a major stressor for clients who are bilingual, immigrant, or both therefore it is imperative to consider immigrant clients' level of acculturation, which might be linked to their command of their native and English languages. Research indicates that bilingual clients may have the ability to express themselves in English in a rudimentary way but may need to use their native language to discuss more emotional subjects (Sue & Sue, 2016: Baruth & Manning, 2006; Ponterotto et al., 2001)

Indeed, this is reflected in the global literature whereby, Asian languages and dialects are not generally spoken elsewhere other than one's ethnic group also depending on degree of acculturation, even within it. It is argued that usually where migration takes place, the youth are more readily and easily adaptable to the ways of living within their host countries, (Fernando, 2010; Furler, et al., 2010; Sewell, 2009; Kramer, et al., 2002). Furthermore, language and communication are particularly relevant in depression care given that working across cultural differences is commonplace in primary care where dialogue is crucial to the therapeutic encounter. Moreover, the lack of access to bilingual health workers, and translated patient educational material are cited as major factors. According to Bhugra, & Mastrogianni (2004) there is no word for depression in South Asian languages and the identified causes are usually put down to "life's ups and downs". This is clearly evidenced by Bindi's narrative where she describes her symptoms and not knowing of such a thing as "depression". Here we have someone diagnosed with a condition recognised in our (UK) contemporary society but without a word for it in her own, hence there may be a lot of difficulty in coming to terms with something that is so 'unknown'?
Additionally, apart from the language barrier that normally exists between practitioner and client in therapy, there are also other variables that potentially interact in such a way as to seriously hinder and distort communications.

v. Exploring Socioeconomic Factors

Socioeconomic status is frequently implicated as a contributor to the disparate health observed among racial/ethnic minorities, which, from a healthcare perspective is an attempt to capture an individual's or group's access to the basic resources required to achieve and maintain good health (Shavers, 2007). According to WHO, (2018), the context of people's lives determine their health including culture, customs, traditions, and the beliefs of the family and the community.

Most Asian Indians who have failed to improve their economic condition often experience depression, other common mental difficulties and even suicide (Segal, 1998). Research indicates socio-economic factors impact on access to services within SAI communities where engaging in treatment intervention bears a significant financial implication (Lamb et al., 2011; Shavers, 2007; Segal 1998). Findings from Lamb et al., (2011) meta-synthesis show there are compelling links between mental health problems in SAI and employment, money, accommodation, and social network. Lamb et al, (2011) claim that an individual's identity can be understood as a complex of investments, receipts and transactions that are given meaning and value through the shared understandings of recipients involving material and immaterial components.

Most of the participants in this thesis talked about being *"unemployed"* or *"finding it difficult to attend treatment appointments"* and suggested financial resources and services such as crèches as an incentive to attend sessions. It is evident that not having enough financial resources to meet basic individual needs can serve as a predisposing and contributing and perpetuating factor to depressive illness (Hoebel, Maske, Zeeb & Lampert, 2017; Freeman et al., 2016; WHO, 2012). With a culture that epitomises ambition and achievement being unemployed brings about shame and impacts on an individual's sense of achievement and worth therefore exacerbating their existing problems with depression. Based on their collective nature and sense of responsibility for the family and others, SAI patients sometimes put the needs of the family before theirs, (Roberts et al, 2015; Sashidaran, 2003). Usually missing treatment appointments over attending a job or work so as to maintain the harmonious balance, and ensuring every essential need is met for the greater good but at the expense of their mental health. In their study to evaluate limited English proficiency as a barrier to mental health service use with BAME by Memon et al., (2016) indicated that SAIs and other BAME might not be aware of available mental health services, or might not be able to access services due to economic and geographic realities (e.g., having to work two jobs, unmanageable distance to facility, lack of transportation and many other reasons). Kazdin, Holland and Crawley (1997) found that logistical barriers including financial burden, an inconvenient clinic location, and time spent on a waiting list and in a waiting room, work conflict, family illness, forgetting the appointment, feeling too ill or feeling well, and lack of transportation as socio-economic factors affecting access to care.

Moreover, socio-economic factors linked to dropouts has been associated with high staff turnover (Klein et al., 2003), wasted resources, including lost revenue and inefficient use of available resources (i.e., less time spent in service delivery, longer waiting lists, limiting the number of clients who can receive care) (Barrett et al., 2008; Reis & Brown, 1999; Armbruster & Kazdin, 1994). In this thesis participants such as Davi voiced their strong desire to work with someone whom they had developed a relationship with and evident in his narrative under the efficacy; appropriateness and relevance section of Category 4; Recovery Processes. Therefore, understanding the complex ways in which race, ethnicity and socio-economic factors uniquely and in combination influence health outcomes is thus a fundamental task in addressing disparities across the socioeconomic spectrum and among racial/ethnic groups (Williams, Leavell, Mohammed & Collins, 2010).

vi. Practitioner-Patient relationship

According to the participant narratives, GPs were considerably knowledgeable about available services and treatment options although most GPs seemed to favour pharmacological options alongside psychological therapy as recommended in the NICE guidelines for depression (NICE, 2018). Indeed, the accounts from participants such as Priya and Ravi expressed the reluctance to accept antidepressants commonly known as Selective Serotonin Reuptake Inhibitors (SSRIs) attributed to fear of addiction or dependency as supported by other scholars, (Green et al., 2008; Edge and Rogers, 2005).

Other research such as those included in a systematic review by Bhui et al., (2015) which explored interventions to improve therapeutic communications between Black and minority ethnic patients and professionals in psychiatric services, indicates that, the quality of therapeutic communication between patient and practitioner is poorer for minority ethnic groups. Indeed, Jayakar (1994) argues that when professional help for mental health is sought, Asian Indians normally hold the expectation that the practitioner will serve as a benefactor or guru who provides specific advice, rather than assisting the client to understand their role in the presenting problem. Bindi who was in her 60s believed the health professionals possessed all the solutions to her health professionals describes how *"people put their faith in professionals"* in Category 4; Recovery Processes. Another factor which may lead to high dropout rates and a failure to complete treatment could be due to differing expectations about therapeutic models of treatments which maybe non-directive, group focused or long term, (Leong & Lau, 2001). Findings from a national cross-sectional survey in England and Wales on patient preference in psychological treatment and associations with self-reported outcome Williams et al., (2016) showed that, increasing the amount of choice that patients have encourages them to take greater interest in their health. Most participants such as Ranjit, Bindi, Priya and Davi reported that choices were limited in Category 4; Recovery Processes; Treatment choices and intervention that they were placed into group therapy against their wish and/or without explanation and treatment/CBT was not explained. Consequently, Davi dropped out of therapy due to these and other reasons as discussed in previous sections.

In combination with other determinants of inequity, gender can profoundly influence interactions between health care providers and patients (Govender & Penn-Kekana, 2008). In the female narratives, Bal, Bindi, Kully and Priya all acknowledge and concur that women practitioners are preferable and make better practitioners because they are *"mothers"* and that *"they understand better than men."* Gender, according to WHO (2001) should be viewed as an underlying social determinant in shaping the interaction between clients and healthcare providers. In her narrative, Priya explains how she felt *"scared"* talking with a male practitioner, indicating being rather passive in her interaction with the male practitioner in comparison to their female counterparts as they didn't *"understand"* what *"women go through internally."*A study by Pikus & Heavey, 1996 with clients who had received psychotherapy found that most female clients preferred a female therapist and most male clients expressed no preference regarding the gender of their therapist.

These gender preferences can also be argued to be based on SAI and their highly patriarchal communities/societies; hence, making gender concordance between practitioner and patient imperative because of socio-cultural and religious norms and practices which not only demarcate gender roles but also restrict social and physical contact between men and women (Sudha et al., 2003; Sleath & Rubin, 2002). According to Kersenns, Bensing and Andela (1997), the majority of persons who prefer female health professionals indicate that they talk more easily to females than to males and feel more at ease during the consultation process.

Furthermore, and overlapping with the emergent category of language and communication, interactions regarding diagnosis and assessment with a GP is perceived as helpful for patients who may fear what is happening and that no one can help (Brown, Ojeda, Wyn & Levan 2000). This was also reflected in the study narratives whereby some participants were reluctant to seek help for fear of being perceived as *"another one from BAME"* or *"just a number".* Sue & Sue (2016) argue that it is not uncommon for clients of marginalized and historically oppressed groups to approach health settings with feelings associated with past experiences of discrimination and oppression. Consequently, patients might access services with multiple suspicions and distrust based on racial and cultural biases in the larger society.

Hence, it is argued that effective communication is essential to the therapeutic encounter when completing assessments, diagnosis and treatment which all have significant impact to patient adherence to treatment and recovery, Furler et al., (2010). According to Lawton et al., (2018), the interactional and relational processes operating during therapeutic interventions known as 'therapeutic alliance' is understood to be paramount and perceived to be a strong determinant of treatment efficacy in psychotherapy, as well as being a variable component of treatment outcome, engagement, and satisfaction. This can be observed in Davi's narrative where he explains the importance of talking to someone with whom he had a good rapport in Categories 3 & 5; Therapy and Recovery Processes, respectively.

Dissatisfaction among SAI and other BAME can emerge if there are cultural differences in expectations and health beliefs between the patient and professional, (Kalathil, 2011; Sewell, 2009; Seeley, 2000). Although some may be knowledgeable about popular models of treatments such as CBT due to education and exposure, practitioners must explain treatment modalities and treatment processes to each individual. This is reflected in Kully's narrative where she explains that she had an "*understanding of psychology"* of which she partially studied in university. On the contrary, Bindi described not understanding how she was “*feeling”*, that she had “*not heard of the word depression before.”*

Kirmayer et al., (2003) argue that when formulating cultural issues, practitioners need to avoid sweeping generalizations or cultural stereotypes but focus on detailed histories and local cultural issues that could be explicitly linked with the patients’ symptoms and distress. When this happens that *“faith”* patients have in professionals is therefore destroyed as reflected in Bindi’s narrative where she talks about going to the GP and how *“people”* believe and trust in the health care services. Bindi expected interventions/treatment to be explained and expected that someone would be able to visit her at home; she also found the materials which were in English difficult to understand and consequently feeling deprived or ‘short changed’ by services to an extent.

Chapter Summary with Unique Findings

In summary, this research set out to explore several factors, aspects, elements, and circumstances that impact and influences the experiences of receiving psychological therapies for South Asian Indian people when experiencing depression. The findings here indicate the person’s level of acculturation, religious affiliation or socioeconomic status have significant effects on seeking or receiving psychological therapy or mental health care.

Although there is great understanding as well as fundamental discrepancies, the findings from this thesis suggest that the impact of culture significantly influences the Asian health belief system consequently impacting on the diagnosis and treatment of common mental health problems. It is also argued that when health professionals do not consider clients’ problems in the context of educational, economic, social, political, legal, and cultural systems, they create barriers within the entire help seeking and therapy processes and as supported by other scholars, (Gopalkrishnan, 2018; Chung & Bernak, 2012). Thus, key unique findings are expounded in the following paragraphs.

Key findings in this thesis are that SAI’s appreciate the importance of talking to *“somebody” “who listened”,* and who would be understanding, of which common factors research indicates as the core requirement for all clients (Wampold, 2015). It is therefore argued that, making assumptions about a patient and their knowledge and understanding about treatment pathways and processes leads to unsatisfied patients who perceive their encounters as unhelpful and not useful for their problems, consequently producing failed treatment alliances. Therefore, this study on exploring South Asian Indian patients' perspective of psychological therapy interventions for depression in primary care is intended to be a resource offering new insights for those providing services and working with BAME groups. Additionally, it goes wider than this and the understanding takes account of the cultural norms and influences on support seeking behaviours.

Another critical finding is that patients would like to be viewed as major stakeholders and therefore ought to be equally involved in developing of health policies, shaping health care services and the administration, and delivering of care. Participants advocated for collaborative transparent partnership working with mental health care providers where there is mutual respect, shared expertise, proactivity, flexibility, and a willingness to have challenging conversations about models of care that can better manage the increasing levels of demand for mental health. This is perceived to help deliver improved outcomes for SAI people with mental health problems such as depression.

Furthermore, there is a crucial finding that also offers new insights into theories of shared vision and values such as shared understanding and commitment to direction of travel, that is, support to and within communities at the earliest point as well as think family and reduce stigma. The study clearly shows people from SAI and (BAME) communities require considerable mental health literacy and practical support to raise awareness of mental health conditions, rebuild trust between patients and professionals and combat stigma.

Therefore, in keeping with symbolic interactionism, a person's interpretations of recovery and what was beneficial for them was based on the social interaction between them and the professional and their understanding and experiences of therapy within their own contexts and not based on the modality or length of treatment. Participants reported that not experiencing a positive and comfortable feeling when meeting with a practitioner for the first time would determine whether they attended the remainder of their sessions or drop out without completing treatment. Therefore, this means first encounters are crucial as they determine service uptake which would impact positively on dropout rates. Aggleton (1990) on the significance of communication in symbolic interactionism wrote:

> *"People construct understandings of themselves and of others out of experiences they have and the situations they find themselves in. These understandings have consequences in turn for the way in which people act, and the manner in which others react to them."*
> (Aggleton, 1990, p.91)

As identified in the literature review and from a sociological perspective, a substantial number of people from BAME inclusive of SAI communities are often reluctant to seek help from mental health services, reject psychiatric interpretations of their experiences and seek to understand their experiences within their own contexts (National Survivor User Network, 2014). Consequently, reluctance to seek help for such reasons leads to delayed contact resulting in individuals reaching crisis points (Rastogi et.al, 2014; Keynejad, 2008; Sainsbury Centre for Mental Health, 2008; Sheikh & Furnham, 2000). This has been influenced through a lack of awareness and information about mental health problems within some BAME communities, such as SAI groups. However, from the findings in this thesis and elsewhere it is evident that many SAI and other BAME service users, families and carers are disappointed with current services which they often perceive as misunderstanding and/or misrepresenting their situation, (Fernado, 2014; Gervais, 2008; NIMHE 2004; Sashidaran, 2003).

Thus, having interpreted and discussed the thesis finding in this Chapter, the next Chapter explores the outcome of the study by elucidating the key recommendations for future research and for practice, leading into the thesis denouement with lessons learnt and gaps identified within the thesis.

Chapter 5: Study Implications & Thesis Desistance

Introduction

This Chapter explores the outcome of the study through exploring the impact of the study findings on healthcare development and conceptualising the findings together in order to produce recommendations for practice and future research. As explicated in the preceding Chapter key findings in this thesis suggest that there is a new pedigree of patients experiencing depression who wish to be viewed as major stakeholders within IAPT decision making policies. A decision regarding access to services is a personal choice based purely based on individual evaluations and perceptions they hold in terms of potential benefits to their wellbeing. For SAIs dropping out of services is determined by their experiences and perceptions of the initial encounter or indeed when one feels well enough, there is no need to attend further sessions. The concept of being *"listened"* to and *"understood"* from their individual contexts was a determinant factor for one to access or indeed accept treatment.

Study limitations are also discussed and an overall message regarding the experiences of SAI when receiving psychological therapies for depression in primary care concludes the thesis.

i. Recommendations for Practice

Following on from unique contributions, findings from the thesis indicate that there is a need for health practitioners to understand and engage with the patients' wider life experiences. Cultural sensitivity and acknowledging diversity are encouraged, as well as using and adopting different models of treatment other than CBT. Addressing cultural and ethnic differences when developing and implementing treatment plans is encouraged and regarded as imperative. Additionally, using resources outside of the field of psychology such as traditional cultural healers; and modifying conventional forms of treatment to be responsive to the cultural needs of the client is suggested as observed in most of the participants' reports on raising awareness and promoting health in Category 5; Service Development. This means a move towards collaborative and corroborative ways of approaching health care thus increasing access and fewer stigmas for mental health problems such as depression. This is reflected in Ravi's anxiety of not knowing whether the

"*English"* practitioner could *"understand"* or *"relate"* regarding *"cultural issues."* Therapy with Asian Indians should therefore be geared toward achieving a balance between the individualistic demands of Western culture and the interdependence of the Asian Indian family. To concur, Davi in his narrative states that, engaging "*community elders"* and visiting *"the Gurdwara"* maybe helpful and informative.

However, in my professional practice as an IAPT practitioner, engaging with patients' wider life experiences is limited or non-existent due to the target and tick boxing driven nature of IAPT that there is little to no time to achieve this. Arguably, as a BAME (African) practitioner, I struggle to comprehend how a non-BAME, or indeed a privileged BAME practitioner who does not have to help family *"back home"* would be able to understand or appreciate *"the other'*s" life experiences of constant struggle and haggling to make ends meet, and those of extended family by spending 50 minutes every fortnight adapting CBT to meet and understand their needs, especially when these needs lie in a history of economical oppression rooted in colonialism (Clark 2019), which endures in modern society. According to Indome (2018) and from an intersectional point of view, these are systematic forms of oppression which continue to impact marginalised groups negatively. As a BAME person and practitioner, it can be argued that adapting CBT rather than researching and attempting to discover a new evidence-based approach to therapy for SAI is this very form of continued oppression and an exhibition of western superiority.

Additionally, NICE Guidance for Improving Access to Mental Health Services for BAME (2017), specifically stipulated guidance on managing and providing care for those with common mental health disorders such as depression. Best practice entails providing information about local care pathways to patients and their carers, considering the person's knowledge and understanding of mental health disorders and their treatment, as well as ensuring the appropriateness of such information to the communities using the pathway NICE (2017). There has been persistent advocacy for active patient and community participation within the UK since the NHS and Community Care Act in 1990; therefore, being attentive to narratives of service users' experiences is imperative in bringing about change. Another lesson learnt from this study is the importance of continuous involvement of service users in monitoring progress, training, planning and service provision and resurrect the objectives of the Delivering Race Equality DH (2005). Moreover, the creation of standards for supervision and continuing professional development from a relational perspective on transcultural psychological and culturally sensitive ways when working with SAIs and BAMEs.

According to Ibrahim & Ohnishi, (1997), it is imperative for practitioners to be open minded rather than pigeon-hole the patient based on their existing knowledge or understanding of the culture. Healthcare practitioners and professionals are encouraged to take in consideration the level of acculturation of that individual, as well as specific perception the patient may hold on gender roles, and other aspects are unquestionably crucial in informing treatment. Using clinical and case supervision in practice may be a platform to address and highlight issues of gender roles as Mann et al., (2017) suggests that family remains at the core of SAI's lives. From an intersectional perspective, traditional gender roles that sees women devalued may contribute to severe health problems in SAI women (Bhattacharya et al., 2010). Shramko et al., (2019) suggest that, the obstacles that prevents women, children and families from leading healthy lives could be the intersecting social categories such as gender, race, rurality, ability, and interlocking systems of oppression such as racism, sexism, able-ism and widespread trauma. Correspondingly, as a Black woman (like participant Priya who felt like a failure as a mother due to depression) I have always put the needs of my family first and adhered to the traditions and values handed down to me, alongside the echo of my African mother's voice always ringing in my ears that as a woman, I must persevere and be strong, that there should be no room for failure as a mother and wife and a professional (being at the last of the order); this of course negating the fact that I live with chronic musculoskeletal health conditions that affects my mental health significantly. However, I am aware that unlike other BAME and SAIs I possess the power of the intellect as an academic and professional and can benefit and gain certain privileges based on this power in environments where systems of oppression continue to thrive.

Moreover, Inman and Luu (2017) argue that, one of the most frequently addressed cultural topics in clinical supervision is gender along with race, where gender is perceived as socially constructed and inextricably tied to societal attitudes, values, and belief systems. According to Naz et al., (2019), therapists lack the confidence to ask questions about a service user's ethnicity, culture, or experiences of racism due to a fear of making mistakes or offending the patient. Thus, Naz et al., (2019) suggest that providing therapists with the time and space in supervision to reflect upon these issues may enhance their confidence and skills when working with SAIs and other BAME patients. Therefore, supervisors are encouraged to empower and educate supervisees in matters relating to gender roles and power especially when working with BAME patients such as SAIs and focusing on how clinical practice can be affected by sexism and oppression (Inman and Luu, 2017). In professional practice, many female clients have made complaints regarding therapeutic relationships where practitioners have encouraged traditional sex roles with bias in gender roles expectations as well as a use of sexist theoretical concepts. Thus, supervision should be used as a platform to reflect on the supervisee’s own biases, lack of awareness or lack of understanding of the issues concerning SAIs and other BAMEs.

Moreover, scholars such as, Juckett, et al.,(2014) and Juthani, (2001), argue that, the practitioners and health professionals alike should not expect automatic compliance from the patients since they represent authority figures; therefore, SAI clients may not feel comfortable to share their disagreements and views about their treatment. Consequently, any differences or discords may manifest through drop outs, noncompliance with protocols, and unhelpful therapeutic relationships. According Juckett et al.,(2014) there is a Power Distance Index (PDI) that characterises the Asian cultures, with PDI denoting the distance or level of respect which an individual must afford to a superior, an ideal which is reflected in Asian conformance to a strict social hierarchy, where medical and health professionals are perceived as authority figures. Therefore, practitioners need to have an awareness of issues of race and ethnicity, as well as power and privilege and these can be explored in clinical supervision. Beyond self-awareness, practitioners ought to remain cognisant that the interpersonal process happening within the therapeutic encounter reflects a social microcosm, where social and economic tensions, inequities, injustices, and misunderstandings may present themselves thus shifting the therapeutic dynamic consequently impacting treatment outcomes (Fuertes, Brady-Amoon, Thind and Chang (2015).

Additionally, due to SAI's fear of being judged and stigmatised because of their mental health problems, practitioners are encouraged to try to maintain control, focus on symptoms, and be interactive. Due to BAME patients' histories of colonialism, racism, sexism and oppression, issues of transference need to be addressed within the therapeutic encounter, especially where the therapist may be perceived or unconsciously experienced as an oppressor or a representative of an unjust system (Fuertes et al., 2015). From an intersectional perspective, it is imperative for practitioners, service managers and commissioners to recognise that what leads to health disparities and inequities are interplays of multiple categories and systems of oppression (Shramko et al.,2019). Therefore, a passive, non-judgmental, and neutral stance may possibly trigger anxiety in the patient and their family,(Fuertes, Brady-Amoon, Thind and Chang 2015; Juthani 2001); indeed, Davi described *neither "finding the love"* nor getting *"the feel good factor"* from the therapist*,* where Bal, Bindi and Ranjit felt *"men don't understand".* The therapeutic encounter should therefore reflect factors such as trustworthiness, transparency, understanding, evident collaboration and empowerment to share power.

Interpreters and bilingual practitioners should be provided. The NICE guidance also stipulates that information about services be provided in a range of languages and formats (visual, verbal, and oral), and that practitioners and commissioners collaborate in developing local care pathways which promote access to services for people from socially excluded groups such as BAME. In her narrative, Priya describes feeling her "*English was not very good"* and that it was*" holding"* her *"back."* It is crucial that services be actively seen to implement new ways of working such as those seen within the IAPT Services in the Midlands where I am based as a practitioner. Changes have been seen in interactive ways of delivering therapy using analogies, drawings, PowerPoint picture slides, and where music has been incorporated in delivering adapted CBT treatments for people with long term health conditions. In the West Midlands IAPT Services have adapted ways of providing CBT to South Asian Women which has been recognised and recommended by NICE in their Guidelines for working with BAME (NICE, 2017). However, the argument is that, the recruitment of practitioners by IAPT services would not be effective if those practitioners are denied the time to engage in useful continuing professional development sessions where they could train and teach more practical multicultural ways of working with patients from South Asian or BAME backgrounds due to Services' focus on targets and tick box exercises. The disconcerting issue here is, how services render themselves effective and equitable whilst delivering services focused on quantity not quality consequently being ineffective and inappropriate for target populations such as SAIs and other BAMEs.

As suggested by the participants in this study NICE (2014) recommends services to employ local needs assessment tools to help structure services, which should take consider out of hours working, home based treatment and the delivery of interventions in other settings other than the GP surgeries. A range of support services to facilitate access and uptake of services such as crèche facilities assistance with travel should be offered where possible. This is indicated in Priya's narrative in Category 5; Improvements: local involvement and socio-economic resources, where she reports that had she not been offered childcare she *"wouldn't have gone back"* for further sessions. Funding is therefore crucial, and commissioners must understand that there are huge amounts of people who live in poverty and cannot afford to pay for travel to seek healthcare. This once again relates to the intersectional processes of the social-political and economic realities within health and social care. In the West Midlands funds have been withdrawn where previously IAPT services where funded for offering Taxi rides to patients who were attending therapy for long term health conditions resulting in large numbers of patients accessing service and completing their treatment.

There is also recognition that unless mental health concerns are more generally accepted by the community overall, those with mental health needs will neither seek nor participate in interventions unless community norms regarding mental health within this close-knit community change. What ought to be addressed are cogent issues such as public stigma, self-stigma, family stigmatizing, help-seeking, and delaying behaviours, quality indicators for mental health care among ethnic minority groups, and others. In IAPT, quality indicators are predominantly statistics oriented with the focus on numbers entering service and statistically moving to recovery based on minimum data sets and psychometric measures for depression and anxiety specific disorder measures such as the PHQ-9, GAD-7. The use of a brief tick box non-specific patient experience questionnaire (PEQ) asking questions around satisfaction with services and practitioners as well as mode of therapy must not be justified as capable of capturing and exploring wholly a patient's experience of IAPT therapies.

Furthermore, incorporating the family unit in treatment maybe be crucial, especially second and third generation SAI family members who can help explain treatment modalities and interventions to family members that are less acculturated (Browne et.al., 2016; Memon et. al.,2016). According to Chadda & Sinha-Deb (2013), the most appropriate psychotherapeutic treatment for SAIs might be family focused interventions with the involvement of families in managing depression and other common mental health disorders. In a study by Meer and Mir (2014), participants reported that family was an underused resource within therapy and that involving family in the psychological treatment of depression was crucial for Muslim men in the UK. According to Memon et.al., (2016), BAME communities perceive a network of family and friends within the community as key in providing a safe framework for the discussion of problems which could be instrumental in ameliorating issues regarding BAME access to mental health services. Since family members are responsible for problem solving and caregiving, the introduction of systemic perspective such as family-oriented therapy is recommended, which is not available within IAPT.

Evidently, as reported by Serrant-Green (2014), there is a fundamental need for healthcare services to be reviewed and planned and these services should be equitable and diverse healthcare in compliance with the requirements of the Equality Act 2010 for which in England is driven by the Equality Delivery System (EDS). According to Cho, Hai, and Jang (2019), programs targeted at reducing the incidence of discrimination and strengthening family solidarity may reduce the prevalence of mental distress such as depression. It is suggested here, that approaches that focus on intergenerational dynamics may be most appropriate in engaging SAI in psychological therapies within IAPT as these may befit the collectivistic nature and group-oriented nature of SAIs. Services need to be improved by considering the specific needs of their local communities, taking into consideration their local contexts and the impact of health inequalities on the communities they serve.

Health promotion initiatives such as providing pamphlets in community centres, religious sites such as temples, and other social settings may help reduce negative attitudes and improve help seeking behaviours for mental health problems (Chen et al., 2013) as suggested by participants in the Service development category in Chapter 5 of the thesis. Due to issues around shame and dishonour, self-referrals to psychological services as an access pathway would be preferential for SAIs since individuals do not have to physically attend the GP surgery; hence reducing the stigmas surrounding seeking mental health care as individuals would not have to go through different services to be able to get the right help. This has already been implemented by services in the West Midlands with significant numbers of SAI accessing services through this route. Moreover, in this digital world era, improvements and redeveloping services can be achieved through media engagement and the use of digital platforms to campaign and raise awareness of common mental health problems such as depression.

Therefore, it would be of fundamental value if services take consideration and incorporate the complexity of cultural factors in the lives of clients within the whole therapeutic encounter and its processes. This could be done through conceptualising clients within the context of broader structural systems, encompassing their collective backgrounds and social support networks, their experience of ethnic group membership and sense of ethnic self, as well as their cultural norms associated with therapy attendance. However, services must not forget to treat people as unique individuals apart from their ethnic identity. These concepts are highlighted in participants' reports in Categories 2,3, and 4; Social Structure, Therapy Processes and Recovery Processes, respectively.

ii. Recommendations for Future research

In the view of the preceding contributions, future research may be necessary with the hope of replicating the findings with larger and more diverse sample sizes to assess for the generalizability of the results. Like single case research, qualitative methodologies can form part of a broader picture producing, as this study has, ideas which can be investigated further using larger samples and different methodologies.

Further research should focus on improving management through training all primary care personnel in multicultural sensitivity, engage and provide health education and promotion. It is argued here that BAME groups such as South Asian Indian patients often bring cultural assets to the encounter, which if connected to a therapeutic process that recognises and appreciates them may lead to compelling treatment engagement as well as effective use of services and significant outcomes.

Subsequently, services must assume an active role in engaging in social justice research and community based participatory research, especially supporting practitioners from BAME backgrounds who may show an interest in leading such research. The methods used need to effectively translate intersectionality theory into practical approaches as suggested by Hankinvsky et. al., (2017), who argue that intersectionality theory gives a conceptual frame of reference with which to examine the social locations of individuals and groups within the broader interlocking structures of power relations. Failure to support practitioners in social justice research can reflect and mimic the very oppressive hierarchical interactions, forces, factors, and power structures that perpetuates healthcare inequities. As discussed earlier in recommendations for practice section of the thesis, research has to be commissioned into brand new ways of engaging SAIs in therapy, such as family therapy and any other new innovative modalities since continuing to only adapt CBT as the best way of addressing issues of appropriate intervention in psychological therapies such the IAPT Program which is rooted in westernism can be argued to perpetuate health inequities from a social justice perspective. Moreover, continuous focus on the adaptation of CBT to suit SAIs without effort to research into emerging theories and models of psychological care to suit their needs would significantly propagate and prolongate intersectional processes such as class, racism, discrimination and interlocking issues of power rooted in colonialism and affecting these already marginalised in groups of people.

From this viewpoint, the continued provision of CBT as the main evidence-based approach to managing depression for SAIs means that interventions and treatments rooted in Eurocentrism are the best forms of treatment thereby discriminating against any other existing approaches and those yet to exist. Adapting CBT as the one solution to the issues presented in this thesis though appropriate and useful to an extent, also means negating the voices of participants in this research who suggested and propositioned innovative and brand new culturally appropriate ways of treatment for depression one of which could be family therapy which IAPT Services do not currently provide as part of its Stepped Care

Model. Thus, much focus on culturally adapted CBT risks the reproduction of social inequities associated with imposing dominant existing perspectives rooted in Eurocentrism.

Moreover, further exploratory research needs to be commissioned to confirm and extend the context surrounding psychotherapy dropouts in order to understand the phenomenon which may lead to these dropouts. Research should be implemented to explore ways to develop sustainable, broad-based, and integrated programmes which can lead to more effective recognition and care and treatment of SAI people with depression. Jakab (2011) reports that, the new European Health 2020 policy endorsed at the 60th session of the WHO Regional Committee for Europe, unveiled an action framework to stimulate health improvements around countries in Europe through the development of participatory processes with member states, sectors and partners. Jakab claims that;

> *"The time has come to ensure that these values (the right to health and health care; equity, solidarity, sustainability; the right to participate in decision making relating to personal health and that of the society in which people live) are not simply paid lip service but that they firmly underpin government policy at all levels, as well as action in the public and private sectors of the economy and in civil society."* (Jakab, 2011; p. 131).

From non-positivist paradigms such as constructivism, critical theory, and postmodernism, research is usually perceived as a researcher–participant coproduction of knowledge, (Karnieli-Miller et al., 2009). Accordingly, co-production in research with third sector organisations that are deemed to be significant and possible of playing an active role in mental health advocacy for SAI should be implemented. This co-production of research agendas may lead to more effective and efficient treatment interventions resulting in equitable health outcomes. Involving BAME as research partners will hopefully result in long-term gains and help in transferring and translating findings and recommendations into everyday clinical practice. The co-production concept is broad and can range from service co-planning and co-commissioning, service co-design and co-delivery, to co-assessment, co-monitoring, and co-evaluation, (Wilson et.al., 2019; Bovaird and Loeffler, 2013). Respectively, Codjoe, Barber and Thornicroft, (2019) argue that, the process of co-production and community ownership carries significant potential in advancing processes of trust in professionals and demand for services, especially if programmes are aimed at mental health promotions and tackling stigma.

Thus, to improve the implementation of treatment and services, social justice community-based research related to intersectional processes that cause depression in South Asian Indians needs to be strengthened. Hence, it is proposed that, it is time for initiatives to be geared towards supported partnerships between health professionals and the public so they can jointly identify and prioritise crucial and appropriate research tailor made to their needs (Yaraghi et al., 2015; Bovaird & Loeffler, 2013; Jakab, 2011). Within these partnerships, services and practitioners must firstly engage in public awareness through educating communities by showcasing examples of successful completed research and projects. The expectation would be for local communities to acquire an interest in participation and constructively engage in co-producing meaningful research with intended meaningful, useful and change oriented outcomes ((Wilson et.al., 2019; Yaraghi et.al., 2015). Consequently, co-produced research exploring the efficacy of community outreach programmes and engagement with local leaders must be commissioned as this may lead to future meaningful outcomes and bring about change for SAIs and BAME groups of people.

iii. Concluding Recommendation

'Putting patients first' has become the favoured mantra of politicians and senior policymakers in health and social care. Policy makers and services need to recognise that applying Western values and expectations of behaviour on South Asian Indians does not result in effective outcomes. The aim has been that people should have a stronger voice in decisions about health and care, and that services should better reflect their needs and preference. So far, people are not as involved as they want to be in decisions about health and care. Therefore, it is hoped that this thesis will contribute to a new narrative about the involvement of patients in health through highlighting the way forward, both conceptually and practically, that it will build confidence and inspire action.

The time has come for personalised and individual tailored care to become the focal point for health and care reform, and for the fundamental design principle to be seen as what is most appropriate and useful to people. There is need for assuming a democratic approach where people have rights as citizens, with those who use or are affected by health services getting actively involved in the administration of such services, as well as having certain rights regarding what they receive from that service. Concurringly, Mulley, Trimble and Elwyn (2012), argues that systems ought to adopt co-production value-based approaches whereby the best value for money from health and care system can be achieved through knowing and actively responding to what people need and want. Consequently, the care that is delivered will reflect and meet patient preferences, hence, they receive *'the care they need (and no less), and the care they want (and no more)'*.

Therefore, this study has provided some unique insights into how South Asian Indians perceive the psychological care provided to them when experiencing depression and processes of how that care is accessed. Factors that impact on making decisions about accessing care and healthcare interaction between professionals and patients were also explored and what follows is a brief discussion on limitations and study challenges of the research.

Study Challenges

When carrying out empirical research, there is a significant need to identify the limitations of a study as this helps in placing findings in context, giving insight into probable errors that may emanate from the whole research process and consequently determining the relevance of the findings to other related subject area.

Firstly, given the small sample size in the current study, the presented findings should be considered preliminary. This study involved a small, unrepresentative sample and it may be that other patients framed by different historical and contextual influences may report different experiences given that the UK SAI population is a highly diverse entity, and the participants here represented a diminutive fraction of this population. It was also not possible to conduct a comprehensive analysis of other ethnic specific phenomenon such as spiritualism because almost all patients brushed over the question. Furthermore, there is an acknowledgement that in researching a minority ethnic group, I may not have possessed the appropriate cultural sensitivity required. According to Higginbottom & Serrant-Green

(2005), researchers need to acquire comprehensive culturally sensitive research skills as there may be constraints and challenges when researching these groups of people.

On reflection this challenge may have occurred at the recruitment stage of the research where potential participants where quite apprehensive about taking part. This unwillingness to participate may be influenced by structural and societal issues, such as prevailing ideologies within the dominant society (Higginbottom & Serrant-Green, 2005). From an anecdotal point of view and as a BAME practitioner who is aware of the dynamic of power systems in society, SAI women being the usual people in the West Midlands to access services compared to the male counterparts, may have shied away from participating in the study in the study due to societal oppressing gender systems; from this context women are perceived as mainly reproductive beings inferior to their male counterparts hence allowing gender colonisation (Clark 2018; Indome, 2018). In this instance SAI women may have felt that they were not *"entitled or privileged"* enough to participate in the study or that their historically silenced voices did not matter.

Reflexively, akin to me, a Black-British African practitioner/researcher I empathise/d and identify with these women as I examine my doctoral research journey and struggling to get funding for my Project as well as being refused funding by the very service my research study aimed at improving; consequently forcing me to retreat to my societal and hierarchical *"rightful place"* where I *"belong".* Fortunately, I was able to take on extra employment to be able to fund my studies thus defying expectations and the very system and processes that intended to silence me by denying me opportunities to achieve that which I seek. There is a belief that my lack of opportunities especially in my practice due to my race and gender, mirrors the lack of opportunities my family and siblings experienced in an African country pre and post colonialism by the British. Hence, I have become to accept that I am still colonised since I continue to be treated differently with my place at the bottom of the hierarchy. Therefore, this continued oppression and power relations is the very negative factor that sustains health disparities and inequities.

Additionally, I recognise that my own ethnicity being Black African may to some extent influenced the progression of the research either positively and/or negatively as I found most participants being quite over-familiar with me during the process, although which possibly may have been due to a keenness to share their stories with me regardless of my ethnicities.

Another factor is that important information may have been missed by excluding those people who could not speak English as there were no facilities or resources to employ interpreters due to the costs involved as the study was personally funded. In addition, the use of the category South Asian Indian is contentious in that it must not be assumed to represent a homogenous group of people with identical backgrounds and experiences.

A further limitation of the present methodology, and a criticism often made of qualitative research such as grounded theory concerns the small sample of participants within the study and concerns that arise over the generalisability of the findings. However, this must be set against the richness and depth of the data which can emerge from detailed consideration of such a small group of people as claimed by Bowen (2008).

Moreover, another challenge that presented itself during the research process was managing and navigating the complex NHS research governance process in attaining NHS Ethics Clinical Research Approval which took nearly 12 months. According to Woods et al., (2016) and Snooks et.al., (2012) obtaining the necessary approval and permission for clinical research requires successful negotiation of the ethical and R&D layers of the NHS. From a researcher and active practitioner point of view, this process presented as significantly time consuming and relatively bureaucratic. However, to alleviate some of the challenges, contact and support from CLRN West Midlands was constantly sought as well as support from the University Research Ethics experts who were significantly insightful and resourceful and helpful in managing the hurdles. Noteworthy, University Research Approval was sought twice following the feedback, guidance, and requirements of the initial decision of the NHS Research Ethics Committee, consequently delaying participant recruitment and data gathering processes.

Thesis Conclusion

Despite a significant volume of reports exploring IAPT CBT treatments and intervention effectiveness in Primary Care for depression since its inauguration in 2008, (the majority being statistically based), its effectiveness for South Asian Indian and other BAMEs remains intriguingly under researched.

Responding to this gap in knowledge, this thesis has attempted to provide insights into SAI experiences of depression and how they seek, access, and perceive IAPT psychological therapy as a form of treatment in primary care. Since this study is professionally based, its findings carry significant messages to health policy makers that may potentially inform and influence the way mental health care is commissioned and implemented. To an extent findings reflected SAI patients' experiences of IAPT CBT and how they perceive this type of psychological therapies. Moreover, to a significant extent, some of the findings echoed previous research by many including, Bhat, (2015), Bhui et al., (2015), Cheng et el., (2013) Kapadia et al., (2013), Abdullah & Brown (2011), on South Asian Indians helping seeking behaviours and associated processes of accessing psychological/mental health services as well as outcomes.

Noteworthy, some of the findings are also reflected in the current Five Year Forward View (NHS England, 2016), which talks about ease of access to psychological therapies for all, the importance of ending the stigma around mental ill health. Focus is also on the Department of Health and Public Health England to engage local communities and help build a grass roots social movement to raise awareness of good mental health and support. Finally, the findings provide a contemporary frame of reference regarding factors that may impact the help seeking behaviours of South Asian Indians. Hence, this cutting-edge study significantly contributes to the evidence base in view of theoretical and empirical insights through the analytical identification of processes that impact and influences the experiences of psychological therapies for SAI with depression.

Although implementing a grounded theory analysis to the study came with challenges, it has provided a platform from whence new knowledge can be translated into practice as well as informing and challenging widespread ongoing practice.

The findings described here can be used to support successful research based on a co-production framework as recommended by participants in the study which may lead to improved treatment and outcomes in similar patient groups.

The aspiration is that this study will contribute to a new narrative about involving citizens in shaping health, thus illuminating the way forward, conceptually, and practically, consequently building confidence and inspiring action.

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GLOSSARY

Aetiology	The cause, set of causes, or manner of causation of a disease or condition.
Acculturation	Cultural modification of an individual, group, or people by adapting to Or borrowing traits from another culture.
BAME/BME	Black, Asian and Minority Ethnic. It is used to describe all ethnic groups including those of Irish or Mediterranean origin and east European migrants with the exception of White ethnic groups; this includes individuals of mixed ethnicities. It does not relate to country origin or affiliation.
BSc. Hons.	Bachelor of Science Honours Degree; an undergraduate academic degree awarded for programs that generally last three to five years.
CBT	Psycho-social intervention that aims to improve mental health; CBT focuses on challenging and changing unhelpful cognitive distortions and behaviours, improving emotional regulation, and the development of personal coping strategies that target solving current problems.
Collectivistic	Collectivistic cultures emphasize the needs and goals of the group as a whole over the needs and desires of each individual; In such cultures, relationships with other members of the group and the interconnectedness between people play a central role in each person's identity.
Constructivism	A theory based on observation and scientific study about how people construct their own understanding and knowledge of the world, through experiencing things and reflecting in those experiences.
Cor-morbidity	More than one illness or disease occurring in one person at the same time.
CQC	Clinical Quality Commissioning - monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.
Cosmopolitan	Composed of persons, constituents, or elements from all or many parts of the world.

Database	An organized collection of data, generally stored and accessed electronically from a computer system.
Dependability	Refers to the consistency and reliability of the research findings and the degree to which research procedures are documented, allowing someone outside the research to follow, audit, and critique the research process.
DH	The Department of Health - develops policies and guidelines to improve the quality of care and to meet patient expectations in UK.
DRE	Delivering Race Equality in Mental Health Care (DRE) - an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black, Asian and minority ethnic status, including those of Irish or Mediterranean origin and east European migrants.
DSM (V)	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association (APA**).**
Efficacy	A method of achieving something, to produce the intended result.
Emic	Pertaining to or being a significant unit that functions in contrast with other units in a language or other system of behaviour.
Empirical	Based on, concerned with, or verifiable by observation or experience rather than theory or pure logic.
Epistemology	A field of philosophy concerned with the possibility, nature, sources and limits of human knowledge.
Equity	The quality of being fair and impartial.
et.al	An abbreviation for the Latin phrase et alia which means "and others."
Ethnicity	An ethnic group; a social group that shares a common and distinctive culture, religion, language, or the like**.**
Etic	Relating to or denoting an approach to the study or description of a particular language or culture that is general, non-structural, and objective in its perspective.
Ethnocentric	Believing that the people, customs, and traditions of your own race or or nationality are better than those of other races.

Eurocentric	Focusing on European culture or history to the exclusion of a wider view of the world; implicitly regarding European culture as pre-eminent.
GAD-7	The GAD-7 is a useful screening tool in primary care and mental health settings and symptom severity measure for anxiety disorders. A total score for the seven items ranges from 0 to 21; Interpretation. Scores of 5, 10, and 15 represent cut-points for mild, moderate, and severe anxiety, respectively.
GP.	General Practitioner - a doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital or specialist care services.
GT.	Grounded Theory - is a systematic methodology in the social sciences involving the construction of theories through methodical gathering and analysis of data. This research methodology uses inductive reasoning, in contrast to the hypothetico-deductive model of the scientific method.
HRA	Health Research Authority – an executive non-departmental public body of the Department of Health in the United Kingdom. The HRA exists to provide a unified national system for the governance of health research.
Hypothesis	A supposition or proposed explanation made on the basis of limited evidence as a starting point for further investigation.
IAPT	Improving Access to Psychological Therapies - A National Health Service United Kingdom initiative to provide more psychotherapy to the general population. It was developed and introduced by Labour Party as a result of economic evaluations by Professor Lord Richard Layard, based on new therapy guidelines from the National Institute for Health and Care Excellence as promoted by clinical psychologist David M.Clark.
ICD (10)	The International Statistical Classification of Diseases and Health Related Problems 10th revision is a medical classification List by the World Health Organization. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.[1] Work on ICD-10 began in 1983, became endorsed endorsed by the Forty-third World Health Assembly in 1990, and was first used by member states in 1994.

Ideology	A manner or the content of thinking characteristic of an individual, group, or culture.
Minority	A racial, ethnic, religious, or social subdivision of a society that is subordinate to the dominant group in political, financial, or social power without regard to the size of these groups.
NICE	The National Institute for Health and Care Excellence - an executive non-departmental public body of the Department of Health in UK which publishes guidelines, advice and information services for health, public health and social care professionals.
NIMHE	National Institute for Mental Health England - a medical organisation organisation established in 2001 under the leadership of Professor Louis Appleby to coordinate research, disseminate information, facilitate training and develop services.
NHS	The National Health Service is the umbrella term for the publicly-funded healthcare systems of the United Kingdom.
NSUN	The National Survivor User Network (NSUN) is an independent, service-user-led charity that connects people with experience of mental health issues to give sufferers a stronger voice, feel supported and have the power and the platform from which to have direct influence at every level. It recognises the isolation and discrimination experienced by people who experience mental distress and their needs beyond clinical treatment.
ONS	The Office for National Statistics is the executive office of the UK Statistics Authority, a non-ministerial department which reports directly to the UK Parliament.
Ontology	The philosophical study of being in general, or of what applies neutrally to everything that is real.
Paradigm	A standard, perspective, or set of ideas. A paradigm is a way of looking at something.
Phenomenology	An approach that concentrates on the study of consciousness and the objects of direct experience.
PHQ-9	The Patient Health Questionnaire-9 - The major depressive disorder

	module of the full PHQ which is used to provisionally diagnose depression and grade severity of symptoms in general medical and in mental health settings. PHQ-9 Scores of 5,10,15 and 20 represents mild, moderate, moderately severe and severe depression, respectively.
Positivism	Positivism is a philosophical theory stating that certain knowledge is based on natural phenomena and their properties and relations. This means information derived from sensory experience, interpreted through reason and logic, forms the exclusive source of all certain knowledge.
Reflexivity	The examination of one's own beliefs, judgments and practices during the research process and how these may have influenced the research.
RCPsych.	The Royal College of Psychiatrists - professional body responsible for education and training, setting and raising standards in psychiatry in the United Kingdom.
RCT.	Randomised control trial - a trial in which subjects are randomly assigned to one of two groups: one (the experimental group) receiving the intervention that is being tested, and the other (the comparison group or control receiving an alternative (conventional) treatment The two groups are then followed up to see if there are any differences between them in outcome. The results and subsequent analysis of the trial are used to assess the effectiveness of the intervention, which is the extent to which a treatment, procedure, or service does patients more good than harm. RCTs are the most stringent way of determining whether a cause-effect relation exists between the intervention and the outcome.
Relativism	The doctrine that knowledge, truth, and morality exist in relation to culture, society, or historical context, and are not absolute.
SAI.	South Asian Indians – An ethnic group with ethnolinguistic composition of the diverse population of South Asian Country of India.
Schema	In psychology and cognitive science, a schema describes a pattern of thought or behaviour that organizes categories of information and the relationships among them.
SCMH	The Sainsbury Centre for Mental Health - Organization that works to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services.

	It also focuses on criminal justice and employment, with supporting work on broader mental health and public policy**.**
S.I.	Symbolic Interactionism - a major framework of the sociological theory and relies on the symbolic meaning that people develop and build upon in the process of social interaction.
SSRI's	Selective serotonin reuptake inhibitors - a class of drugs that are typically used as antidepressants in the treatment of major depressive disorder and anxiety disorders.
Structuralism	A term that implies elements of human culture must be understood by way of their relationship to a broader, overarching system or structure. It works to uncover the structures that underlie all the things that humans do, think, perceive, and feel.
Transferability	The degree to which the results of qualitative research can be generalized or transferred to other contexts or settings.
Westernised	The process of adopting or being influenced by the systems of the West, such as Europe or North America.
WHO	The World Health Organisation - A specialised agency of the United Nations responsible for international public health; The WHO Constitution, which establishes the agency's governing structure and principles, states its main objective as "the attainment by all peoples of the highest possible level of health."

APPENDICES

University of Salford
School Of Nursing Midwifery & Social Sciences
University of Salford
The Crescent
Salford, Greater Manchester
M5 4WT
United Kingdom

Telephone: 01612955000

Ref: Participant Invitation Letter

Dear Prospective Participant

Re: South Asian Indian patients' perspective of psychological therapy interventions for depression in Primary Care: A grounded theory approach study.

My name is Grace Johnson and I am a student on the Doctoral Programme in Health and Social Care at the University of Salford & A Psychological Therapist with the NHS.

As part of my Programme I am conducting a Research Project which aims to examine and explore the experiences of people from South Asian Indian people who have received psychological/talking therapy for common mental health problems, namely depression in Primary care, i.e., within GP Surgeries or Medical Centres.

The aim of this study is to explore the impact of therapies such at Cognitive Behavioural Therapy (CBT) on South Asian Indian groups of people, and to explore their views and opinions about the current care provisions available to manage common mental health problems such as depression.
People agreeing to take part in this study will be invited to participate in a one-to-one interview with me, which will be held across 2 Birmingham Medical Centres. For your reassurance, no identities will be revealed and all information will be treated in the strictest of confidence.

If you would be interested to participate please contact;

Researcher: Grace Johnson
Telephone: 07985883801; **Email:** g.johnson3@edu.salford.ac.uk

PROSPECTIVE PARTICIPANT INFORMATION SHEET

Study Title: South Asian Indian patients' perspective of psychological therapy interventions for depression in Primary Care: A grounded theory approach study.

My name is Grace Johnson and I am a student on the Doctoral Programme in Health and Social Care at the University of Salford & a Psychological therapist in the NHS. As part of my studies I am carrying a Research Project which aims to look the experiences of South Asian Indian communities who have received psychological/talking therapy for common mental health problems, such as depression within GP Surgeries or Medical Centres.

I would like to thank you very much for considering participating in this Research Study. Before you make a decision about whether or not to take part in the study, I would like to explain what the Project is about. This information sheet is very important so I would encourage you to read it carefully so you can make an informed choice about whether to participate.
If you have any questions or should you need any further clarification about the study-contact me using the details included below.

What is the purpose of the study?
The purpose of this study is to explore the effectiveness of talking therapies delivered in Primary Care through people's experiences of it. I am also interested in people's views about what works for them, in order to better understand which therapies are more appropriate for people from South Asian Indian communities.

Participating
You have been invited to take part after expressing an interest in this research; however, being invited does not mean you have to take part. You have a right to say no at any point.

If you meet the criteria on the flyer you will receive an invitation to a one-to-one interview with me, which will be held at a Medical Centre in Birmingham. The interview should last 60 minutes and will be audio-taped on an encrypted voice recorder (with your permission) and will later be listened to by me.

Taking part will give you an opportunity to look into your experiences. It is also hoped that should any healthcare inequalities be highlighted by the project, it will provide Health and Social Care Policy makers with evidence to enable service development and policy change to address some of those inequalities.
Due to the nature of what the study aims to explore you may find some questions quite personal and/or sensitive. As a participant should you feel any discomfort or distress at any point or stage of the interview you have a right to make your concern known to me and the interview will be paused or stopped at any stage. Time will be made available for any questions or concerns after the interviews for those who may require it (known as debriefing). You can withdraw your consent to participate at any point of the Research process at no disadvantage to you.

What if there is a concern?

If you have any concerns about the study or wish to make a complaint, you have a right to contact either myself or the Director of The Doctoral Programme at the University of Salford; Dr Elaine Ball, School of Nursing, Midwifery, Social Work & Social Sciences, email e.ball1@salford.ac.uk Telephone 01612957280. However, if you remain dissatisfied please contact: Dr Jo Cresswell, Associate Director for Research, email j.e.cresswell@salford.ac.uk Telephone 0161 295 6355; or via the NHS to Ms. Ellen Edwards, Research Support Facilitator, Primary Care, NIHR Clinical Research Network (CRN), email ellen.edwards@nihr.ac.uk Telephone 0121 204 1823.

Will my taking part in the study be kept confidential?

All information including direct quotes will be made anonymous and kept safe and confidential. Significant sections of the data will be discussed and reviewed by academic assessment bodies as part of examining the Doctoral Research Project. However, be reassured this will only be done by authorised individuals from the University of Salford and external examiners, who are duty bound to confidentiality and other Research Codes of conduct. All gathered Research data and participant information will be held for 3 years according to the Caldicott Guidelines 2006 following the project completion and submission and in line with University of Salford ethical guidelines. Thereafter information it will be destroyed.

Are there any circumstances where confidentiality might not be kept?

If any situation arises and you give any information during the interview or at any point of the research process which leads to a serious concern about your safety or the safety of others, it may lead to further discussion with the Research Project supervisors and/or other appropriate third parties. However, where necessary, I will discuss any concerns with you beforehand.

What will happen to the results of this research study?

The findings and outcome from this research will be written up as a Thesis. It may also be shared through academic, health and media publications or other Seminars and Conferences. Any verbatim material used will be fully anonymised. The findings may also be of use or beneficial in informing some Health and Social care Policies.

Who has reviewed the study?

This project has been approved under the procedures of the University of Salford Ethics Committee and NHS Research Committee.

Further information and contact details

Researcher: Grace Johnson
Telephone: 07985883801; Email: g.johnson3@edu.salford.ac.uk

IRAS Project ID: 182614

Participant Identification No for this Study:

Consent Form

Project Title: South Asian Indian patients' perspective of psychological therapy interventions for depression in Primary Care: A grounded theory approach study.

Name of researcher: Grace Johnson

Please initial the box

Taking Part

1. I have read the information sheet date 18th January 2017 Version 3.0 and have been verbally informed about the above research and I understand what I am being asked to do. ☐

2. I have been given the opportunity to ask questions about the study and all questions have been satisfactory answered. ☐

3. I agree to take part in the study which will include being interviewed, audio recorded and direct quotes being used in the final report/thesis. ☐

4. I understand that my taking part is voluntary; I can withdraw from the study at any time without giving any reasons for why I no longer want to take part and that my withdrawal will not affect any aspect of mine or my family's care. ☐

5. If I do decide to withdraw I understand that the information I have given will not be used in the research. ☐

Use of the information I provide for this study only

6. I understand that my personal details will be kept confidential and not be revealed to people outside the research team. ☐

7. I understand that my words may be quoted in publications, reports, web pages, and other Research outputs, but these will be anonymised at all times. ☐

8. I agree to take part in the study. ☐

___________________________	________________________	_________
Name of participant	**Signature**	**Date**
___________________________	____________________	_________
Researcher	**Signature**	**Date**