A deeper look at how therapists experience working with Black clients in clinical practice using Cognitive Behaviour Therapy: A Grounded Theory

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THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION REASONS:

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Preface

Over the last three years I have been on a challenging journey as I have embarked on the task of completing my thesis and the associated research. This challenge was emphasised with trying to achieve a balance between academic commitments and the practical application of learning during clinical placements. Developing this fine balance served to hone skills that have been important in further shaping my understanding of counselling psychology.

Interest in the chosen research area was in the making several years ago following the completion of my Psychology bachelor's degree and during a trip to the Caribbean which involved voluntary work within a number of psychiatric hospitals. This experience served to cultivate a curiosity around active psychotherapies within particular communities where methods of talking therapies were beginning to emerge alongside more common and indeed trusted drug therapies. For this research the interest of exploring a 'tried and tested' type of therapy and consideration of the sensitivities of culture contributed to what has emerged into this thesis offering.

Along my journey as a Cognitive Behaviour Therapist (CBT) and Counselling Psychologist working in various services got me thinking: cognitive behaviour therapy, the therapeutic relationship, Black clients, culture, relating and I considered what it might mean, from a therapists' perspective to work with specific minority groups.

As a Black British woman I have my own beliefs, morals and values influenced by and through my cultural background and Caribbean heritage as a first generation British citizen. Some of my own experiences as a Counselling Psychologist developed my idea when working with Black and minority clients and the exchanges that took place within the therapy room. I found that in these instances when using CBT, issues around sociocultural factors such as religion, family, housing and language were raised as areas pertinent to clients during therapy and at times I wondered about how some of these factors might be worked with in sessions during short term therapy.

Some of the personal comments I have received from clients that I have worked with from Black and minority backgrounds in our CBT work together have been: *"You won't understand" – (Portuguese CBT client with Interpreter); "I'm a Black man…I shouldn't be here, culturally this goes against everything" – (Young Black Caribbean male); "Are you from the West Indies? – Which island? – Have you eaten today?" (80 year old Caribbean female).* I can recall at times feeling helpless, unconfident, mothered and unsure as to whether I would be able to understand the client who from these examples initially felt that I couldn't. I wondered about clients relating to me who felt that I may not be able to relate to them, their experiences and whether the role of cultural differentiation played a part and how this is addressed; how therapists may deal with clients where ethnic issues may arise and how using CBT to work with each of these clients to meet their needs is achieved.

Since the beginning of this research, this process has, at times felt arduous and overwhelming. It is gratifying however to reflect on this journey as I look back over my training, building an idea and strategizing this to form a piece of work. On entering into this training program, I was fortunate to possess some previous knowledge and my previous CBT training which has significantly impacted my life both professionally and personally.

My motivation for pursuing this training program was to build on my experiences as a CBT therapist and to harness skills with the learning of other therapeutic frameworks and I feel that my growth into a Counselling Psychologist will be an on-going journey. However, I believe that my initial motivation in this has been achieved and I will continue to pursue avenues to assist in my professional development as a Counselling Psychologist. I greatly underestimated the life-changing experience the last three years would have had on my life and it is hard to believe that this immensely challenging training is finally coming to an end. I am grateful for all of the opportunities I have had along the way and the people I have had the privilege of working with including lecturers, work colleagues and fellow students who have helped me along the way.

This research begins with an attempt to understand therapist's opinions of working using Cognitive Behaviour Therapy with Black clients and goes on to address various methods of desired preferences of practice using adaptive protocols. There is a further consideration of what factors might arise during therapy that serve to change evidenced based practice. Following the thesis is a case study on working with a client who self–referred for psychodynamic therapy which focuses mainly on the importance of the therapists-client relationship and the challenge I faced of moving from a predominantly Cognitive Behaviour Therapy style, to developing a psychodynamic focus and practice in my training. The thesis ends with a publishable paper.

Section A: Doctoral Research

This section includes the Doctoral Research entitled, '*A deeper look at how therapists experience working with Black clients in clinical practice using CBT.'*

The doctoral research used grounded theory to explore the experiences of therapists using CBT, attempting to develop a theory around how therapists might practice using CBT with particular groups; in particular to understand the way in which therapists work with Black African, Black Caribbean and Black British clients and if there are instances of adaptations to CBT protocol and how this might present. A total of seven semi-structured interviews made up of therapists including Counselling, Clinical Psychologists and CBT Therapists were included as part of the qualitative study. Constructivist grounded theory was used for data analysis where an emergent theory of CBT and adaptation was considered. Finally the findings of this research are discussed and analysed along with the inclusion of existing literature and the practice of counselling psychology is considered as the basis whereby the research can contribute and assist in on-going practice and service development.

Section B: Client Case Study

A case study is provided to explore the clinical work with a client who accessed therapy for psycho-dynamic intervention having had a course of CBT therapy within the IAPT service a year prior to this. The case study highlights session sixteen of twenty-four and focuses on the relational exchanges of the client and myself and of our work using a psychodynamic approach. The case study further highlights the practice of counselling psychology in the context of a providing therapy in a non-profit organisation and aims to demonstrate both the challenge of working psycho-dynamically having primarily a purist cognitive behaviour therapy background and the importance of the therapeutic relationship.

This case was chosen as it was a very challenging case for me moving away from CBT. It demonstrated the importance of the relationship, working collaboratively and creatively and highlights how powerful the therapeutic alliance can be in achieving change. The work with this client presents key aspects of my development as a psychologist and my own understanding of focusing more on relational aspects of human to human contact in therapy, the process of formulation, early object relations and transference and countertransference.

Section C: Publishable Paper

The chosen journal for application of the publishable paper is the Cultural Diversity & Ethnic Minority Psychology journal. This covers articles which offer overall teaching to contribute to both experimental and clinical work for theory, practice and an evolution of cultural and ethnical psychotherapy.

The publishable paper outlines the four main categories developed from the data which were outlined in the thesis. These main categories included *Category 1: Appropriateness, Category 2: Therapy congruency, Category 3: Developing my therapy style, and Category 4: Curiosity.* One core and over-arching category is '*CBT in practice: A process of working with Black clients'.* An emergent theory was developed with an attempt to explain a process of how therapists use methods of adapting CBT during clinical practice to work more efficiently with their Black clients.

Summary

Cognitive Behaviour Therapy has become a popular choice of therapy over the years for use with clients from various ethnicities and psychological presentations. It is my hope that the overall offering of this portfolio serves to provide some thought into meeting service expectations and the expectations of a client with practical methods of tailoring CBT to clients. I hope that the opinions of the therapists in this research can also be a source of reflection, where particular techniques or perspectives have been found to work well that may not be universally known or even accepted. It is my expectation that this

piece of work is by no means the finished product but can contribute to possible further development and research for social learning of which I would hope to continue to be a part of.

SECTION A: DOCTORAL RESEARCH

A deeper look at how therapists experience working with Black clients in clinical practice using Cognitive Behaviour Therapy: A Grounded Theory

Jana Hanchard

Supervised by Dr Jessica Jones Nielsen

Abstract

As the use of Cognitive Behaviour Therapy (CBT) becomes more prevalent in clinical practice, over the last four decades, more recently there has been an increasing call for the adaptation of CBT following concerns that traditional CBT approaches may not account for particular and unique experiences encountered by marginalised populations (David, 2009; Eamon, 2008). Research has found that CBT may be more effective if it was culturally adapted to meet the needs of Black minority groups (Rathod et al. 2015; Naeem, 2015 and that therapists commonly 'drift' away from evidenced based techniques (Waller et al. (2012). Yet there has been a lack of studies exploring the efficacy and experience from the perspective of therapists in relation to minority racial groups and treatment outcomes.

This study attempted to understand CBT from the perspective of the therapist. The aim was to understand how therapists use CBT to work with Black African, Black Caribbean and Black British clients, if there are instances of adaptations to the CBT protocol and what this might look like. Qualitative interviews were conducted with seven therapists, including Counselling and Clinical Psychologists and CBT therapists working mostly within primary care NHS and the Improving Access to Psychological Therapies (IAPT) service.

From the data four main categories were developed. The Core Category: 'CBT in practice: A process of working with Black clients.' The four categories were: (1) Appropriateness, (2) Therapy congruency, (3) Developing my therapy style, and (4) Curiosity. The results revealed a tentative theory to explain a process of how therapists use methods of adapting CBT to work more effectively with Black clients, to increase therapeutic rapport and engagement, including aspects around culture, religion, language, psychological-mindedness, acculturation to the host country, education and age.

The implications of this study contribute to the field of Counselling Psychology by helping to demonstrate some practical applications of CBT with clients who present from African and Caribbean ethnic backgrounds and to assist with sustained therapy engagement.

CHAPTER 1. INTRODUCTION

This paper considers the emerging idea that Cognitive Behaviour Therapy (CBT) may be more effective if it was culturally adapted to meet the needs of Black minority groups (Rathod et al. 2015; Naeem, 2015). This notion has developed through previous research which has commonly taken up a position exploring therapy experiences from the client perspective. Over the past few years there has been a limited number of studies that have made attempts to explore the views and experiences of therapists delivering CBT particularly with Black clients (Rathod et al., 2010; Bennett-Levy, 2014). The outcome of these studies have acknowledged that during therapy, adaptations to CBT were often required for certain Black and minority groups, though there has been relatively little specificity regarding the process of adaptation and of the opinions of the therapists who might take up this position.

The UK Department of Health committed to a significant increase of psychological therapists in the National Health Service (NHS) and set about installing a major training initiative. This service initiative emerged from debates about the need to make psychological therapies available as part of standardised care for people with anxiety and depression (the Layard report; Layard et al., 2006). In order to achieve this, the IAPT program commissioned a set of modality-specific competence frameworks which would be used to develop training. This framework contains a common element, a domain of 'Generic Therapeutic Competences' (Roth, 2015), such as the ability to engage clients or to develop the therapeutic alliance. The competences are organised into five overall domains including *generic, basic, specific, problem-specific CBT skills and meta-competences*, the purpose of which is to assist with aspects of competent service running and evaluation including its use in commissioning, service organisation, clinical governance, supervision, training, registration and research. It is important therefore to examine how therapists might construe generic competences in relation to the theoretically consistent elements of their therapy, the use and application of CBT and engaging with evidenced based content. The terms 'culturally adapted' and 'therapy drift' in CBT describe methods where therapists might work in ways that are not strictly kept to evidenced based expectations for clinical practice. The term cultural adaptation refers to "*the systematic modification of an evidence-based treatment or intervention protocol that considers language, culture, and context in such a way*

that it is compatible with the client's cultural patterns, meanings, and values." (Bernal et al, 2009). Waller (2012) introduced the idea of *'*drift'. In the context of therapy drift is '*when we actively decide not to deliver key components of a therapy or passively avoid them – whatever the justification.'* (Waller, 2016). A review conducted by Waller et al. (2012) found that 80 CBT therapists commonly 'drift' away from using evidenced based therapeutic techniques, specifically with that of CBT in a study on effective treatment for eating disorder clients, calling for stronger training and a closer supervision if therapists were to give a more structured form of CBT for treatment efficacy. In the case of working with ethnic minority groups this lack of efficacy is particularly important when examining how therapists might work with CBT to build a more idiosyncratic model around a client. Within Waller's review, specific CBT techniques or manualised CBT was used particularly by therapists who were very experienced working with eating disorder clients. Around 50 percent of therapists did not use a single core CBT technique routinely, with 56.6 percent reportedly using motivational work, concluding that very little standardised CBT was being practised. Waller's approach to this idea of drift is based primarily on the action of moving away from established manualised methods that govern clinical practice - empirically supported treatments (EST) or evidenced-based practice (EBP). One in the same, this method of practice provides a manualised way of *doing* therapy that is established through research, training and scientific evidence showing that they work. Waller (2009) goes on to outline that consistently delivering an EST or EBP version of CBT would be ideal, however in reality this is not always possible due to therapists themselves; their own perceptions, cognitive distortions and emotional reactions which impact therapy. Therapists therefore become poor at implementing the full range of tasks that are necessary for CBT to be effective, particularly with that of behavioural change (Waller, 2009). Therapist drift can therefore be conceptualised as a therapists' failure to deliver treatments that they have been trained to deliver, or failure to deliver them adequately, even where resources exist to allow them to do so. Such failure can be a consciously or an unconsciously-driven course of action. Regardless, it has the same consequence – the patient receives treatment that deviates significantly from the evidence-base, reducing their chances of improvement or recovery. Reasons for therapist drift include: therapist knowledge base, beliefs and attitudes, emotions and safety behaviours, self-belief, philosophical stance, clinical judgement and social milieus, to name a few (Waller & Turner, 2016).

The process of 'drift' therefore, appears to be somewhat inevitable and one that appears to be detrimental to the success of CBT and patient wellness. Although Waller postulates a possible lack of confidence or therapist anxiety which might offer reasons for drift, there is also the consideration that the intention behind drift could be one adopted by therapists to individualise or tailor therapy to suit client need. Thompson-Brenner and Westen (2005) for instance, found that CBT therapists who showed drift during therapy in more complex client presentations, tended to engage in psychodynamic methods. Psychodynamic theory can be viewed as a valuable approach in understanding and working with issues which might touch on race relations, oppression, racism and discrimination, issues which might directly impact BME clients (Alleyne, 2009, 2011; Berzoff, 2011). The suggestion is that as BME clients might be either less aware of psychological therapies or less likely to engage with such services, they are more likely to display therapy interfering behaviours which could lead to therapist drift.

Some studies examining the effectiveness of CBT have found high dropout rates among Black and Hispanic populations (Magill & Ray, 2009; Mak et al. 2007; Miranda et al., 2005; Voss Horrell, 2008). Windsor et al. (2015) states that the question about whether CBT is effective for clients of African or Caribbean decent is difficult to answer as studies that have indicated CBT effectiveness for Black and minority ethnicities (BME) have used culturally-adapted approaches (Foster, 2007; Kohn & Oden, 2003; Miranda et al., 2003, 2006; Organista, Munoz & Gonzalez, 1994) such as language considerations, interpreters and integrating cultural elements into treatment (Sue et al., 2009). Further studies have also made a call for the adaptation of CBT as there is concern that traditional CBT approaches may not account for particular and unique experiences encountered by marginalised populations (David, 2009; Eamon, 2008). A number of reviews conducted have found that CBT would be acceptable and may be more effective if it was culturally adapted to meet the needs of black minority groups (Rathod et al. 2010, 2013, 2015; Naeem, 2015).

Over the past decade there have been many empirical investigations into psychotherapy and minority groups (Bernal, Bonilla & Bellido, 1995; Hwang et al. 2015; Rathod, 2010; Voss-Horrell, 2008. There has also been an effort to understand differences that may perhaps exist between ethnic

groups in the expression of certain disorders and in response to psychotherapy itself (Rathod, 2010). Along with these increases to broaden understanding has seen an increase of studies exploring the clients view, stance and intimate experience of how they found therapy, as substantial evidence now shows that a variety of treatment approaches, notably behavioural and cognitive behavioural therapies are efficacious in remediating anxiety (Carter et al., 2012). However, there appears to be a distinct lack of studies exploring the efficacy and experience from the perspective of the therapist using CBT in relation to minority ethnic groups and treatment outcomes that they have personally worked with. A review conducted by Bassey and Melluish (2012) exploring the cultural competence of newly qualified IAPT therapists trained to deliver CBT, found that therapists can work in a culturally competent and sensitive manner without the need for comprehensive training based on a cultural competence guide which suggests that empathy and sensitivity is innate and does not or indeed cannot be taught by way of training. In consideration of this, the ability for therapists to draw on their own personal and professional experiences may count as significant when relating to others. With few studies addressing the latter, three questions remain:

a) Are standard CBT interventions being currently adapted with Black and minority clients?

b) What are the experiences of therapists and their views of working with CBT with Black client groups and of adaptation? How do these views inform their practice?

c) If adaptation of CBT interventions takes place, what does this look like?

The primary focus of this chapter is to understand the constructs of working with Black clients, how CBT is used and the perceived complacency about 'diversity' practice in CBT with Black clients and other factors that may come from this, including culture and how this might influence therapy. I wish to be careful not to steer into exploring factors around ethnicity itself and lose the focus on *how* congruency with CBT therapy is achieved in practical terms with this client group, but I appreciate that issues around ethnicity and diversity will undoubtedly serve as a significant part of this research.

1.1 Research Terminology

The following terms were used within the research and to ensure a clearer understanding of these terms they will be defined here. The terms "west", "western" and "non-western" are used in reference to countries and culture. Western countries and cultures are defined as those from Europe, Americas and American-West, and Australasia. Non-western countries are those characterised as Central Asia, Far East, Middle East, Western Asian, North Africa and South Asia. Cultures within these countries are referred to as eastern or non-western cultures (Thompson & Hickey, 2005).

The Oxford Dictionary of English defines the term "BME" or "Black Minority Ethnic" as members of 'non-white communities in the United Kingdom' (Oxford Dictionary of English, 2015). BME individuals are not a homogeneous group and are diverse in itself made up of African and Caribbean, Asian communities including those from Indian, Pakistani, Bangladeshi and also Chinese ethnicities (Gill, Kai, Bhopal & Wild, 2007). Ethnic minority groups then are considered to be those with a cultural heritage distinct from the majority population (Manthorpe & Hettiaratchy, 1993). BME will be used in the following chapter and throughout the research in reference to cultural groups that define this categorisation. However, this research will in particular focus primarily on Black African, Black Caribbean and Black British ethnicities to allow future research to gain experiences of specific cultural groups and the term 'Black' will at times provide an overall identifying statement encompassing each of the latter groups.

1.2 Cognitive Behaviour Therapy: Definitions and Theory

In the early 1960s Aaron Beck embarked on a series of experiments to understand the underlying development of depression and to identify key methods to offer manageability in the field of mental health and treatment. Beck identified negative cognitions, primarily thoughts and beliefs, as a primary feature of depression, the focus of which to develop a short-term treatment to target a patients' negative thinking present in depression (Koles, 2012). Cognitive Behaviour Therapy, derived from Beck's original Cognitive Therapy, makes up a structured, present-focused and short-term form of psychotherapy, mostly assuming a current problem-focused and therefore goal oriented perspective, modifying dysfunctional thinking and maladaptive behaviours (Beck, 2011). Over the years Beck and

others have successfully adapted therapy to cover a range of other disorders other than depression including generalised anxiety, obsessive compulsive disorders, post-traumatic stress, specific phobias and social phobias. Although the application for various presentations has changed, the theoretical underpinnings of CBT have remained largely consistent, based on conceptualisation of individuals specific to their thoughts, feelings and behaviours in relation to a specific presenting problem. The treatment is based on a formulation characterising a disorder, identifying patterns of behaviour relative to that disorder, thereby identifying the associated thoughts, feelings and behaviours maintaining the problem (Beck, 2005).

A number of forms of cognitive behaviour therapy exist sharing characteristics with Beck's therapy, but with variations concerning conceptualisations. These include rational emotive therapy (Ellis, 1962), dialectical behaviour therapy (Linehan, 1993), problem-solving therapy (D'Zurilla & Nezu, 2006), acceptance and commitment therapy (Hayes, Follette, & Linehan, 2004), exposure therapy (Foa & Rothbaum, 1998), cognitive behavioural analysis system of psychotherapy (McCullough, 1999), behavioural activation (Lewinsohn, Sullivan, & Grosscup, 1980; Martell, Addis, & Jacobson, 2001), cognitive behaviour therapy often incorporates techniques from all these therapies and others psychotherapies, within a cognitive framework.

The cognitive model underlying cognitive behaviour therapy proposes that dysfunctional thinking, which influences mood and behaviour, is linked to all psychological disturbances. When a client learns to explore and evaluate their type of thinking in a more balanced and realistic way, such as changing unhelpful automatic thoughts, they can experience improved emotional and behavioural functioning.

There are ten basic principles as outlined by Beck (2011) forming the general practice of cognitive behaviour therapy:

(1) Cognitive behaviour therapy is based on an evolving formulation of a patient's problem and an individual conceptualisation of each patient in cognitive terms which is then shared with the patient. (2) Cognitive Behaviour Therapy requires a sound therapeutic alliance (3) emphasises collaboration

and active participation (4) Cognitive Behaviour Therapy is goal oriented and problem focused (5) is present-focused (6) is educative, aiming to teach the patient to be their own therapist with an emphasis on relapse prevention (7) Cognitive Behaviour Therapy is time-limited (8) sessions are structured (9) Cognitive Behaviour Therapy teaches patients to identify, evaluate and respond to their dysfunctional thoughts and beliefs (10) Cognitive Behaviour Therapy uses a variety of techniques to modify thinking, mood and maladaptive behaviours. Although cognitive strategies such as socratic questioning and guided discovery are central to the cognitive behaviour therapy process, behavioural and problem-solving techniques are essential, amongst other techniques from other orientations that are implemented within the cognitive framework.

There have been three levels of conceptualisation within CBT outlined by Kuyken, Padesky and Dudley (2009). *The descriptive, cross-sectional and the longitudinal*. The descriptive level is similar to the generic model of CBT also known as the five aspects or areas (Padesky & Mooney, 1990) which outlines thoughts, emotions, behaviours and physical aspects and their interrelations (Padesky, Kuyken & Dudley, 2011b). The cross-sectional conceptualisation level identifies triggers, responses and maintenance cycles. The longitudinal formulation incorporates both descriptive and cross-sectional levels and more specifically developmental history that link to the presenting issues. This would incorporate core beliefs and dysfunctional assumptions along with early life experiences (Kuyken, Padesky & Dudley, 2008; Padesky, Kuyken & Dudley, 2011a). Beck's position outlines a generalised model that can provide an over-arching perspective on human functioning in a simple way. The ten basic principles outlined by Beck (2011) provide a clear and standardised protocol to follow, if somewhat structured, much like CBT. But what if this protocol is not followed? The question as to how this model is utilised by the therapists and implemented, could shed a light on what principles work or adhered to and others that are perhaps not. Certainly in consideration of primary care services, CBT offers a time-limited and structured approach with a prescribed format and process for the therapy process (Rathod, 2010). CBT used exclusively with clients from BME backgrounds has been open to criticism by a number of researchers with a suggestion that there is a loss of humanness

through its prescriptive presentation. Hays (1995) reviewed the applications of CBT and outlined several limitations in terms of multiculturalism. The view that CBT takes a scientific stance, with a focussed and rational style Hays describes as linear, on which the formulations and interventions are based and can be suited to more western cultures (Mark, 2010). Whereas Ornstein (1977) hypothesised that eastern cultures have a non-linear cognitive style that are less restrictive and more emotional and intuitive. Humanistic psychology, in its theory and therapeutic techniques emphasises the human individual's capacity for choice, freedom and self-development. Historically the division between humanistic approaches and the behavioural and cognitive therapies is substantial. Humanistic psychologists thought the behavioural approach was uniformly mechanistic, while humanism was holistic and contextual: *"mechanistic science (which in psychology takes the form of behaviourism) [is] too narrow and limited to serve as a general or comprehensive philosophy" (Maslow, 1966, p.3).* Behaviourism supposedly focused entirely on a passive organism responding to external contingencies, or input-output explanations drawn entirely from animal learning, while humanism dealt with an active organism that was different in many ways from nonhuman animals, particularly, in the area of cognition (Maslow, 1966). Humanistic psychology emphasized existential and interpersonal themes such as meaning, purpose, values, choice, spirituality, self-acceptance, and self-actualization—all of which were thought to be beyond the reach of behavioural psychology. Jenkins (2001) highlighted the interpersonal themes of humanism and their relevance to multiculturalism, in particular the potential for freedom of expression for those from Black communities. Jenkins proposes that the humanistic view is open to a multi-causal and multicultural perspective accounting for human events which extends beyond the cognitive and behavioural experience. Thus the development of one's human agency can occur only in the nurturing context of the sociocultural world in which an individual lives. The humanistic view argues then, that cultural traditions will propose different ways of living out one's individuality.

1.3 The role of culture

Culture can have a significant impact on how an individual understands psychological issues and therefore the way in which they express their issues. Cultural values and beliefs can influence help-

seeking behaviours, presentation and reporting of symptoms, as well as the engagement in psychological interventions (Kleinman, 1977, 1988; Zhang, Snowden & Sue, 1998). This would also have an impact on how a therapist practices therapy with the individual. Increasingly over the past decade there has been an increasing call for a move towards the incorporation and consideration of cultural issues into the therapy process (Rathod, 2010). American Psychiatric Association (APA) and the DSM-5 Cross Cultural Subgroup (DCCIS) came together to produce and disseminate a tool for psychiatric practice: the Cultural Formulation Interview (CFI). This evidenced-based tool is comprised of a number of questionnaires to help clinicians in making person-centred cultural assessments to inform diagnosis and treatment planning (DeSilva, 2015). Culture is defined by the DSM-V as:

> *"…systems of knowledge, concepts, rules and practices that are learned and transmitted across generations…includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of the world and their experiences" (American Psychiatric Association 2013, p. 749).*

The model of Cognitive Behaviour Therapy proposes that individuals are affected through a combination of predisposing, precipitating and perpetuating factors, exploring what made an individual vulnerable to a problem, and what keeps the problem going. The relevance of culture as it relates to social learning and development serve to construct cognitive development and identity as outlined through definition by APA (2013) and so having an understanding of culture can assist in further understanding cognitions, external learning experiences and of how we make sense of the world around us.

1.4. Collectivism versus Individualism

Landrine (1992) labelled a constructed view of self with two defining identifications. The first is the *self-as-social*, where the self is defined by the way in which it fulfils the role prescriptions of the family and/or community. The second is the *self-as-illusion* or *receptacle* which views individuality as

a type of vessel whereby immaterial forces such as spirits, ancestral or higher force may inhabit. In either of these positions, conceptions of self is not thought to be the primary source of action or indeed of focus or rather importance. But instead it is that the situations, relationships and experiences are the culturally constituted and culturally acceptable explanations for thoughts, feelings, behaviours of the individual (Jenkins, 2001).

Jenkins (2001) highlights the conceptual perspective on personality and the sense that *self* is differential between western and eastern cultures. The primary focus of mainstream psychotherapeutic viewpoints during the 20th century tended to be on the improved psychological functioning of the *individual* person. Such a way of addressing psychological problems can be seen to be an outgrowth of the particular indigenous view of the individual characteristic of a westernised society. However, because the *self* can be seen to reflect "the shared moral understandings within a particular culture of what it means to be human" (Cushman, 1995, p. 23), the western view on this topic is one that is not necessarily shared by other cultures. Jenkins suggests that the cultural ideal as identified in westernised cultures places an emphasis on autonomy and on the individual.

Allik and McCrae (2004) explored worldwide personality traits across thirty-six different cultures using the five-factor model of personality (Digmam, 1990). It was found that people from European and American cultures were higher in individualistic perspectives and traits such as extraversion, open to new experiences and lower in agreeableness. Whereas, people from Asian and African cultures had more collectivist traits such as introversion, traditionalist and more compliant. By contrast Jenkins (2001) epitomised this difference with an African worldview which suggests *'I am because we are, and because we are therefore I am'.* This view makes no specific distinction between self and others.

Hays and Iwamasa (2006) agreed with Jenkins sharing the view that as a direct result of these distinct differences in self-perception this can hinder cognitive and behavioural change processes (Iwamasa, Hsia & Hinton, 2006). Hays and Iwamasa (2006) defined CBT as being founded by middle-class, European-Americans, which would have been considered the dominant social group and as such, the universal norm. These values would be orientated towards personal autonomy, independence, future goals, seeking change and individualism (Hays & Iwamasa, 2006). These values are from a western

individualistic culture and contrast to what an eastern collectivist culture encompasses. For example, Scorzelli and Reinke-Scorzelli (1994) in an earlier study (as cited in Naeem, 2012, p.116) explored whether CBT conflicted with the religious beliefs and cultural and family values of graduate Indian psychology students. The study found that some eighty-two per cent felt that the principles of the CBT approach as a talking therapy, conflicted with their values and beliefs. Forty-six per cent stated that CBT was in conflict with their sociocultural beliefs, such as family values and forty per cent outlined that CBT conflicted with their religious beliefs. Naeem, et al. (2009) made reference to the impact of religious beliefs, where being Hindus, the belief that is that humans do not have control over their own destiny. The participants also held strong collectivist beliefs which although CBT challenged, it did not change the students belief in abiding by the rules and the values of their family and community (Naeem et al., 2009; Scorzelli & Reinke-Scorzelli, 1994). Laungani (2004a) outlined four interrelated core values or factors that discriminate western culture from Asian culture: (a) Individualism and Communalism (collectivism), (b) Cognitivism and Emotionalism, (c) Freewill and Determinism and (d) Materialism and Spiritualism. Rathod, Kingdon, Pinninti, Turkington and Phiri (2015) and Naeem (2012) supported Laungani (2004a) as they found Asian people to be more community orientated. The basis of the CBT approach is on rational reasoning, however Asian people are more likely to believe in a spiritual explanation and ideas of determinism and may also take an emotional approach towards problem-solving and relationship centred (Pande, 1968). The basis of this research in exploring the methods of working with BME groups acknowledges that differential values might exist in expressions of spirituality, collectivist views, cognitive and emotions as suggested by Laungani (2004a) and that standardised treatments do not require a change or adaptation but simply a curiosity in providing understanding and insight into problematic functioning. As previously mentioned one of the earlier questions this research hopes to consider included an exploration of the experiences of therapists and their own views of CBT with Black client groups. The basis of this will be further explored in the next section.

1.4.1 Therapists' experience of delivering standardised CBT

The development of manual-based psychological treatments for a wide range of clinical disorders has significantly impacted clinical treatment and practice. Theory-driven, manual-based treatments have become a particular feature of evidenced-based treatments for specific clinical disorders. Advantages of manual-based treatments include less reliance on intuitive clinical judgement and more on well-documented efficacy, to aid in training and supervising therapists in specific clinical strategies and techniques and the development of self-help materials derived from manual-based protocols (Wilson, 1998; Fairburn et al, 1997). Despite these contributions, manual-based treatments have not been without criticism (Addis, Wade, & Hatgis, 1999; Garfield, 1996).

Addis, Wade and Hatgis (1999) outlined some concerns that therapists had expressed about manual based psychotherapies. These concerns include the impact on the therapeutic relationship itself being negatively affected, that manual treatment ignores individual client differences and emotions, and not meeting the needs of complex clients and restriction of clinical innovation and creativity. In contrast Najavits et al.'s (2000) study, found that 75% of the 47 CBT therapists surveyed, viewed manuals highly positively and were viewed regularly as part of the intrinsic motivation to improve skills. Further to this, therapists also did not believe that manuals were too simplistic nor impeded their development. The study found that therapists described their ideal manual as being a problem-solving resource which suggested what to do during sessions, descriptions of specific techniques, highlighting potential problems and use of worksheets. However, the study is limited in that it did not look at the relationship between therapists' views of manuals and their actual performance such as process or outcome data. Addis and Krasnow (2000) address this limitation in a national survey of 891 psychologists' attitudes toward psychotherapy treatment manuals. Psychologists ranged from varying theoretical orientations with a range of attitudes about treatment manuals from ranging from negative to positive. Survey results showed psychologists viewing treatment manuals as having a dehumanising effect on the therapeutic process, supporting Addis et al.'s (1999) assertions. Psychologists also thought that manuals emphasised technique at the expense of flexibility and the therapeutic relationship. Psychologists shared having different preconceptions of treatment manuals and that their attitudes towards manuals

could be formed through discussion with colleagues and reading literature rather than actually having any direct experience of using treatment manuals.

In support of treatment manuals, Godley's et al. (2001) research describing therapists' reactions to the use of manual-guided therapies for the treatment of adolescent marijuana users, showed that therapists felt that manuals provided structure and consistency to their therapeutic work and that manuals were easy to use and to prepare for a session aiding guidance and focus. The second most common theme was the restrictiveness of working with manual-based therapies. Therapists, however, did incorporate their own personal style and creativity to make the intervention more client-centred as they found increasing flexibility within an intervention. Themes related to deviation from the manual included serious clinical issues, logistical reasons, uncooperativeness and lack of motivation from the client, inappropriateness of the material because it was too complex and incorporation of a family meeting as the manual did not provide guidance on family involvement. This study helped shed light on both positive and negative aspects of manual-guided therapy from the therapists' direct experience of manual use.

An investigation by Waller (2009) explored the implementation of CBT protocol, manuals and treatments of CBT Therapists. His view was that in practice, CBT therapists do not fully apply all treatments and protocols within the standardised CBT approach and that there is a certain drifting away from standardised practice. Waller postulates that this centres on the therapists' own thoughts, feelings and behaviours in the form of cognitive distortions, emotional reactions and avoidance and use of safety behaviours. He addressed therapists' own emotions about their own performance concerning anxieties and a fear of negative evaluation about performance evaluation which could lead to not fully implementing standardised CBT. He also highlighted that CBT therapists fail to implement behaviour change interventions fully such as exposure and behavioural experiments (Bennett-Levy, 2003). Becker, Zayfert and Anderson (2004) provided evidence of exposure therapy for PTSD being underutilised. A survey of 852 therapists was conducted on the attitudes towards and utilisation of exposure therapy for clients diagnosed with Post Traumatic Stress Disorder (PTSD). The survey found that a large majority of therapists working from a CBT model stated that they did not use exposure

therapy with PTSD clients. Around half of the therapists reported some familiarity with exposure work for PTSD, yet only a small proportion actually used exposure therapy to treat PTSD. Waller (2009) put forward the view that this can be related to therapists protecting the client and/or avoiding any emotional distress which may be caused with using exposure therapy with trauma clients.

Another view perhaps not considered could be that clients themselves could benefit adequately from stabilisation and this preferential use of grounding work over exposure techniques, does not necessarily degrade standardised treatment depending on clinical judgement and where the client is. A further issue Waller (2009) highlighted with clinical practice of CBT Therapists was a lack of maintaining a structured CBT approach with a type of neglect of the physical needs of the client, focusing mostly on the cognitions, emotions and behaviours. It would seem that a significant critique therefore is in the approach taken, reference made once again of the therapist tending to drift in and out of standardised protocol where not enough time is spent on the utilisation and application of CBT techniques. Waller (2009) takes the view outlining that CBT Therapists are more willing to utilise and integrate third wave therapies such as Acceptance and Commitment Therapy (ACT), Dialectical Behavioural Therapy, schema therapy and mindfulness rather than focus on fully implementing CBT protocol. Rather than viewing this as an enriching of CBT for the purpose of developing idiosyncratic experience through other treatment models, there is a suggested of a type of 'bastardising' of CBT taking place, thereby diluting its potential effects or benefit (Waller, 2009; Waller, Stringer & Meyer, (2012). Overall, Waller's (2009) study puts forward a view that a key problem in the effectiveness of CBT manuals is that it might not be properly implemented even by experienced CBT therapists which calls into question therapist competency; a suggestion further supported by Brosan et al. (2007) suggesting the efficacy of CBT is dependent on therapist factors and the competence of the therapist and how they are able to portray the model effectively.

Beck (1996) and Teasdale (1996) recognised that the beliefs of therapists about their role and their preconceptions about what should work in therapy can influence their practice of CBT. Further examples show therapists choosing a flexible approach with CBT. Thompson-Brenner and Westen

(2005) found that CBT therapists displayed therapist drift in cases where clients presented with complex difficulties, adopting a psychodynamic approach alongside their CBT work.

In a study looking at CBT therapists, Waller et al. (2012) conducted research with 80 CBT therapists using CBT with eating disorder clients. Frequency of the use of CBT techniques were reviewed. During the study Waller had found that therapists were using specific CBT techniques less than protocols actually stated, especially by those therapists who were most experienced working with eating disorders and anxiety disorders. Waller found that approximately 50 per cent of therapists did not use a single core CBT technique routinely and the majority (56.6 per cent) reported relying on motivational interviewing as opposed to Socratic questioning. This study has shown that although CBT therapists might be referred to as such, the CBT label does not necessarily suggest that they are in fact practicing CBT. This notion supports previous findings by Tobin, Banker, Weisberg and Bowers (2007) where only 6 per cent of 256 clinicians reported that they worked closely to CBT treatment manuals and a further 98 per cent of the therapists indicated that they used both behavioural and dynamically informed interventions working with eating disorders. Even though this research is limited to eating disorders, it demonstrated that few CBT trained therapists work closely to CBT treatment manuals and that most therapists practice in a way that Waller (2009) outlined, drifting from the CBT intervention from the cognitive behavioural model which actually informs their use.

1.4.2 Cultural Considerations for CBT

The IAPT programme recognises the need for the cultural competence of its workforce as it utilises the Ten Essential Shared Capabilities Framework (Hope, 2004) and has developed Positive Practice Guidelines for BME clients (DH, 2009) for the purpose of working with language, cultural and religious requirements and to ensure that clients can suitably access services with continued engagement. There is currently a lack of empirically-based studies involving people from BME communities and inadequate evidence that empirically-supported therapies are effective with BME communities (Dryden & Branch, 2012). Studies predominantly show that RCTs based on CBT efficacy have mostly been conducted in non-minority populations (Miranda et al., 2005), which perhaps suggests that variables such as race, ethnicity and class have not been controlled or evaluated (Smith, 2008).

The NICE guidelines recognise that BME communities have specific needs but do not offer advice or guidance on how to appropriately consult with those needs. In his writings, Beck (2011) shared guidance for therapists to only utilise CBT treatment methods with the type of clients that research studies have demonstrated as showing effectiveness. Another area of contention with the IAPT programme highlighted by Summerfield and Veale (2008) is the suggestion that psychological therapies are a reflection of the cultural ideal for the self, grounded in the industrialised Western version of a person as previously mentioned. This is supported by Scorzelli and Reinke-Scorzelli (1994) (as cited in Naeem, 2012, p. 47) who outlined that most current theories of therapy were developed in America or Europe and therefore it is expected that these theories are likely to conflict with the cultural values and beliefs of minority individuals and their suitability to BME people is limited. Schneider et al. (2001) states that formal assessments and psychotherapeutic activities are likely to be influenced by the social and historical contexts by which they have been developed, as such early pioneers of psychotherapy have been "those from European and Euro-American backgrounds" and individuals from such cultures (Schneider et al. 2001 pp.39).

Hays (1995) reviewed the multicultural applications of CBT and found that despite its popularity and use, practice oriented research on CBT historically focused mostly exclusively on people of European American ethnicities and identities (Hays, 1995; Iwamasa & Smith, 1996; Suinn, 2003). For instance, in an earlier study Casas (1988) reviewed psychological abstracts of the preceding 20 years and found only three studies of cognitive behavioural therapy treatment of anxiety disorders in those from BME groups, two of which had samples of only two people each. In a 1996 U.S. survey of the three leading behavioural journals, only 1.31 per cent of studies were found to focus on BME groups. An overview of CBT studies now cover a substantial range of disorders, however none directly serve to integrate cultural considerations throughout the studies (see Beck, 1995, 2005; Dobson, 2001; Ledley, Marx & Heimberg, 2005; Greenberger & Padesky, 1995; Salkovskis, 1996).

The U.K. Office of National Statistics (2016) estimates that by 2050 the BME population could increase to make up approximately 30 per cent of the UK population. With this burgeoning growth, comes a growing body of psychological research which demonstrates how cross-cultural competence

and a deeper understanding of cultural differences can facilitate therapy and improve the assessment process (Dana, 2000; Pope-Davis & Coleman, 1997; D.W. Sue, 2001). Over the last few years, the American Psychological Association (APA) and the American Counselling Association have published guidelines which draws attention to the importance of cross-cultural competence for clinicians, therapists and researchers (APA, 2000a, 2000b, 2002, 2004; Roysircar, Arrendondo, Fueres, Pnterotto, & Toprek, 2003).

Several implications of the lack of cross-cultural referencing across CBT outline a number of factors impeding therapy progress with some BME groups. In reference to Scorzelli and Reinke-Scorzelli (1994) (as cited in Naeem, 2012, p. 116) earlier study on the religious beliefs, cultural and family values of graduate Indian psychology students receiving CBT, certain cultural values and norms it seems can hinder or perhaps challenge CBT application and the cognitive and behavioural change process (Iwamasa, Hsia & Hinton, 2006). These include the concept of self and identity as it can be collectivist in some cultural groups, such as Asian and African groups which place greater value on the family group than the individual. These supports in African American culture drawn from the extended family is an important source of strength and support originating in African cultures that can include blood kin, 'fictive kin' who are blood-unrelated, which can include members of the church family or neighbourhood (Boyd-Franklin, 2003). Spiritual beliefs and religious institutions are additional sources of strength and support in the black community as compared with other ethnic groups (Taylor, Mattis & Chatters, 1999). For many individuals in the black community, religion and meaning-enhancing attributions regarding God are significantly associated with individual and family wellbeing (Blaine & Crocker, 1995; Ellison, 1997). Religion and spirituality have an impact on understanding, help-seeking and expression of mental health (Cinnirella, Loewenthal & Miriam, 1999; Loewenthal, 1995; Mayers, Leavey, Vallianatou & Barker, 2007). Within some Asian and African cultures exists a belief that not following a religion can lead to mental health issues (Iwamasa et al., 2006; Kelly, 2006) and some South African cultures believe that evil spirits or curses are the cause of mental illnesses or the result of particular spiritual practices (Uys & Middleton, 2010). Taylor, Mattis and Chatters (1999) found that African Americans were more likely to turn to religious and spiritual support compared to other ethnic

groups. -Traditional spiritual healers or herbalists including natural medicines are also popular within some Black cultures for help with mental illness with less emphasis placed on seeking medical or psychological intervention due to the stigma that might be attached within those communities (Kelly, 2006). Mental illness and subsequent service engagement is therefore viewed as bringing shame on the individual and suspicion by others, so openly expressing emotions are discouraged. This then relates to the underutilisation of mental health services by overall BME individuals as belief in traditional methods of support is preferred and therapy is viewed as a ritual rather than a process to help achieve real change (Naeem, 2012; Saeed & Mubbashar, 2000; Shaikh & Hatcher, 2005). Therefore, it is vital to consider the client's expectation from psychological therapy and their understanding.

In reference to African Americans, Taylor et al. (1997) suggests that overall, surveys show that proximity, subjective closeness, and frequency kinship interaction contribute to the physical and emotional health of African Americans. Beyond African Americans, all Black immigrants (West Indians and Africans) share an African cultural legacy, Black Immigrants also have unique cultures related to their country and its history of colonisation. For instance, many Black Caribbean's are influenced by British culture or Black South American's are influenced by Spanish cultures (Black, 1996). These differences in terms of acculturation mean that often different degrees of acculturation have been linked with both mental illness and attitudes towards mental health and psychological therapies (Chang, 2007). Acculturation is defined by Klonoff and Landrine (2000) as the extent to which adoption of dominant culture versus one's indigenous culture takes place. It can be suggested that acculturation into a western culture may change traditional opinions from a BME background. Hardy (2004) highlighted that common cultural tendencies among African Americans may present challenges to traditional or indeed embracing of psychotherapy depending upon acculturation. Jenkins (2001) outlines that consideration needs to be given to people of colour who as recent immigrants and who are therefore less acculturated to mainstream western societies, require attention to the type of therapy intervention and technique given (Landrine, 1992). The belief therefore is that modalities that are more consistent with features of the individual's cultural background, such as family and network therapies, might be more appropriate and that such therapies do not emphasise the individual's autonomy and

separateness in the handling the issues of life which may be in conflict with traditionally held collectivist views. Schneider et al. (2001) states that this might seem to reflect the more person-centred and humanistic orientations.

Emotional openness can be defined as 'a degree to which a person is comfortable talking to others about personally distressing information' (Kahn & Hessling, 2001). In a comparative study viewing emotional openness and attitudes of seeking counselling of Caribbean College students residing in the U.S and the Caribbean, Greenidge and Daire (2010) investigated the differences between responses to therapy between both groups. The results indicated that there was no significant difference in the level of emotional openness between students who lived in the U.S. and those who lived in the Caribbean. Interestingly however, although there was no statistical difference between both groups with emotional openness to therapy, students residing in the U.S. showed higher mean scores for emotional openness than those in the Caribbean. This difference can perhaps be accounted for. Ali and Toner (2001) examined symptoms of depression between local Caribbean women and Caribbean women living in Canada. Results showed that greater self-reliance over reliance on social networks developed for those who had migrated, with those who had migrated also reporting higher depressive symptoms than women who still resided in the Caribbean. This provides a different conclusive account of the research of that of the college students, where migrated students were more emotionally open to engage with therapy services, migrated depressed women in Canada had a greater level of self-dependence, mistrust of counselling professionals, shame, embarrassment and a fear of being perceived negatively (Marwaha & Livingston, 2002). It could mean that underlying beliefs by local Caribbean individuals exist about what it means to engage with therapy services. This could also mean that therapists face particular challenges of therapy engagement and receptivity when applying the core principles of CBT due to particularly underlying beliefs.

Of the few studies that have examined mental health issues of an indigenous Caribbean population, there is no research addressing the role of emotional openness, experiences and attitudes towards therapists and those that therapists may have in providing therapy to clients from a Caribbean

ethnic background. Within Caribbean communities, there is a strong stigma attached to mental health services and those who would seek to engage with these services are often viewed negatively, lacking the ability to adequately care for themselves (Edge & Rogers, 2005; Marwaha & Livingstone, 2002; Peluso & Blay, 2004). Where support is needed it is generally more common for this to be derived through the church, specifically local Ministers as there is less stigma attached to religion.

Boyd-Franklin (1998) writes that in valuing direct experiences in deciding whom to trust, a therapist's academic achievements and suggestions might be ignored by African Americans until they are sure of the "vibes" they get from the therapist. Similarly Palmer et al. (2012) suggests that the effectiveness of the counselling with individuals from a Jamaican heritage is dependent on overcoming negative attitudes towards talking therapies and economic barriers. Using two case studies Walker (2012) analysed the treatment of eating disorders in Jamaican adolescents and found that both CBT and family therapy taken together served to provide positive outcomes in changing thoughts, beliefs and behaviours noting that in both cases having a conscious awareness of one's thoughts was vital in order for change to occur. Walker advised and further concluded however that, when working with Jamaican families, one should be prepared for family resistance and that therapy should subsequently be tailored towards to the patient in dealing with stigma that may be attached to help-seeking behaviours, creating possible difficulties for treatment efficacy and that there are idiosyncratic considerations to consider to ensure that CBT is tailored to patients, although no information was provided specifically around what this tailoring would look like. The study showed improvements when patients were treated with CBT and with family therapy. Whether this treatment 'tailoring' was a method of cultural adaptation as various researchers have suggested, or was simply the therapy style of the therapist is unclear.

Atkinson and Gim (1989) carried out a study of 557 Asian-American students involving acculturation and attitudes towards seeking psychological support. The students whose acculturation strategy was host-oriented were most likely to recognise the need for psychological support and were willing to talk to a psychologist as they were most tolerant of mental health stigma (Chang, 2007). Zhang and Dixon (2003) found a positive relationship between Asian international students' levels of acculturation and their attitudes towards seeking professional psychological help. Asian international

students whose acculturation strategy was host oriented to the American culture were more positive to seeking psychological help and had more confidence in their mental health practitioner as they felt less stigmatised. This supports Atkinson and Gim (1989) that Asian Americans underutilise mental health services as their cultural values conflict with psychological therapy. Acculturation is not only related to help seeking but also impacts the understanding of mental health problems such as their causes. Kung (2004) investigated the causal attributions of schizophrenia by Chinese Americans caregivers. Those participants that had acculturated to their host country identified biological causes of schizophrenia in comparison to those that were least acculturated to their host country who were more likely to believe in supernatural causes (Chang, 2007).

In terms of CBT this is an approach which promotes independence for the client to become their own therapist. This western concept of psychotherapy of taking responsibility for one's own life experiences can cause conflict with general BME clients coming from a traditionally collectivist culture. Therefore BME clients may view a therapist as an authority figure that is expected to have all the answers giving away any responsibility they might have in creating change (Laungani, 2004a).

Language also plays a significant role in the success of achieving an understanding of mental health. Psychological concepts can vary drastically between cultures, where some psychological concepts and phrases not existing in some cultures at all (Iwamasa et al., 2006). Research has also indicated that the term depression itself is not present in the languages of eastern cultures (Manson, 1995) as in localised areas it is construed differently (Bhugra & Mastrogianni, 2004). This is evidenced by Sulaiman, Bhugra and de Silva (2001) who found that people from eastern cultures such as from Arab countries and Dubai described depression with complaints of general ill-health using descriptions such as aches, pains and weakness (Bhugra & Mastrogianni, 2004; Naeem, 2012).

There are various cultural differences to consider with different ethnic community groups that would influence the process of counselling and psychotherapy. As discussed, the most important factors to consider are the influence of religion, family structure and roles, acculturation, language and cognitive styles (Iwamasa et al., 2006).

1.5 Cognitive Behaviour Therapy and cultural adaptation. A critical focus.

The rate of mental health difficulties varies between different ethnic groups which could be related to differences in cultural and socio-economic circumstances and accessibility to services (Mental Health Foundation, 2015). Statistical reviews have found that Black African and Caribbean individuals in the UK are twice as likely as White British individuals to be diagnosed with a mental health issue and as such are less likely to access treatment (Hill, 2003). More commonly suggested is that Black African and Caribbean individuals are also more likely to be diagnosed with severe mental health disorders such as schizophrenia and least likely with depression (Mental Health Foundation, 2015).

1.5.1. Adapting CBT: How other orientations are utilised

Cognitive Behaviour Therapy has over the years been extensively researched, the first outcome study published in 1977 (Rush, Beck, Kovacs, & Hollon, 1977), with more than 500 outcome studies currently validating the efficacy of cognitive behaviour therapy for a wide range or psychiatric disorders, psychological and psychosomatic problems (Butler, Chapman, Forman, & Beck, 2005; Chambless & Ollendick, 2001) and Cognitive Behaviour Therapy has also been adapted for patients with diverse levels of education as well as various cultures and ages.

1.5.2. A call for culturally sensitive CBT

To address issues concerning the applicability of CBT with BME individuals, many researchers have in recent years made attempts to adapt CBT in consideration of collectivist ideals and cultural norms of BME groups. This has mostly been achieved by incorporating what is deemed as relevant information as 'culturally sensitive' defined as family, beliefs, religion, social norms and values (Gielen, Draguns & Fish 2008; Matsumi, 2008). An initiative was put forward for developmental guidelines for potential adaptation.

The IAPT scheme developed the *BME Positive Practice Guide* (DH, 2009). This document outlined guidance and steps to understanding the needs of different cultures, working with barriers to access service and engaging with BME communities. However, the CBT competencies framework (Roth and Pilling, 2007) and the national curriculum for training IAPT CBT therapists (DH, 2008) do not specifically address cultural awareness.

1.5.3 Research on culturally adapting CBT

Bassey and Melluish (2012) sought to explore these aspects of cultural competence of IAPT therapists who were newly trained in delivering CBT. This study sought to understand whether their CBT practice was consistent with the current guidance as set out through the IAPT scheme and therefore how training contributes to their development. Participants made up focus groups where participants were interviewed across three different psychological services. The findings of Bassey and Melluish (2012) study support the position that newly qualified CBT therapists did not consider their IAPT CBT diploma to have sufficiently addressed the issue of culture and its influence on the practice of CBT. The study concludes that therapists are able to achieve cultural sensitivity without requiring comprehensive training as the competence guidance suggests. It would seem that although a range of perspectives and practices were consistent with cultural competence guidance, credence for cultural developmental progress was attributed to personal as well as professional experience, and to personal motivation to develop cultural competence. It can be viewed that broadening cultural awareness and sensitivity is achieved through a social constructivist experience to develop learning which can take place within the therapy room between therapist and client. The ability to draw on one's own personal and professional experiences and to be informed through the therapeutic relationship is sufficient for cultural competence and may be the primary factor in its development. With a consideration of building awareness of factors around cultural competence Sue (1990) outlined three main areas that therapists would need to address when working with BME clients: *culture-bound communication styles*, *socio-political facets of non-verbal communication* and *counselling* as a subset of communication style or temporary cultures. Hays (2001) also outlined considerations for cultural factors with an addressing framework to personalise therapy to the patient and to enable the therapist to think more reflectively in terms of their own culture, cultural views, biases and areas of inexperience. This framework summarises several areas deemed as most significant including: age and generational influences, religion and spirituality, ethnicity, socioeconomic state, indigenous heritage, sexual orientation, developmental and acquired disabilities and national origin and gender.

Recent studies including Hinton et al (2012), Bernal et al (1995), Kohn et al. (2002), Domenech Rodriguez et al. (2004) each sought to explore the adaptation of CBT with a focus on the treatment

preferences and efficacy of CBT and BME groups. Rathod et al. (2013) conducted a study to assess the effectiveness of culturally adapted CBT with Black African and Black Caribbean patients with psychosis**.** This study was a single blind multi-site randomised control trial (RCT) of two groups, *culturally adapted CBT* (caCBT) for ethnic minority participants compared to *treatment as usual* (TAU). The overall aim was to make culturally specific adaptations and to illicit from both patients and practitioners of their attitudes and responses to CBT and of how cultural influences might be impactful. This study found that when comparing results for groups of TAU and caCBT groups, participants in the caCBT group achieved statistically significant results with the Patient Experience Questionnaire (PEQ) and that culturally adapted CBT for psychosis in this trial was acceptable and effective. The results suggested that CBT was beneficial and there was a strong preference from patients to talk rather than become reliant on medication. Overall CBT was found to be an acceptable therapy for Black client groups. The findings served to highlight many interesting sociocultural/political areas of importance for the patient and awareness for the therapist including *role of religion, racism and its effects, opinions of treatment and CBT, shame and stigma, being arrested by the police and barriers in accessing therapy*. Although the study recognises that CBT can be acceptable if culturally adapted, based on its findings CBT is an acceptable approach for patients included from such communities involved in the study. Implications such as those sociocultural factors described, for practitioners, can provide some important areas to consider, however no specific emphasis on the adaptation methods themselves is significantly addressed. Although individualised therapy is encouraged for clients in therapy, in practice therapists would then require an understanding of client-related factors pertinent to culture which may impact therapy outcome. Rathod et al. (2013) concluding that the findings of this study have practical implications for therapists and health practitioners using CBT with people with psychosis from African-Caribbean and Black African communities in the U.K.

Naeem et al. (2009, 2015) similarly conducted randomised controlled trials on the effectiveness of culturally adapted CBT and implementing this. In Naeem, Ayub, Gobi, and Kingdon's (2009) initial study, this addressed research in the Pakistan community in Pakistan to assess whether CBT for depression is compatible with locally held beliefs and values and whether it can be an acceptable, accessible and effective treatment for depression in a low income country. This study was primarily to

develop guidelines for adapting the Southampton adaptation framework (Naeem et al., 2009) using four steps for adaptation, beginning with information gathering, preliminary adaptation design, preliminary adaptation tests and adaptation refinement (Sue, 1990; Bernal et al., 1995; Hwang, 2006; Tseng, 2004). Through this study Naeem (2009) identified several themes of culture, circumstances that would influence capacity for learning and beliefs, rules of engagement, expression of distress of distress and symptoms, family and communication, also proposing steps towards cultural adaption of the CBT model and factors requiring attention in frameworks within this community. The practice of traditional healing and beliefs about psychotherapy were found to have a profound effect on the process of help seeking behaviours. A limitation was in the consideration of factors relating to health and the health system; this is understandable when one considers that therapists, traditionally educated and working in western countries, are working in well-established health systems. In the context of practicing with CBT in Pakistan, issues relating to health and social support, and variations in beliefs and cognitions made the practice of CBT difficult without the considerations of adapting the model. The study proposed that therapists would need to be '*orienting clients to therapy*.' In relation to the teaching and understanding of CBT as an idiosyncratic model, does not fit with a need to orientate or shape clients to suit or fit the model and is contrary then to culturally adapt the model. In a more recent randomised controlled trial followed up by Naeem (2015) again in Pakistan, the research set about implementing the CBT adapted framework for psychosis (CaCBTp). The findings suggested that culturally adapted CBT for psychosis can be an effective treatment for patients diagnosed with schizophrenia.

An issue with RCTs assessing the effectiveness of culturally adapted CBT is uncertainty around the adaptation method. Although themes emerged highlighting specific areas of cultural importance, there was little to suggest which specific adapted CBT techniques were effective or necessary (Hinton et al., 2004; 2005; 2011; Saeed et al., 2015). Naeem et al. (2015) suggested that an important factor such as the involvement of a family member was necessary as families are traditionally heavily involved in a patient's care and that in Pakistan culture, understood that family involvement enhanced the acceptability of treatment (Habib et al. 2014). Rathod et al (2015) also highlighted that client and therapist match regarding language and ethnicity could also contribute to the outcome. Another factor

is that the therapists in Naeem et al. (2015) study were psychology graduates and not accredited CBT therapists unlike Rathod et al (2015) using only BABCP accredited therapists. It is unclear then issues relating to inexperience or a differentiation with therapy style between Pakistan and UK might account for some of the results. It is also important to note that much of the focus of these studies is on the clients' experience in therapy with little attention paid to the therapist. The studies are also predominantly conducted with South Asians rather than with an overview of CBT with other BME groups such as African and Caribbean individuals. Therefore, cultural themes raised from the studies in favour of culturally adapted CBT may not be generalisable to other cultures and experiences outside of Pakistan.

Comparatively, studies which have sought to understand practitioner perspectives include research conducted by Bennett-Levy et al. (2014) which found that CBT can be effective for Aboriginal Australians when using the perspective of practitioners trained in CBT. In this study thematic analysis was used to explore the experiences of therapists over the course of one year as they used CBT strategies for mild to moderate mental health problems. Questions raised from the study asked *(1) Whether CBT appears to be useful for Aboriginal Australians? (2) If so, what elements of CBT are perceived to be effective? And (3) what adaptations might be made to CBT to enhance its effectiveness with Aboriginal Australians?* Key elements of CBT were highlighted to be effective from the study, with therapists stating *that CBT was highly adaptable, is a pragmatic therapy, has a structured, safe and containing space and promotes self-agency* and valuable techniques (Bennett-Levy et al; 2014, p.4). Therapists concluded that CBT techniques worked well with Aboriginal clients, in particular pictorial formulations, psycho-education, Socratic questioning, agenda and goal setting, homework, skills training, identifying and testing negative thinking and behavioural experiments (p.5). Therapists noted that the visual aspect and use of diagrams were seen to be particularly helpful with Aboriginal clients which assisted with establishing a collaborative approach.

It was concluded that an important requirement for CBT with this client group however was for a consideration of adaptation and that this would need to acknowledge different social and cultural contexts. CBT has therefore been successful but as these broader studies show, this success has limits in terms of cultural sensitivities which serve as personal validations, self-empowerment and a person-

centred approach. In a review of the research on psychological therapies for Aboriginal Australians, Dudgeon and Kelly (2014) found that although CBT can be useful but is not culturally responsive, it can form part of an approach that would be culturally appropriate; that the tools and underlying principles of CBT that consider patterns of our thoughts, emotions, behaviours and physiological responses are only tools which form a much broader framework which could thus help to strengthen Aboriginal Australians well-being.

Naeem (2010) also addressed the experiences of psychologists using CBT in Pakistan forming part of a project in 'developing culturally sensitive CBT'. The study involved in-depth interviews with psychologists and their experiences of working in hospitals in Pakistan. Thematic analysis revealed a number of cultural adaptations incorporated in the CBT:

- Urdu equivalents to standardized CBT language
- Family members accompanying patients during sessions to help with homework when required
- Religious stories and themes from Prophet Muhammed and the Quran were used to clarify issues
- Culturally appropriate homework

One striking observation in style of therapy was of psychologists describing a less collaborative and more instructional approach in response to client need and expectation. Psychologists concluding that CBT was not adequate in its format, however they outlined only general therapeutic issues in working with South Asian patients which were not solely related to CBT. A further conclusion was of psychologists' attempts to tackle hurdles within therapy by doing whatever they felt was suitable (Naeem et al., 2010). It was unclear if some of the issues relating to this chosen stance was due to the lack of experience of the therapists with CBT as the therapists and psychologists included in the study were not qualified CBT therapists (Hinton et al., 2004; 2005; 2011; Naeem et al., 2010; Habib et al., 2014). One other consideration for psychologists choosing to do whatever they felt was suitable might perhaps be another example of therapist drift and moreover inadequate training or experience. Waller (2009) highlighted that a significant problem in effective CBT is due to inappropriate application of CBT even by experienced therapists; further supported by Brosan et al. (2007), questioning therefore whether CBT ineffectiveness is partly due to therapists' lack of confidence and/or experience in

implementing manualised CBT and losing sight of why specific steps for a disorder-specific protocol should be undertaken. With this in mind, McHugh (1994) describes two types of therapists; the 'Romantics' and the 'Empiricists'. The former serve to prioritise their intuition and clinical judgement perhaps over evidenced-based or manualised guidelines in clinical decision-making. Therapists who practice as Empiricists however prioritise scientific evidence in governing their clinical decisions.

In relation to African Caribbean and Black African patients, a study conducted by Rathod et al. (2010) considered both the views of patients and health professionals. One of the research directives was to identify strategies that CBT therapists and other mental health practitioners consider as supportive or non-supportive with patients. The findings suggested a number of outcomes from therapist views. Some themes raised around therapy barriers included: *racism/colonial history, spirituality and religion and individualism versus collectivism*. Therapists reported that they were not well prepared, that is, were not trained sufficiently to address racial issues that may come up in therapy and that touching on issues relating to race in the session was anxiety provoking for them. From the study therapists also acknowledged that when being confronted with religion or spirituality in therapy they felt overwhelmed and tending to avoid dealing with this directly. Some therapists felt incompetent and untrained in supporting clients with religious issues and that faiths such as Islam or Christianity were complex leading to difficulties in distinguishing between spiritual and psychotic beliefs. In relation to language and communication therapists also emphasised the need to be observant and not solely reliant on interpretation when working with interpreters. Findings and recommendations emerging from the study endorse previous research that an adaptation tool developed to aid therapists in cultural competence is compulsory. However African-Caribbean/Black African/Black British patients and South Asian patients showed some differences, with examples of Black patients reporting finding CBT very useful and helped with their issues. Asian patients showing a greater need for family inclusion and interpreters to assist with language barriers. It may be that patients from Asian groups require more assistance with therapy and an adaptation tool may apply more to one group than another.

1.5.4 Summary of the literature review

These studies have attempted to address the need for culturally adapting CBT and the type of adaptations required overall for BME groups. The studies however fail to outline clearly the defining characteristics of an adaptation method itself although they do show the relative areas where sociocultural issues are particularly important.

Rathod et al.'s. (2010, 2015) studies developed CaCBTp based on the views of clients and CBT therapists but did not provide details about adaptation content and did not provide narratives on the experiences of receiving or delivering CBT. Naeem et al. (2009) developed a framework for adapting CBT in non-western cultures. The Southampton adaptation framework does not provide information on the process of adaption but does highlight useful insight into the core themes raised as part of cultural importance and identification. One of the studies (Naeem et al., 2010) focussed on the experiences of psychologists delivering CBT with Pakistani clients. However, it did not identify the specific issues with CBT or the adaptations that are required to the CBT model. The psychologists surmised that CBT in its current format was not suitable, however they only outlined general therapeutic issues in working with South Asian clients which were not solely related to CBT, the focus overall across the studies revealed factors perhaps only relevant and indeed relative to the Asian culture and community. Much of the cases presented are also in reference to severe symptoms of mental illness with little explored in terms of mild to moderate symptomology. Bennett-Levy et al. (2014) suggests that the overall principles of CBT are underlying and can then form the basis for problem analysis. The CBT model is simply a concept, providing a structure to enable the therapist to build a picture, a view supported by Bassey & Melluish (2012) that this understanding is something that can be acquired through experiential learning and does not require literal training. Bennett-Levy et al. (2014) conducted a study to explore Aboriginal therapists' perspectives on the suitability of CBT for individuals within the Aboriginal community where high intensity and low intensity programs were utilised. The principal research questions included: '*do CBT trained Aboriginal counsellors perceive CBT to be useful with their Aboriginal Australian clients? If so, what are the elements of CBT that appear to be effective? What adaptations might make CBT effective, or more effective with Aboriginal Australians?'* Formal

manualised CBT was used including agenda-setting, Socratic questioning, thought records, goal setting and behavioural experiments over a 12-month period. Findings from the study suggested that therapists overall felt that CBT had a significantly positive impact specifically in areas of clients' well-being, increasing therapist knowledge and confidence in therapy delivery and therapists' well-being through self-practicing CBT skills. CBT was therefore found to be highly adaptable through both high intensity, one to one settings and low intensity forms for shorter self-administering mental health care, through computerised-based programs and mobile apps. CBT was also concluded to be highly pragmatic using goal-setting-type methods to work with complex problems to achieve practical problem-solving and change. An interesting excerpt and narrative from this study from one of the therapists' sharing their experiences of Aboriginal clients stated '*I don't have people coming in and saying "I really want to talk about the pain, or the trauma and everything….people want to get on with things."*

The containing, safe, structured and focused approach of CBT was deemed highly appropriate for people who appeared to be seeking practical change and progress. Bennett-Levy et al. (2012) concluded that this study was significant in that it encourages a move towards evidenced-based practice within Aboriginal mental health. It was noted that there is difficulty in engaging indigenous clients within therapy consistently and for multiple sessions. So attendance may be a problem and therefore the effectiveness of therapy continuity and success could be compromised. There is however something to be learned from Bennett-Levy's study overall which focused on very indigenous and culturally-'rich' communities where CBT was found to be significantly impactful.

The Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S Department of Health and Human Services are now requiring that organisations document the use of evidenced based programs to monitor experiences of mental health practitioners in identifying issues that may arise during practice in clinical practice (Nelson & Steele, 2007). On this side of the Atlantic the National Institute of Clinical Excellence (NICE, 2009) also raised the issue of the consideration of culture with black and minority ethnic patients with Schizophrenia living in the U.K. As the studies by Rathod (2009, 2010, 2015) and Naeem (2009, 2015) show there can be benefits of adapting an already established and standardised method of therapy but there are equally strong arguments against

considerations for adaptation for specific ethnic groups. The issue of generalisability arises in areas opposed to the notion of adaptation, which propose that human behaviour as a construct has similarities across all groups, that as we all experience joy, anger, pain, distress and so on, epidemiological and personality data reveal few ethnic differences in psychopathology (Sue, 2009).

1.6 Research contribution and rationale

1.6.1 Contribution to Counselling Psychology

The present study focuses on a specific ethnic group rather than the more general BME referencing to minority groups within the UK. As the research area is still relatively new within the UK this can provide meaningful insight into therapists' experiences and practice with a specific group, observing the outcomes of that practice thus informing future research and practice development.

The study's contribution to Counselling Psychology can serve to build understanding from personal accounts of therapists who have worked with specific ethnicities using CBT. By understanding the interactive process of therapy through experiences of Counselling and Clinical Psychologists and CBT Therapists working with CBT with Black African/Caribbean and Black British clients will outline significant processes that take place involving CBT adaptations, the utilising of different frameworks or 'therapy drift', working with sociocultural factors in therapy and creativity. The study will serve to explore the subjective experiences of therapists with regards to their CBT training, sense of preparedness, personalisation to therapy and therapy style. A grounded theory methodology will serve to generate theory through shared experiences from the research interviews.

1.6.2 Rationale for the Research

Past research has commonly taken up a position to explore therapy experiences from the client perspective. With regards to CBT there have been a limited number of studies (Naeem et al., 2010, 2015; Rathod et al., 2010; Bennett-Levy, 2014) that have made attempts to explore the views and experiences of therapists delivering CBT to BME clients. Added to this is that also work has mostly been done with Pakistani clients. The outcome of these studies have acknowledged that during therapy,

adaptations to CBT were often required for certain BME groups. However, across each of these studies, they have failed to clearly define the specific aspects of adaptations made to the CBT model.

Most of the studies that developed culturally sensitive CBT frameworks were not carried out in the UK, with the exception of Rathod et al. (2010) which specifically focussed on psychosis with BME clients. These studies have also focussed on specific ethnic groups and have not involved qualified CBT therapists. RCTs which have assessed the effectiveness of culturally adapted CBT did not address which specific CBT adaptations were the most effective and also did not attempt to judge the necessity of each individual adaptation (Hinton et al., 2004; 2005; 2011; Hwang et al., 2015; Kohn et al., 2002; Naeem, Gul et al., 2015; Naeem, Saeed et al., 2015).

The present study will attempt to address some of these gaps in the existing literature by being one of the first to carry out research on the experiences of Counselling and Clinical Psychologists and CBT therapists delivering manualised CBT specifically with Black African, Black Caribbean and Black British clients within the UK's psychological services. The present study will also attempt to illicit from therapists, through interviews of their experiences in order to understand what processes of CBT adaptation might look like within clinical practice, and to explore any challenges and strategies of practice that may arise.

CHAPTER 2. METHODOLOGY

This chapter begins with an explanation of the research focus, posing the research question and explicating the constructivist paradigm used in the conduct of this study. Constructivism as the learning theory informing the research and its integral links with grounded theory as the acquisition of knowledge is also described. Epistemological and ontological positions in relation to the study's theory on learning our state of being are also explored. A discussion of the various grounded theory perspectives is presented with consideration given to the choice of the grounded theory method used in this study. Reflexivity in terms of researcher subjectivity, objectivity and sensitivity is also discussed.

2.1 Research Question

The study was designed to explore the experiences of therapists including Cognitive Behaviour Therapists, Clinical and Counselling Psychologists who use Cognitive Behaviour Therapy (CBT) with Black African, Black Caribbean and Black British client groups using a grounded theory approach. The research question on which this study is based is: How do therapists work with Black clients using CBT?

An important aspect of grounded theory is the relevance of reflexivity and I understood that importance of reflecting on the assumptions and beliefs that I may bring to this study prior to the process of data collection and the impact this may further have on the analysis process.

2.2 Development and aim of the research

I wished to understand the process of *how* CBT is used in a therapy setting, with a consideration of possible adaptations dependent on client need and presentation, to analyse the experiences of the therapists working with these client groups, and to explore any personal challenges, barriers and/or recommendations that may arise during therapy. My growing interest of culture and psychology development following a voluntary placement in 2002 at a mental health hospital in Jamaica, which promoted pharmacological treatments above psychotherapies and where during this placement I heard accounts from both inpatients and visiting family members of their beliefs of 'madness' and evil spirits

resulting in the loss of sanity. The mistrust, I came to understand was handed down from early postcolonial mental health practices and drug treatments.

Since my CBT training in 2011 I have had various experiences of working within the NHS with clients who have openly expressed their discomfort at being in therapy and that CBT did not meet their expectations of therapy as they wanted to talk but not directly create change. I wished to develop my understanding but moreover to understand from the perspective of the therapist as my belief was that these differences exist and it was important therefore to provide therapists with a voice.

The aim of this research was to address the interactive process of therapy through the experiences of CBT Therapists, Counselling and Clinical Psychologists using Cognitive Behaviour Therapy (CBT) as a model of treatment with Black African, Black Caribbean and Black British client groups. The study served to explore the subjective experiences of therapists with regards to training, clinical approach and practice with CBT with Black clients. The study served to understand the use and process of CBT in a therapy setting, with a consideration of cultural adaptations and to analyse the experiences of the therapists including personal challenges, barriers and/or recommendations that may arise during therapy with Black African, Caribbean and Black British clients.

Using Constructivist Grounded Theory to generate theory through systematic research for the emergence of concepts analysed through interviews with Counselling/Clinical Psychologists and CBT Therapists acknowledged subjectivity and the researcher's involvement in the construction and interpretation of data (Charmaz, 2014). Epistemologically, constructivism emphasises the *subjective* interrelationship between both researcher and the participant and co-constructed meanings (Hayes & Oppenheim, 1997; Pidgeon & Henwood, 1997). My role as the researcher therefore formed part of the research endeavour rather than as an objective observer. One of the key lessons of this research was of the opinions of Counselling/Clinical psychologists and CBT Therapists and their approach to learning in their own way, constructing meaning that is unique to them, which is what this research was seeking to explore. Constructivism means that, as a researcher understanding the therapists, their learning, beliefs or behaviours requires an awareness of clients experience and culture in clinical practice, recognising that they don't potentially see the world differently to therapists, but experience it

differently. An important aspect of grounded theory methodology is the significance of process, describing 'the linking of sequences of action/interaction as they pertain to the management of, control over, or response to, a phenomenon' (Strauss & Corbin, 1990, p. 143). Grounded theory coding served to *address the process by asking: (1) What is happening/emerging? (2) What actions make up/form the process? (3) What specific outcome or emerging data/theory can be found? Achieving this through a recursive process fits well with shaping further enquiry.*

I believe Charmaz's Counstructivist Grounded Theory (2006) is an ideal methodological approach to explore social phenomena and that, within this study the client's beliefs and responses to CBT and the therapist's beliefs about client's beliefs and CBT form part of a socially constructed phenomena. To ensure a reliable research design, it was important to consider a research paradigm congruent with considerations of the nature of reality.

2.3 The Research Paradigm

A paradigm can be defined as a '*set of interrelated assumptions about the social world which provide a philosophical or conceptual framework for the study of that world'* (Filstead, 1979, p. 33). The constructivist (or interpretivist) paradigm is in marked contrast to the positivist assumption of a single objective and external reality, constructivism adheres to a relativist position that assumes multiple and equally valid realities (Schwandt, 1994). Lincoln and Guba (2000) indicate that the central purpose of a study in the constructivist paradigm incorporates a relativist ontology and subjective epistemology. This assumption holds that reality is constructed in the mind of the individual, rather than it being a singular entity (Hansen, 2004).

The constructivist position takes a hermeneutical approach, which maintains that meaning is hidden and must be brought to the surface through deep reflection (Schwandt, 2000; Sciarra, 1999). This reflection can be constantly stimulated by the interactive researcher-participant dialogue. Thus a distinguishing characteristic of constructivism is the centrality of the interaction between the investigator and the object of investigation. Only through this type of interaction can a deeper meaning be discovered. The researcher and the participants therefore jointly create (co-construct) meanings.

The research paradigm of constructivism-interpretivism therefore sets the context for this study. The strategy behind this research was therefore in line with such beliefs that we are influenced by our subjective history and cultural contexts, which subsequently shapes our view of the world and the meaning of truth. To consider drawing together a firm research foundation and base on which to construct the overall strategy, I considered a paradigm with hopes of developing a theory. The qualitative research paradigm takes a constructivist-interpretative standpoint on the basis that learning is acquired when individuals construct their understanding of the world through directly interacting with it (Bradley & Postlewaite, 2003). Learning can then occur when new experiences of the world are processed and constructed by the individual.

2.4 Grounded Theory

Grounded theory methodology was originally described by Barney Glaser, a quantitative researcher and Anslem Strauss, a qualitative researcher, in the mid-1960s. In their pioneering book, *The Discovery of Grounded Theory* (Glaser & Strauss 1967) these two sociologists articulated the strategies that they had adopted in a collaborative research project on dying (Glaser & Strauss 1965, 1968). First published as "a process that articulated the discovery of theory from qualitative data" (Robrecht 1995:170), the method arose out of the combined research histories of Glaser and Strauss (Dey 1999; Charmaz 2000a; Stern & Covan 2001; Clarke 2005). Grounded theory methodology stemmed from, and is fundamentally linked with, Symbolic Interactionism (Smith & Biley 1997; Charmaz 2000a; Milliken & Schreiber 2001; Ezzy 2002; Clarke 2005). The link between the theoretical ideas of Symbolic Interactionism and the methodology in conducting grounded theory research is represented by grounded theory methodology (Milliken & Schreiber 2001).

2.4.1 Schools of Grounded Theory

When designing a study it is important that consideration be given to relevant methodological issues (McCallin 2003). In consideration of this, extensive readings in the area of grounded theory methodology were undertaken. This extensive reading of grounded theory methodology provided an opportunity to identify and understand some of the differences between the schools. The review of grounded theory literature highlighted that the differences incorporated both methodological and

method issues with underlying ontological and epistemological assumptions and variations of the original authors of grounded theory.

Although grounded theory was originally described by Glaser and Strauss in the mid-1960s, a review of the literature identifies a divergence in the original authors' views and development of grounded theory since their original statements in 1967 (Glaser & Strauss 1967) and 1978 (Glaser 1978). Since this time the two authors have taken grounded theory in different directions (Charmaz 2000a), Glaser alone and Strauss with colleague Juliet Corbin.

This divergence of the 'original' grounded theory led to the creation of two 'schools' of grounded theory; the Glaserian version based on the original work and the subsequent writings of Glaser; and the Straussian version Strauss based on changes made to the original version with Corbin (Benoliel 1996; Heath & Cowley 2003; McCallin 2003; Charmaz 2006). McCallin (2003) suggests that the Glaserian version of grounded theory has further developed and been reframed.

The Glaserian version of grounded theory has its ontological roots in critical realism. Critical realism assumes that an objective world exists independently of our knowledge and belief and as such the researcher is considered to be independent of the research (Annells 1996). This stance is in contrast to the Straussian version of grounded theory which has its ontological roots in relativism where it is argued that reality is socially interpreted. In light of this, Strauss and Corbin's (1998) writings encourage the researcher to be involved throughout the method and process of research itself. The Constructivist version of grounded theory (Charmaz, 1990, 2000b, 2003; Charmaz & Mitchell, 2001), like the Straussian version, has its ontological roots in relativism. However, the Constructivist grounded theorist takes a reflexive stance on the basis of acknowledging studied life giving close attention to the empirical realities, an individuals collected renderings of them and locating themselves within these realities (Charmaz, 2005). Glaser remained consistent with his explanation of the grounded theory method for many years after his divergence with the ideas of Strauss in relation to the direction of the method. Glaser defined grounded theory as a method of discovery; the categories were emergent from

the data, the method relied on empiricism which was often direct and narrow and analysed a basic social process (Charmaz, 2006). Strauss and Corbin's version focuses on the use of their new technical procedures rather than placing the emphasis on the comparative methods of the earlier grounded theory approaches. Glaser's version is described as a more patient, relaxed approach that waits for the theory to emerge from the data. One of Glaser's criticisms of the Straussian version is that Strauss and Corbin's procedures force data and analysis into preconceived categories (Charmaz, 2006).

Constructivist grounded theory adopts traditional grounded theory guidelines however it does not subscribe to the positivist assumptions postulated in earlier formulations of the methodology (Charmaz, 1990, 2000b, 2003; Charmaz & Mitchell 2001). In accordance with the apparent paradigm, constructivist grounded theorists take a reflexive stance on the basis of knowing and representing studied life. Therefore, the constructivist approach to grounded theory assumes a flexible approach, and is in part a response to Glaser and Strauss's invitation in the original statement of grounded theory method for researchers to use strategies flexibly and in their own way. Charmaz (2005, 2006) provides the researcher with a way of 'doing' grounded theory whilst taking into account the theoretical and methodological developments of the last four decades.

2.4.2 Straussian versus constructivist grounded theory

The chosen methodology for this study is a qualitative approach using Constructivist Grounded Theory to generate theory through systematic research for the emergence of concepts analysed through interviews with CBT Therapists, Counselling and Clinical Psychologists. Constructivism denies the existence of objective reality and instead realities are seen as social constructions of the mind, with many such constructions as there are individuals (Guba & Lincoln, 1989). Historically the use of grounded theory holds significant benefit in that it opens up conceptualisations for the direction of research and allows for emerging ideas to be formed from the research interviews and subsequent data. Since the origination of the premise of grounded theory Glaser (1992) has stated that 'all is data' in that any information around the research inclusive of interviews, observational data, surveys, statistical information must be taken into account. Grounded theory then seeks to construct theory about issues that are important in people's lives (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Issues therefore arise that are of importance to participants, as in this case therapists, emerging through stories and experiences familiar to the researcher and one who is training in this area. For the consideration of this research, moving from early grounded theory which sought to discover patterns of behaviour in the data and conceptualise properties through abstraction (Glaser & Strauss, 1967), constructivist grounded theorists seek to understand difference and variation among research participants and to co-construct meaning with them (Charmaz, 2006). Epistemologically, constructivism emphasises the *subjective* interrelationship between both researcher and the participant and co-constructed meanings (Hayes & Oppenheim, 1997; Pidgeon & Henwood, 1997). My role as the researcher therefore forms part of the research endeavour rather than as an objective observer.

Comparatively objectivism in grounded theory (Glaser, 1992) emphasising logic, analytic procedures, comparative methods, and conceptual development with assumptions of an external yet discernible world, unbiased observer, and discovered theory did not fit with the research and the chosen participant group. Glaser, Strauss, and Corbin's versions of grounded theory include assumptions about objectivity, the world seen as an external reality; relations between participants and observers/researchers, the nature of data, and author's representations of research participants (Charmaz, 2000). In objectivism then, there is an assumption that data is awaiting collection in an external world or that methodological procedures will correct limited views of the studied world.

2.4.3 Constructivist Grounded Theory

Constructivist grounded theory emerged as an alternative to objectivist ideas. A constructivist approach means looking at more than simply how an individual views their situation. Constructivists consider the *how* and perhaps *why* individuals or participants construct meanings and actions in certain situations. It not only theorises the interpretative work that participants do, but also observes that a resulting theory is an interpretation (Bryant, 2002: Charmaz, 2000a, 2002a, 2008a, 2009b). This theory also depends on the researchers' view and cannot stand outside of it. This means that the researcher must be alert to conditions where differences and distinctions arise for a participant. Constructivist grounded theory can therefore extend the focus to the socio-cultural context of people's experiences; extending the focus of grounded theory to:

… *"interconnecting social worlds, arenas, matrices of structure, trajectories of action, resources, hierarchies of power and influence, social policies, hierarchies of suffering…of ordinary people and their lives" (Charmaz cited in Denzin, 2007, p.454).*

Constructivist grounded theory seeks to understand differences and variation among research participants and to co-construct meaning with them (Charmaz, 2006). For constructivist grounded theory Charmaz states that:

"…Constructing constructivism means seeking both respondents meanings and researcher meanings. To seek respondents' meanings we must go beyond surface meanings and presumed meanings. We must look for views and values as well as acts and facts. We need to look for beliefs and ideologies as well as situations and structures. By studying tacit meanings we clarify, rather than challenge respondents' views about reality." (Charmaz, 2000, p. 525)

An important consideration and strategy for this research was to take a standpoint that did not easily reach any sort of conclusion or resolution about the nature of truth and reality, influenced purely by external forces without internal, socio-cultural and subjective experiences. In consideration of this Charmaz acknowledges the risk in any inductive method such as the constructivist approach is an over-emphasis on the individual, emphasising the active reflective participant to the neglect of the larger social forces acting upon him or her and she is mindful that the researcher needs to learn how social forces affect the participant and what if anything they think, feel and do about them (Charmaz, 2000). For therapists, the risk of an overemphasis of their experience meant to explore varying experiences of working with specific ethnic groups and how such social forces may affect and inform clinical practice and what then CBT Therapists and Psychologists think, feel and do about such learned experiences of using specific therapeutic frameworks with specific ethnic groups. Constructivist grounded theory was the chosen methodology for this research as *"data does not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts"* (Charmaz, 2000 p.524).

2.4.4 Rationale for Grounded Theory

It is the constructivist view, based on relativism that makes sense for this research. One of the key lessons this teaches is that every learner, or in this case of Counselling, Clinical Psychologists and CBT therapists, is individual and will approach learning their own way, constructing meaning that is unique to them, which is essentially what this research seeks to explore. Constructivism means that, as a researcher understanding the therapist, their learning, beliefs or behaviours requires an awareness of clients' experience and culture in clinical practice, recognising that they don't potentially see the world differently to therapists, but experience it differently. For this study I felt that to explore experiences involved tracking CBT Therapists, Counselling and Clinical Psychologists subjective experiences of using CBT from assessment, throughout the course of therapy until completion and discharge of the client. An important aspect of grounded theory methodology is the significance of process, describing '*the linking of sequences of action/interaction as they pertain to the management of, control over, or response to, a phenomenon'* (Strauss & Corbin, 1990, p. 143). Grounded theory codes will address the process by asking: (1) What is happening/emerging? (2) What actions make up/forms the process? (3) What specific outcome or emerging data/theory can be found? Achieving this through a recursive process fits well with shaping further enquiry.

The constructivist view for which this research takes is on the basis that CBT Therapists, Counselling and Clinical Psychologists develop their understanding and knowledge of therapy through practice, reflection and that reality is acquired through these mediums including challenges faced when working with a variety of clients of varying ethnicities and backgrounds thus informing socio-cultural knowledge. This learning theory provides an ideal route to shape emerging themes from the interviews; thereby abstracting meaning from the data to develop an emerging theory which could provide enough variation across the data to assist with future considerations for clinical practice. As it stands, there are no presumptions around hypothesis and/or outcome when using a grounded theory approach and the epistemic experience of therapists accounts for their social/material environment.

To consider why this is an area worth examining I became interested in cross-cultural research and acknowledge that due to the increase of such research provides a scope for a greater understanding

of responses to different treatment modalities and how therapists themselves find working with clients from varying ethnicities. Following increased trends in immigration, many larger countries are now becoming much more cognizant of the health and social service needs of its increasingly culturally diverse population. Considering the perspectives of therapists and how they are able to understand the client in *their* world is as significant as that of the client and how they can, in turn be adequately understood by the therapist.

The relevance of constructivist grounded theory within the research context considers that:

• Constructivist grounded theory assumes that what CBT Therapists, Counselling and Clinical Psychologists see and hear depends on their prior interpretive frames, and modes of generating and recording empirical materials.

• It suggests that both data and analysis is constructed by the researcher and participants through an interactive process where they construct a shared reality (Charmaz, 2003; 2006).

• It studies how and why CBT Therapists, Counselling and Clinical Psychologists construct meanings and actions in specific situations and when working with specific ethnic groups.

• It is shaped by the researcher's perspectives, values, interactions and environment.

• It acknowledges that the resulting theory is an interpretation of varying subjective experiences of reality (Bryant, 2001; Charmaz, 2000).

• It assumes multiple realities and multiple perspectives on these realities.

• The approach is designed to focus on the "processes" and "change" (Charmaz, 2003).

It assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects' meanings" (Charmaz, 2003, p.250).

The initial direction for this research was to take an interpretative phenomenological analysis (IPA) approach, which carries many strengths in line with the research as is concerned with individuals' subjective rather than objective accounts and attempts to access this subjective experience by engaging with the participant's world (Smith, 2006). It was a challenge when considering an interpretative phenomenological approach, which was closely considered for its premise with exploring the processes

through which participants make sense of their own experiences, using personalised accounts of the processes they have been through and seeking to utilise an assumed existing universal inclination towards self-reflection (Chapman & Smith, 2002). The strengths of IPA for this research is the focus on understandings, perceptions and views of participants and therefore the subjective positioning (Reid, Flowers & Larkin, 2005). This forms self-reflection and refers to the way that IPA assumes that participants seek to interpret their experiences into some form that is understandable to them. In terms of data analysis IPA relies on an interpretative process, the interpretative role of the researcher in terms of data analysis forms a significant part of the process. Smith (2004) addresses the question of how one is to establish what a 'good enough' interpretation is. The interpretative role of the researcher in terms of data analysis was as much a consideration for the research as with the participants' constructivist and interpretative position. On this basis grounded theory was a preferable methodology over IPA with the researcher having a collaborative role in data interpretation without preconceptions. Willig (2012) states that a chosen study's theoretical orientation, its focus and overall procedural process is always interpretive in qualitative work. On this basis Willig (2012) emphasies the importance of the researchers role – their emotions, thoughts, preferences and opinions and to account for these during the research process and data analysis through personal memo writing. The interpretation in IPA and discourse analysis highlight differences in data interpretation. Frosh and Emerson (2005:310) state that: *there is still a variation among qualitative procedures between those that are relatively 'top down', dominated by theoretically-derived* categories *imposing an interpretative 'grid' on data in order to interrogate it according to the assumptions or perceptions derived from those categories, and those that are relatively 'bottom-up', eschewing theory as far as possible at least until the data has been examined performatively in terms of its own emergent properties.*

So as previously stated while all qualitative research is interpretive in its analysis, not all methodologies place interpretation as its primary data analysis. Grounded theory for instance, has an emphasis on theory building and is interpretative in terms of the researcher making sense of what participants are saying, but also considers what is going on in the social contexts of participants' learned experiences. The data is intentioned to be interpreted at face value and not to be viewed with a critical

or suspicious eye. Therefore emerging data is to be fully grounded within the participants account and experience, keeping as close to the narrative as possible.

Discourse analysis emphasising human language as a socially contextual performance (Charmaz & McMullen, 2000) was also a methodological approach considered for this study, which focuses on talk and texts as social practices (Potter & Wetherell, 1988), thus rejecting traditional cognitive explanations of psychology where actions are questioned as a consequence of mental processes, but rather how mentalist notions are constructed and used in interaction (Wetherell et al. 1997), a commonality shared with a constructionist view of the importance and emphasis placed on the role of language. When conceptualising the idea around the research and specifically exploring the participants' world, it was important to adopt a multi-dimensional approach. 'Knowledge is seen as constructed in the processes of social exchange' (Charmaz, 2006) which considers so much more than language. A basic tenant of discourse analysis is that individuals use language to construct their versions of the social world and that language is a constitutive part of this (Davis and Harre, 1997; Wetherell, 1998). From a constructivist perspective, discourse analysis has a rather limited perspective relating meaning-making to processes in text and rhetoric which are not social (Knorr-Cetina, 1995). To further discount the relevance of a discourse analytic paradigm for this research was the motivation to approach the research without preconceptions and therefore without an experimental hypothesis. For discourse analysis the focus around how specific actions are accomplished asks questions which requires an understanding of the detailed, contextually sensitive manner in which versions are constructed and as well as an appreciation of the conversational organisations in which such constructions are embedded.

The constructivist positioning of this research seeks to explore the subjective and internal experiences of CBT Therapists and Psychologists who have worked with Black Caribbean clients in clinical practice and how CBT may be used and or adapted. Since the premise of this study is to 'make meaning,' the constructivist approach is ideal as it requires the creation of a sense of reciprocity in the process of interaction between participant and the researcher when co-constructing meaning. The hope therefore to develop a theory that is grounded in the Counselling Psychologist's experiences in practice.

2.4.5 Epistemology

Epistemology, or the *study of knowledge*, is 'a way of understanding and explaining how I know what I know (Crotty, 1998). Epistemology inquiry therefore views the relationship between the 'knower' and the 'knowledge' and how meaningful sense is made of the world (Denzin & Lincoln (2005). When thinking about the epistemological positioning of this research, meant considering how we come to know social reality. The epistemology can be defined as the relationship between the researcher and the reality (Carson et. Al. 2001) or how this reality is captured or known. The epistemological standpoint then for this research assumes a constructivist perspective. Constructivism views all our knowledge as 'constructed' in that it is contingent on convention, human perception and social experience (Mastin, 2008). Our knowledge does not therefore necessarily reflect any external realities, as suggested by objectivism.

As previously stated epistemologically, constructivism emphasises the subjective interrelationship between both researcher and the participant, to understand difference and variation with co-constructed meanings (Charmaz, 2006; Hayes & Oppenheim, 1997; Pidgeon & Henwood, 1997). Grounded theory assumes no preconceptions about research development and outcome (Charmaz, 2000). Epistemologically however the constructivist view of how we develop meaning-making in clinical practice suggests that our knowledge is informed through human-connectedness. It is this viewpoint that drives the research in exploring therapists' experiences in clinical practice and how their knowledge has been shaped when working with Black Caribbean clients.

2.4.6 Ontology

Ontology is the *study of being* (Crotty, 1998) with the purpose of raising basic questions about the nature of reality and the nature of the human being in the world (Denzin & Lincoln, 2005). The apparent thread between all forms of constructivism is that they do not focus on an ontological reality but instead on constructed reality (Charmaz, 2006). When considering the ontological perspective of this research this meant considering how reality may be viewed. Within constructivist grounded theory the commonly held position is that *'reality cannot actually be known, but is always interpreted'* (Strauss & Corbin, 1990) in this case the mutual creation of knowledge by the researcher and the

research participant (Charmaz, 2000, 2006). Constructivist grounded theory therefore embraces the ontological stance of relativism that focuses on local and specific constructed realities (Lincoln & Guba, 2000). In terms of considering how participants view their subjective experience of social reality, reflects a relativist concept that 'points of view have no absolute truth or validity within themselves, but they only have relative, subjective value according to differences in perception and consideration (Baghramian, 2004).

This philosophical position corresponds well with the research and in context of Counselling/Clinical Psychologists and CBT Therapists as the target participant group, of varying ethnicities, education, experiences and understandings. The variation across the participant group engenders various interpretations as the means of construction of co-created realities and the assignment of meaning to social action and interaction (Annells, 1996). The research thus moves away from a classic grounded theory ontological position of objectivity (Glaser, 1992) which views experiences as external. As the researcher, the relativist ontological position will provide the opportunity to partake in the interpretation of realities constructed. When taking this into consideration my own place within the research, adopting a reflexive position is therefore fundamentally important.

2.5 Reflexivity

Constructivist grounded theorists take a reflexive stance towards the research process. My reflexive stance as the researcher was something that I considered throughout this process. By shifting attention to the researcher and their influential role, 'knowledge is situated, contingent, and intimately related to the epistemic subject and their social and material environment (Breuer & Roth, 2003). My reflexive mode and interaction with data and emerging data rather than taking a distanced stance kept me engaged, which Charmaz (2006) maintains that a lack of this positioning can lead to surfacing of the researcher's own implicit assumptions and interpretations to an extent that it may begin to hold a position of objectivity (Charmaz, 2006). In a constructivist grounded theory perspective and considering the idea that knowledge is seen as 'constructed in the processes of social exchange' (Charmaz, 2006) means the researcher's influence is unavoidable. The importance of adopting a

reflexive stance means that as the researcher and being of Black Caribbean ethnicity, I have reflected on:

- How I will impact interviews as a [Black Caribbean ethnicity] researcher?
- CBT therapists, Clinical/Counselling Psychologists' response to the researcher
- My own interpretations and assumptions that therapists experiences with Black client groups will be differential
- Therapists being interviewed will be able to describe and recall applied CBT applications and experiences.

Reflective Memo Excerpt

From the outset of this research, I found myself having to explain the research question to therapists who showed some initial interest into the study. Therapists who were from a BME background such as African, Caribbean, Pakistani or Indian as therapists could identify with the research rationale. I found however, that occasionally some therapists from non-BME backgrounds questioned the rationale of the research on why race and ethnicity should be a factor in CBT application. I wondered about these differences between BME therapists and non-BME therapists questioning perspectives towards the research.. This difference alone made it worth exploring. I have to admit that I believe that I had my own insecurities about interviewing non-BME therapists as not wishing to cause offense or to appear to personally question what they might, or might not be doing in therapy and therefore appear judgemental.

My intention was to maintain a transparent position throughout the course of the study. On a whole my professional role as a CBT Therapist and Counselling Psychologist trainee, and a black female, have influenced my world perspective and I appreciate therefore that through experiences I may have encountered over the years, could impact the research. Being mindful of this was of particular importance for the production of unbiased data interpretation and the research findings. At present I work in a primary care talking therapies service and understand the professional and ethnical

commitments that come with working in mental health. But I also identify with the wider Caribbean and African community that is often reluctant to engage with psychological therapy services due to holding deep suspicions and mistrust about mental health services and I have consequently often found myself in the past having to 'defend' the profession. I therefore feel that I have a personal connection to the research content and investigative curiosity to understand more about working with individuals in clinical settings and from such backgrounds.

Although I am curious as to the opinions of other therapists, I have my own views and experiences in direct relation to how I work with CBT and clients who are from certain BME backgrounds. I have had experiences where clients from some BME backgrounds have struggled with certain aspects of CBT, showing some degree of resistance to the relationship of interpretations, behaviours and outcome, homework, Socratic questioning and thought challenging, where I have adopted other therapeutic perspectives in place of CBT altogether within a step 3 CBT service. This decision to 'step away' from CBT has been met with disapproval in supervision where the expectation has been that CBT *should* indeed be used despite resistance. On the basis of my own experiences within this area made me aware of the possibility of forming my own judgements and assumptions about other therapist's experiences who work in a similar service. In order to consider how my own personal and professional experiences might affect the data collected I have used reflective spaces throughout and I have also stated my assumptions about the research in section 2.1.

This research initially began with the motivation to explore the experiences of therapist's who work in the Caribbean, but the decision was made to focus the research attention to the UK as studies of working with BME clients is still relatively under-researched here.

The importance of reflexivity could not be underestimated here. It might be assumed that some favour could be shown towards those therapists from BME backgrounds that appear to 'embrace' or connect with the research topic, perhaps for personal or professional reasons and as such my views towards them and/or their opinions during interviews could be interpreted differently perhaps to non-BME participants and may therefore be interpreted to 'connect less' to the research. The research rationale was fundamentally about exploring views on CBT and working with certain BME groups and

as such, interviews would therefore provide the opportunity to address any underlying views and opinions and to see what comes out during the interview process. Maintaining a reflexive stance then was important in drawing out the most accurate content for data analysis and interpretation. This is fundamentally why I am passionate about the research topic and I feel that it is important to explore further to build understanding around the topic of culture and psychology and of working with BME groups.

2.6 Data Collection

2.6.1 Participant recruitment criteria

This study was led by the research question in addressing the personal narratives of therapists who have been formally trained in CBT and therefore have experience applying standardised or manualised CBT, having worked with diverse ethnic ranges of clients, notably those from African and Caribbean backgrounds.

The following is a list of the inclusion and exclusion criteria for the research participant sample:

Inclusion Criteria:

- Provisional or full accredited CBT Therapists; Counselling and Clinical Psychologists
- Having been trained in or familiar with the use of manualised CBT
- Male or female participants
- Have worked with Black Caribbean/African and/or Black British clients
- Working or have worked in primary care NHS services or the private sector

Exclusion Criteria:

- Newly qualified therapists who may not have sufficient experience to explore phenomena

2.6.2 Research Design

The investigation used a qualitative methodology. Specifically, a constructivist grounded theory method (Charmaz, 2001) was used, based on semi-structured and open ended questions for interviewing therapists. This particular method utilises a set of structured procedures to generate constructs which are grounded in therapists' experiences. The study was designed and implemented by the primary researcher, a graduate and Counselling Psychology trainee.

2.6.3 Ethics

Ethical clearance was sought and obtained from the relevant Research Ethics Committee, City University and ethical approval form (see Appendix A). Access to potential participants for this study was sought through advertising, including an advert posted in various locations of therapy practice and through email. Participant care and safety as outlined in the debriefing form (Appendix E) were conducted in line with the BPS (2004). Following interviews the debriefing form provided included contact numbers of organisations that could provide support and information should participants need it. The issues of anonymity and confidentiality have been addressed in a variety of ways throughout the course of this study. Guidelines for the study were outlined in a 'participant information sheet' (Appendix C) providing principles of which the study should follow. These guidelines included:

(1) Participant consent (2) Confidentiality and anonymity (3) Freedom to withdraw from the interview (4) debriefing information, (5) contact numbers provided of support services.

It was felt that questions during the interviews may touch on sensitive issues around working with specific ethnicities, coping with distress, and to some degree performance evaluation. As the interview involved speaking with therapists rather openly about their own experiences for the purposes of adding to a knowledge base about working with BME clients using standardised modalities, it seemed beneficial for there to be a platform where discussion could be generated for therapists to express their opinions openly. This helped to lower any risks of harm to therapists who were able to express themselves and were also given freedom to withdraw from the interview at any time. Consideration was also given to the safety of the researcher, as interviews were conducted at the service building where each therapist worked and the practice manager made aware of the interview time and location.

Prior to interviews therapists were informed that confidentiality and anonymity would be upheld throughout the process and of the inclusion of transcribed excerpts of their anonymised responses within the thesis write up.

The recording of interviews were completed using a software recording program called Smart Record 4.0.6 and were anonymised using a pseudonym for therapists and saved to a USB stick that was locked in a filing cabinet. In accordance with BPS guidelines, all data will be destroyed after 5 years from the end of the study.

2.6.4 Recruitment

The initial stage of the recruitment process took place by word of mouth by informing colleagues who became aware of the study. Further advertising of the study was also achieved through emails sent to services including The Black, African and Asian Therapy Network (BAATN) and the African and African Caribbean Counselling Greenwich Mind. Recruitment posters (see Appendix B) were also placed in practice services where therapists worked. By use of these methods a total of 7 participants were recruited for the study. Each potential participant made contact of their interest in taking part in the study.

Reflective memo excerpt

Although interest seemed to be generated around the study, there appeared to be some reluctance from some therapists to take part. I found that mostly Black and Asian therapists showed the most interest. I wasn't sure if this was perhaps due to therapists having a sense of relating to the client population this study focuses on. I wondered also if some reluctance was perhaps due to what it might mean for therapists to have the focus on working with Black clients; the sensitivity of ethnicity-related issues can be very sensitive topics. Because I was aware of this developing recruitment challenge, I had to attempt to recruit non-BME therapists through word of mouth..

The recruitment process for this study was somewhat challenging. My hope was to have ethnic variation across the therapists included within the study to ensure variance across opinions and experiences.

2.6.5 Participants

The participants included within this study were a collection of seven therapists made up of Cognitive Behaviour Therapists, Counselling and Clinical Psychologists. The criteria at which to meet to partake in the study included: (a) using CBT frameworks in clinical practice (b) having previously worked with Black-African/Caribbean and Black British clients (c) currently working as a CBT therapist, Counselling or Clinical Psychologist (d) to feel able (emotionally and cognitively) to participate in an extended interview (e) having been trained in or familiar with the use of manualised CBT. Additionally, there was a great deal of variation in terms of gender and ethnicity. Table 1 includes a complete description of each of the participants using identification codes to describe them.

Table 1. Relevant Demographic Details of Participants

PARTICIPANT	AGE	YEARS IN PRACTICE	JOB ROLE & PRIMARY ORIENTATION	SERVICE	ETHNICITY	GENDER
STEPH (PILOT)	51	6	CBT Therapist – CBT	Primary Care	Black British	Female
SEB	49	3	CBT Therapist – CBT	Primary Care	White South African	Male
KATE	39	10	Clinical Psychologist – CBT	Primary Care	Indian	Female
LIZ	40	8	Counselling Psychologist – Person-centred	Primary Care	Pakistan	Female
WENDY	45	40	Counselling Psychologist – Integrative	Private Sector	Black African	Female
JAMES	60	9	Clinical Psychologist – Integrative	Private Sector	Chinese	Male
JANE	38	9	CBT Therapist – CBT	Charity/Private	Black British	Female

2.6.6 Interviews

Interview preamble questions. A preamble to the interview included a spoken introduction, where I discussed with participants that being a black female and the researcher, my role was to assume a curious position in relation to the interview questions and ultimately participants' experiences. During

the interview introduction participants were also asked brief questions of their age, ethnicity, professional title and how many years of clinical practice.

The primary method of data collection in this study was an in-depth, semi-structured interview protocol using an interview schedule to guide the process. The schedule outlined open-ended questions to help with initiating discussion on relevant experiences and to provide general guidance for the interview process.

A pilot interview (Appendix F) with a CBT Therapist provided insight into key interview questions that might require changes to ensure a full understanding of what was being asked was communicated. The function of pilot interviews within a grounded theory study can help with learning and building an understanding prior to the formal data collection by identifying key variables that may require attention (Campbell, 1990). The pilot interview therefore assisted in providing data content that would be meaningful for use as part of the interview process in generating reliable data for analysis. The pilot study, therefore helped with providing a rehearsal of sorts for further data collection and that feedback taken from the pilot interview provided particular thoughts and feelings of the participant impacted by the questions or indeed the researcher. Trialling and the subsequent tailoring of questions helped to gage the interview flow and process, guided by direct feedback from the participant once the interview was completed. In relation to reflexivity the pilot interview also provided an opportunity to test the researchers' personal feelings and responses to the questions and to the participant. Minor changes and phrasing of questions were made to ensure that questions were not asked in the 'wrong' way and to avoid judgements that might be placed by the researcher. It was also important to allow movement depending on what the participant might be wishing to explore and what the question might be generating or perhaps hindering at that point.

Overall the pilot interview helped me to consider how appropriate the interview questions were and whether participants felt satisfied with what was expected of them by talking through personal accounts of their work. This helped with changes needing to be made to the interview schedule such as the wording and phrasing of some of the questions and also served to ensure that a reflexive position was maintained by using the pilot interview as a method of personal monitoring of interviewing style

as the researcher. Charmaz (2006) maintains that the researchers' style and questions outline the context and frame of the study, but by asking the 'wrong' questions may result in inadvertently forcing the data and the researcher must therefore be aware of how they pose, emphasise and pace questions.

2.6.7 Procedure

The process of taking part in the study began with participants making contact with the primary researcher where participants were provided with a detailed explanation of the study and asked if they would be interested in taking part. Once confirmation of interest was received, the research information and consent was given and an interview was scheduled. Following the pilot interview, six further interviews were conducted face to face within the service locations of each participant. One interview was carried out via Skype, where the participant could be both heard and seen by video.

All interviews were conducted by the primary researcher and lasted approximately 60 minutes. At the start of the interviews participants were given the choice of whether they wished to stop at any point during the interview process. At the end of the interviews, participants were given a short debriefing form (Appendix E).

An interview agenda was used (see Appendix G) as a guide for questions. True to the semi-structured nature of qualitative work, the interview did not always follow this structure as not every question was used and at times it was more appropriate to follow the flow of the participants' experience. Corbin & Morse (2003) advocate this position and felt that this type of negotiation acknowledges that although the researcher gives the interview its initial direction with questions, the emergent nature of the interview can shift control to that of the participant.

Because qualitative research depends on personal interactions for data collection, strategies for enhancing interview rapport with the participants was essential. The establishment of rapport then was particularly important to this study because the topic discussed during the interview was sensitive and personal. To establish a rapport with the participants, a few minutes of initial small talk about their day and work was discussed.

2.7 Analytic Process

The data collected through the interviews were analysed using the basic principles of grounded theory. The goal of this method is to allow constructs to emerge directly from the data and therefore presumably reflect the participants' experiences accurately. Charmaz's (2006) constructivist grounded theory involves several steps in which to extract basic concepts from the transcripts and organise them into increasingly comprehensive codes and categories.

2.7.1 Role of the literature review in grounded theory

Within grounded theory exists the expectation that the literature review is best placed after the data analytic process and theoretical saturation has been achieved. The place for the literature review in grounded theory research has been a much disputed topic. Classic grounded theorists such as (Glaser & Strauss, 1967; Glaser, 1978 advocate for a delaying of the literature review and avoiding being influenced by earlier studies and ideas. However some awareness of the research should be held prior to conducting the research to ensure that sufficient and knowledge can be applied the subject area (Fassinger, 2005). It was decided for the literature review to be carried out after data collection and analysis. Reading around the subject served to provide developing ideas and knowledge.

2.7.2 Transcriptions

The primary researcher transcribed each of the seven interviews conducted. Each of the audio files were transcribed following the interview to prepare for coding (see Appendix H).

The interviews were transcribed by the researcher. To facilitate confidentiality, all identifying information had been removed from the data and each participant assigned another name which do not represent any identifiable reference to the participants or the order in which the interviews occurred.

To ensure the transcriptions were accurate, interview audios were replayed whilst re-reading the transcribed interviews. This approach also assisted in becoming fully immersed in the data. Memo-writing and comparative analysis was used throughout the study and also assisted the process of initial, focused coding and categories (Charmaz, 2004).

2.7.3 Initial Coding and Interpretation

The early stages of engaging with and defining the data is described by Charmaz (2006), where initial coding serves to form a link between data collection and developing and emergent theory. Through the process of coding, the researcher can begin to define what is happening in the data and to start the process to explore what that data means.

The initial codes are to be grounded in the data and can be provisional, allowing the researcher to remain open to developing possibilities as the coding process continues towards focused coding. Coding achieved in this way means that the data can remain as free as possible from the opinions held by the researcher. Initial coding also serves in guiding the researcher into what kind of data to collect in the next interview, directing the flow of research early on and throughout the data collection process. The following excerpt (see Figure 1 below) taken from an interview with a participant who has been given the pseudonym 'Seb' began with him describing his thoughts on his CBT training:

Figure 1. Initial line by line coding

'..I think that a lot of my training was afterwards, er, through what I see, you know looking and watching the press, you know so when I see Padesky coming…run and pay for it, do it! When I see Stephen Holland coming, you know complicated depression…run and pay for it, do it! When I see Sabine Wilhelm coming, you know for OCD, do it. I just don't think the training was wonderful that's all. But I think my learning was after that.' *Seb (22-33)*	**Learning achieved through own means** **Learning through observation** **Learning through research** **Preference leading research and published professionals** **Poor training** **Learning achieved through own means**

The coding in Figure 1 shows first-hand data with an attempt to summarise and account for each piece of text. The codes here, for instance, show a process based on Seb's experience of his learning. In order to illicit meaning from what is being said, the first step of initial coding moves into analysis of Seb's experience and of his CBT training. The process depicted through the codes used therefore show Seb moving from how learning is achieved to his opinion about the training itself. Participants' sharing their views and experiences throughout therefore helps to generate theoretical constructs by the successive organisation of initial coding, focused coding, conceptual categories, theory direction and

construction found in the transcribed data. This process involved coding and categorisation at different stages to attend to emergent areas of possible theoretical interest. The first stage of initial coding included discrete parts, such as a word, phrase or sentence used by the participant to help to define what was happening in the data, such as what was being said in order to make sense of what it means.

2.7.4 Focused coding

Following on from initial coding, focused coding involves a selective phase using the most significant or frequent initial codes to sort, synthesise, integrate and organise large amounts of data (Charmaz, 2006). Focused coding therefore helps to pinpoint and develop initial coding, to identify the most salient codes necessary for further analysis. The purpose of constructing codes is to be actively naming data. The codes therefore emerge through the scrutiny of the data and deriving meaning within it. Through this active and repetitive interaction with the data this helps the researcher to ask different questions of it based on what is emerging. The coding process is therefore the interpretative researcher's view, by actively choosing words and phrases that constitute the codes. There is therefore an initial interaction with the participant and subsequently interacting with them again many times over through the study of their statements and observed actions and re-envisioning the scenes in which the interview took place. Constructing codes and later refining them through focused coding gives way to attempting to understand participants' views and actions from their perspectives (see Figure 2 and Appendix J for example). This means exploring beyond what is said and looking further to interpret underlying and tacit meanings. As a result, through coding, unforeseen areas may be discovered and new research questions may arise and focused codes can be compared with other codes. After each interview, comparisons can be made with the previous interview(s). Focused codes were then logged and grouped into subcategories which were later further grouped into categories with the final stage of constructing a core category.

Figure 2. From initial to focused coding

'My training in CBT, my training was at…University and I think my training wasn't fantastic'…
Initial coding: '*Poor Training*'

'Because people who've studied at Oxford or you know, not just the name but a lot of the lecturers are the people who write the textbooks. But at…University both the lecturers were Counselling Psychologists'
Initial coding: '*Wish to be taught from the writers*' and '*Counselling Psychologists inefficient*' – Focused recoding as '*Poor Training*'

'So they, [lecturers] from a counselling background and you know, so the training I don't think…the training was not great because I think it was just to get 'the stamp'
Initial coding: '*Poor Training*'

'I just don't think the training was wonderful that's all.'
Initial coding*: 'Poor Training*'

'But I think my learning was after that.'
Initial coding: *Learning Achieved Through Own Means;*
Focused coding, re-coded as *Poor Training*

2.7.5 Memo-writing

The process of memo-writing assists in engaging an emergent category. Charmaz (2006) writes that an emergent category through memo-writing develops through letting your mind move freely for exploration and discovery. It is here that the observation and reflections of ideas about what has been seen, heard, sensed and coded could be examined. Categorisation of codes was done by selecting certain codes seen as particularly significant and abstracting common themes and patterns observed in several codes. As categories are developed, this raises the conceptual level of data analysis from descriptive initial coding to a more abstract and theoretical level. Through comparisons, each category is cross-compared with other categories. It is through these theoretical categories that help to form the concepts of a developing theory. Charmaz (2006) highlights that the central role of memo-writing for the construction of theoretical categories offers an opportunity to reflect throughout the interview process and keeps an active involvement in the analysis and the development of ideas. Memo-writing was used during the study to create a space to converse with myself about the data, choosing codes, develop ideas,

where questions arose during the memos that helped to direct the analytical process. Using memo-writing early on whilst engaging in coding and analysis assists in developing theoretical sensitivity and creates an interactive space for the researcher to consider their thoughts and ideas, discoveries about the data, emerging categories and the developmental path of the analysis (Charmaz (2014) and further develops conceptual ideas as it emerges through constant comparisons (Glaser & Holton, 2004). An example of a memo

Figure 3. An example of memo-writing.

'I wondered about his thoughts of voodoo existing alongside his understanding of psychoses. He seemed surprised that his colleague, a professional could believe in the existence of voodoo, it was significant that he mentioned that she was from Jamaica, which perhaps suggested that this could be cultural although he regarded it as nonsense. Would he have been less surprised if this belief was held by a client or non-professional? I should have asked. I wanted to attempt to bring Seb back to focusing on his work with a client and felt that we might be going off track here, but then wondered about how he might work with a Jamaican client whose central beliefs included spiritualism. I had questions about how he might work with this client, how he would work to understand their sense of reality which brought me back to the research question.

(Memo excerpt participant - Seb)

2.7.6 Constant comparison and theoretical sampling

The use of constant comparative methods (Glaser & Strauss, 1967) provides comparisons at each level of analysis. Constant comparison provides insight into how the data relates to what has previously been said about similar data. Through this process of going back and forth with emergent analyses and other data, the researcher is able to analyse emerging categories (Willig, 2008). Grounded theory therefore requires constant comparison to assist in shaping the emerging theoretical concepts whilst remaining fully grounded in the data itself (Charmaz & Henwood, 2008).

2.7.7 Theoretical saturation

In grounded theory, theoretical saturation is achieved when no new data can be found or emerges from the data. Although this process is ideal, it is important to note that reaching theoretical saturation is the goal of analysis rather than a reality (Willig, 2008). This study has intended to reach theoretical saturation, however the revision and change to categories and adjusting perspectives have seen an ongoing process. 'Theoretical sufficiency' (Dey, 1999) then might suggest that the end thesis is not final but is seen as a "pause within a never ending process of generating theory" (cited in Dey, 1999, p.117).

CHAPTER 3. ANALYSIS

3.1. Introduction

The research question guiding this research was to explore the experiences of therapists' and their methods of using CBT when working with Black clients. In answer to this question this chapter will serve to provide a narrative and analysis of therapists' experiences. The analysis of interviews using a Constructivist Grounded Theory approach, will describe the main categories that emerged from analysing the data. In this chapter excerpts of transcribed data will include quotes from participant interviews, illustrated in italics alongside the name assigned to each participant.

The research aim is focused on CBT therapy from the perspective of the therapist; to elicit from therapists of their opinions and interpretations of the way that Black clients culture may influence their attitude and therefore their responses to CBT and how they might work with adapting therapy. This data has raised considerations for future research, with categories highlighting significant experiences around training, adaptation of standardised practice and the process of working with a particular client group. The benefit of grounded theory, as outlined by Charmaz (2000) therefore helps to open up the research for emerging ideas which may not have been known.

The research question was therefore kept in mind throughout the study to consider 'how therapists experience working with Black clients in clinical practice using CBT?' Grounded theory places particular focus on the *how*, in understanding what makes up an experience. In this case, where CBT has a standardised process and how therapists might apply this in practice.

3.2 Core Category: CBT in practice - A process of working with Black clients

This presents a central category that encompasses the overall data. The findings suggest a process that takes place for therapists, where the translation of knowledge in CBT work is dependent upon training, therapy style, life-experience and development of the therapist themselves. Therapists are choosing to 'adapt' CBT by combining the cognitive and behaviourally focused framework centrally focusing on thoughts, feelings and behaviours with other modalities in order to work better with clients from Black client groups. Other modalities or positions mentioned in interviews include Existentialism

with an emphasis on individuality, Acceptance and Commitment Therapy (ACT), person-centred and humanistic approaches. The general view is that CBT was found to be too rigid and linear, and as such, does not work well particularly with Black African and Black Caribbean clients as a didactic focus within therapy, with less emphasis on homework outside of the therapy was preferred. This rigidity was felt to directly affect the client experience and potential for client drop-out and by assuming a person-centred approach. Some therapists asserted that having a particular focus on the therapeutic relationship above the CBT protocol, helps with sustaining engagement, understanding and overall therapy success.

What became evident was that the action of adapting CBT through the bringing-in of other perspectives and positions and dropping the CBT agenda and homework was shared only amongst the Counselling and Clinical Psychologists and that CBT Therapists maintained utilising a purist approach. Despite this, perhaps obvious difference, all therapists shared misgivings about applying CBT in a purist form with Black clients. There seemed to be a need to cultivate an approach that was very much framed around the relationship between therapist and client as a primary recommendation and the exploration of the CBT model – *cognitions, feelings, behaviour*, as secondary. Messages that CBT was better worked through within the therapy room, gave to the idea that homework was rarely incorporated into clinical work if at all; psycho-education was helpful in outlining aspects of difficulties. Half of the therapists who had completed both high intensity/CBT training programs and Clinical or Counselling Psychology training felt that CBT training programs inadequately covered aspects of working with culture and diversity. Clinical and Counselling psychologists felt that training sufficiently addressed working with diverse groups.

From the data analysis four subcategories were formed across the interviews. These subcategories were: *appropriateness, therapy congruency, developing therapy style and curiosity.* These subcategories on a whole reflected experiences shared by therapists during the interviews and was extracted from the data through coding and constant comparative analysis ensuring that by moving back and forth between different sets of interviews and data, similarities and differences could emerge

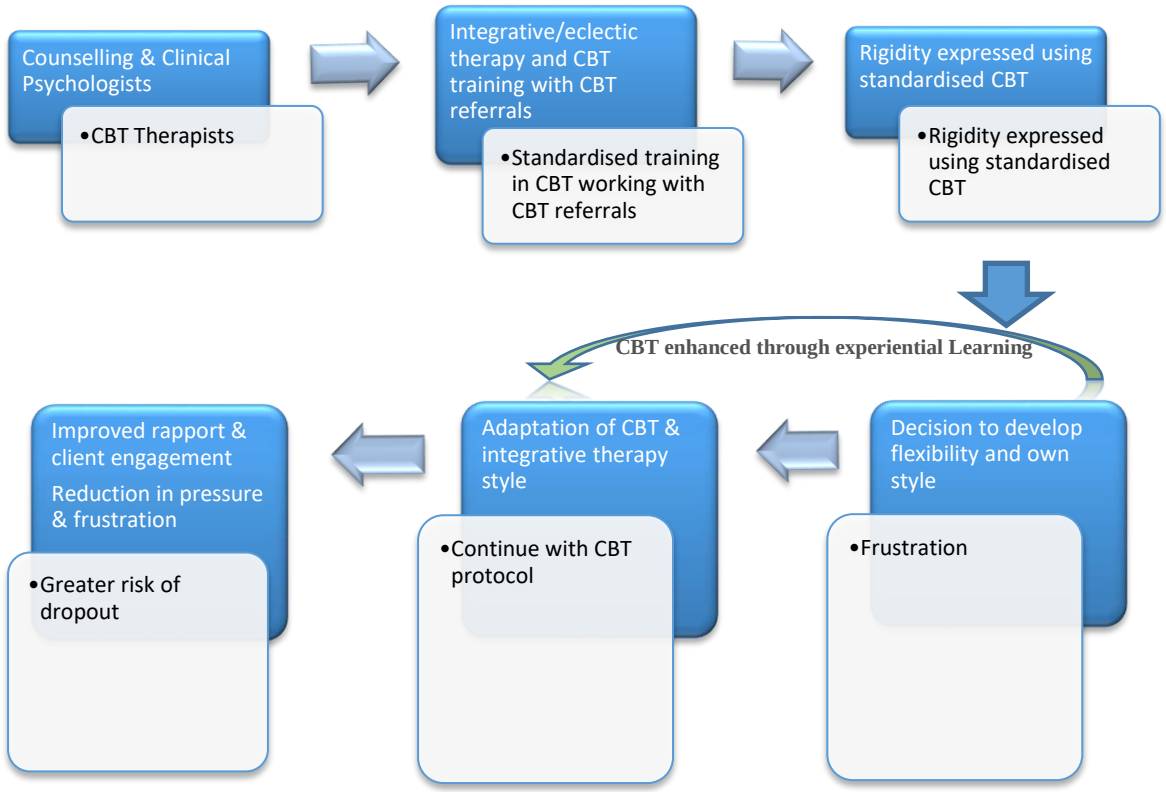
between categories. These subcategories therefore are a product of this comparative analytic process and are outlined in Table 2.

Table 2. Core Category and subcategories

Core Category: CBT in practice. A process of working with Black clients			
Category 1 Appropriateness	Category 2 Therapy Congruency	Category 3 Developing my Therapy Style	Category 4 Curiosity
Rigidity	Managing Preconceptions	Humanism	Culture
Pressure	My Experience	Flexible	Collectivist view
Dropout	Adaptation	Training	----

The subcategories outlined above help to portray important parts of information that have been broken down through analysis. In this way, the complexity and diversity of what is being said can be recognised where an emerging theory can tentatively be seen. The process of the therapy experience can be seen where therapists describe aspects of CBT treatment which forms how they go about doing it. An emergent theory of the experiences of therapists and the process of utilising CBT with Black clients and how they consider adapting CBT is captured in Figure 4.

Figure 4. Conceptualisation of an Emerging Theory: A Process of Therapist experience of CBT with Black clients



3.3 Category 1: Appropriateness

This section presents personal views and feelings shared by therapists of their experiences and process of working using CBT with Black clients.

The term 'Appropriateness' was chosen to outline the opinions of therapists and the question of suitability for this client group. Within the sub-category of 'Appropriateness' are *rigidity*, *pressure* and *dropout* developed to communicate underlying feelings and experiences of therapists emerging as a result of commonly held beliefs of the different impacts of working with CBT on the therapist in a literal way.

3.3.1. Rigidity

Therapists shared a common opinion that CBT felt rigid and inflexible when worked with in a purist way with Black clients. Each of the following accounts are of therapists who have worked with either Black Caribbean (BC) and/or Black African (BA) clients stating that CBT for them, felt impersonal and difficult to explore cultural depth with their clients which might include aspects around beliefs, religion, customs, language, expression of distress, norms and values. Below James gives an account of certain aspects of CBT that he feels might be particularly difficult to work with and in turn how difficult this might be for a client who finds the idea of therapy in the 'classic' sense as a talking therapy challenging:

> *"CBT can often construe as rigid and structured and there's no flexibility because one of the aspects of CBT is about thought records, keeping records, keeping home-work. For an elderly or a middle-aged ethnic person having to come with a language problem, language barrier and more importantly talking therapy is something quite alien…*because *it's a very western concept so they find it very difficult let alone to engage with someone.*" (*James: 58-65)*

James makes a direct statement that with CBT *there is no flexibility*. This lack of flexibility seems to be a consequence of the method used including keeping various records and homework. The reality of imposing these methods on an elderly person with language barriers is particularly challenging when the idea of talking is hard enough. It seems that factors including language barriers, stigma and expectations that might arise around homework might be difficult for those who find therapy 'alien'. There is something here that emphasises the simplicity of engagement in the first instance as the concept of talking with an outsider might be challenging for particular groups. For James, the written materials are to blame for this rigidity. Steph similarly shares the view of moving away from written materials and adds that the use of thought records are less preferable from a clients' perspective:

> *"I don't tend to use thought records. People that I've worked with feel better talking with you in session rather than writing" (Steph: 57-58)*

In describing the style of talking, Wendy went further to state that exploring a problem requires a Socratic process for guided discovery as CBT requires instead of a didactic approach. Wendy seems to feel however that a didactic style is preferable for African and Caribbean clients:

"…it's not about the individual it's about the collective, so the community sets pace of what you do and so if you are doing therapy, CBT for instance with somebody from African Caribbean or from BA origin maybe they might struggle because "just tell me, just tell me what to do" so it depends on how the person has got acculturated to a western paradigm, so it depends on where people are." (Wendy: 28-34)

Jane went further to explain why a didactic style might, in some cases, be preferable:

"You know in the Black community, for instance in church the older generation, so those from the Caribbean are coming from a very strict moral place, whether parental, schooling or religious. They're used to being directed on what's right or wrong" (Jane 50-53)

There seems to be a felt sense of therapists trying to balance the style of therapy and the expectations of clients themselves. It is this pursuit of balance that perhaps leads to the feeling of rigidity through written materials where therapists are trying to find an appropriate way of working, as clients might require a more flexible platform to tell their story. Along with written materials, the agenda was also highlighted as another element that added to rigidity for therapists. In managing rigidity, Wendy goes on to talk about the agenda when working with an African client:

"I wasn't so rigid with the agenda, I allowed her to set the pace, give her that room…in CBT we are very rigid with the agenda" (Wendy: 67-68)

Steph similarly identified the role of agenda setting in CBT as rigid and what this was like in practice in her experience:

"The rigid way of doing the agenda and you know, sort of coming in with an idea of a difficulty that we need to talk about and something that they've practiced, that didn't go so well, that we can talk about, those are the specific aspects that…maybe they lack that idea of CBT being structured and would move more into 'this is my problem, this is what I want to talk about, what do you want to take away, you know, it's fine to talk about it. So structurally you know, just identifying specific areas like, cognitive restructuring, for example was difficult in that sense that you talk about the negative automatic thoughts, the beliefs, work through it how this is translated into similar situations that you come across." (Steph: 95-107)

The language used by Steph in description of the CBT experience with Black clients as 'rigid' and 'structured' is similar to James and Wendy's earlier comments. It is worthwhile noting that Steph uses the term "the rigid way of *doing* the agenda" as if this is a task that is a rather prescribed or scripted method, Wendy also states "I wasn't so rigid with the agenda". Demonstrating something about the therapist being intentional in their approach, the expectation perhaps of what CBT requires

to ‘set the scene’ for the session and that this might be felt as a hindrance with little deviation as a set path for the session. The agenda however is context dependent. Kate goes on to describe where a deviation from a structured CBT outline is at times necessary depending on what the client is bringing to therapy and what they would wish to address:

> *“One lady who was Somalian, she was a refugee…who had some experiences in the civil war, came here as refugees and I think with them applying the CBT model almost felt irrelevant, I mean they were just traumatised the stories were so, so sad and it just seemed they needed some human contact, some kindness…so I would say I tried to apply general advice…but north of that I wouldn’t, I wasn’t doing strict CBT”. (Kate: 76-84).*

Liz also expressed views about CBT being protocol driven/focused and less client focused:

> *“…so if it’s a depression protocol if you do it strictly, then you’re not asking or personalising…” (Liz: 78)*

It is interesting to note the language used by the therapists to describe how they experience working with CBT here. Words such as *rigid, structured, protocol, ‘no flexibility*’. It was clear that there were strong views about the structure of CBT and the feelings of being restricted to practice in a particular way as therapists. Jane told me that she often felt service pressure to apply a strict CBT protocol and

Memo Reflection:

Whilst interviewing Jane I was thinking about my own current experience and over the past few years having worked in Improving Access to Psychological Therapies (IAPT) services as a locum CBT Therapist. I noticed having a similar perspective in responding to service pressures, the time-bound expectation and I wondered that if CBT was being felt too as rigid and structured with particular clients. As I reflect on this I notice how frustrated I began to feel. I have been angry for a long time and somewhat resentful of the service and its expectations of me as a therapist as performance is evaluated based on recovery rates of

that carrying service expectations, with little room to change approach to therapy made it difficult to meet client expectation if this expectation was significantly different to the CBT model.

> "*Sometimes I feel like I'm working for the monster, I have to keep feeding the monster and the conveyer-belt of clients just keep reeling in and I'm expected to just keep reeling out the same scripted way of 'doing' CBT and if I don't I'm not being evidenced-based. Sometimes it's just down-right non-human." (Jane: 58-62)*

I felt anger from Jane and an overwhelming sense of frustration that seemed to be triggered more from service expectation, thus impacting Jane's ability to engage in a more meaningful way in her therapy experience with her clients. It could be that Jane felt that her focus in sessions could be distracted by service pressures including governed by use of the outcome measures for mood and anxiety monitoring, service evaluation and recovery rates and a personalised percentage performance of therapists based on treatment outcomes.

I wondered about the expression of rigidity of CBT and its structure as counter-productive and what this might mean in terms of modality preference and treatment choice. I wondered whether therapists simply preferred working in a particular way or whether therapists were suggesting that BC and BA clients perhaps required a particular approach to therapy. The challenges of adhering to a rigid structure could perhaps be down to the therapist and their own preference of a particular style of working. What seemed to be coming across from therapists however, was that BC and BA clients require something different from them. Therapists appear to be feeling that they are unable to meet the needs of BC and BA clients effectively whose expectations of therapy might create resistance to CBT. Therapists it would seem are attempting to 'open-up' their clients who might otherwise seem rather closed to the idea of attending a talking therapy service. Perhaps this suggests that there are particular beliefs held about therapy by clients, which might include mental health stigmas, stereotypes and a lack of therapy resources in countries of birth for BA and BC clients, which might be what therapists themselves are attempting to manage here. This rigidity could therefore be a direct result from what clients may be thinking or feeling about therapy, where the therapist is then required to acclimatise clients by using a varied approach that may not fit a traditional CBT style.

3.3.2 Pressure

This subcategory evolved from the growing sense of pressure shared by some of the therapists which was touched on in the previous subcategory. Kate explained where this sense of pressure perhaps originates and what might be some contributory factors:

"I suppose we're under so much pressure to sort of get the job done quickly" (Kate: 264)

Kate goes on further to describe how she would attempt to work, noting the necessity for sensitivity and efficiency in incorporating cultural aspects into the model of CBT:

> *"…what you're supposed to be doing is quite focused and circumscribed so if someone's culture or religion or beliefs would seem to be impinging on their problem then I would see it as relevant to challenge or address but I suppose knowing that they are part of a cultural belief system I would be more careful to not, to respect that this is in someone's kind of, back-drop, this is the back-drop to their life and I can't assume that they can just change it, challenge it, because that will have an effect on their system." (Kate: 284-293)*

It seemed through Kate's statement that this particular client came to therapy with factors describing deeply rooted underlying beliefs and that there was a sense of not having enough time to work through these beliefs which might be causing maladaptive feelings or behaviours. The role of service expectation creates a tremendous amount of pressure and means that some difficulties, however meaningful might just need to be left. There appears to be a struggle between managing the culture of the service and the needs of the client. This struggle for Kate means that she is faced with prioritising the culture of the client over that of service expectations. Jane's previous statement and Kate's here both highlight the challenge of working within a performance-driven environment and the direct impact that this can have on culture-specific work. Wendy explained that this is similar experience for her. Like Kate, Wendy too describes that using CBT at times carries with it a degree of expectation and pressure which might suggest a felt sense of underlying service expectations. She also suggests that by taking on another perspective such as Mindfulness, this helps to dispel feelings of pressure:

> *"So I'm using my own self too because sometimes, when I was just doing Beckian CBT, I had a weight of expectation on me, so much pressure like 'Oh you've got to get this right, you have to get this right' but when I take on this Mindfulness perspective, it made me understand when I am feeling 'Oh what am I going to do now?' and I can relate, I can stand back and watch that even in the moment" (Wendy: 210-217).*

Throughout this interview there were messages that working in a purist way with CBT felt restrictive for both Wendy and her client and that a richer CBT experience was achieved through a person-centred approach and working mindfully which was an approach incorporated into the overall CBT. Wendy went on to describe the outcome of a client who was autistic and selectively mute. After treatment she spoke with the clients' Mother:

"…the Mother said, he's engaged with you, because of the way you've approached the session. It's not saying just that I've got to see a psychologist, it's just so relational and he engaged, he opened up he told me things about himself and I said 'wow, I was told you didn't talk but you are talking' he said 'yes' he was giving me eye-contact and I just thought 'wow'. So that's the kind of things I've evolved in learning how to be with people and not too much of, well we have goals, but I'm not being oppressed by 'I've got to get this done!'" (Wendy: 231-240)

In terms of methods of working Wendy appears to suggest that the success for this client was based on her adapted approach to CBT and on the basis of choosing to be more flexible by drawing on Mindfulness and person-centred approaches she was able to deliver CBT in a more meaningful way. The evolution of Wendy's learning and practice appears to place an emphasis on relational aspects that go perhaps above CBT materials. Wendy mentions the importance of having goals but not being oppressed by them; the way to manage pressure for Wendy therefore is by taking up a position which is more focused on the relationship and being less structured with CBT, allowing more room to work with other perspectives that can be incorporated into meaningful work.

Jane very directly shares a similar perspective about being less focused on the agenda, the depression model and behavioural activation:

"*I just feel that often times we have to be seen to fit within a particular model and at times that feels stifling especially if it's not really working. Added to that, there's a type of pressure from the service perspective, you know? At times I feel like I lose sight of what's really meaningful for the client and sometimes they just want to talk about the depression, forget behavioural activation!" (Jane: 126-129)*

In this case Jane moves away from evidenced based CBT.

There is an overall sense of what's *supposed* to be done, what's *expected* of therapists. It is unclear whether this sub-category is pressure felt from the 'service-down' and/or from the client. Perhaps there is an overall sense of pressure as described in some of these experiences. What is clear is a need for speed and efficiency and the pressure of working against time itself to do things right. It should be noted that each of these therapists currently work in an IAPT service so there might be something to be said of the expectations of the service itself.

Jane and Wendy each shares aspects of how they manage pressure. It would seem that stepping away from CBT alleviates some of this pressure to always be 'doing' and although this may not show

a direct relation to working with BA and BC clients, Kate's experience of prioritising cultural aspects of therapy work above service pressures suggests that therapists are finding ways to manage service expectations that perhaps creates pressure by stepping away from CBT protocols, enabling therapists to become more focused on having room to talk instead of attempting to create change through technique-driven work. Kate suggests that a clients' belief-system is their back-drop and cannot, or perhaps should not necessarily be changed or challenged. The suggestion that developing a style that emphasises a more mindful and person-centred approach promoting acceptance seems to be how some of these therapists prefer to practice, feeling less pressured with clients once this is achieved, where techniques such as behavioural activation are side-lined to allow room to talk about difficulties.

3.3.3 Dropout

When therapists were asked about black clients engaging with CBT, the issue of dropout was raised as an important concern. A number of therapists (Jane, Kate and Steph) each shared experiences of client dropout and what they felt about this. To illustrate this, Kate begins with the following statement which outlines the number of cases of dropout:

> *"And actually it's interesting to think about it because I can think about 3 younger people in their 20s who one was a woman and the other two were black men. And interestingly they all dropped out of treatment. Yeah two dropped out and one had a number of DNAs (Did not Attend) and cancellations so I had to discharge" (Kate: 98-102)*

Kate goes on to describe how the cases of dropout have affected her and the questions that this raises for her once she reflects on what this might mean for the client and what it might mean for her:

> *"…so I can think of a number of these young people who dropped out and then I'm thinking to myself and I'm thinking is that particular to them being Black and there's something in me that's thinking 'Oh God, you know if that's the case that's terrible, that's really bad, what's going on? Um…yeah is there something about the approach? Is it something about me? What is it that's going on that isn't being talked about that isn't being acknowledged?" (Kate: 110-117)*

This message seems to portray a degree of shock and Kate's realisation that dropout might go beyond the type of treatment model and how the significance of the relationship might be a factor. This view of the relationship and therapist-client rapport as a factor is supported by Seb:

I don't know, maybe there's just not that therapeutic alliance formed with the therapist, perhaps there's not enough empathy I think. I just think that there could be pros and cons (Seb: 284-289)

Seb highlights both the therapeutic alliance and empathy as ways of making a client feel engaged and that the absence of this could lead to a client disengaging and potentially dropping out of therapy. Seb's accounting of the significance of the therapeutic alliance is relevant to Jane's following experience in this case:

"I remember at the time and even now, actually feeling frustrated, I felt bad… I feel like I was trying to push behavioural activation onto her and the Black British lady, there was a lot of early experiential trauma driving her OCD and I think she just felt overwhelmed at the idea of even having therapy or maybe I didn't spend enough time building that relationship. She only attended four sessions and didn't come back after that." (Jane: 102-107)

Steph also shared her experience of drop-out with a number of black clients:

"So I have to say that I've seen only about four clients that were from the Caribbean, none from an African background and none of them have completed treatment. One of them I think got close to completing the fifth session, so uh…outcome in that sense has been patchy. However the one that got close to five sessions did not demonstrate any progress in the minimum data set that we collect, you know the measures did not indicate that." (Steph: 85-93)

Steph went on further to give an account as to why she felt these clients may have left treatment early:

"Gut feeling, what comes up strongly is that sense of, you know, you don't talk about these things, you don't put your hand up, you don't go to therapy, it will just pass, you know that sort of thing so really I think the kind of cultural sense is that it will pass so do something else or ignore it." (Steph: 76-81)

The above reflections from Steph seem to state that a narrative about therapy exists from the perspective of the client within the Black community that you don't talk about personal issues in therapy, instead the feeling will pass and so will the problem therefore therapy is not really needed or is perhaps 'frowned upon'. The idea that there exists a shared idea of what psychotherapy means within the Black community seems to be communicated here, where talking about personal and intimate issues is negative and should not be discussed in therapy. One wonders where this assumption is being driven or how it is conceived. Steph's opinion however, appears to be based on a 'gut feeling' which implies that she too is aware of such an idea, which might suggest that this is a largely known

and universal understanding within the Black community. As a lady who is of African origin herself, perhaps there is something here that she herself knows.

James makes personal cultural links as with his own ethnicity and the Asian community and highlights that therapy is a two-way process, again showing the importance of the relationship and building rapport:

> *"The Asian thing is the perspective…that the preconceived ideas is that we do not share something private to a stranger. It's a two-way process as well because we try to get an understanding and our betterment in terms of providing therapy for ethnicity people but equally it's a two-way process, they also too have pre-conceived ideas about us as therapists, yeah? So they have preconceived ideas about you as well as saying 'what is it that you can do for me?'" (James: 133-141)*

James makes the point about the client's position and of what they might be feeling about us. He goes on to describe the position that he takes:

> *"I think the CBT knowledge is secondary to the primary thing which is to get to know the person as another human being to another human being. I think that is the way to do it because without the trust, from experience, like you said the dropout, they won't come to the next session, they just won't turn up." (James: 111-116)*

Going back to Wendy's earlier comment on rigidity and the relationship, the significance of the therapeutic relationship is outlined here and the role this has in maintaining sustained engagement, lowering the risk of client dropout. James describes that knowledge of CBT falls secondary to the building of trust to ensure that a client can feel safe to return for the next session. Seb and Jane also give accounts of not establishing a strong enough rapport leading to dropout. The three shared experiences that come through across the interviews is that (1) dropout has been largely experienced by therapists with clients from Black backgrounds; (2) some clients from particular Black backgrounds might struggle with the idea of being in therapy due to culturally held beliefs and (3) the building of trust and the relationship is particularly important to sustain engagement. The challenge in managing rigidity felt from therapists is compounded by the need to work quickly and efficiently. This pressure perhaps compromises the relationship, an experience felt by Jane who felt under pressure to keep to evidenced based practice.

However, the ethnicity of therapists could perhaps be a factor in client dropout. As a CBT therapist who self-identifies as Black British, Steph and Jane experienced dropouts with their Black clients. Seb, a White male and South African, did not report having this experience. Comparably, one might consider the impact the therapist might have, even unknowingly on the client.

Memo excerpt

'I think of my own experiences as a Black CBT Therapist and the degree of dropout that I too have experienced with Black clients over the years. Recently I was told by an African Male client that he saw me as 'English' and that if I were African he would not have returned to therapy after our initial session together. The risk of talking to an African therapist would mean that I would know too much perhaps about his background, could have links with people within his community that he too might know and ultimately would leave him vulnerable to confidentiality breach.

I recall also speaking with two Asian clients, one male and the other female who both expressed not wanting to be seen by a therapist from a similar ethnic background, or struggling with being transparent in sessions when an interpreter is present, due to insecurities of the cultural relation within the therapy room creating too much familiarity.'

This appeared to be a sensitive topic to raise with therapists. I wondered if the issue of client dropout, in this case clients specifically from African and Caribbean backgrounds, might be a contentious issue in consideration of my role as researcher, reflexivity and questions this might raise about how therapists might be viewed by me, their experiences of dropout, their capabilities and possible judgement and assumptions. In reflection, the following memo captures this:

Memo reflection excerpt (Seb):

'...on issues relating to experiencing dropout he seemed irritated and shrugged at the question without answering. I returned to my earlier thoughts and wondered if Seb felt that exploring experiences of working with BA, BC and BB was non-sensical. After the interview was over Seb remarked on Aaron T. Beck in recent years advocating for therapists' cultural sensitivity and adaptation of CBT, stating that it was all "PC [politically correct] rubbish". Seb went on to state if it meant that we should have therapy for 'tall, short, large, small, green, pink, LGBT...EFG' – sarcastic I thought. I took the overall meaning that we are people and as CBT suggests working with basic principles of human response – thoughts, emotion, behaviour and physical response, is universal. Seb's feelings here show strong views and a dismissal of the idea of difference and what this might look like, culturally attesting underlying beliefs and experiences and how this then may effect human responses.'

It is clear that there have been experiences of dropout and of therapists using various ways of working to make CBT more relational and less "prescriptive" as James describes. What is interesting to note is that therapists (Jane, Steph, Kate) that shared experiences of client dropout for Black clients they had worked with, were CBT therapists and comparatively therapists who were less purist in the way that they worked (James, Wendy, Liz) such as existentialism, ACT, person-centred and some psycho-analytic approaches shared that they did not experience client drop out of clients who were from Black backgrounds.

3.4. Category 2: Therapy congruency

This section presents a category shared by therapists of their creativity and harmonious process of knowledge gained over the course of previous job roles, education and training and how this is translated during the course of therapy. Each of the sub-categories: *managing preconceptions, my experience* and *adaptation* developed from individual accounts of the personalised ways that therapists

have developed in how they work with Black clients; the process of communication and the importance of striving to assert a degree of independence in utilising CBT.

3.4.1. Managing Preconceptions

Following on from Category 1 – *Appropriateness* and the previous subcategory *dropout*, *managing preconceptions* was formed from therapists dealing with what they believed their clients felt about therapy. The portrayal of talking therapy within the media, historical accounts, stereotypes and stigma could create an idea about what therapy might mean and how this can then impact the therapy relationship and overall experience.

When therapists were asked about their experiences of working with clients from Black British, Caribbean and African backgrounds and CBT engagement, most of the therapists shared similar thoughts about preconceived beliefs they believed their clients had about therapy. In his experiences James described views from both Black and Asian clients and has found there to be beliefs that therapy is not culturally accepted:

> *"Yes they have preconceived ideas but from a different perspective. From a West Indian perspective is that it's not okay for you to say that, it's not okay for you to do that, after all you are not me…Black. The Asian thing is the perspective, the preconceived ideas is that we do not share something private to a stranger." (James: 130-135)*

It struck me about the challenge James' view creates and what this might mean for therapy engagement. James mentions there being a 'different perspective' that exists amongst individuals from West Indian backgrounds. What seems to be implied here is the difference between the therapist and client perspectives. The implication is the degree of difference between the client and the therapist based on beliefs about talking about deeply personal things which James is aware of. Like James, I wondered about Steph's earlier account and her "gut feeling" of why client dropout could occur, basing this on it not being okay to talk about personal matters within a therapy setting for some clients. Both therapists here share a prior knowledge of this cultural 'rule' or perhaps they are sharing their own preconceptions about their clients too based on ethnicity and assumptions that might be made when a client presents from a Caribbean or African background. James went on to talk directly about these beliefs and the preconceptions that clients may have about therapists:

"…they also too have pre-conceived ideas about us as therapists, yeah. So they have preconceived ideas about you as well as saying 'what is it that you can do for me." (James: 138-141)

There may be a reciprocal preconception-exchange taking place about the other from both the therapist towards the client and the client towards the therapist. James describes having to think about responding to thoughts about him and whether he can meet clients where they are. The question 'what is it that you can do for me?' suggests an underlying degree of doubt or perhaps suspicion that James professes to exist within *his beliefs* of preconceptions that clients might have towards therapy, drawing on his own cultural position within the Asian community and the similarities that might exist there. Wendy expounded on this, speaking quite explicitly about being open to where a client may be coming from. She also touches on racial aspects and how this may drive some preconceptions or possibly even suspicions about therapy:

"It depends how willing people are to shift and move and that should determine how we work with them. But we have to look at that with all coming from the effects of colonisation, slavery, what stories have been told, what narratives are there in the family, you know all these things people hold it." (Wendy: 579-584)

I was beginning to feel that trying to manage preconceptions was about dealing with the consequence of a sense of 'separation' in the therapy room and the therapist then having to attempt to 'meet in the middle' with clients who hold narratives or beliefs about the therapy experience that can create barriers. James highlights this challenge of 'bridging this gap' to meet clients who may be coming to CBT from a disenfranchised position:

"West Indian families, single-parent issues, it's all part of the norm, a high proportion are through single-parents and they are struggling and then when you try, if you are not sensitive enough, they may think that you are being judgemental about being a single parent, you know. Because they perceive the way, they perceive through their own vulnerability." (James: 143-149)

James goes on to say:

"…we all have preconceived ideas, so it's part of your case conceptualisation…pre-conceived idea, the schema, where is it coming from?" (James: 152-155)

James sees an opportunity to explore the preconceptions as part of the conceptualisation process, working directly with the belief and not viewing them as something that would create separation or barriers with CBT work.

"Yeah especially for people who have felt bogged down and when you go to the board and let them sit there and you do the board like teaching or like lecturing they don't do it properly. I have heard comments, because I was a supervisor previously, where the therapists come and say they don't like that board because they feel like they are talking down on them, especially when they are a certain ethnic group." (James: 247-253)

James shares the view about the style of therapy, in this case the use of the board. The implication here was again the process of a kind of separation occurring between therapist and client that would be created through use of the board which may lead to thoughts of feeling patronised. Jane similarly shared her experience of working with a client who had strong cultural beliefs against therapy, however that did not reduce the need for engagement:

"One particular guy, he was a young black gentleman born here who said that being in 'the room' went against everything, but he came because the GP referred him for CBT. It seemed like it just didn't sit right with him but he said that he just needed to talk." (Jane: 156-159)

Jane, James and Wendy each share particular instances of working with preconceptions as a process of bridging the gap caused by beliefs held by clients. The process of management comes in the form of conceptualisation in understanding these beliefs and that through exploring truth, opens up the simplicity that 'he just needed to talk' as noticed by Jane. The recognition that preconceptions from the client perspective do exist, can create challenges and barriers during therapy or have been useful as part of conceptualisation. Liz offers an alternative perspective describing preconceptions from the opposite side, what a therapist might think towards his client:

"…it's valuable not to assume you know if you are of the same culture; how the client is feeling or you know, in order for them to feel understood I think, even as a therapist I ask 'how does that fit in with your beliefs or culture?' because I think that's important as I may not know and that then is lost in therapy which is very important. So I will often ask if there's something I don't understand about a culture." (Liz: 63-66)

Liz emphasises the importance of querying from the position of the therapist, to glean understanding which she frames around culture. This experience of holding assumptions that are not acknowledged or explored and the consequential impact, was personally shared by Jane as she reflected on a session:

"I felt like I should know because I shared a similar West Indian culture and upbringing, and felt guilty when I couldn't understand her…I should've been able to understand her being black too." (Jane: 168-171)

Jane expressed this somewhat sadly and appeared downcast when recalling this experience. There was a sense that she may have felt that she had failed in some way. Wendy pointedly asserts as if in response to Jane:

> *"I can't say 'oh I've got all this training on cultural diversity or cultural competence now I know' I don't know how that person is experiencing their culture and what it means to them so it's just being with each person I see. Or I can't say 'oh I'm African so I know what an African thinks about, I'm Black so I know…' I don't know where people are at". (Wendy: 301-307)*

The transparency of Wendy's statement, describes a therapist being able to stand back from their own preconceptions giving the client room to move forward with their own. Not falling victim to the idea of coming with a type-of-knowledge acquired through training is grounding for the relationship.

The shared experiences described within this sub-category of *managing preconceptions* suggests a process involving a balancing act taking place where therapists are having to think about what they know, what they think they know and what they are expected to know which is constantly being reflected upon, discussed and conceptualised during sessional work. The challenge therefore to be able to deal with preconceptions that might cause an indifference to the therapy experience appears to be a challenge underlying therapy itself.

The existence of preconceptions was not one-sided. The suggestion from James is that clients have preconceptions about therapy, but that therapists too have their own beliefs about the client and their cultural experiences, which was also shared by Liz. As part of the process of managing preconceptions, as well as managing their own, therapists are also not expected to think about what they think clients might know. Instead therapists must be informed from clients of their beliefs, thoughts and feelings and use the formulation as an explorative tool to understand the presenting problem and to conceptualise underlying beliefs about therapy itself. It would seem that the emphasis of the use of Socratic questioning within CBT as a way of understanding the presenting problem, also provides an opportunity to explore preconceptions that might exist about being in therapy. Therapists appear to suggest that the importance of making room to consider what clients think about being in therapy is as much a part of an exploration of the presenting problem itself. The importance of self-monitoring, is a process that therapists appear to use during therapy to ask of their clients and be

informed by them. The importance of self-monitoring is fundamental as Jane showed that being led by assumption can lead to feelings of guilt due to having expectations about clients before being informed by the client. Working with preconceptions is clearly very difficult. The process of managing preconceptions appears to exist with balancing knowledge, self-monitoring and the use of conceptualisation.

3.4.2. My Experience

Throughout the interviews there was a sense of therapists having so much knowledge and having then to be mindful of how this is best placed. There appeared to be a feeling of apparent freedom or perhaps relief in being able to work with CBT fluidly with an integrative approach, by exploring clients' preconceptions and beliefs that might exist from a cultural standpoint of Black clients and what they might think or feel about therapy itself.

It became clear through the interviews and analysis that therapists use their past experiences to build their knowledge and CBT skills to work effectively with their Black clients. The challenge therefore is in translating this experience in the therapy room. James begins with describing this challenge of knowledge, experience and translation balance in practical terms:

> *"…it took me 2 years to do my postgraduate diploma and then another 2 years to do my Masters and then my doctorate so in terms of academic knowledge, I have lots but translating it is the problem." (James: 213-216)*

James then explains that the issue of translation is a skill. Despite qualifications and empathy there is a skill required in working effectively and therapeutically:

> *"You can have compassion for all you want but if you do not translate it in the way you say and how you translate it, regardless of ethnicity it won't work." (James: 305-307)*

James appears to emphasise the technique is through translating knowledge by what the therapist says and how they say it. The term 'translation' is used a number of times by James which could mean the act of communication. Language is a key part within the process of engaging clients in therapy in order to apply knowledge about CBT and how this could help in practical terms. James goes on to state that being newly qualified, he would be inexperienced with translation and may not be able to

provide this effectively. Having experience therefore allows James to be able to consider *how* best to work:

> *"…if I was newly qualified then I would see CBT in very black and white terms, but having experience, I use CBT in conjunction with other modalities, it's no different in terms of how you utilise it, because CBT is not exclusively black or white, CBT is a technique it's a method, it's how you utilise the method" (James: 297-301)*

James continues:

> *"I'd be so focused on the way I should do things, you tend to forget that the person is a human never-mind about what ethnicity the person is." (James: 322-324)*

James appears to suggest that shortcomings exist of CBT that get in the way of the therapist communicating effectively with clients. The ability to manage preconceptions and effective communication with Black clients is important to open up clients to therapy and breakdown stigmas. What seems to be suggested by James is that this important aspect of connecting with Black clients is prohibited by some aspects of CBT where therapists are having to focus on 'doing things'. In terms of a lack of experience James describes that the focus as a newly qualified person will be on the model or technique over the person, therefore 'getting in the way'. It becomes easy then to lose sight of personalising CBT and cultural identity rather focusing on the structure in doing things in a prescribed way.

> *"Because like any of us, once we're qualified we are so energetic in terms of just trying to get our knowledge across. Knowledge is just a concept, CBT is a concept, no more no less, but it's how we utilise it." (James: 341-345)*

Liz reiterated this perspective:

> *"I've had a number of years of experience. I think if I was freshly out of uni and working in an IAPT service for example. I think at this point I've learned to adapt CBT to different backgrounds." (Liz: 7-8)*

Like James, Liz uses language like 'fresh' to emphasise an idea around therapist ability in relation to experience. Liz goes on to say that over time as her CBT experience has naturally matured, so has adapting CBT to different client groups. The connection between ability and experience suggests a very personalised way of *doing CBT* even with a specific model. Wendy further emphasises this in the following:

"…what's coming up for me is the way I've transformed in the way I am, not as a therapist because I guess before I came into being a therapist I've been a social worker and that sort of pruned me and opened me up to it being about the people I'm working with not just my own…you know it's not like "oh I've got this good thing I'm coming to give to you" but to open them up to what is in them so that is what my social work training gave to me which I put into my CBT training and put into my counselling psychology training and I find that's so compatible with that." (Wendy: 117-127)

Here Wendy describes her past experience in social work and how this plays a role in framing how she translates her work with CBT. In the previous sub-category similarly to *James (111-116) - Dropout*, Wendy highlights the importance of the relationship, in particular her experience of being opened up in the way which her counselling training has made possible.

Seb goes on to share that he has been able to build his experience and knowledge through continued professional development and courses run by specialists:

"you know and I think that a lot of my training was afterwards, er, through what I see, you know looking and watching the press, you know so when I see Padesky coming…run and pay for it, do it! When I see Stephen Holland coming, you know complicated depression…run and pay for it, do it! When I see Sabine Wilhelm coming, you know for OCD, do it." (Seb: 21-30)

The use of past experiences, job roles and education all count towards experience. The suggestion here by Seb, along with James and Liz is that being newly qualified is associated with an inability to know how best to work with clients perhaps in particular instances. James goes on to describe that the approach is something that requires development:

"That experience has made me to be, helped me to understand that the modality is secondary to your approach. Then if the approach is right, CBT can be as effective as any other modality. Because thinking process is what we do, we are different from you, only we think. But if you put it in a clinical way, how CBT works, then especially so for ethnic minorities to understand where you're coming from." (James: 328-334)

Therapists must consider this translation of knowledge using a personalised approach drawing from job roles, continued professional development training and general life experience.

The translation of knowledge seems to be an important part of understanding how to work with this client group. Therapists seem to suggest that working with this modality develops over time in order to work transparently with this client group, after which time then there is room and perhaps a confidence to incorporate the cultural considerations that are necessary to work with a diverse client

group. These therapists appear to suggest that newly qualified therapists are too incompetent to provide the cultural insight required to engage appropriately with diverse client groups.

3.4.3 Adaptation

There are different ways with how therapists work with CBT depending on the client. Integration emerged during interviews of how knowledge is exchanged. This subcategory highlights therapists' experiences in adaptation, to get a closer look at what this might look like in relation to how aspects of CBT might be changed or utilised in addition with other methods of working during therapy with a Black clients. James summarises this directly:

> *"…I use CBT in conjunction with other modalities, it's no different in terms of how you utilise it… CBT is a technique it's a method, it's how you utilise the method that encompasses the humanism within it. Then it could be CBT, psychoanalysis, person-centred, it could be acceptance commitment therapy or even sub-confession therapy." (James: 298-304)*

James begins by describing his use of CBT along with other modalities and how this is best achieved. He seems to suggest that other modalities including person-centred and Acceptance and Commitment therapy (ACT) help to draw out a humanism focus from CBT. Using a humanistic perspective emphasises the whole person:

> *"…if you adapt it to the humanistic model then it encompasses disability, ethnicity, gender…anything else that just encompasses it." (James: 314-316).*

James gives a sense that CBT is not humanistic enough and needs help to connect with the other, fully and more intimately in order for a client to feel engaged. James goes on to further make this point:

> *"CBT in some ways is like psychoanalysis because psychoanalysis, I'm sure you're aware that it's very middle-class, you know it's very robust and it's very analytical and it needs a bit of intellect. CBT in some way has those kinds of traits that you have to think, you have to analyse, you have to conceptualise. But imagine working with an ethnic minority? For them it's so alien to have therapy…working on your thought process, because to them it's just not about thinking although it is, but to them it's about how they feel. So that's why I say the knowledge that I have of CBT and with other modalities is there, but translating it to a level where the patient can relate to you that is the key." (James: 257-269)*

The use of language here is interesting and quite descriptive in terms of how CBT is viewed by James and how he then might think of CBT in relation to how he views his clients. James describes CBT as middle-class, robust, requiring analysis, conceptualisation and requiring intellect. There is a

sense here that some clients from minority groups might be disproportionately less educated than some groups and therefore might not be cognizant of the style of therapy framed around thought exploration where the expectation might be to focus instead on feeling. With that said, the importance of using other modalities to translate CBT in a way that can be meaningful is a method that James highlights as the key. Like James, Wendy too shares a similar view of the role that intellect and education have in the ability for a client to work well with CBT:

> *"I think it's just some people are ready for…some maybe middle class…maybe white middle class educated people can adjust to CBT you know like er…very prescriptive…'yeah let's do cognitive restructuring', but whether it's black people or white working class I find that you can't just do CBT to use as usual with them." (Wendy: 168-173)*

Like James there is an emphasis on social class and what the reference around this might suggest. Wendy goes on to say that in her view a CBT approach cannot be used singularly with Black people or white working class due to its prescriptive nature. She goes on:

> *"I've sort of moved on from doing Beckian CBT and I'm more into Acceptance and Commitment Therapy now so even though I say I'm a CBT Therapist I do more Acceptance and Commitment Therapy and this third wave therapy because it's so humanistic." (Wendy: 177-181)*

Wendy expounds on her preference of incorporating ACT into her work:

> *"Well another thing I have learned along the way, just adding, ACT is a Mindfulness-based CBT approach and when you are working…it's relational it's not setting yourself 'you know I'm the expert and I'm doing this to you' you don't do ACT to people you do it with people." (Wendy: 199-204)*

I wondered about the assertion here and what might be implied. Like James, Wendy also describes incorporating ACT into her CBT work. Wendy describes ACT as a Mindfulness-based CBT approach, assuming that this approach offers a relational style unlike that of traditional CBT which positions the therapist as the expert who 'does things' to the client.

As part of the interview schedule, research was shared with therapists of adaptation opinions. I wished to share with therapists of the questions being raised of the suitability of CBT and of the suggestion around change to the protocol. When asked about the recent call emerging through research for CBT to be adapted for ethnic minorities and what her thoughts were about this Wendy responded:

> *"Do you know that people have adapted CBT… as far back as…maybe 2007 or 2006 I went for training…Systemic family CBT…so embedded within the 5-areas approach of CBT is the systemic, so it incorporates the systemic approach with CBT. Some people do*

CBT for couples and they put the ecological approach in there, the family of origin and just listening." (Wendy: 328-339)

Liz similarly shares of changes to CBT that she has made directly resulting from diverse ethnicities that she has worked with:

"I've worked very diversely I think I've been lucky enough to work in various boroughs of London, which is very diverse and erm…I've worked with lots of different ethnic backgrounds and so I've learned to adapted my CBT skills to fit the person that comes to me rather than them fitting the CBT box. So I've made changes here and there, I might sometimes talk about religion, I might not, I might just talk about a culture, depending on what's relevant to the client and I might bring that in as and where it needs to." (Liz: 119-123)

In contrast however, Liz also emphasises that treatment efficacy is not placed solely on the technique, if at all, but on the style in which therapy is applied. It is therefore down to how the therapist works:

"I think therapists need to be aware of the impact that culture has on a person and mental health and how to adapt CBT, or the relevant questions to ask. Does CBT need to be changed? I don't know actually, the techniques work as long as you have an awareness of cultural difficulties or backgrounds or…I don't think necessarily the protocols need to be written again. Adapted…again nothing fits for all. I mean there are differences between BC, BA, BB as you said so how many adaptations do we make? I think we have a standard and then we, as therapists, adapt it to the person sitting in front of us." (Liz: 100-104)

Cultural awareness is highlighted here. Liz emphasises the importance that therapists must have and an awareness of where a client may be coming from can assist with understanding the presenting problem which directs the therapist and the conceptualisation process. Liz directly questions whether CBT needs to be adapted and answers by inferring that the principles are themselves universal but there must be some awareness on the therapists' part of issues arising culturally that might require addressing.

Similar to James and Wendy, Kate goes on to describe how through her training she developed her primary CBT work, supporting this with the use of other frameworks:

"…psychodynamic approaches, systemic and other models like CAT…so I would say we were fed a lot of ideas, so sometimes I would be thinking from different perspectives…I would say my practice would've been CBT informed but kind of supported work, exploratory, when that felt like that was appropriate. Yeah so I think that's what I mean when I say not really being hard-core CBT." (Kate: 29-35)

Kate does however report that soon after completing the High Intensity training this impacted how she further practiced:

"…that really sharpened up my CBT practice….and tightened up my thinking and for a while after that I was working in quite a structured CBT way…my practice became quite tightly focused around CBT." (Kate: 22-24; 38)

In contrast to earlier shared experiences from James, Liz, Kate and Wendy of adapting CBT and in response to being asked about experiences of adaptation Seb responded:

"…I don't think it's a case of adapting the CBT…you know, CBT that's specially adapted for autism yes, but I think, you know CBT that's specially adapted for short people, or CBT that's specially adapted for dark-skinned people?..." (Seb: 258-273)

Seb appears to see the relevance for working differently with CBT with a client presenting with social learning difficulties, but not in cases of ethnicity or for framework change. Seb appeared to be sarcastic at this point in referencing 'short' or 'dark-skinned' as a means for adaptation.

**Memo Reflection excerpt:*

I found myself thinking about reflexivity here. I was becoming increasingly irritated by what I felt was Seb's indifference to the research. Or was it to me? Did Seb feel that I might be indirectly suggesting that Black clients need to have specially tailored therapy? What was it like talking with a Black researcher about this topic at this point for Seb and how was this making him feel? If I were feeling irritation and some degree of discomfort I wondered if this was something that was being felt in the room and if so skewing the research content.

It is clear that some therapists including Wendy and James here can see the benefit of using adaptive methods, including the introduction of other modalities, such as ACT to translate their knowledge to tailor CBT to Black clients. As Counselling Psychologists both Wendy and James have learned to develop a personalised style influenced through their training and experience. Interestingly as a CBT Therapist, Seb appears affronted at adaptation suggestions for CBT to the point of being offensive. I wondered how this might translate during his CBT work and indeed of his willingness to work flexibly with clients where cultural sensitivities need attention. Therapists do appear to have different methods of how they work with their clients and the exchange of knowledge of CBT. The need to take more time with Black clients in order to build up therapeutic rapport seems to be needed for therapists to be able to work more effectively with clients on matters concerning cultural aspects

that may demand more time and attention. This development of style is further explore within the next category.

3.5 Category 3: Developing my therapy style

As described in the previous categories, there appeared to be a sense from the therapists that CBT can seem too structured and prescriptive, perhaps for the therapist in their preferred way of working. The translation of knowledge and *how* CBT is used in relation to working in practical terms with their Black clients will be addressed in more detail. This category continues with focusing on *developing my therapy style* and how therapists build on utilising various approaches, positions and techniques. The three sub-categories *humanism*, *training* and *flexibility* were developed from therapists sharing such views as to what they felt were the most important aspects underlying their CBT work.

3.5.1. Humanism

Within the previous sub-categories including *rigidity* and *adaptation*, therapists appear to criticise aspects of CBT on the basis of adopting a CBT approach using socratic questioning, homework and therapy materials. Both Wendy and James shared that they combine CBT work with other models. The suggestion seems to be that without this combined or integrative method CBT as a therapeutic approach appears to be lacking something that might be required to work with their clients who have presented from Black backgrounds. There appears to be a relationship between the application of CBT and the role of humanism. The subcategory *humanism* explores the deeper meanings of how therapists feel about CBT in relation to working with particular clients and gains a further insight into their opinions as to why they feel working with some Black clients might be challenging. Suggestions of incorporating humanistic models into CBT work are presented. James begins by making a categorical statement about CBT with regards to humanism:

"It's non-humanistic." (James: 284)

James then goes on to explain what he means by this:

"CBT is a technique it's a method, it's how you utilise the method that encompasses the humanism within it." (James: 300-301)

James explains that CBT is a technique and therefore is simply a way of executing a particular framework, which comes back to the importance of translation. As previously highlighted it is the style whereby CBT is explored which will elicit a humanist perspective, making CBT feel more personal. Seb describes just that:

"I treat the person in front of me irrespective of the skin colour." (Seb: 60-62)

Seb continues:

"It comes back to the person. You're treating the person, it's a person sitting opposite you." (Seb: 214-216)

Seb appears to imply here that a person is not synonymous with their culture or can at least be explored or seen separately, which seems hard to imagine. The repetition of the word 'person' seems to emphasise the importance of seeing one as an individual and how then they might communicate their own views. Wendy goes on to describe why humanism is so important. She however differs from Seb in counting ethnicity very much as part of the process, where Seb does not:

"I learn how to see people as human first. And because it's important within the Black population people need to be seen as 'I am Black' because being Black has been seen to be something that is a deficit, you're not human enough so if you don't recognise my blackness then you're not recognising my humanity, that I'm human and I think that's so important and I've seen some of my white colleagues who want to embrace that and then the black client might feel that they're patronising, so they feel like they're can't get it right" (Wendy: 556-565)

I felt that there was so much being said here regarding identity. There are contrasting views between both Seb and Wendy taking place. Wendy was passionate in communicating her thoughts about what she feels her clients might have felt about the importance of being viewed by their ethnicity and what this might mean for them. Wendy seems to convey that 'seeing the person as a whole' can help in viewing them as more human and perhaps less 'patient'. I felt that Wendy had very strong feelings around humanity and ethnicity. Alongside the contrasting views of Seb and Wendy, reveals also the contrasting ethnicities of both therapists, with Wendy as a Black African therapist viewing the importance of assuming a humanistic view with her clients as inclusive of their ethnicity as an aspect to explore. Seb, as a White South African therapist felt that assuming a humanistic position with

clients seems to refer to ethnicity holding less meaning and perhaps need for exploration. It would seem that Wendy felt that adopting an exploratory humanist position to her CBT work was very much the standpoint that she adopted prior to perhaps delving into exploring the presenting problem. James also shares this view:

> *"Yeah if you adapt it to the humanistic approach such as self-actualisation, self-esteem, their needs, then it encompasses disability, ethnicity, gender…anything else that just encompasses it." (James: 313-315)*

James had shared a similar view with Wendy where a humanist approach encompasses all things including ethnicity which places the person very much central. I thought about James' earlier statement that he did not feel that CBT was humanist which made me think that James believed that the best way for him to work with CBT was through the humanist model. By not assuming this position then raises potential risk which James goes on to state:

> *"I'd be so focused on the way I should do things, you tend to forget that the person is a human never-mind about what ethnicity the person is." (James: 321-323)*

James highlights the potential risk of losing the client. Through-out the interviews there has been a sense that the structured nature of CBT means that there is a risk that clients may be lost through intentioned focused more on format and protocol and less on the person. I wondered if this could be a risk relating to client dropout and that on this basis, that therapists are making revisions to the work that may not necessarily take with clients from other ethnicities. Wendy continues to emphasise the relevance of humanism by specifying how CBT aligns with third-wave therapies with Black clients:

> *"I do more Acceptance and Commitment Therapy and this third-wave therapy…it's so humanistic. They actually call it the humanistic CBT [laughs]… and Black client's respond to this version very well" (Wendy: 181-186)*

Wendy for example recognised that she positions herself through combining CBT with ACT in order to develop a more humanistic approach which appears to work well with her clients. Self-actualisation and self-esteem are seen to be very much a part of guided discovery and the humanistic approach is seen to engage more directly with this.

3.5.2. Flexibility

Mostly therapists had expressed that they would draw on other modalities alongside CBT work to make it more humanistic as this method appears to work well as a method of engaging with their

clients. This does not appear to be an approach that is exclusive to Black clients but on a whole as therapists have adapted their own approach following training, in order to work more efficiently and personably with their clients. What does seem to be suggested is the need for this flexibility in order to engage Black clients with CBT work. Therapists seem to have felt a strong sense of freedom to work flexibly to develop a more personalised approach and that at times a purist CBT position felt restrictive and impersonal with Black clients where sociocultural factors such as family, religion and identity might dominate and therefore require exploration. In the previous sub-category, the importance of focusing on areas around self-actualisation, self-esteem, belonging and identity as a foundation to build on either supersede or provides aide in working with thoughts, feelings and behaviours appeared to be preferable.

Comparatively when asked about drawing on other models or working in a purist way with CBT Liz stated:

"I think that's up to the therapist, because the protocol is written for everybody" (Liz: 78)

Liz describes that as the CBT model is a 'one size fits all' the therapist must have the freedom to explore the best fit. There is responsibility for the therapist to take on the choice as to how to work with a protocol that can work for all. Liz goes on to describe, more specifically why working flexibly might be important using the depression model as an example:

"…so if it's a depression protocol if you do it strictly, then you're not asking, I can't think of which protocol includes culture in it (laughs) or to ask questions about it. I'm thinking about the Becks depression model. So the background, the assumptions, it doesn't ask about cultural experiences it just says 'experiences'" (Liz: 78-81).

Liz highlights two things here using Beck's depression model as an example. She begins by talking about working strictly with the model, trailing off slightly before stating that the model does not include aspects around culture. She suggests that working strictly excludes personalisation. Further stating that the model "just says 'experiences'" opens up the idea that there is perhaps something missing within formulation which does not clearly specify cultural factors.

It is important then for the therapist to think very specifically about what those experiences are. When asked about the opportunity to be flexible during sessions, Steph went on to share that she has had to become more flexible with some of the clients that she has worked with from particular backgrounds:

> *"…thinking of the way I practiced with the Caribbean clients has impacted the way that I usually have to think flexibly in the way I present the treatment as a whole" (Steph: 49-52).*

I was curious about this and asked Steph if she might be able to elaborate in order to explain what she meant by 'having to think flexibly' and what she felt were the reasons why she had to take this position in particular with Caribbean clients she had mentioned:

> *"Okay so compared to how I would work with maybe somebody who was White British for example my experience of working with Black African or Caribbean backgrounds, they usually have difficulties engaging or with continuity in treatment so when you present the model in its strictest form whereby its very structured, its boundaried, agenda, homework, all of those things seem…erm…too much work for them should I say" (Steph: 57-65)*

For Steph she makes direct comparisons between White British and BA and BC backgrounds in terms of how she might work. Her reasoning seems to be around the issue of maintaining engagement, as she had previously shared, in category 1 that she has experienced several dropouts with her BA and BC clients in the past. She goes on to state that presenting CBT in its "strictest form" such as the agenda and homework seem to be perhaps overwhelming or perhaps does not meet with initial therapy preconceptions. Steph continues to explain her views on the impact of homework:

> *"I have had feedback in that 'Oh I didn't have time to finish my homework…I forgot…I didn't remember…or I thought I could do it in session…I feel better talking with you in session rather than writing' yeah so comments like that the focus has been how do I engage them in treatment so that you reduce the risk of dropout so there has been that need to be flexible that's what I mean" (Steph: 65-72)*

Steph describes that clients often give a number of reasons as to not doing homework, instead preferring to talk. The focus for Steph is about finding ways and means for her to maintain treatment engagement and then to be flexible with how she might formally approach CBT with that in mind. James seems to hold a similar view to Steph regarding the use of homework:

> *"CBT first of all you come here, we really need to get into the homework but you have to adapt it. What I do especially with people who are ethnic minority, I don't do thought records (James: 218-221).*

James highlights thoughts records specifically as something that he does not use. He goes on to describe the impact of what it might feel like for the client not completing thought records:

> *"…and sometimes when they don't do it, they're so scared to come to the session because there are things that you're supposed to do for the session and because they haven't done it they feel so bad" (James: 235-239).*

Liz also shares similar views:

> *There was some resistance in doing thought diaries, writing it, making it become more real, that kind of stuff. (Liz: 46)*

Along with Steph, James and Liz, Jane also described a similar experience:

> *"I don't know, I feel that my overall CBT approach depends on who I'm working with but I just find that certainly BC clients I've worked with don't really do written homework. They want to talk about things. Often making behavioural changes is something more they can get their teeth into and see change." (Jane: 173-177)*

Jane it seems choosing to focus more on behavioural elements of CBT over cognitive, as shared by Liz:

> *"Behavioural Activation I think was a good way in, because there was some change and then the cognitive side of things, but then that's not specific to the black clients" (Liz:47-48)*

Liz echo's Jane's sentiment that having tangible change was important perhaps prior to cognitive work, but that this is not exclusive to black clients. James gives an account of how he might work in place of doing homework, namely thought records:

> *"I don't do thought records but then I do post-mortem, post-incident, get them to the situation where they felt negated…low self-esteem in their mood…then we establish the alternative thinking that they could have…through dialogue rather than through thought records and it's very effective because if it's retrospectively then they can actually reflect at that moment" (James: 220-231)*

James highlights the emphasis of guided discovery and the collaborative approach that he prefers to use. He describes 'dialogue rather than thought record' and feels that this is effective.

I was struck by the shared experiences of therapists who felt that written homework is something that they don't often reach for with Black clients. I wondered about therapists having to balance the collective preconceptions perhaps held by clients about therapy, as earlier discussed and tailoring CBT to clients' needs. There is something about the client's expectations of therapy, Liz describes, that directly influence how she might practice in order to meet expectations and treatment goals. Of the

clients who express indifference towards 'classic' CBT methods including homework, Liz is directly informed by what the client needs by asking questions at the beginning of therapy, tailoring CBT around this:

> *"I guess that's something that I address at the beginning of treatment ideally and work through that." (Liz: 31-32)*

Liz continues:

> *"…this is quite a strategy-based treatment and is that what you're looking for? Are you able/willing to do homework for example or tasks as I call it outside of the therapy room? and often people will say 'I'm not sure about that', or 'that wasn't what I was expecting of therapy' or of how it should be done in the room almost. So it's the thought of doing outside tasks wasn't part of the expectation of therapy. Whereas I think, maybe BB do a bit more research on it, I don't know" (Liz: 35-38)*

Liz uses the client to guide how flexible she can choose to be based on what the client might bring to the session and being open at the beginning of the session regarding the type of therapy, opening up a discussion about therapy expectations. Wendy describes the benefits of flexibility to go beyond the presenting problem:

> *"But I think the reason why CBT is so popular amongst certain therapists it's tangible you're just working on a small area, but you can ask can you really divide people up? We are whole beings. So if somebody comes to me and they are feeling anxious or are having panic attacks and I'm just working with them to get on the panic, that panic attack comes from somewhere, it will be longer but it's more effective than me just saying okay tell me what are your thoughts, when was the last time you had a panic attack…" (Wendy: 63-69)*

Working flexibly seems to take the form of the therapist being creative in finding ways to explore the presenting problem along with the client to identify expectations for therapy. Moving away from traditional methods of homework, thought records and using the session time to focus on issues seems to be an important part of practice.

3.5.3 Training

Throughout the interviews therapists shared their views on their overall training, including positive and negative aspects and how many continued with further training through continued professional development programs. The importance for therapists developing cultural sensitivity is observed as occurring through theory and teaching practices and experiential learning. The impact of training on clinical practice was keenly shared by therapists who gave individual accounts of how their

personal development has been influenced with a general agreement that more was needed in training programs to include aspects around diversity. Early on in the interview Seb who practices as a CBT therapist shared his views on his CBT training:

> *"…both the lecturers were Counselling Psychologists and for instance one lecturer said that she never ever in her life asked somebody to fill in a thought record sheet and she never will, she said "what rubbish is that?" (Seb: 12-17)*

Seb makes reference to the course conveners being from a counselling psychology background. He goes on to state what he feels about this:

> *"I think my training wasn't fantastic…I just don't think the training was wonderful that's all." (Seb: 6 -11)*

Seb continues:

> *"So they, from a counselling background and you know, so the training I don't think…the training was not great because I think it was just to get 'the stamp', you know and I think that a lot of my training was afterwards" (Seb: 17-23)*

Initial coding and recoding was given as 'poor training.' I wondered if Seb felt that his training was insufficient due to the Counselling Psychologists directing his course. He views his training as 'just to get the stamp' – as if the training seemed protocol driven. Seb goes on to describe how he managed this going forward, taking an independent approach to add to his learning through training events:

> *"…a lot of my training was afterwards, er, through what I see, you know looking and watching the press, you know so when I see Padesky coming…run and pay for it, do it! When I see Stephen Holland coming, you know complicated depression…run and pay for it, do it! When I see Sabine Wilhelm coming, you know for OCD, do it. But I think my learning was after that. (Seb: 22-33)*

I observed that Seb emphasises more than once that his learning was after his initial training on account of feeling that his CBT training was inadequate. When asked about aspects of diversity within his CBT training, Seb responded:

> *"No there was no extra training on that no…well let's put it that way…there could have been one session on it but if we did I can't remember it, it wasn't very good" (Seb: 37-40)*

Like Seb, Steph also practised as a CBT therapist. Steph speaks more directly about her views on her training and aspects of diversity which she felt was missing, consequently leaving her feeling unprepared for working confidently with that in mind:

> *"…there was a bit about diversity but not enough to give you that, what you need to practice as proficiently as you'd like… So generally it didn't feel like it was really enough" (Steph: 22-24; 31-32)*

Steph along with Seb shared the view that efforts were poor regarding CBT training, specifically on aspects of diversity and not having this suitably explored. When asked about diversity Kate draws a comparison between her high intensity (CBT) and clinical psychology doctoral training:

> *"Definitely within the clinical psychology training, I can't think of that on the high intensity training…" (Kate: 41-42)*

Kate who works as a Clinical Psychologist goes on to say:

> *"…in the high intensity diploma, so no lectures on diversity itself…I remember lecturers kind of touching on it, or saying 'okay now we come onto the diversity bit' almost…like a token thing…Yeah so it was more emphasised on the Clin. Psych training and not as much on the CBT specific training." (Kate: 46-57)*

Kate seems to make an interesting observation through comparison of her CBT and clinical psychology training, who like Steph and Seb feel that there was not enough, if anything included on diversity. Liz, who practices as a Counselling Psychologist also felt that she was adequately prepared for working with diverse groups through her Counselling Psychology program:

> *"My CBT training was very structured…it was mainly done under my Counselling doctorate" (Liz: 2-4)*

Jane also shares a similar view with Liz:

> *"My CBT training compared to my counselling psychology program did not cover aspects on diversity, but the DPsych did. That's also reflected in my practice, so for instance if I am working in a CBT way, at work you just go through the standard assessment information then work according to that." (Jane: 34-36)*

There appears to be some differences in the experiences of CBT therapists and Clinical and Counselling Psychologists in terms of feelings about training. It is interesting that CBT has been described as fairly structured throughout interviews and protocol driven and for this reason is perceived as unhelpful for this, especially when working with Black groups. I wondered about this being reflected in the training, not leaving room for exploring much around diverse populations and more on

technique. I reflected on my own training primarily as a CBT therapist and more recently as a Counselling Psychologist and found myself sharing similar views with both Kate and Liz. Training programs often value cultural competence and sensitivity.

In terms of training and diversity, John highlights the importance of existentialism, sharing his views on how therapists could benefit in exploring aspects of diversity in a 'felt' way:

> *"...I think the point is that maybe one of the aspects you need to look at is to get sessional kinds of lectures from a therapist with an ethnic background about how they share their experiences because telling a therapist to be sensitive is one thing, it's about actually gaining experience, experiential learning is the best way rather than through a classroom lecture I think, that is something I think further development from research would be useful." (James: 360-369)*

John shares a practical perspective on incorporating experiential learning into lectures using a sessional approach through therapists from non-white ethnicities. He continues to emphasise the importance of existentialism in training:

> *Then I did existentialism which is one of the great things you can do that we are all human beings at the end of the day (James: 207-209)*

John continues:

> *"...anyone can go to school and get a diploma and a degree, but experiential learning is far more valuable than that." (James: 406-407)*

Wendy shares her views on CBT and training bringing it back to humanism:

> *"So I think CBT has been found to work and I'm not just going to throw away the baby with the bath-water, I'm going to say that CBT is useful, but CBT training needs to give so much more credence to people's culture and worldview and ethnicity because that's what makes the man or a woman. When you see me, the first thing you will see is me being a black person but it's not just about colour it goes deep into everything I do, what makes me tick, how I view relationships, how I view the role of female or male you know?" (Wendy: 339-348)*

Wendy suggests that CBT training is not fully recognising culture in clinical practice. I wondered if the underlying criticisms that seem to be coming through of CBT, the rigidity and need to adapt, was not in relation to the model or CBT principles but the lack of aspects around cultural content and sensitivity within training and how this influences *how* CBT is applied in practice. Wendy states that the model of CBT works well, but that it is the training that requires broadening, to bring alive aspects of cultural sensitivity required to see the client holistically. In contrast to Seb in the previous

sub-category, Wendy states that you cannot separate the person from their culture which is entrenched within all aspects of how a person functions; therefore for those clients from Caribbean and African backgrounds, beliefs-systems, behaviours, interpersonal relationships and outlook make up the functionality of the individual, bringing the training to life and that it is these aspects that are lost within training.

I wondered that Counselling and Clinical programs allowed more room to think about the client, the person primarily, allowing the therapists to adapt, shift and work more freely depending on the presentation, CBT [therapists] perhaps allowing less freedom to do so. The interviews seem to reflect a difference in the degree of satisfaction from therapists regarding their training focusing on diversity issues and consideration arising from working with clients who are from this group. Those regarding themselves as CBT therapists, or who have had core training in CBT therapy, appear to be less satisfied with their training on aspects of diversity than both Counselling and Clinical Psychologists who felt that issues surrounding diversity were adequately met.

3.6 Category 4: Curiosity

Throughout the interviews a clear category that emerged through the transcribing process were therapists' views on assuming a position of curiosity in relation to developing sensitivity with cultural identity to assist with conceptualisation and treatment. The recognition from therapists' who shared a similar cultural background to their clients was to not assume knowledge of their clients' experiences. This was seen as particularly important for therapists to truly understand where their clients are coming from but at times was a position that was difficult to maintain. Maintaining a position of curiosity is important to hold when working in psychotherapy as a whole but for therapists who shared their views in interviews, emphasis was placed on the relevance of this position in terms of culture and how this relates to their clients within the context of therapy.

3.6.1 Culture

This category was labelled *Culture* following Wendy, Seb Jane and Kate's views on how their clients' collectivist views influenced how therapy was done. The concept of being open and curious to culture opens up the idea of what this can look like in practical terms in consideration of formulation

and the approach to conceptualisation in CBT. Liz offers her thoughts on formulation and where culture fits in this. When asked about her views on aspects around culture and how she approaches this in her work she stated:

> *"…with the person in front of you, I think it's you know, it's relevant; it's not written in the protocol but…it's assumed that therapists would maybe integrate that into the work that they do" (Liz:83-84)*

When probed further Liz continues to share what integration might look like using a longitudinal formulation as an example of how she might incorporate a more personalised approach of cultural aspects and conceptualising with her clients, alongside questions that she might also ask to illicit experiences from her clients:

> *"It would maybe be 'cultural experiences', so maybe something labelled 'cultural experiences' so experiences…not everybody then may pick up on 'cultural experiences' and you know often it is important to ask that question, whereas it maybe just 'experiences' – 'Okay I've been bullied at school' actually what about your family background? 'Are you bullied within your family unit because, I don't know because you don't have white skin or you're really dark. So then those experiences are also important that may not necessarily come out with just 'experiences'" (Liz: 86-90)*

It seems that for Liz having a literal 'cultural experiences' component within formulation can be helpful to guide conceptualisation as therapists might not pick up on cultural specifics within 'experiences' alone. The need to delve deeper is helped by guiding experiences of the client in a particular direction or focusing on particular aspects such as skin colour, self-esteem and identity that might otherwise have been missed. Along with Liz who highlighted this suggestion, Wendy also shared the view that there is an assumption that therapists will explore culture, going back to the importance of curiosity:

> *But I think it's just about being curious not assuming that we know. Just curiosity. So what does this mean for you? Is this what it would mean to somebody else from your background? But that might be for a Black person, because the way we all take on from our culture is so different (Wendy: 565-570)*

The similar views coming out here seem to be around the importance of curiosity, questioning, and conceptualisation. Wendy asserts that it is on a cultural basis that each of us operate differently and that this should be the foundation on where exploration should be based. I wondered if aspects of CBT including psycho-education can be difficult in maintaining a curious position. Liz seems to prefer a named section on culture as an inclusive part of the formulation which would help with questions and

eliciting experiences from clients. Wendy however describes curiosity and questioning going hand in hand to maintain a constant source of personalisation throughout conceptualisation:

> *"…If you're going to be an effective therapist…I think you should be curious about what makes people, what makes them tick and it's much more than the person or even the family basically in front of me. So CBT…it needs more people to be trained to take on the culture and it's not just about saying 'oh well you need to understand this' it's about cultural competence how do I become curious about where people are from?" (Wendy: 350-358)*

Wendy highlights the importance that training has once again in becoming cultural sensitive. She goes on to describe that becoming culturally competent is achieved by remaining curious through questioning clients and therapists questioning themselves occurring as a simultaneous process to ensure that curiosity is being maintained. Similarly to Liz and Wendy, John also emphasises the importance of exploring culture through questioning from a position of curiosity:

> *"So culturally as therapists we need to be very acute in what we conceptualise, our case and our formulation to see what you can do…culture should be explored in a Socratic way" (James: 171-179)*

This style of questioning - Socratic, which is an important aspect of CBT, places the client very much at the forefront of leading the therapist in their world through Socratic dialogue. In this excerpt James makes the statement '*therapists to be very acute'* similar to Wendy in the previous excerpt who described '*cultural competence'*. The statements suggest the responsibility and the role of the therapist in terms of developing a cultural understanding, sufficiently building an awareness around this and what this might look like for the client. Each phrase here seems to illustrate both an external and internal demand. I wondered what this might mean in terms of pressure previously voiced by therapists and the need to get it right. Much seems to rest on success and the ever-present risk of incompetence. The formulation used as a tool to guide with cultural competence is also highlighted by Jane as a method of choice similar to that of Liz. However Jane describes building on sections within an already established model to personalise work:

"…so for instance taking the 5-area model I would build around that, adding sections depending on what's being said to tailor the formulation. I do usually ask about faith and prayer as this can often be something that they, clients might stop doing when they're feeling depressed let's say. So for

example, asking "in relation to unhelpful thinking habits, are there more positive or helpful thoughts that you could think about such as the importance of your faith, culture and family?…Also they might stop going to church, so in terms of community they're feeling cut off socially. Or what is the experience of being Black to you? This often will be an important part of CBT work, especially with clients whose Caribbean or African culture resonates strongly for them; so yeah placing 'identity' in there is helpful" (Jane: 163-172).

Jane highlights some interesting points on the formulation and questioning as methods of guiding CBT work. Building on the CBT model for Jane helps with gaining a picture of cultural understanding close to the clients' experience by adding to it; taking up a position of curiosity again features as a means of exploring generational and historical influences that are important for the client in making up their here and now experience. CBT here, becomes culturally responsive, where Jane provides an example of reconsidering unhelpful thinking by directing a client to think about cognitive and behavioural shifts, based on previously identified important cultural aspects that have been added to formulation. In this way, the work begins and remains culturally contextual for clients according to their own frame of reference and identity.

The views of Jane, Wendy, Liz and James highlight that 'client' cannot be separated from 'culture' and it is of utmost importance to understand what that culture actually is. Culturally responsive CBT then requires curiosity where the therapist commits to learning about cultural history from within the therapy room rather than being influenced by this from outside of the therapy session. A 're-working' of the CBT model and flexibility with formulation is also another aspect of building cultural sensitivity and competence for therapists where a picture can be made that provides a method of guiding Socratic questioning and insight for the client. Adding sections to formulation on 'identity' and 'cultural experiences' could aide in deeper exploration.

Suggestions from therapists support the idea that it is the client's job to educate the therapist about their culture and that therapists, although cognizant of certain ideas, stereotypes or personal views they might naturally hold, should not be influenced by them. This view is in contrast to some research later discussed within the discussion chapter. Overall, the role of culture in working

efficiently with clients from Black groups cannot be underestimated. Therapists do appear to use CBT well in drawing out meaningful aspects for clients. The emphasis appears to be less on the CBT on more on the therapist and their ability in *how* they use the model, *how* they follow the clients' story and what questions they ask to gain deeper meaning and insight.

3.6.2. Collectivist View

When asked about using the working model of CBT, commonly known as the 5-areas model all therapists described the importance of themselves holding a curious position with clients, in this case those from Black client groups. Therapists also expressed that the model of CBT is very much centred on exploring the individual which could often be challenging for working with clients whose culture advocates viewing self-identity through family and community contexts for which they have become used to. Wendy offers up a reason for this challenge by firstly reporting collectivist views held by clients and the role of community:

> *"…it's a community, experiences as a child, it's not about the individual it's about the collective, so the community sets pace of what you do and so if you are doing therapy, CBT for instance with somebody from African Caribbean or from BA origin maybe they might struggle." (Wendy 108-113)*

Wendy states that those clients specific to African and Caribbean indigenous communities are more likely to view their problems from a collective perspective and as such this could be difficult to engage with the concept of CBT. Seb shared a similar view when asked about working with black clients and explaining the CBT model to them in session, being mindful of where the client might be, drawing on comparisons between African and western cultures:

> *"You know so perhaps the family is a lot more important, where say in Britain or America being an individual is more important perhaps, you know, so striving for the individual and bugger the family." (Seb: 156-162)*

Seb goes on to hypothesise connections with family breakdown, mood disorders and anxiety. He continues to describe the significance of family:

> *"Where in Africa it's all about the family and sticking together. So perhaps where part of the depression or the anxiety is because of the break-up of the family." (Seb: 162-167)*

I felt that Seb was giving a personal account at this point. Seb being South African, seemed to be drawing on comparisons between cultures. He talks of inclusivity and collectivism which he

describes as central to South African culture. I wondered if these distinct differences suggests that a presenting problem having connections with the family makes it difficult for some clients to focus on themselves. The therapists then having to 'sell' this different individual perspective is the challenge:

> *I mean in South Africa we have this term 'Ubuntu' you know "I'm part of the group" and that's exactly the way of Ubuntu but it's more about the collective rather than me, whereas in America you're praised as an individual, you have to run ahead of the pack and be the best. Where in Africa it's more 'us'. (Seb: 169-179)*

Kate also shares a very similar view with both Wendy and Seb in terms of individualism and collectivism, directly specifying that CBT is less suited to individuals who adopt a collectivist view. She further draws on her own experiences with this in mind and is informed by her personal experiences in her own therapy sessions having been raised in an Asian family:

> *"...maybe what I'm noticing is more that CBT probably suits people who live, who have kind of grown up and lived in a sort of western lifestyle and I suppose by that I mean, you know it's quite individualistic, you know you have your home, you have your job, you know the family isn't the back-drop; and I suppose I can relate to that" (Kate: 166-171)*

I felt that what was also being said was something around privilege, lifestyle and ownership. Kate describes this through the focus on owning your home, holding down a job with less focus on family being the back-drop. I thought back to James' earlier comments on working in services in impoverished areas where issues around housing, social services, employment and benefits were factoring as the main difficulties.

Jane offered a similar view regarding a clients' collectivist position with a client that she had worked with recently, but however provides another view on how a therapist can work with collectivist client-views versus individualist CBT views:

> *"I remember this particular client, she was a lovely lady, really softly spoken from Zimbabwe I think. When we were doing pain and pacing work, she couldn't understand that she wasn't supposed to push through the pain. She felt that it was wrong not to. When we explored that she shared that growing up, her Mother would beat her if she did not do all her chores and that was just part of her culture. She struggled with the overall CBT model because she didn't think that she should be thinking of herself at all. But it's because of the CBT model that she saw another perspective that was different to her own. I think she just needed permission that it was okay to see things differently." (Jane: 125-133)*

What is striking in this account shared by Jane is the contrast between the client holding a stance that see's CBT as wrong, making behavioural work and pacing difficult. Jane however goes on to describe the power in offering up an alternative position which despite going against her client's beliefs, was undoubtedly beneficial to offering up change. The ability to manage these pole positions where CBT is described by therapists to be individualistic and clients from BA and BC groups are more collectivist, is overcome through being open, curious and aware of difference and using the difference to open up alternatives. I wonder if by providing an alternative perspective, both therapist and client would be curious in knowing the outcome of a pacing homework task.

This open curiosity is described by Kate who goes into detail to share how she sees the need to go beyond the model:

> *"...I'm just more open to the fact that there isn't kind of one reality or one way of doing things, you know people live very different lives, life in so many different ways that we shouldn't assume, as therapists, that people want certain things. Or the same choices are available to them as to other clients. So I think I know what we might offer in terms of the CBT model as a very westernised model, I know that's not the whole picture. So yeah I think it just helps me to be open-minded about that." (Kate: 243-252)*

Kate highlights several points about the role of curiosity. By being curious a therapist makes less assumptions about client need and the existence of multiple realities. It is also important in recognising differential opportunities and choices available to clients and going beyond the model in order to gain a clearer picture of this is significant to ensure that therapy is personalised. This suggests something being said about a lack of opportunities whether educational or employment that are available to all. Seb also highlights the existence of multiple realities:

> *"I think I take into account the fact that perhaps there's a different way of seeing things from different cultures, like family values are different." (Seb: 151-155)*

Like Kate and Seb, Wendy goes on to mention the importance of curiosity as a basis for development of her own understanding:

> *"...still have to be culturally competent and I'm curious about where people are coming from and I think over time that's what I've learnt to be." (Wendy: 96-98)*

The importance of maintaining a curious position for the therapists is necessary in framing the CBT model around the client.

Memo Excerpt:

Although curiosity features as a significant component for cultural competence, not giving way to assumptions about the client, I wondered if assumptions could help with exploration. Following the interview, Jane shared that she could understand being punished for not completing her chores as this was an experience similar to her own growing up. I too recalled instances of punishment for not completing chores. Culturally we could both understand her clients' experience.

3.7 Summary

The purpose of this chapter was to present the analytic engagement of the current research through the methodological process of using grounded theory. The interviews provided rich material of CBT therapists, Counselling and Clinical Psychologists and their particular experiences of working with Black clients using CBT as a psychological method of treatment for mild to moderate mental health disorders. Attempting to capture the essence of personal accounts, interpretation of underlying thoughts and feelings in order to generate a representative analysis of their experiences was the endeavour of this research and was particularly challenging. Sensitive issues pertaining to race would undoubtedly raise some feelings during the interview process and managing reflexivity as my role impacted and possibly influenced transparency and the data was a constant consideration. Although the research rationale was to investigate the idea of CBT adaptation in practical terms for Black clients, as the call in previous research has articulated, a significant amount of data was also gleaned from the transcripts.

All therapists appeared mostly willing to discuss their experiences, the way that they worked and the impact of working. Seb showed signs of irritability and appeared to be somewhat resistant to explicitly discuss issues raised in relation to working with Black clients and client dropout and seemed indifferent to the idea of a change to standardised CBT practice in relation to ethnicity. This I felt may have created a rupture of sorts during the interview process in drawing out his experiences, however these observations may indirectly provide some insight into differential experiences and ways of

working between CBT therapists and Counselling and Clinical psychologists. With a consideration of Category 1 *appropriateness*, those who described themselves as Counselling and Clinical Psychologists - Kate, Wendy, James and Liz, each reported that they would adapt CBT when working with mostly Black Caribbean and Black African clients by drawing from others models or psychological perspectives in order to enrich the therapy experience for the client to make it more 'humanistic', establish therapeutic rapport and build trust and ensure sustained therapy engagement, therefore reporting having no cases of dropout. James, Wendy and Liz also felt that adaptation was necessary as Black Caribbean and Black African clients were more suspicious of therapy and therefore required flexibility concerning therapy approach. Each of these therapists emphasised the importance of taking on a humanistic perspective, stepping away from homework, written tasks and using a mixed didactic and socratic route to guided discovery. The consideration for this direction in their work was to establish a more personable approach in working with the most pertinent issues around social need, family, religion and beliefs. Conversely, Steph and Jane, both CBT Therapists were both more purist, each reporting all or most of their Black clients dropping out of therapy during a course of CBT therapy. Seb, also a CBT Therapist, however did not report having any experiences of dropout with Black clients that he had worked with over the course of his practice of CBT therapy when assuming a more purist approach.

Therapists had also expressed having strong feelings of frustration when having to work from a primarily standardised CBT position. This gave rise to the idea that standardised CBT made therapists feel restrictive in their way of working. These outcomes will be explored in more detail in the discussion chapter.

CHAPTER 4. DISCUSSION

This study aimed to explore the process of how therapists experience working with Black clients using CBT. More specifically was the intention to understand how CBT might be adapted to suit the needs of the client as and when issues around cultural sensitivities might arise and what strategies, techniques or other modalities might be utilised in order to make CBT more applicable for the client and how therapists' own experiences might inform their style and practice. The purpose of this study was to gain a personalised account from therapists themselves who have worked with Black African, Caribbean and Black British clients in order to generate a reliable view of first-hand experiences.

Constructivist grounded theory was chosen as the most appropriate methodology for this study. The hope was that through this methodology knowledge could be generated to best describe subjective experiences of how therapists feel and how they work with a view to developing an emergent theory. Qualitative interviews were conducted with 7 participants who were either Clinical or Counselling Psychologists or CBT therapists. From these interviews four main categories emerged following data analysis: ***Category 1****: Appropriateness,* ***Category 2:*** *Therapy Congruency,* ***Category 3:*** *Developing my Therapy Style and* ***Category 4:*** *Curiosity*. These categories were formed from the data, representing experiences and expressions from therapists across the interviews of their feelings about CBT itself and how they approach working with Black clients in their clinical work, including the particular aspects that are most important to consider with their approach. A core category of '*CBT in Practice: A Process of Working with Black Clients'* was chosen to unite all strands of the data and categories in order to provide an explanation of therapist opinion.

In this chapter a review of the findings will be discussed. The main categories and core category will each be explored to address meaning extrapolated from the data where a tentative emergent theory will also be presented. This will serve to propose a relationship between the categories and to conceptualise therapist's views of CBT, CBT application and what they pick up from clients as cues to dictate and inform the decisions that they make. This chapter will also address the strengths and weaknesses of the overall research and evaluate future considerations for research development.

I hope that the findings from this research can initiate personal reflections for Clinical and Counselling Psychologists and CBT therapists and also contribute to CBT training and services governing standardised practice.

4.1 Main Study Findings and the Literature

This study served to address the many factors therapists must be aware of and operate under to achieve therapy congruency. What seemed apparent was that achieving therapy congruency meant stepping away from standardised CBT practice where therapists work mostly in an integrative way in order to meet the needs of clients from Black ethnicities. Therapists mostly felt that CBT was lacking a humanness and in its rigidity, exposed the risk of not developing sufficient therapy congruency increasing risk of client dropout. The relationship was expressed as fundamental to the success of therapy and that relying on a purely protocol driven approach of CBT was inadequate to work in a way that kept Black clients engaged. Some therapists, notably those from counselling and clinical psychology training and backgrounds shared aspects of adaptation of CBT in order to better meet client's needs. What became evident was that therapists who shared experiences of CBT adaptation such as a reduction in tools, namely thought records, homework and less of a Socratic style were Clinical and Counselling Psychologists with CBT Therapists working mostly within the CBT framework alone. CBT Therapists expressed experiencing frequent degrees of dropout with Black clients that they had worked with, comparatively Clinical and Counselling Psychologists reported little to no instances of client dropout over the course of their practice with Black clients. As part of an integrative approach Clinical and Counselling Psychologists expressed the importance of specifically adopting a humanistic model as part of their work with a person-centred approach and third-wave aspects as the most important parts for working in a CBT way with Black clients. This combined approach of integrative practice and CBT adaptation appears to provide an individualised approach useful in personalising CBT. Studies have supported such a stance, advocating that humanism as a pluralistic position is the most appropriate foundation on which to establish CBT frameworks with clients from African and Caribbean backgrounds. Studies have also found that a person's way of living in any cultural setting cannot be accounted for by the environment, cognitive or biological factors alone (Jenkins, 2001). The therapists

in this study adapted CBT to work with Black clients that they had worked with in the past. The therapists used a humanistic approach for a more relational rapport, further adapting CBT by drawing on other modalities to form part of their overall work.

Table 3. Summary of how therapists work

Therapy congruency achieved through experiential learning and linguistic styles – e.g. therapists drawing on personal ethnical positions
Less socratic more didactic
Adaptation of CBT with other modalities in place or alongside CBT framework
Therapist preference for exclusion of materials – e.g. homework
Focus on relationship
Integrative therapy style - Humanistic approach and model to respond to culture focusing on subjective meaning

The emergent theory identified in Figure 4 and Table 3 captures the process of the therapist's feelings, methods of practice and strategies of working with CBT. This identifies two processes occurring. The first process in Figure 4 highlights the therapist's own interaction with the CBT framework that seems to be felt by both psychologists and CBT Therapists – frustration, confining and the subsequent development of an integrative style adopted by psychologists and adapted style to the CBT standardised practice. There also exists the therapist's belief of how the client responds to this change in style. For therapists the emphasis of working from a humanistic model was seen as a significant addition to CBT work. Numerous studies have identified that CBT might conflict with cultural values (Hays & Iwamasa, 2006; Rathod et al. 2009; Bernal et al. 1995; Bennett-Levy, J. et al., 2014; Kingdon, 2015). A review of CBT conducted by Kantrowitz and Ballou (1992) as far back as 1992 found that the emphasis in CBT regarding cognitions, logic, and rational thinking strongly favours dominant cultural perspectives which include definitions for rationality. In this study therapists described CBT as rigid and inflexible and that the paper materials often used in conjunction with homework contributed to rigidity and the therapeutic feeling that felt 'alien' for clients and indirectly for therapists also with this client group. This method leads to feelings of frustration for therapists. The critique is that this cognitive emphasis can easily lead to an undervaluing of the importance of spirituality in the face of cognitive rationality. In addition, CBT's focus on changing oneself can contribute to the neglect of cultural influences that can restrict a person's ability to create and in so

doing affect implementing change. Consequently, Hays (2006) states that this internal focus, if not sufficiently balanced by a perspective that recognises the power of the environmental influences, may contribute to developing a sense of blame of the client for problems that are primarily environmentally based. This perspective, as shown in Figure 4, shows therapists integrating a humanistic perspective into their CBT work. Some early studies supported the view that adopting a humanistic approach that does not ignore spirituality was the most appropriate perspective to consider for effective treatment. Maslow (1966) and Sutich (1976) on the humanistic movement acknowledging the experience of the fully functioning person, were dissatisfied with the idea of social transformation occurring without consideration of the spiritual.

As suggested above, therapists found that when working with Black clients using CBT, it felt rigid and inflexible as fully engaging with those from African and Caribbean backgrounds requires a greater relational approach, for which therapists felt CBT could not provide when utilised on its own. Although CBT therapists also expressed rigidity and some frustration, they continued to work in a standardised way using CBT, which as Figure 4 shows, increased the risk of client dropout. Clinical and Counselling Psychologists who each expressed rigidity with the CBT framework found that developing their own style was important in their way of working, the emphasis of which was on the relationship. In this study the personalised accounts of the appropriateness of CBT with Black African and Caribbean clients who may be less acculturated than Black British suggests that CBT must be adapted in order to be beneficial.

Some recent studies have called for the adaptation of standardised CBT (e.g. Naeem et al. 2009, 2015, 2016; Hwang, 2015). Such randomised controlled studies have suggested that adapted CBT is more appropriate for Black African and Black Caribbean clients, but fail to provide details on what this adaptation looks like. As outlined in Table 4 therapists reported adapting CBT in a variety of ways. Firstly this emphasised the removal of materials and homework assignments from therapy, including the agenda. Each of these examples make up the process of what CBT adaptations within this study are. Adaptations as defined by the experiences of therapists in this study will be further addressed in section 4.3. Other aspects of working integratively for psychologists also included ACT and person-

centred modalities, working primarily from a Humanistic model, combined with principles of CBT and the model. Integrating aspects concerning *self-actualisation, self-esteem, love, safety, and physiology* forming Maslow's (1966) hierarchy of needs were often utilised alongside or in place of manualised CBT focusing on thoughts – feelings – behviours, and as such were considered to be central to therapy, either exclusively of CBT principles altogether or concurrently driving the overall work.

The view of rigidity with CBT felt as a shared experience within the relationship meant that therapists had to find another way to work collaboratively. Personal accounts from therapists highlight their observation of the relevance of religion, spirituality, collectivist views including the family (blood-kin and non-blood-kin such as the church family), poverty, unemployment and traditional views held by clients themselves about therapy. Therapist's accounts of working with some of these factors express the difficulty at being able to work with some of these areas when sticking closely to cognitive and behavioural work. James, Steph, Wendy, Kate and Jane each shared experiences of finding the principles of CBT rigid concerning the structure and agenda setting, with James and Kate both describing the irrelevance of CBT techniques including Socratic questioning, thought challenging, cognitive restructuring and behavioural activation when sociocultural issues arise including social and deprivation. James, Kate and Liz described that issues concerning poverty and trauma meant that CBT work became irrelevant and they shifted to a more humanistic and person-centred approach prior to tentative behavioural activation work. The view from therapists was that clients were new to the idea of therapy and that the introduction of CBT as the initial 'gateway' into therapy was simply too linear to address the degree of culturally relevant factors requiring attention.

Wendy, James and Kate reported actively deviating from practicing CBT with Black African and Black Caribbean clients by using a less structured approach of CBT and making various adaptations to the CBT model. Their sense of CBT was the difficultly to apply in practice, impeding the therapeutic relationship and going against clients' beliefs and value systems resulting in clients perhaps feeling unable to process CBT. The pressure of engaging clients was felt by many of the therapists and was highlighted within this category. Jane, Liz and Kate each described wanting to explore wider sociocultural issues but being constrained by time-bound service expectations and recovery rates.

Bassey and Melluish (2012) presented in their study an analysis of cultural competence and therapist experiences in IAPT services and recognised the efforts of therapists to work with BME clients by paying attention to relevant cultural factors but feeling restricted by the demands of the service. Studies such as Bassey and Melluish (2012) and Steel et al. (2015) suggest that more time is required to sufficiently address wider sociocultural issues and also in communicating and adapting the CBT approach to meet individual needs and that services needed to acknowledge this, making allowances for the added time required for culturally sensitive practice, thereby increasing the therapy experience and reducing pressure. IAPT workers were found to experience pressure and a lack of autonomy in their roles in a study investigating therapist burnout in IAPT services. This lack of autonomy in their roles and workloads were found to be related to emotional exhaustion, job dissatisfaction and resulting higher staff turnover (Steel et al. 2015). This study further surmised of the danger where therapists would find means of coping by depersonalising their clients. The conclusion therefore was for IAPT services to increase the number of theoretical frameworks within the IAPT services for therapists.

The significance of the development of the therapeutic relationship in this research is outlined and the role this has in maintaining sustained engagement, lowering the risk of client dropout. James felt that knowledge of CBT comes secondary to the building of trust to ensure that a client can feel safe to return to the next session. Seb and Jane also gave accounts of not establishing a strong enough rapport leading to dropout. The three shared experiences that come through across the interviews is that cases of dropout have been largely experienced by therapists with clients from Black backgrounds, where some clients might struggle with the idea of being in therapy due to culturally held beliefs about psychotherapy itself; the building of trust and the relationship therefore is particularly important to sustain engagement. The challenge in managing rigidity felt from therapists is compounded by the need to work quickly and efficiently as outlined by both Jane and Kate. This pressure-of-time perhaps compromises the relationship increasing the risk of dropout. Each of the three factors present in this category (rigidity, pressure and dropout) as Steele (2015) suggests increases the danger of depersonalisation with clients.

The appropriateness of CBT for Black clients appears to be based on the style of the therapist, of their knowledge and how they translate that knowledge which comes back to style. The utility of generic knowledge about culture and the conceptualisation of the issues and experiences of the client help to provide a personalised account. James describes CBT simply as an approach which can be just as effective as any other modality with BME clients. James along with Wendy, Kate and Liz each give an account as to what their approach would entail. Skills relevant to effective communication and the building of the therapeutic relationship, achieving a shared understanding and collaborative process, whilst incorporating culturally sensitive strategies were evident across the interviews in this study. Similar views were shared by the therapists in a focus group in Bassey and Melluish (2012) study on therapist experiences of CBT, where main themes emerging for CBT appropriateness were *awareness, knowledge and skills.* Cheek's (1976) pioneering work also described how a CBT approach to counselling and psychotherapy can be effective with African American clients with a consideration of style including linguistic style and life experiences. Counselling and Clinical Psychologists - Wendy, James, Kate and Liz gave accounts of development of style and incorporation of cultural exploration during conceptualisation. CBT Therapists - Jane, Steph and Seb did not describe a style too separate from standardised CBT.

Wendy, James and Kate reported actively deviating from practicing manualised CBT with Black African and Black Caribbean clients by using a less structured approach of manualised CBT and making various adaptations to the CBT model including existentialism, person-centred and third-wave CBT approaches such as Mindfulness and ACT in order to incorporate religious beliefs, the community and collectivist views and identity. Cognitive and behavioural interventions were adapted by incorporating culture, religion and language. A number of intervention studies have found that integrating clients' spiritual and religious beliefs in therapy is at least as effective in reducing depression than standardised treatments (Azhar & Varma, 1995; Azhar, Varma, & Dharap, 1994; Berry, 2002; Hodge, 2006; Hook et al., 2010; McCullough, 1999b; Pargament, 1997; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Razali, Hasanah, Aminah, & Subramaniam, 1998; Smith et al., 2007; Tan & Johnson, 2005; Wade, Worthington, & Vogel, 2007; Worthington & Sandage, 2001). Recent research has shown that 77

percent to 83 percent of clients over the age of 55 wish to have their religious beliefs integrated into therapy but may be too afraid to broach it to therapists themselves, perhaps due to societal stigma (Stanley, 2011).

The success of developing therapy congruency is reflected in the process of how therapists work with Black clients, influenced by their own ethnical position and experiences. Therapists developed cultural sensitivity through differential experiences and cultivated their style of CBT therapy by being informed through these experiences that exist within their own families and communities where stigmas exist about therapy itself and where cultural sociocultural factors such as the family, religion, beliefs, norms and values that rank highly within particular communities. Personal and experiential learning appears to be fundamental to underpinning how therapists work and their decision to adapt CBT appears to be dependent upon cultural subtleties that therapists might pick up on. Therapists who feel that they are developing strength in cultural competence through their Asian, Pakistani, Caribbean and African experiences, can build an understanding around similar experiences that may exist within other ethnicities in order to think about a considered approach to therapy.

James, Kate, Seb and Wendy each share personal accounts of cultural practices that exist within their culture. Interestingly, each of these therapists are from very different ethnical backgrounds and cultures – Chinese, Pakistani, South African and Western Africa, yet James, Kate and Wendy each describe using a very similar approach to their CBT work with Black clients, uniting humanism, a reduction in CBT tools and an increase in didacticism in their approach. The differentiation between therapist's own cultures but the use of a similar approach in therapy-style with CBT suggests a common shared idea about Black clients that exists based on therapists knowledge and previous therapeutic work with clients who they may have worked with from similar backgrounds. Although there is an overall recognition from therapists of the importance to not assume knowledge but through the process of social constructivism, be informed through their clients, there is a 'knowing' that seems to already exist for therapists who have been informed of what some Black clients might need mostly through their own

experiential learning. James outlined the importance of experiential learning and that this cannot be underestimated for the benefit of rapport building, curiosity and transparency.

Kolb et al. (1984) writes on the theory of experiential learning which emphasises the central role that experience plays in the learning process. This theory offers a unique perspective on learning and development which appreciates the subjective experience within the learning process and suggests that learning is achieved through four continuum modes of grasping experience: (1) Concrete experience – involvement in a new experience; (2) reflective observation – developing observations about one's own experience (3) Abstract conceptualisation – creating theories to explain observations and (4) Active experimentation – using theories to solve problems and decision-making (Kolb et al. 1984). Within the context of how therapists work, particular learning styles such as *perception* and *processing* appear to be a successful factor in the way in which therapists develop their learning and subsequent relating with their Black clients. Learning styles including *experience, reflection, conceptualise and testing*. Effective learning, in particular the development of cultural sensitivity in clinical practice can be possibly achieved through this progressive process: 1) having a concrete experience followed by (2) observation of and reflection on that experience which leads to (3) conceptualising and making sense of concepts which are then (4) used to test hypothesis in future situations, resulting in new experiences.

It would seem as though Counselling Psychologists Wendy, Liz and James and Clinical Psychologist Kate, found that they were able to work successfully with Black clients using CBT, which at times despite feeling rigid, based on their personal experiences of learning acquired through their own life experiences, were able to reflect on their cultural position, drawing on humanistic principles, and applying this perspective, a process which resulting with no instances of client dropout. Keeping Kolbs learning styles in mind, James drew on his own *experience* and *reflection* in experiential learning informing him to be mindful of cultural sensitivity saying:

> *"The Asian thing is the perspective…that the preconceived ideas is that we do not share something private to a stranger. It's a two-way process as well because we try to get an understanding and our betterment in terms of providing therapy for ethnicity people but equally it's a two-way process, they also too have pre-conceived ideas about us as*

therapists, yeah? So they have preconceived ideas about you as well as saying 'what is it that you can do for me?'" (James: 133-141)

In so doing James uses his experiential learning as an Asian man to understand 'difference' in terms of identity but appears able to appreciate the cultural subtleties for the client by drawing on his own experiences of mental health stigmas that exist within his own culture. James emphasises this understanding:

"Yes they have preconceived ideas but from a different perspective. From a West Indian perspective is that it's not okay for you to say that, it's not okay for you to do that, after all you are not me…Black. The Asian thing is the perspective, the preconceived ideas is that we do not share something private to a stranger." (James: 130-135)

Moodley & Palmer (2014) state that for the therapist to communicate and conceptualise the client's distress effectively, there must be technical skill and a theoretical knowledge of the 'other'. In the chapter 'New Ethnicities', Hall (1996) writes on discourse and describes that Black people speak from 'a particular space, out of a particular experience' (p.258) and that this waiting narrative is further complicated by being in the space of the therapist. Moodley & Palmer's (2014) emphasis on the importance of theoretical knowledge highlights the role that cultural knowledge, sensitivity and competence play in therapists' utilisation of therapeutic tools.

'Cultural knowledge' is defined as – '*a knowledge of cultural characteristics, history, values, beliefs, and behaviours of another cultural group'*, whereas 'cultural sensitivity' is defined as *knowing that differences exist between cultures, but not assigning any significance to the differences* (Hogan-Garcia, 1999).

'Cultural competence' is a bringing together of these two concepts. It would appear that it is through this ability to culminate this knowledge into pre-existing frameworks that a competent therapist can be able to engage fully and personally with a client utilising all aspects of CBT effectively. As previously discussed experiential learning can be an aspect of learning that informs cultural sensitivity. The application of continued learning and practice can add to an overall style of therapy but without a theoretical knowledge of cultural identity success can be compromised (Moodley & Palmer, 2014). Ridley (1985) felt that cultural competence is an ethical obligation and that within the development of

cross-cultural skills, should be considered at a level on par with other specialised therapeutic skills and further argued that the delivery of quality services is particularly difficult due to the cultural and institutional influences that determine the very nature of services themselves.

In a review Sue et al (2009) looked at the case for cultural competency in psychotherapeutic interventions, focusing on the therapist' treatment tactics considered to be culturally competent. The consideration was that if therapists were competent to conduct psychotherapy, there should be a demonstrable example with a range of culturally diverse clients. Proponents of cultural competency believe it to be a relative type of skill and one which can depend on the therapists' cultural orientation, as could be seen in the position of James through experiential learning.

There have been a number of studies outlining the relevance of cultural adaptations to CBT to improve treatment outcome on a range of various ethnicities such as Kohn's et al (2002) study on culturally sensitive CBT with depressed low-income African American women; De Coteau et al. (2006) guidelines on CBT modifications to Native Americans; Miranda et al. (2003a) for Hispanics' Rossello & Bernal (1999) and cultural adaptations to CBT in the reduction of depression in Puerto Rican youths.

CBT adaptation for the purpose of developing therapy congruency involved more literal modifications such as a simplification of CBT techniques in line with the client's level of education and psychological mindedness. This also involved therapists practicing with an integrative approach by incorporating humanistic and third-wave CBT approaches. A study on religiosity and CBT by Pearce et al. (2015) was the most recent to develop and implement a new religiously integrated adaptation of cognitive behavioural therapy for the treatment of depression in the U.S. His study supported previous research and adaptations made by therapists within this study. He outlined that religious CBT can use the client's own religious traditions as a foundation to identify and replace negative thoughts to reduce psychological distress. Pearce (2015) made his religiously integrated cognitive behavioural therapy model applicable to Christianity, Judaism, Islam, Buddhism, and Hinduism. James, Wendy and Liz emphasised the importance of taking on a humanistic perspective in the venture of religious exploration, as they felt that their Black Caribbean and African clients were more suspicious of therapy and therefore required flexibility around the approach, which saw them stepping away from homework, written tasks

and using a mixed didactic and socratic route to guided discovery and self-empowerment. The consideration for this direction in their work was to establish a more personable approach in working with the most pertinent issues around social need, family, religion and beliefs. The use of a didactic style as a means of adaptation with CBT in Kohn's et al. (2002) study on CBT for group therapy in depressed African American Women formed part of this adapted treatment plan. Kohn et al. (2002) defined adaptations as structural and didactic referring to changes in the content of the material to be covered each week. Structural adaptations included adding experiential exercises and changes to some of the language used to describe cognitive behavioural techniques; didactic adaptations included creating a healthy therapeutic relationship, African American family issues and African American identity. This is similar to the experience of James, Jane and Wendy who each identified experiential learning and didactic methods as structural adaptation techniques that were fundamental to the personalisation of the therapy experience. This didactic method as a preferable method for Black clients is further supported by Cheek's (1976) 'didactic assertiveness training' approach with African American clients where a directive approach was considered beneficial as "Blacks have little time (or money) to fool around" (p.67). James made reference to poverty and the sense that the immediacy of unmet needs directs the therapy and style where Wendy also described being told "just tell me, just tell me" from clients from Black African and Black Caribbean backgrounds pushing to a didactic approach and therefore pushing the therapist away from standardised CBT.

It was clear that trying to integrate change through adaptive methods was seen as more necessary for James, Wendy, Kate and Liz who each being Counselling and Clinical Psychologists felt that without these methods of adapting CBT and integration this could result in client dissatisfaction where their clients could be lost.

The motivation to adapt CBT and adopt an integrative perspective seems to be for the benefit of clients who might otherwise struggle with the standardised approach. However there seemed to be another process occurring alongside the motivation to meet client's needs where the therapist wished to develop autonomy and independence with *how* they do therapy. The drive in 'developing my therapy style' was the name of this category based on an emerging theory of therapists' taking action with the

rigidity of CBT work and perhaps the needs of the client directing them to do so. In this study therapists achieved flexibility by shifting the style of CBT work learned in training. Steel et al. (2015) postulates that by increasing the number of theoretical frameworks that IAPT therapists can draw on in providing opportunities for work in different modalities and with varied client groups is likely to increase a sense of personal accomplishment, protecting against burnout. In this study half of the therapists (Steph, Liz, Seb) who had completed both high intensity/CBT training programs and/or Clinical or Counselling Psychology training felt that CBT training programs inadequately covered aspects of working with culture and diversity, describing overall training as inadequate leading therapists venturing out to find additional training opportunities. Whereas Clinical and Counselling psychologists felt that training on their programs sufficiently addressed working with diverse groups. Similar views were found in recent studies by Steel et al. (2015) and Bassey and Melluish (2012) where for most therapists the training programme was not considered to have adequately addressed the issue of culture and its influence in the practice of CBT and subsequently felt that training did not appear to cover cultural competence in the level of detail evident as a requirement in literature. Different to Bennett-Levy (2014) who described the efficacy of CBT with indigenous Aboriginal communities and of the High Intensity therapists who were in favour of its applicability, CBT therapists in this study who stuck with a manualised CBT approach experienced higher dropouts. So what could be happening here? The sense perhaps born out of frustration was that CBT therapists did not feel like completely competent practitioners as a result of their training in manualised CBT centring on disorder-specific presentations. As a result, CBT therapists appeared to struggle to work trans-diagnostically, supporting Binne's (2015) view that therapists trained in manualised CBT lack the skills to formulate individual case conceptualisation due to the IAPT programme medicalising psychological distress which fails to provide CBT therapists the opportunity to develop a varied understanding of conceptualising the presenting problem and maintaining factors outside of this. The implications of this can result in a prescribed version of therapy which lacks personal considerations or the readiness to work creatively whilst keeping pace with standardised practice. As such, overall therapists recognised that adaptations to CBT were needed to work with Black client groups, but Counselling and Clinical psychologists felt

equipped to implement this adaptation and change whereas CBT therapists did not, would not or could not.

Therapists went on to express the need for reflective space to consider cultural issues and provide access to supervision with relevant experience. This acquired competence to personal and professional experience was reflected in Wendy's experience who used her social work training to inform her CBT practice, James's previous work as a counsellor in existential and person-centred therapy and Seb's knowledge of African culture where he once lived in Africa. Acquired competence through life experiences naturally works alongside technical training helping therapists to develop a style of therapy through intuition and personal motivation to learn about the influence of culture in therapy. In this study therapists shared experiences of adopting a flexible stance with CBT. James, Wendy both heavily critiqued CBT for lacking a humanistic perspective which was detrimental to the building of relational rapport with their clients. Developing therapy style saw both Wendy and James adopt an existential-humanistic perspective where, along with Kate would use of third-wave therapies for overall use with CBT practice but supported specifically for relating with Black African and Caribbean ethnicities. This style is in keeping with recent research on cultural competence of IAPT therapists by Bassey and Melluish (2012) who found therapists expressing a range of ways of modification of interventions to accommodate cultural influences. Some themes emerging from Bassey and Melluish's (2012) addressed evident tensions that stemmed from difference perspectives on what was required to meet the need of BME clients when doing CBT, two such tensions as 'technical' and 'ethical'. Technical tensions were in reference to necessary approaches to effectively apply CBT and ethical tensions referring to responsibilities associated with therapy. Issues around technical and ethical tensions were reflected in this study where Seb appeared defensive regarding technical change and did not feel it necessary to consider cultural difference but moreover the humanness of the person which ultimately views us as the same. Liz also felt that the technical considerations of CBT were paramount and should be upheld, however Liz and Kate both suggested that the responsibility was with the therapist to choose how best to adapt therapy and that CBT should indeed be adapted for the purpose of client benefit. It would seem that CBT training provides the technical content leaving therapists to work more

independently with developing ethical considerations. This is reflected in Bassey and Melluish's (2012) study where some tensions were evident in the different opinions of therapists regarding CBT with BME clients and what ethical responsibilities rest with the therapist. Such as, cultural issues relevant to a particular client should be determined in a case by case basis and through the therapists' exploration of cultural factors with the client and researching of cultural factors outside of therapy if necessary. To attempt to incorporate a knowledge base around a particular ethnic group is considered to increase stereotyping and create barriers for both the client and therapist. Therefore therapists should have the flexibility to sufficiently gather information pertinent to clients individually. The development of therapy style is dependent on therapists not being reliant on knowledge gained through training but also informed through life experience and the therapeutic relationship to achieve flexibility. In this study there were mixed views regarding working with clients where they were, whether that involved a strictly held CBT rationale or working outside of that. In line with Bassey and Melluish's (2012) study different views were also seen reflecting the necessity to strictly adhere to the CBT model, where some therapists had experienced situations where they did not feel that the CBT model or rationale worked well and instead moved away from this. Others felt that facets of the CBT model were necessary if therapy was to work. Neither approach is therefore seen as necessarily contrary to cultural competence or 'wrong' as long as there is sufficient evidence that the client is able to work with the concepts.

Therapists pursuit of therapy style is very much dependant on the contextual factors impacting the client. This demonstrates that there are further considerations for the therapist regarding awareness, curiosity and open-mindedness to cultural difference before the building of the therapeutic relationship, adaptation strategies and therapy style can even take place which will be further expanded on in the following section.

In this study Wendy, Seb, Kate and Jane shared very similar views regarding the role of individualism and collectivism, directly specifying that CBT is less suited to individuals who adopt a collectivist view. Each of the therapists outlined any indifference to the principles of exploring an individual's own thinking, behaviours and emotion offers up and it is through the use of third wave techniques such as compassion-focused therapy (CFT) and Acceptance and Commitment Therapy

(ACT) which, through remaining curious can be beneficial to offering up change through alternative ideas. The ability to manage these pole positions where CBT is described by therapists to be individualistic and clients from BA and BC groups are more collectivist, is overcome through being open, curious and aware of difference and using differences to open up alternatives. This supports the view where Cheek (1976) advised that although CBT can be used appropriately for different cultural-racial backgrounds, the caution and curiosity required of therapists could not be underestimated, who stressed that simply attempting to modify traditional forms of psychotherapy, is not all that is needed to work ethically and effectively with culturally diverse client groups but in the awareness of how contextual factors impact client's lives. In this study there were differences between the perspectives of Psychologists collectively and CBT therapists on issues relating to therapy style, where Psychologists ventured onto methods of adaptation to meet cultural need and CBT therapists keeping to stricter methods of CBT principles. One thing that was clear across all of the interviews was the importance of assuming a position that was open to understanding the client's perspective. Wendy, Seb, Kate and James spoke specifically about the futility of knowledge and training without experiential learning. Wendy talking about learning "over time" to be curious, that this was something that was acquired through experiential learning. Kate emphasising being open-minded to more than one reality. There is much in the literature to support a curious position for therapists to take regardless of the modality being used (Orlinsky and Ronnestad, 2005; Wampold and Imel, 2015; Rogers, 1989). Kingdon et al. (2015) took a similar view that if a therapist who works from a position valuing individual needs and independence with a client who places greater meaning on a collectivist position and culture (communal needs) the client might not engage of respond effectively if the therapist assumes their own values, or indeed the perspective as ascribed to by training. The reason for non-engagement as described by Kingdon (2015), may be that the treatment solutions offered are inevitably weighted towards an individualistic assumptions which may run counter to those of the client's native culture resulting in distrust and possible disengagement.

A further consideration in terms of acculturation may be when the client has acculturated to the host country, such as Black British, but the family has not. The client may then embrace the therapists

view and principles of CBT but struggle with practicing these outside of the therapy room and at home, thus rendering the intervention ineffective.

The contention that therapists experienced between self-identification was noted by Jenkins (2001) who wrote on '*individuality in the collective'*. Specifically taking the view that although Westerners 'overvalue the importance of the unique and masterful individuality', the recognition of the relational quality of non-Western cultures, such as African or Caribbean, may incorrectly dismiss the importance of individual agency. James, Jane, Kate and Liz each provided examples where they were able to gently and sensitively introduce such ideas of individuality to clients who might be coming from an otherwise collective perspective. The importance of curiosity described by therapists used with particular effect with clients, meant not projecting personal views but seeking to explore plausible alternatives, which CBT essentially is all about. The combining of CBT with humanism, as suggested by James, Wendy, Liz and Kate helps to further introduce the prospect of an alternative reality to thoughts, feelings and behaviours once relational quality and one's humanity have been established. Many theorists including Jenkins (2001); Lukas (1989); Frankl (2000); Ivey (1995) have argued this point on the positive applicability of humanism and/or existential-humanism and Gestalt techniques as a beneficial means of engaging particularly with non-white ethnicities. The success of such psychotherapeutic perspectives could be due to humanism offering the capacity for the individuals' choice, freedom and self-development.

Jenkins (2001) theorised that these principal concerns could offer much for African American clients who historically may have felt that these principles were neglected or unavailable to them and as such humanism psychology may be attractive to African Americans. Whether this attraction extends to all Black ethnicities is debatable, however the case for humanism in multicultural psychology suggests that the psychological basis for individual freedom of the will is about taking a stand or making a choice. The *freedom* in the free will is the option for alternative conceptions of the given experience, such as alternative perspectives offered up within CBT. This emphasises autonomy and independence of the individual self, a notion of which may appear irrelevant to those clients, such as Black Africans

and Caribbean's who may operate from a collectivist position, as expressed by therapists within this study.

4.2 Strengths and Limitations of the Study and Suggestions for future research

The strength of this study lies in its qualitative nature as it has resulted in the contribution of an emerging theory of therapists adapting CBT therapy to work effectively with Black clients. The present study is one of the first of its kind, as previous research has focused mainly on studies on CBT with Pakistani clients in the U.K, severe mental illness, and from the client perspective. A further strength is the addition to an acknowledged underrepresented research area into psychotherapy and BME groups. Various calls over the years from multiple organisations including APA (2002), DSM-5 Cross Cultural Subgroup (DCCIS) (DeSilva, 2015) and the National Institutes of Health (2001) for increased awareness into multiculturalism, diversity and cultural competency, and the rate of dropout of BME clients who do access psychotherapy services comparatively to non-BME ethnicities (HSCIC, 2016) have been made prompted by documented mental health disparities between ethnic groups (Schulman et al. 1999). I hoped that this study would provide some insight into the practical workings of therapy from the therapists' perspective, to understand CBT adaptation more definitively and whether this process was being used as a method of working with Black client groups, to contribute in minimising dropout rates with Black Caribbean and Black African clients (Kingdon et al. (2016).

In this study Clinical and Counselling Psychologists shared their experiences and attempts to culturally adapt CBT when working with some of their Black African and Black Caribbean clients, less so with British-born Black clients, including the bringing in of other modalities, third-wave approaches and the dropping of CBT materials during sessional work. The study provided an opportunity for therapists to share their views on methods of treatment, personal learning and reflections that they have amalgamated through personal life experiences, previous job roles, training and professional development over the course of their clinical practice. This study demonstrates therapist's working in U.K based organisations and their experiences of CBT, adaptation and important considerations for training and development and supervision. The grounded theory methodology provided an opportunity to generate understanding around the subject of psychotherapy and Black clients using CBT without

the constraints of hypothesising an outcome, but to allow subjective experiences to shape the context of an emerging theory.

The use of a quantitative approach as a future consideration could serve to effectively capture the wider view of therapists across larger areas and psychotherapy services and could therefore provide more generalisability than that of a qualitative methodology. Importantly the categories in this study have only been partially defined as complete 'saturation' had not been achieved (Corbin & Strauss, 2008). It is for this reason that further research could be carried out in the future with an aim to engage in further theoretical sampling to fully saturate the findings gathered so far. Traditional expectations of grounded theory highlight theoretical sampling of participants, which involves recruiting participants with different experiences of a phenomenon in order to investigate the multiple dimensions. The intended view of grounded theory is for the researcher to continue to recruit until theoretical saturation is reached. From the outset of the research it has been difficult to ascertain how many participants to recruit in order to achieve saturation. Typical grounded theory studies report that a reliable participant sample size should consist of approximately 10-60 participants (Starks & Trinidad, 2007). Therefore a further limitation of this study was in the sampling size providing only 7 participants. However a constructivist perspective postulates that truths are not based on generalisability from large sample sizes, instead they focus on how the phenomenon are constructed through personal experiences and the subjective data that can contribute towards a developing theory. Taking this into account, although reliable opinions were shared for the purpose of this study, a larger sample size could perhaps offer a richer contribution to overall theory. The consideration of this point is that a larger number of participants could have identified further information that was not highlighted by the current participants. In terms of variation among ethnicity, a strength within this study was that therapists were from varied ethnic backgrounds. A significant larger sample size was unfortunately not possible as this would make the size of this study unmanageable and therefore was not considered for practical reasons.

4.3 Implications and Suggestions for Counselling Psychology Practice

The central challenge that therapists face when working with clients is gleaning an understanding of the different way that clients construct meaning, how they deal with challenges and what sources of

strength or coping strategies help to sustain them through stressful life events. The findings of this study demonstrate some practical applications for successfully approaching CBT when working with clients who present from African and Caribbean ethnic backgrounds. Therapists shared their views on how they managed difficulties and barriers when clients struggled to engage with the concepts of CBT and how they managed this through developing a style of therapy which was more eclectic rather than purist. In so doing, therapists often 'adapted' CBT through changes in sessional work and through other models and perspectives in order to present CBT as more humanistic and relational for which they felt that it lacked and as a consequence could be the fundamental cause for client dropout. Put another way, within this study therapists seem to be working integratively in order to establish methods of best applying a 'cultural fit' for clients who might be presenting with issues which might require a more relational approach. Previous research highlighting high dropout rates amongst Black clients reportedly expressing "*considerable dissatisfaction with the approaches in therapy they received*" (Fernando, 2004; Rathod (2010). Such findings justify the recent development of measures by the DSM-5 Cross Cultural Issues Subgroup (DCCIS) on multicultural methods during assessment to understand specifics about a client's needs.

The findings in this study show that Counselling and Clinical Psychologists mostly described their current practice as integrative, even when working within IAPT services with clients referred for CBT, choosing to incorporate approaches such as psychodynamic, person-centred and third-wave approaches alongside delivering manualised CBT, in order to achieve flexibility and adaptability. What might be termed as therapist drift, as suggested by Waller (2009) could be viewed as integrative practice for the Clinical and Counselling Psychologists who made changes based primarily on their own cultural and therapy experiences and knowledge and the needs of the client and such drift or integrative practice could be viewed as one in the same here. For Clinical and Counselling Psychologists there were however some adaptations to CBT which involved altering the cognitive and behavioural interventions to better suit the individual needs of the client, such as changes to homework approach, reduced Socratic and increased didactic style and a reduction in behavioural experiments and materials. The adaptations took into account the client's culture, religion, language, psychological mindedness, acculturation to

their host country, education and age. The therapists' confidence in CBT and their self-identity as therapists also influenced their overall practice of therapy. Historically counsellors and psychologists have spent much time debating the 'best' models or theories to use when working with specific client groups (Ivey, 2002). However therapists have increasingly come to realise that many ways exist in helping clients to deal with the challenges and problems that bring them to therapy. Studies have shown that this realisation in recent years has led many therapists to embrace a more eclectic approach to psychotherapy (D'Andrea & Daniels, 1994), as reflected in the approach that Psychologists took within this study as can be seen in Table 4. The view that this study offers is the benefit of Psychologists using an adaptive and eclectic approach of CBT with Black clients that rather than becoming locked into one particular psychotherapeutic theory, is the growing tendency to utilise strategies that might come from different theoretical models when working with people from diverse client populations and who manifest a broad range of concerns and problems in a counselling setting. This type of flexibility and open-mindedness appeared to be something desperately called for by therapists in this study who reflected pressure, a sense of rigidity, either feeling unable to practice with open-mindedness and flexibility or not having time enough to do so. Given the rapid increase of cultural-racial diversification within the UK and counselling services, the importance of maintaining a flexible and open-minded approach in psychotherapy has been underscored by many theorists and researchers, who have identified that traditional Western counselling theories requires a shift, as they are often not sufficiently helpful, or may even pose a threat, when used with culturally diverse clients who may have very different beliefs about mental health, psychological illness and helping strategies (D'Andrea & Daniels, in press; Sue & Sue, 1999).

The models commonly referred to as those that therapists would adapt CBT, were ACT and humanistic models. Several articles investigating the use of ACT comparatively with CBT suggest that ACT is not hostile to traditional CBT and is not directly buoyed by whatever weaknesses traditional CBT might have and is therefore part of the larger behavioural and cognitive therapies perspective (Hofmann & Asmundson, 2009; Forman & Herbert, 2009; Hayes, Strosahl, et al., 1999). ACT however questions the validity where CBT needs to apply "*the cognitive model of a particular disorder with the*

use of a variety of techniques designed to modify dysfunctional beliefs and faulty information processing characteristic of each disorder" (Beck, 1993, p. 194), or to identify distorted cognitions and then to challenge thinking to realign such distortions reflected in thought diaries. Therapists in this study often opted to omit thought diaries – the style of 'cognitive distortion analysis', 'dysfunctional belief modification' work due to being cognizant of cultural sensitivities and choosing to incorporate more acceptance and compassion work into the overall cognitive approach, with a focus on self, values and commitment to action. The holistic and contextual approach of humanism thus provides an approach that can be appealing to Black African and Caribbean clients. According to Kim & Gudykudst (1988) inter-cultural communication can be based on one of three traditions including Positivist, Humanist and Systems traditions. Here the emphasis of the humanistic tradition stresses the freedom of individuals and of the understanding of the course of actions taken by individuals (Maslow, 1966). The humanistic model therefore promotes the historical meaning of experience and its developmental and cumulative effects at both the individual and social levels, making it beneficial for collectivist views.

A significant implication for Counselling Psychology and indeed the services by which therapists operate is the sense of restriction and pressure that therapists described within this study, and within published research of working with BME clients by paying attention to relevant cultural factors but feeling restricted by the demands of the service (Melluish, 2012). This study draws attention to the challenge of addressing sociocultural needs within too rigid a time-frame and the pressurised feeling that this creates for therapists. Studies including Bassey and Melluish (2012) and Steel et al. (2015) suggest the benefits of services providing more time for therapists to sufficiently address wider sociocultural issues, communication and adaptation of the CBT approach to meet individual needs. Such allowances for the added time required for culturally sensitive practice, may provide a welcomed flexibility for the therapy experience and time for relationship-building increasing trust, therapist autonomy and reduction in pressure; IAPT workers found to experience pressure and a lack of autonomy in their roles (Steel et al. 2015).

This study took an ontological position that was relativist, with the idea that knowledge and truth exist in relation to culture, society or historical context on which an individual is grounded. The

therapists' role in exploring, identifying that position and applying a standardised set of principles that work within the constructs of cognitive and behavioural set of functions for therapists within this study has been challenging. Paying particular attention to the subtleties of clients who might be collectivist in their approach can be useful for having an awareness with managing CBT views that might create resistance.

This study further raised issues around aspects of training and data gathering during assessments. Across the research interviews CBT therapists had reported that they found their CBT training had inadequately addressed issues relating to diversity. However Counselling and Clinical Psychologists felt better prepared to work with diverse cultures. Some questions might be raised about the readiness of CBT Therapists of working eclectically with diverse ethnicities. Jenkins (2001) reported that much needs to take place at the assessment. The DSM-5 cultural formulation (DeSilva, 2015) puts forward the role of cultural assessment as standardised and part of clinical review and intake. It may be that UK services could benefit from a consideration of reviewing current assessment protocol and looking more closely at how cultural assessment could benefit both client and mental health professional, ensuring that personalised and broader information is gleaned from the client which would help therapists to be more adaptive around the client's needs. On cultural assessment Jenkins (2001) writes that how we function as clinicians is relative to who we are as people, over and above training and that formal assessments carries with it the responsibility of the therapist who through administrative tests, interviews and systematic observation must ascribe empathy and capacity to "*feel one's way into another's emotional position"* (Jenkins, 2001. P.144).

The existential-humanistic, psychodynamic and cognitive behavioural traditions have tended to focus solely on the individual, often with little attention given to the sociocultural factors which might include family, religion or social contextual issues. As a result, such traditional theories are increasingly embracing broader social spectrum in consideration of wider social-contextual issues. Taking into account some of the issues raised here, there may be a consideration for brief therapy services such as IAPT largely offering CBT to review client-intake and clinical procedures on the basis of therapy adaptation and cultural assessment tools. An essential issue to think about is how the therapist will

overcome a client's reticence to discuss very personal matters as described by therapists in this study. This was managed by therapists choosing to step back from CBT protocols and tools and driving a more humanistic approach. The use of adaptation methods provided the basis for identifying thoughts and behaviours, accepting emotions, whilst compassion encouraged expression and meaning-making and finding sources of coping through collectivist perspectives and outlets. An addition of cultural assessment tools I would hope could help to provide a deeper insight into working more effectively with the wider BME population and I hope that these findings and suggestions allow for a better understanding of this phenomenon posed by the research in providing therapists and mental health professionals with more tools and ideas on how to help this client group.

4.4 Final Reflections and Conclusion

4.4.1 Epistemological and Methodological Reflexivity

I thought about my position in relation to the research in terms of reflexivity. As a CBT therapist currently working in the NHS, I wondered about my position as a therapist having worked with CBT for the past seven years. I thought about my job role within the context of the chosen research and participant group and how my job, if known by potential participants might affect their responses and transparency. During interview preamble, participants were told of my professional role as a CBT therapist but that for the purpose of the research and the interviews, I would assume a counselling psychologist trainee role and therefore a curious position, as this would have less of an impact on imposing my own judgements, expectations and views. Although I do admittedly hold my own views in some way in view of the research area, assuming a curious position to the interviews and consequently the therapists and their views was important as they may hold particular thoughts about me working as a CBT therapist but also being a black female, whether they might feel judged by me as the interviewer and possibly undermined as the interviewee. Assuming a curious position attempts to avoid contamination. Although Strauss and Corbin (Corbin & Strauss, 2015; Strauss & Corbin, 1990) recognised that a researcher can bring their personal and professional experience and knowledge acquired from the literature, I was mindful of perhaps hindering the opinions and experiences during interviews from therapists. Bruer and Roth (2003) highlight the risk in shifting attention to the

researcher and their influential role and that influencing knowledge is situated, contingent, and intimately related to the epistemic participant and their environment. I had to be careful therefore to remain impartial and curious in my role as researcher so as not to influence the data during the interview process. The reflexive mode and interaction with data and emerging data rather than taking a distanced stance keeps the researcher engaged, which Charmaz (2006) maintains that a lack of this positioning can lead to surfacing of the researcher's own implicit assumptions and interpretations to an extent that it may begin to hold a position of objectivity. The constructivist grounded theory perspective considers the idea that knowledge is seen as 'constructed in the processes of social exchange' (Charmaz, 2006) and therefore the researcher's influence is unavoidable. Within this study the importance of adopting a reflexive stance meant that as the researcher and as someone of Black Caribbean ethnicity, asking therapists of their experiences with this client group, I had to consider how I would impact interviews as a Black Caribbean ethnic researcher; how counselling/clinical psychologists and CBT therapists' would respond to me as the researcher and my own interpretations/expectations of counselling/clinical Psychologists and CBT therapists experiences.

I found the constructivist grounded theory methodology to be flexible but also challenging; forcing me to reflect on my own position as researcher and practitioner. I feel that this approach was appropriate in the overall process of analysis of the data, and served to generate an emerging theory about how therapists work using particular skills and approaches with a particular client group which represents a view of CBT adaptation and practical problem solving.

The research throughout prompted me to be more reflexive. I would use the memos to note feelings, thoughts and beliefs to ensure that these were accounted for and did not bias research. However, it is inevitable that my views have a place in the emerging theory, as locating the study within the constructivist-paradigm I understand that multiple realities exist and the prospect that language and my interpretation of that language, constructs these realities. I therefore view the final outcome of this study as a construction of the therapist's experiences and attempts at describing these experiences and processes and my own attempts to interpret these.

My reflexive role throughout this study has been an interesting journey for me both as a CBT therapist and as a counselling psychologist. My stance has been similar to therapists in this study in terms of the way that I practice with clients as a CBT therapist within the IAPT service and as a counselling psychologist outside of that. Similarly, CBT therapists in this study who experienced conflicting views and resistance to some CBT principles with Black clients, restrictions with therapy autonomy, time-constraints impeding cultural exploration, service pressure and dropout were all too familiar. I felt at times that I was speaking back to myself as a participant within the interviews. Interestingly, however the experiences of counselling and clinical psychologists was also a familiar story and one that accounted for acknowledgement of cultural differences by using an eclectic or integrative approach to work with clients from BME backgrounds.

4.4.2 Personal Reflexivity

My growth and progression from a pluralistic position of CBT to assuming a more integrative approach helped me to understand the differences in positions that CBT therapists and Clinical and Counselling Psychologists have taken in this study and the benefits that a broader psychotherapeutic spectrum can serve when working with diverse cultural populations.

I feel privileged to have had the opportunity for other practitioners to share personal insights of their therapy experiences and to listen and attempt to understand the processes through which therapists try to work and position themselves with their clients. Engaging with this research has really helped to reposition myself as a Counselling Psychologist as I have steadily transitioned in my own style of CBT and broader therapeutic knowledge, practice and application.

Upon embarking on this research I reflected on the motivations, that this study was never about questioning whether CBT could be helpful with Black clients, but seeking knowledge on the inner workings from therapists of how CBT methods or alternative perspectives that might enhance the therapy experience is used for a cultural group where therapy might be viewed as not for them. Engaging with these therapists has impacted me as an individual and a therapist, by confirming some of my views about being sensitive to the collectivist views held by some BME clients and working more

flexibly with CBT protocols as I felt that early on my practice as a CBT therapist years ago I recall the rigidity of my own practice and experiences.

4.4.3 Conclusion

Over the last few years there has been a well acknowledged need for growth in the understanding of culture, diversity and how this relates to psychotherapy. Therapists who incorporate third-wave approaches including ACT and CFT, humanistic and person-centred models with Black clients suggest achieving a richer CBT therapy experience for clients who would otherwise find CBT too rigid and impersonal. This study initially asked the following questions: (a) Are standard CBT interventions being currently adapted with Black and minority clients? (b)What are the experiences of therapists and their views of working with CBT with Black client groups and of adaptation and how do these views inform their practice? (c) If adaptation of CBT interventions takes place, what does this look like?

This study has provided some answers in understanding how some therapists work and of how their CBT approach is influenced through experiential learning, personal cultural experiences and knowledge and differential modalities to assist in developing a more idiosyncratic therapy style to attend to wider social issues that may otherwise be missed or neglected during a standard CBT approach for the purpose of therapy efficacy. It illustrates how therapists are able to work with managing dropout and pressures by recovery rates to 'do well' in short term therapy. However, the reliance on the therapists' sense of the competences they employ can only go so far when addressing cultural issues and the responsibility of services and service policies must assume a governing role. This suggests that there is an opportunity to review and develop guidelines and a greater specification of assessment protocols for clinical practice in moving forward. I feel fortunate to have worked so closely with these therapists who can provide very useful insight into how services and as such, therapy is managed for the benefit of improving therapeutic practice. It is my hope that this study has served to address an area within UK research which is relatively new and has provided an opportunity to consider methods of service and training development for Black clients working with mental health practitioners who utilise a CBT approach.

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List of Appendices

Appendix A - University Research Ethics Approval Letter

Psychology Research Ethics Committee

School of Arts and Social Sciences

City University London

London EC1R 0JD

4th February 2016

Dear Jana Hanchard

Reference: PSYETH (P/L) 15/16 147

Project title: A deeper look at how therapists experience working with black clients in clinical practice using CBT.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [redacted] in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards,

Hayley Glasford

Student Administrator

Email: [redacted]

Katy Tapper

Chair

Email: [redacted]

Appendix B - Recruitment Poster

CITY UNIVERSITY LONDON

EST 1894

Participants needed for research exploring how therapists experience working with black clients in clinical practice using CBT

Are you a qualified CBT therapist, Counselling Psychologist or Clinical Psychologist?

We are looking for you to take part in a study exploring the use of CBT in clinical practice, in an interview lasting approximately 1 hour.

For more information about this study or if you are interested in participating, please contact:

Jana Hanchard on [redacted] or Email: [redacted]

This research project is being supervised by Dr Jessica Jones Nielsen (Email: [redacted])

The study has been ethically approved by City University. If there are any complaints or concerns you can contact Anna Ramberg: [redacted]

Appendix C - Participant Information Sheet

A deeper look at how therapists experience working with black clients in clinical practice using CBT

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The overall aim of this study is to explore the personal experiences of CBT therapists, Counselling Psychologists and Clinical Psychologists of varying ethnicities who utilise CBT frameworks with Black-African/Caribbean and Black British clients.

More specifically the study will serve to look at:

- Culture and its relevance in the context of therapy
- Considerations of adaptation of frameworks
- The effectiveness of CBT with this client group
- How therapists themselves are impacted through clinical practice

This study forms part of the Counselling Psychology DPsych at programme City University.

Why have I been invited?

You have been asked to be included within this study to explore your opinion on the role of culture in therapy and your experiences using CBT with this client group. You are one of 8-10 therapists who have been selected to help provide variation within the target population.

Do I have to take part?

Participation in this study is voluntary. If for any reason you will be unable to take part in this study you are free to decline or withdraw at any stage during the interview process. If you do wish to take part in the study, you are free to avoid answering questions which are felt to be too personal or intrusive.

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It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

- *The interview will last for approximately 1 hour*
- *The research study will last for approximately 3 months*
- *The interview will involve semi-structured questions.*
- *This is a qualitative grounded theory method to develop a framework around improving therapy and practice*
- *The interview will be recorded*
- *The interview will take place in an agreed location*

What do I have to do?

You will be asked to participate in an interview which will explore your experiences of working with specific ethnic groups.

What are the possible disadvantages and risks of taking part?

Disclosing some sensitive information and experiences regarding your work as a Counselling Psychologist. A list resources will be provided in case of any distress. If you do encounter any psychological or emotional discomfort or wish to discuss the information above (or any other risks you may experience), you may contact the researcher.

What are the possible benefits of taking part?

The benefits of taking part in this study include a contribution to service development.

What will happen when the research study stops?

Once the research has ended Information collected (including interview recordings) will be deleted.

Will my taking part in the study be kept confidential?

- *Only the researcher will have access to the data from this study*
- *Audio recordings will be kept confidential*
- *There will be no use of personal and identifiable information*

What will happen to the results of the research study?

The information from the interview will be used for analysis and will be used to form the thesis. During any potential and future publications, anonymity will be upheld. A copy of the publication/summary of the results can be provided. This can be obtained once the research is completed and upon request from the contact information in the debrief sheet given at the end of the study.

What will happen if I don't want to carry on with the study?

If for any reason you do not wish to take part in the study, you are free to withdraw from the study without an explanation or penalty at any time.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: **A deeper look at how therapists experience working with black clients using CBT.**

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London, Psychology Research Ethics Committee. Code/ref: PSYETH (P/L) 15/16 147.

Further information and contact details

The research supervisor Dr Jessica Jones Nielsen can be emailed at: [redacted]

Thank you for taking the time to read this information sheet.

Appendix D - Consent Form

Title of Study: **A deeper look at how therapists experience working with black clients in clinical practice using CBT**

Ethics approval code:

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped • making myself available for a further interview should that be required	
2.	This information will be held and processed for the following purpose: to explore experiences and respond to the research question. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose set out in this statement and my consent is conditional on	

	the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____ _____ _____

Name of Participant Signature Date

_____ _____ _____

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

Appendix E - De-Brief Information Sheet

CITY UNIVERSITY LONDON

A deeper look at how therapists experience working with black clients in clinical practice using CBT

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it is finished I would like to tell you a bit more about it.

The aim of this study is to evaluate the experiences of CBT therapists/Clinical/Counselling Psychologists of varying ethnicities who utilise CBT frameworks with Black-African/Caribbean and Black British client groups in one to one therapy.

The study will serve:

- To understand personal experiences of working with these client groups
- To explore how therapists themselves are impacted though clinical practice
- Illicit experiences of the effectiveness of CBT with this client group
- To adapt formulation or not to adapt formulation? Culture and its relevance and/or incorporation into CBT formulation and how this is achieved.

If during the course of this interview you have any queries or require further information regarding this research, then please feel free to contact me and/or my supervisor.

I hope you found the study interesting. If you have any other questions please do not hesitate to contact me at the following:

[redacted] or [redacted]

Alternatively you can email my research supervisor Dr Jessica Jones Nielson: [redacted]

Ethics approval code: PSYETH (P/L) 15/16 147.

Appendix F - Pilot Interview

JH: How would you describe your training in CBT and were there aspects of diversity within training?

S1: So my experience of training in CBT has been that related to the High Intensity program and that is about a year and half that it took me to train in Kent and sort of, two or three days in practice and then one day in University when you did the theory base. So in practice you get a chance to work with various disorders or the range of anxiety or depression, having supervision, being able to identify training cases that would count towards your clinical hours, providing structured sessions in a way that uses evidence base formulation to treat specific disorders; meeting theoretical aspects you have to demonstrate understanding of theoretical base, how to explore what one working group works, role plays um…yeah.

JH: So it sounds as though there was a lot of training to know how to work with clients on a one to one basis.

S1: Yeah. However in terms of the training preparing me to work with black or ethnic minorities approach there wasn't…there was a bit about diversity but not enough to give you that, what you need to practice as proficiently as you'd like. There was one lecture but that was it really. So mainly that bit I'd say was under-represented. There was one lecture on that but that was it really. Compared to the other bits you have lectures, you have practice, you have role plays, you know you do a bit more over a range but this appeared to be a one off thing that was probably inserted into the course. So generally it didn't feel like it was really enough to do the trick.

JH: So has working with black clients impacted how you might practice and how this might be?

S1: So in practice I've worked mostly in the Kent area which didn't seem to have much ethnicity compliments to the work I do there, it's mainly working with White British but moving to London recently, probably in the past 6 months or so has opened me up a bit more in working with people who are you know diverse ethnic backgrounds, typically I've worked with Caribbean clients and Asian backgrounds.

JH: So moving to London, I guess has been more culturally diverse sounds as though it opened you up to working more with black client groups. And would you say that working with these groups impacts the way you practice clinically?

S1: Not generally the way I practice, but thinking of the way I practiced with the Caribbean clients has impacted the way that I usually have to think flexibly in the way I present the treatment as a whole and the model.

54. JH: So you have to think flexibly?
55. S1: Yes
56. JH: Could you expound on that?
57. S1: Okay so compared to how I would work with
58. maybe somebody who was White British for example
59. my experience of working with Black African or
60. Caribbean backgrounds, they usually have difficulties
61. engaging or with continuity in treatment so when you
62. present the model in its strictest form whereby its
63. very structured, its boundaried, agenda, homework,
64. all of those things seem…erm…too much work for
65. them should I say? I have had feedback in that "Oh I
66. didn't have time to finish my homework…I forgot…I
67. didn't remember…or I thought I could do it in
68. session…I feel better talking with you in session
69. rather than writing" yeah so comments like that the
70. focus has been how do I engage them in treatment so
71. that you reduce the risk of dropout so there has been
72. that need to be flexible that's what I mean.
73. JH: In your opinion do you have an idea as to why
74. Black African/Caribbean clients may have struggled
75. to engage?
76. S1: Gut feeling, what comes up strongly is that sense of, you know, you don't talk about these things, you don't put your hand up, you don't go to therapy, it will just pass, you know that sort of thing so really I think the kind of cultural sense is that it will pass so do something else or ignore it, so yeah.
77. JH: Can you recall a particular when you've worked with a BA/BC/BA and whether there were any changes to how you would work with CBT?
78. S1: So I have to say that I've seen only about four clients that were from the Caribbean, none from an African background and none of them have completed treatment. One of them I think got close to completing the fifth session, so erm….outcome in that sense has been patchy. However the one that got close to five sessions did not demonstrate any progress in the minimum data set that we collect, you know the measures did not indicate that. However when you talk about how do you personally feel? Has CBT been useful? These few sessions that you've attended, they seem to verbally describe the sense that it's been useful for the first time that they've had that space to talk to somebody about it. But the sense that actually talking about it doesn't necessarily mean that they feel any better, and I have sort of entailed that to aspects that usually make CBT have more effective outcome in terms of you know homework for example, actually doing what we talk about in sessions, taking it away practicing it and bringing it back but that appears to be a big area that was difficult to really get through.
79. JH: Okay so it seems that just talking about it, perhaps wasn't sufficient but then on the other hand as you stated before, having a structured, agenda way of doing CBT doesn't quite work either would that be right?
80. S1: The rigid way of doing the agenda and you know, sort of coming in with an idea of a difficulty that we need to talking about and something that they've practiced, that didn't go so well, that we can talk about, those are the specific aspects that actually…maybe they lack that idea of CBT being structured and would move more into 'this is my problem, this is what I want to talk about, what do you want to take away, you know, it's fine to talk about it. So structurally you know, just identifying specific areas like, cognitive restructuring, for example was difficult in that sense that you talk about the negative automatic thoughts, the beliefs, work through it how this is translated into similar situations that you come across.
81. J.H. Okay so as far as the outcome, the outcome of the experience of this client didn't mesh with the measures..
82. S1. The outcome measures remain high, however when you interview or talk with the client, that it doesn't look like the scores have reduced, the client had said something like,

actually I think it was okay coming to talk with you, not necessarily that they feel less depressed. So that concept of mismatch that actually it's not coming for somebody to do something but it's actually taking away or taking on board specific skills that you practice that would translate into that outcome.

83. JH. So in your view you're hearing one view from the client and seeing something else reflected in the measures. What do you feel personally as to was the outcome was? Do you feel the CBT in this instance was helpful?

84. S1. I think that the outcome relates…I will base it on what I think the client was feeling, not on what I feel and what the client was telling me, didn't sound like an entirely positive outcome for them, if that makes sense?

85. JH. Yeah…do you feel then from your perspective that CBT worked or was helpful in that particular experience

86. S1. Erm…it did not work fully as I intended to, because of the limitations that were translated by the client but maybe there's a bit more in exploring cultural beliefs or some kind of beliefs around coming in to therapy what does that mean? Expectations as well, all of these things. Yeah and I think maybe a bit fair to work with services as well, to open up a bit more to make Black African, Caribbean's and other ethnic minorities to let them know that treatment is geared towards the mass world and that we…how best do we make them feel that actually this is for them as well. Because I think therapists that they come and see, is of a certain….what is it?

87. JH: So there's, from what you're saying there's a need for inclusivity but maybe black clients aren't quite feeling that sense of inclusivity.

88. S1: I think that's part of what I've seen, that could help to a certain extent, but maybe there should be more research around that to see for sure what needs to be done.

89. JH: Okay. You mentioned there something around, I think cultural viewpoints of the clients…thinking about BA, BC or BB clients and maybe culturally values, attitudes that one might consider culture to mean, can these values beliefs, all of these types of things, be it religion, can these things enhance or hinder the CBT process?

90. S1: In my experiences I think it's rather hindered CBT rather than enhanced it. For example, that same client had that very strong request not to contact anyone or not to send any letters home or to not let anyone know that he's accessing CBT but then there were beliefs around that, that people would see it as being a weak man, a weak person, so if that is the belief around that in their own sort or society, you're less likely to share what you're doing in therapy you're less likely to tell a friend for help, this is my homework could you help me, remind me or could you do this with me. Everything becomes really covered up in the way that you don't want it to be known. So I think with that aspect to educate a bit more, that actually it doesn't mean weakness, it doesn't mean any of these things. Maybe it's rather a strength than a weakness because if you seek help then you're looking at addressing your problems in a maybe a more evidenced based way rather than just views and assumptions that probably doesn't work.

91. JH: so there's something about educating clients then you're saying then maybe.

92. S1: to change attitudes and beliefs hopefully

93. JH: So I guess when you're thinking about maybe a BA or BC client's beliefs maybe if they have certain cultural beliefs that maybe related to religion or things of this regards important to the client, do you feel that these types of beliefs can be incorporated into formulation?

94. S1: I think as far aspects of maybe maintenances of difficulties, would makes sense in that way, that actually why is this being maintained in that way, what sort of avoidance processes are going on? And the aspects of the formulation this would make sense you know, and hopefully give them that rationale if you like, to erm…of behaviour change maybe or belief change.

95. JH: Okay so thinking about research certainly current research thinking about certain aspects of culture, I guess one thing I probably want to ask from you really is how do you see culture? How would you define it?

96. S1: Culture is some experience you have been exposed to as you've been born and growing it's an experience of belief that you see around that is the norm in your look out, area where you grow up, or your village or your people that you can identify with, or the language that you speak, so culture can really be all that you know and that forms your beliefs. Okay I coming

from Black African you know, specific tribe, this is how we do it, we don't for example when a child is born, we don't name it for a week or so, that is just a culture, it's just accepted practice.

97. JH: So in a way, then I guess there's something about culture forming part of identity in a way, so many differences. Do you feel that thinking about CBT being quite structured and a certain way of working, in the way then that you view culture, do you feel that knowing this or thinking about culture, that you [as the therapist] need to be able to know about the culture or the cultural experiences of the client in order to understand the client?

98. S1. Absolutely. Absolutely and it's that an the standing that maybe men don't talk about different things, that's the culture that as a black man you don't cry for example and then you come to therapy and talk about these things and you start crying, this is something that really, culturally you wouldn't want it to go out there, so it's part of your own identity as a man 'what sort of man am I that I'm crying?' So, yeah it's a big thing.

99. JH: So it's really important in order to understand the client and where they're coming from

100. S1: Where they're coming from yeah.

101. JH: So having said that some research has also suggested the need for 'culturally adapting' CBT. What are your thoughts about adapting CBT, and have there been occasions where you have done so?

102. S1: I think there is certainly a need adaptation to reach the wider diversity in that if these beliefs are really culturally based that has prevented people accessing services in the first place then maybe adapting CBT to their cultural needs, might make sense, they could relate to it a bit more. They wouldn't see it as, you know, too imposing as such, that actually this reflects my culture as well I can identify with it, it makes sense. It's okay, so...specifically in terms of homework I have had to adapt a bit around that because of the sense of weakness that they don't want others to notice that they're coming to therapy, maybe some of the homework will be left loose and somebody might read it and they will know; I have tried to adapt therapy to meet them half-way in that sense. However somehow possibly that might impact on outcomes I don't know. That's what I try to do.

103. JH: So in as far there maybe being occasions where you've adapted in practice that's been maybe with homework..

104. S1. Yes

105. JH: Yeah I wanted to ask when you ask there being a need to culturally adapt, where would that be or what could be adapted or what could that look like do you think?

106. S1: Specific structures in CBT for example the homework bit, okay normally this is what CBT suggests that gives better outcomes…blah, blah, blah, to fit with this cultural beliefs or to fit with these cultural needs, maybe you can be coming to therapy you would adapt it in a way that would give longer session times so that homework could be done in session first and then continue onto other sessions, so some kind of adaptation like that so they could feel accommodated for their needs in that way

107. JH: Okay and going back to what you said earlier and this sense of inclusivity or feeling that there is a personal connection that's engaging with their identity and their culture

108. S1: Well so if you understand their cultural backgrounds what is the norm for them, what do they do, what are their expectations and that makes sense to be able to adapt to make them feel that way, at least that will give some continuity that they will come back for the next session and it looks like that's what you need to see in treatment that they will come back and to continue

109. JH: So thinking about that, I mean would you say that there are difference in response between a say a Black British client whose culture maybe around their environment, you know inner city London, really multi-cultured…

110. S1: There is a difference…

111. JH: …to somebody coming from a village setting as you mentioned in Africa or the Caribbean, do you think there is a difference type of response between those groups?

112. S1; Typical difference would be the beliefs around carrying maybe therapy work around to do as part of your daily routine at home for example, it will feel a bit meaningless or alien to someone who is not born in this culture compared to someone who is born here,

understands the sense of routine, the sense of independence, doing this will come more easily to them, perhaps than somebody from different culture background who probably hasn't been that exposed to that way of living in England for example. So there is a difference.

113. JH: Right, so CBT would maybe feel easier to engage with for those, Black British, who may be have more of a western influence to maybe somebody who has been brought up in a different or non-western setting?

114. S1: Exactly

115. JH: Have you experienced any barriers of the BC clients that you have worked with and how you have managed this?

116. S1: It's challenging to get them to attend sessions regularly. There's always one reason or another as to why they cannot attend next week. You try to work around it but sometimes it's really difficult. So I don't know it it's a sense of priority or a sense of…it's difficult.

117. JH: So sounds as though not being fully engaged with the therapy?

118. S1: Mmm yeah.

119. JH: In your view, do you feel comfortable working with BC or BB clients? Do you have any issues or anything like that?

120. S1: Mmm that's an interesting question actually. [Pauses and appears to be thinking] I think sometimes it poses some kind of challenges for me because I'm of a Black African background, some clients feel that I should know where they're coming from and sometimes to be honest I just don't know and I can't get my head around, you know, that way of thinking or belief. So specifically there are some beliefs around that craft that present in therapy and they believe their difficulties are witchcraft based rather than psychological based and that poses a big challenge.

121. JH: A challenge for…you?

122. S1: For me yes.

123. JH: In what way?

124. S1: Well to, I don't really have much understanding of witchcraft and that isn't where my speciality is, my speciality is in CBT and psychotherapy to treat difficulties psychologically based, but the client that does not believe that their difficulties are psychologically based so there's that miss-match isn't there?

125. JH: So a client may have an expectation that you should know of be aligned?

126. S1: Yeah that I should know and, you know, maybe understanding in that way rather than to work with them from a psychological approach like CBT, that's the challenge.

127. JH: So that has been a challenge for you?

128. S1: Mmm…

129. JH: Do you have anything further to add or anything else that you'd wish to say or reflect on earlier questions?

130. S1: Yes so all of those things makes engagement quite tough. But generally more work, education and everything.

131. JH: So to summarise, certainly education is needed?

132. S1: Yeah

133. JH: Okay

Appendix G - Interview Agenda

Preamble – my position in relation to this topic

What is your core profession?

How long qualified?

Ethnicity?

Personal development, training & practice

1. How would you describe your training in CBT, what training was like

were there aspects around diversity included as part of training?

2. Past research has found there to be a high drop-out rate with black client groups in mental health services.

a) Have you found there to be any barriers or challenges with BA/BC/BB clients in response to CBT and how you managed this?

b) Have you come across any differences *between* ethnic groups, for instance how Black British clients may respond to CBT differently to Caribbean born clients?

3. a) Can you recall a particular time when you have worked with a client from a BA/BC/BB background and whether there were any particularly helpful or unhelpful techniques, such as Socratic questioning, homework that may work better or worse than others?

Culture and its relevance in therapy

4. How do you view culture and does this have a place in therapy?

5. Some research have named aspects of culture requiring attention during formulation including: identity of the client; conceptualisation of illness; spirituality/religion; language; psychosocial factors.

With a consideration of the use of evidenced-based CBT, in your view are factors associated with culture necessary for the success of therapy? And can these variables be incorporated into formulation?

Formulation

6. In recent years some research has suggested the need for culturally adapting CBT. In your view do you feel that CBT needs to be adapted [to consider cultural need of a client] or is it currently adequate?

7. Have there been any occasions where you have adapted CBT in practice when working with any of these client groups?

8. Has working with varying ethnicities, impacted your clinical practice? If so how?

9. This is the end of the interview. Were there any questions you wished to elaborate on further or any questions you found difficult?

Do you have anything further you'd like to add - Anything that I may have missed – Any difficulties or issues – Feelings

Appendix H - Example of Transcript

S2 – White Male
Job Title: CBT Therapist qualified 3 years
Ethnicity: South African

JH: How would you describe your training in CBT, so your experience of learning CBT and were their elements of working with ethnic minority groups?

S2: My training in CBT, my training was at Bucks University and I think my training wasn't fantastic because, yeah Bucks, because people who've studies at Oxford or you know, not just the name but a lot of the lecturers are the people who write the textbooks. But Bucks University both the lecturers were Counselling Psychologists and for instance one lecturer said that she never ever in her life asked somebody to fill in a thought record sheet and she never will, she said "what rubbish is that?". So they, from a counselling background and you know, so the training I don't think...the training was not great because I think it was just to get 'the stamp', you know and I think that a lot of my training was afterwards, er, through what I see, you know looking and watching the press, you know so when I see Padesky coming...run and pay for it, do it! When I see Stephen Holland coming, you know complicated depression...run and pay for it, do it! When I see Sabine Wilhelm coming, you for OCD. I just don't think the training was wonderful that's all. But I think my learning was after that.

JH: Okay and regarding the second part to the question, do you feel that your training included any parts on working with varying ethnicities?

S2: No there was no extra training on that no. Not well let's put it that way...there could have been one session on it but if we did I can't remember it.

JH: Okay.

JH: So would you change how you practice CBT depending on the ethnicity of the client? So for instance with black clients?

S2: I don't think it's impacted how I practice. Oh how I practice or think differently? [*appears to be thinking*] I think differently from perhaps peoples different life experiences, but I haven't learnt something new, or new techniques, or a new way of dealing with certain people in a different certain way because I just treat people. So for me it's just like diagnosis as well, I'm not really interested in diagnosis, I treat the person in front of me. So I've had a lot of client who say, you know I really wanna know it I've got autism or I really wanna know if I'm bipolar and I say "well what difference does it make if someone gives you a label," you know. So I treat the person in front of me irrespective of the skin colour.

JH: Okay so it's very much about the individual?

S2 – White Male
Job Title: CBT Therapist qualified 3 years
Ethnicity: South African

S2: Yes the individual, precisely and their circumstances. I think as well working in the UK you have such a wide range you know, well it's the biggest melting pot in the world I think, so I assessed a Polish lady yesterday and when I saw the surname I ran and got a polish data set and when I came into the room I said "you're Polish aren't you?" and I had the polish data set with me and she said "yes but I've lived here for 20 years, so you know, she doesn't need the polish data sheet. So I think there's just such a mix of people yeah.

JH: So there's something about being here, living in the UK for a period of time where ethnicity becomes...

S2: ...less of an issue

JH: Less of an issue

S2: Yes and also I think for me personally I think, dealing with...not specifically black people from the Caribbean but black people in general, I wouldn't say it's easier for me but maybe that is the right word to use I don't know, because I am from Africa, you know so I think I can relate maybe better I dunno rather than some guy from Oxford whose you know "Oh yes, oh yes" [imitation 'posh' accent] I think.

JH: So can you recall a particular time then when you've worked with a client from either a Black African/Caribbean or Black British background and whether there were any changes to the way you would usually practice CBT?

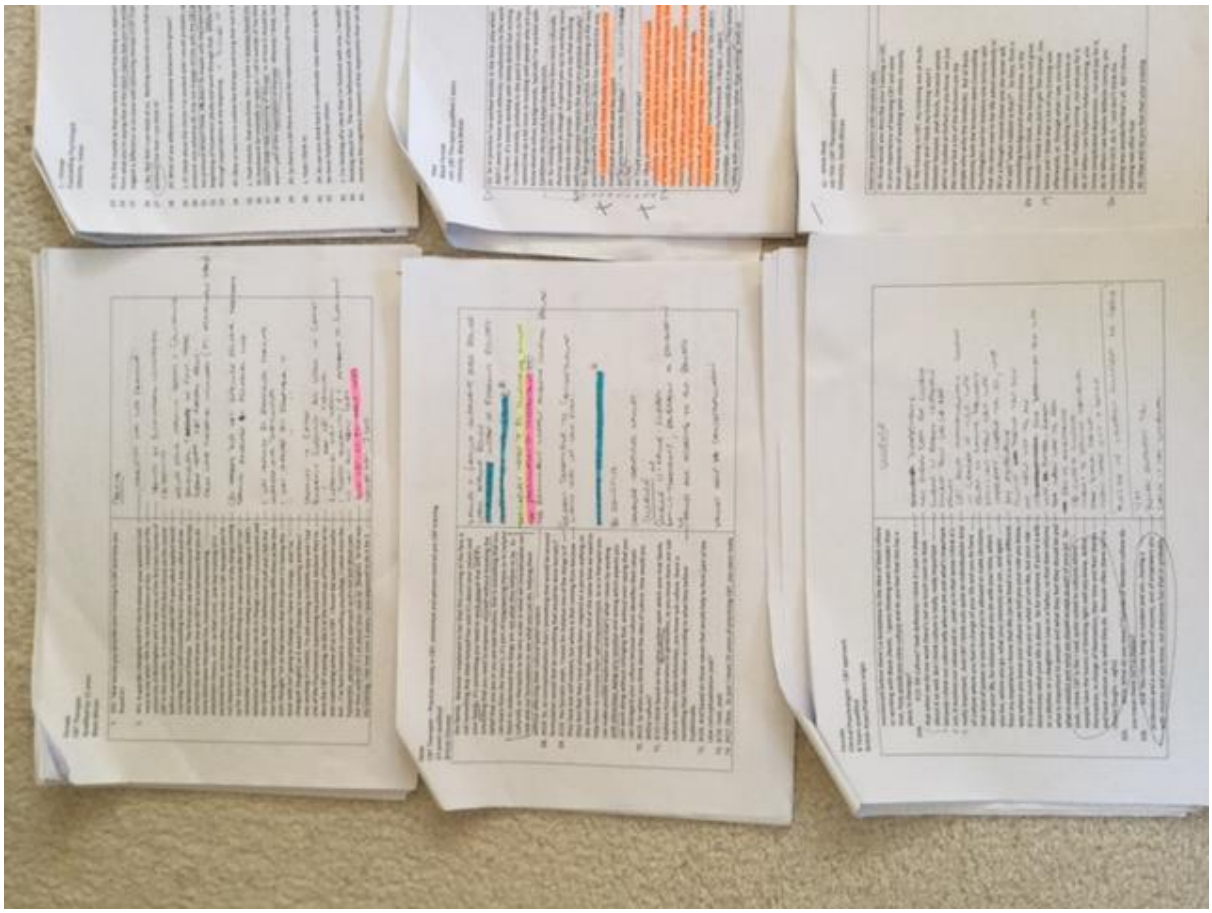
S2: Like how I would use CBT for any client? No, I'm just trying to think...I mean it's not related to CBT but I worked with a lady from, I'm not sure if she was from Jamaica but she was a mental health nurse, when I worked with the home treatment team and the lady said that she'd been...oh what do you call it, you know the voodoo dolls or something, when they poke needles in the eyes and black magic or something and that's why her Mum had said that she'd become psychotic and when we drove away the mental health nurse said to be "wow that woman's not well, the stuff about black magic, that's all very true, that's definitely true but she's definitely psychotic but the other's stuff's definitely true, you know with the voodoo doll you can make someone very ill" and I thought that was for me quite eye opening. A mental health nurse, a fully qualified mental health nurse, a general nurse and a mental health nurse and she said "oh no that's one hundred per cent" so there I agree with the lady but "she was definitely psychotic"

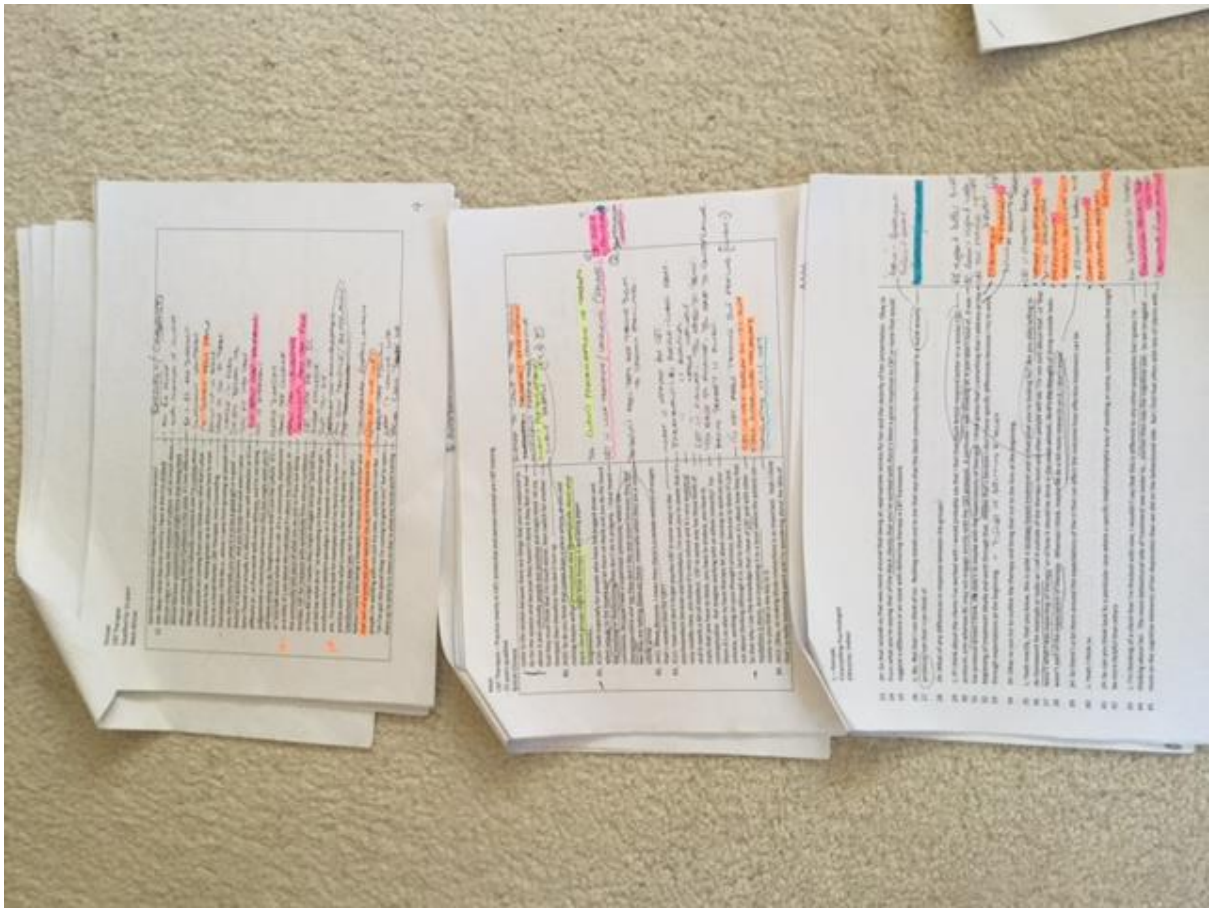
JH: So for you there's a disparity there?

Appendix I - Sample of Initial Coding

Box 4. S2: Like how I would use CBT for any client? No, I'm just trying to think…I mean it's not related to CBT but I worked with a lady from, I'm not sure if she was from Jamaica but she was a mental health nurse, when I worked with the home treatment team and the lady said that she'd been…oh what do you call it, you know the voodoo dolls or something, when they poke needles in the eyes and black magic or something and that's why her Mum had said that she'd become psychotic and when we drove away the mental health nurse said to me "wow that woman's not well, the stuff about black magic, that's all very true, that's definitely true but she's definitely psychotic but the other stuff's definitely true, you know with the voodoo doll you can make someone very ill" and I thought that was for me quite eye opening. A mental health nurse, a fully qualified mental health nurse, a general nurse and a mental health nurse and she said "oh no that's one hundred per cent" so there I agree with the lady but "she was definitely psychotic" JH: So for you there's a disparity there? S2: Yeah! Part of what she saying is nonsense and crap but the stuff about black magic and voodoo dolls is one hundred percent and I'm sat there going really?? Erm…I think I take into account the fact that perhaps there's a different way of seeing things from different cultures, like family values are different. You know so perhaps the family is a lot more important, where say in Britain or America being an individual is more important perhaps, you know, so striving for the individual and bugger the family. Where in Africa it's all about the family and sticking together. So with a patient, perhaps where part of the depression or the anxiety is because of the break-up of the family, you can understand that so much better because that's so much more important.	No change Nurse from Jamaica Voodoo dolls Black magic Mum believed in voodoo Psychosis due to voodoo Nurse believed in black magic She is psychotic Voodoo is true and real Voodoo can cause psychosis [?] I was surprised A professional should know better Disapproving She believed in voodoo She agreed with the Mother Disbelief Spiritualism Shock I can understand cultural difference Family values are different Family is more important Western family values are different Collectivism and Individualism African culture Mental illness and culture coexist Family breakdown leads to mental illness

Appendix J - Sample of Development from Initial Coding to Focused Coding





SECTION B: CASE STUDY

The transitioning therapist: Moving from CBT to psychodynamic practice

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.

SECTION C: PUBLISHABLE MANUSCRIPT

‘A deeper look at how therapists experience working with Black clients in clinical practice using Cognitive Behaviour Therapy: A Grounded Theory’

A deeper look at how therapists experience working with Black clients in clinical practice using Cognitive Behaviour Therapy: A Grounded Theory[1]

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Abstract As the use of Cognitive Behaviour Therapy (CBT) becomes more prevalent in clinical practice, over the last four decades, more recently there has been an increasing call for the adaptation of CBT following concerns that traditional CBT approaches may not account for particular and unique experiences encountered by marginalised populations (David, 2009; Eamon, 2008). Research has found that CBT may be more effective if it was culturally adapted to meet the needs of Black minority groups (Rathod et al. 2015; Naeem, 2015 and that therapists commonly 'drift' away from evidenced based techniques (Waller et al. (2012). Yet there has been a lack of studies exploring the efficacy and experience from the perspective of therapists in relation to minority racial groups and treatment outcomes.

This study attempted to understand CBT from the perspective of the therapist. The aim was to understand how therapists use CBT to work with Black African, Black Caribbean and Black British clients, if there are instances of adaptations to the CBT protocol and what this might look like. Qualitative interviews were conducted with seven therapists, including Counselling Psychologists, Clinical Psychologists and CBT therapists working mostly within primary care NHS and the Improving Access to Psychological Therapies (IAPT) service.

From the data four main categories were developed. The Core Category: *'CBT in practice: A process of working with Black clients.'* The four categories were: (1) Appropriateness, (2) Therapy congruency, (3) Developing my therapy style, and (4) Curiosity. The results revealed a tentative theory to explain a process of how therapists use methods of adapting CBT, to work more effectively with Black clients to increase therapeutic rapport and engagement, including aspects around culture, religion, language, psychological-mindedness, acculturation to the host country, education and age.

The implications of this study contribute to the field of Counselling Psychology by helping to demonstrate some practical applications of CBT with clients who present from African and Caribbean ethnic backgrounds and to assist with sustained therapy engagement.

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[1]To be submitted to *Cultural Diversity & Ethnic Minority Psychology*

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Introduction

Cognitive Behaviour Therapy derived from Becks original Cognitive Therapy makes up a structured, present-focused and short-term form of psychotherapy, mostly assuming a current problem-focused and therefore goal oriented perspective, modifying dysfunctional thinking and maladaptive behaviours (Beck, 2011). Over the years Beck and others have successfully adapted therapy to cover a range of other disorders other than depression including generalised anxiety, obsessive compulsive disorders, post-traumatic stress, specific phobias and social phobias. Although the application for various presentations has changed, the theoretical underpinnings of CBT have remained relatively constant, based on conceptualisation of individuals specific to their thoughts, feelings and behaviours in relation to a specific presenting problem. The general treatment protocol of CBT is based on a formulation characterising a disorder, identifying patterns of behaviour relative to that disorder and identifying the associated thoughts, feelings and behaviours maintaining the problem.

A number of forms of cognitive behaviour therapy exist sharing characteristics with Beck's therapy, but with variations in conceptualisations. These include rational emotive therapy (Ellis, 1962), dialectical behaviour therapy (Linehan, 1993), problem-solving therapy (D'Zurilla & Nezu, 2006), acceptance and commitment therapy (Hayes, Follette, & Linehan, 2004), exposure therapy (Foa & Rothbaum, 1998), cognitive behavioural analysis system of psychotherapy (McCullough, 1999), behavioural activation (Lewinsohn, Sullivan, & Grosscup, 1980; Martell, Addis, & Jacobson, 2001), cognitive behaviour therapy often incorporates techniques from all these therapies and others psychotherapies, within a cognitive framework.

The cognitive model underlying cognitive behaviour therapy proposes that dysfunctional thinking, which influences mood and behaviour, is linked to all psychological disturbances. When a client learns to explore and evaluate their type of thinking in a more balanced and realistic way, such as changing unhelpful automatic thoughts, they can experience improved emotional and behavioural functioning. Some studies examining the effectiveness of CBT have found high dropout rates among Black and Hispanic populations (Magill & Ray, 2009; Mak et al. 2007; Miranda et al., 2005; Voss Horrell, 2008). Windsor et al. (2015) reasons that the question about whether CBT is effective for clients of African or Caribbean origin is difficult to answer as studies that have indicated CBT effectiveness for Black and minority groups have used culturally-adapted approaches (Foster, 2007; Kohn & Oden, 2003; Miranda et al., 2003, 2006; Organista, Munoz & Gonzalez, 1994) such as language considerations, interpreters and integrating cultural elements into treatment (Sue et al., 2009). Further studies have also made a call for the adaptation of CBT as there is concern that traditional CBT approaches may not account for particular and unique experiences encountered by marginalised populations (David, 2009; Eamon, 2008). A number of reviews conducted have found that CBT would be acceptable and may be more effective if it was culturally adapted to meet the needs of black minority groups (Rathod et al. 2010, 2013, 2015; Naeem, 2015).

Past research has commonly taken up a position to explore therapy experiences from the client perspective. With regards to CBT there have been a limited number of studies that have made attempts to explore the views and experiences of therapists delivering CBT to BME clients (Naeem et al., 2010, 2015; Rathod et al., 2010; Bennett-Levy, 2014). The outcome of these studies have acknowledged that during therapy, adaptations to CBT were often required for certain BME groups. However across each of these studies, they have failed to clearly define the specific aspects of adaptations and what process of change occurs in relation to the CBT model. The present study will attempt to address some of these gaps in the existing literature by being one of the first to carry out research on the experiences of Counselling, Clinical Psychologists and CBT therapists delivering manualised CBT specifically with Black African, Black Caribbean and Black British clients within the UK's psychological services and to gage the opinions of therapists in a more intimate way in order to understand what CBT adaptation might look like within clinical practice, and to explore any challenges and strategies of coping.

Method

Participants

Recruitment of participants was purposeful and were selected based on the criteria that they accredited CBT Therapists, Counselling and Psychologists, spoke fluent English and had experience of the application of the CBT framework and have worked with individuals from the Black community. The latter criteria was specified in order to ensure that participants were able to draw on personal experiences in clinical practice and to account for personal and varied methods of working. Recruitment of participants involved a poster that was placed throughout various psychological services, recruitment emails to mental health services and word of mouth.

A total of seven therapists (three CBT Therapists, two Counselling Psychologists and two

Clinical Psychologists) of varying ethnicities were recruited.

Procedure

Grounded theory (GT) is a qualitative method that aims to put together an explanatory model from the data. It is often used for the study of new areas within research (Willig, 2008). It strives to construct theory and does so through an inductive process of data collection (Morse, 2001; Mills et. al., 2006). GT was originally developed by Barney Glaser and Anselm Strauss who sought out to develop a method that would move data to theory that were 'grounded' in the data (Willig, 2008).

The aim of this research is to explore the process through which therapists go through to work with Black clients using CBT and what methods of adaptation might be used with the treatment model. At present, research on cultural adaptation predominantly focuses on describing the necessity for it rather than explaining the process of it. In areas where there is hardly any research GT is often applied in order to produce preliminary theories of a particular phenomenon (Strauss & Corbin, 1998), making GT an appropriate approach for the present study. GT allows for theoretical sampling, which can help explore the differences and similarities of therapist's individual experiences and differential ways of working. It also permits the adaptation of interview questions following a previous interviews, which allows potential to investigate and capture the unique processes of different individuals. Grounded theory postulates itself as appropriate for socially constructed experiences (Goulding, 1998; Charmaz, 2003).

Interviews

Semi-structured interviews were used as the method of data collection. Each interview lasted approximately 60 minutes and was audio-recorded. Interviews began with a broad question to allow participants to reflect on what initially attracted them to the study and to discuss their training and standardised method of CBT practice and experiences of working with ethnic minorities. Questions were phrased in an open-ended way to encourage an in-depth exploration of themes. From there, there were three main areas that were covered: (1) Personal development, training and practice (2) culture and its relevance in therapy and (3) formulation.

Each interview did not always follow the same structure as the interview agenda was edited in response to emerging themes following each interview (Charmaz, 2006).

Analytic Strategy

The investigation used a qualitative methodology, specifically a constructivist grounded theory method (Charmaz, 2006). This particular method utilises a set of structured procedures to generate constructs grounded in the participants' experiences. The study was designed and implemented by the primary researcher, a graduate and Counselling Psychology trainee. Constructivist grounded theory (GT) requires a comparative, inductive and flexible approach whilst acknowledging the position of the researcher (Charmaz, 2006). Constructing the core category and four categories involved a number of stages. Interview transcripts were analysed in line with Charmaz's (2006) guide to constructing GT. Through the process of initial coding, fragments of data was studied line-by-line, at times adopting participants' words as codes. Initial coding opens up pathways to developing focused codes. In order to do so it was important to focus on the most important initial codes and then iteratively test them against the extensive data. Relationships between subcategories were noted during memo taking, which took place throughout analysis. Once relationships between subcategories were developed, overarching categories were formed; this helped separate out the most important findings from the data. From here, examples of shared experiences were discovered from the participant's quotes

Results

Four main categories emerged from the data: Appropriateness, Therapy Congruency, Developing my Therapy Style and Curiosity. The overall core category: CBT in practice: A Process of Working with Black Clients.

CBT in practice: A Process of Working with Black Clients

The findings suggest that Counselling and Clinical Psychologists often adapt CBT when working with Black client groups who require a more relational approach to therapy and as such CBT was criticised as lacking humanism. These therapists would often adapt standardised CBT such as, the CBT model and formulation by drawing on principles of the humanistic model, Acceptance and Commitment Therapy (ACT) and existentialism often omitting homework and the agenda with more focus on the relationship for which these therapists highlighted as key for maintaining therapy engagement of this client group. As such Counselling and Clinical Psychologists reported no instances of client dropout. CBT Therapists did not report any adaptation to their methods of working

with CBT, describing a purist approach to clinical practice. They reported often feeling that this way of working was rigid and inflexible. CBT Therapists reported experiencing client dropout with almost all of their Black clients over the course of their clinical practice. There is further reflection upon these four categories in the cycle presented below.

Appropriateness

Participants shared a common view that CBT was too rigid for use with Black clients. They described often feeling pressure to work in a standardised way and reported experiencing client dropouts. For example Jane reported that she often felt service pressure to apply a strict CBT protocol and that carrying the expectation of the service, with little room to change approach to therapy made it difficult to meet client expectation if this expectation was significantly different to the CBT model.

"*Sometimes I feel like I'm working for the monster, I have to keep feeding the monster and the conveyer-belt of clients just keep reeling in and I'm expected to just keep reeling out the same scripted way of 'doing' CBT and if I don't I'm not being evidenced-based. Sometimes it's just down-right non-human." (58-62).*

Alongside feelings of service pressure James gives an account of certain aspects of CBT that he feels might be particularly difficult to work with and as a result the difficulty that this might present for a client who finds the idea of therapy in the 'classic' sense as a talking therapy challenging:

*"CBT can often construe as rigid and structured and there's no flexibility because one of the aspects of CBT is about thought records, keeping records, keeping home-work. For an elderly or a middle-aged ethnic person having to come with a language problem, language barrier and more importantly talking therapy is something quite alien…*because it's a very western concept so they find it very difficult let alone to engage with someone." (*James: 58-65)*

James makes a direct statement that with CBT there's not flexibility. This lack of flexibility seems to be a consequence of the method used including keeping various records and homework. The reality of imposing these methods on an elderly person with language barriers is particularly challenging when the idea of talking is hard enough. It seems that factors including language barriers, stigma and expectations that might arise around homework might be difficult for those who find therapy 'alien'. There is something here that emphasises the simplicity of engagement in the first instance as the concept of talking with an outsider might be challenging for particular groups. For James, the written materials are to blame for this rigidity. Steph similarly shares the view of moving away from written materials and adds that the use of thought records are less preferable from a clients' perspective:

"I don't tend to use thought records. People that I've worked with feel better talking with you in session rather than writing" (Steph: 57-58)

In describing the style of talking, Wendy went further to state that exploring a problem requires a Socratic process for guided discovery instead of a didactic approach as CBT requires. Wendy seems to feel however that a didactic style is preferable for African and Caribbean clients:

"…it's not about the individual it's about the collective, so the community sets pace of what you do and so if you are doing therapy, CBT for instance with somebody from African Caribbean or from BA origin maybe they might struggle because "just tell me, just tell me what to do" so it depends on how the person has got acculturated to a western paradigm, so it depends on where people are." (Wendy: 28-34)

Jane went further to explain why a didactic style might, in some cases, be preferable:

"You know in the black community, for instance in church the older generation, so those from the Caribbean are coming from a very strict moral place, whether parental, schooling or religious. They're used to being directed on what's right or wrong" (Jane 50-53)

There seems to be a felt sense of therapists trying to balance the style of therapy and the expectations of clients themselves. It is this pursuit of balance that perhaps leads to the feeling of rigidity through written materials where therapists are trying to find an appropriate way of working, as clients might require a more flexible platform to tell their story. Along with written materials, the agenda was also highlighted as another element that added to rigidity for therapists. In managing rigidity, Wendy goes on to talk about the agenda when working with an African client:

"I wasn't so rigid with the agenda, I allowed her to set the pace, give her that room…in CBT we are very rigid with the agenda" (Wendy: 67-68)

Steph similarly identified the role of agenda setting in CBT as rigid and what this was like in practice in her experience:

"The rigid way of doing the agenda and you know, sort of coming in with an idea of a difficulty that we need to talk about and something that they've practiced, that didn't go so well, that we can talk about, those are the specific aspects that…maybe they lack that idea of CBT being structured and would move more into 'this is my problem, this is what I want to talk about, what do you want to take away, you know, it's fine to talk about it. So structurally you know, just identifying specific areas like, cognitive restructuring, for example was difficult in that sense that you talk about the negative automatic thoughts, the beliefs, work through it how this is translated into similar situations that you come across." (Steph: 95-107)

The language used by Steph in description of the CBT experience with black clients as rigid and structured is similar to James' and Wendy's earlier comments. It is worthwhile noting that Steph uses the term "the rigid way of *doing* the agenda", Wendy also states "I wasn't so rigid with the agenda". Demonstrating something about the therapist being intentional in their approach, the expectation perhaps of what CBT requires to 'set the scene' for the session and that this might be felt as a hindrance with little deviation as a set path for the session.

Therapeutic alliance and empathy were highlighted as ways of making a client feel engaged and that the absence of this could lead to a client disengaging and potentially dropping out of therapy:

"I remember at the time and even now, actually feeling frustrated, I felt bad… I feel like I was trying to push behavioural activation onto her and the Black British lady, there was a lot of early experiential trauma driving her OCD and I think she just felt overwhelmed at the idea of even having therapy or maybe I didn't spend enough time building that relationship. She only attended four sessions and didn't come back after that." (Jane: 102-107)

Steph also shared her experience of drop-out with a number of black clients:

"So I have to say that I've seen only about four clients that were from the Caribbean, none from an African background and none of them have completed treatment. One of them I think got close to completing the fifth session, so uh…outcome in that sense has been patchy. However, the one that got close to five sessions did not demonstrate any progress in the minimum data set that we collect, you know the measures did not indicate that." (Steph: 85-93)

Steph went on further to give an account as to why she felt these clients may have left treatment early:

"Gut feeling, what comes up strongly is that sense of, you know, you don't talk about these things, you don't put your hand up, you don't go to therapy, it will just pass, you know that sort of thing so really I think the kind of cultural sense is that it will pass so do something else or ignore it." (Steph: 76-81)

The above reflections from Steph seem to state that a narrative about therapy exists in the black community that you don't talk about issues in therapy, instead the feeling will pass and so will the problem therefore therapy is not really needed.

Therapy Congruency

Therapists shared similar views about client's cultural beliefs impacting therapy. James below described views from both Black and Asian clients in his experience where beliefs that therapy is not culturally accepted are held:

"From a West Indian perspective is that it's not okay for you to say that, it's not okay for you to do that, after all you are not me…black. The Asian thing is the perspective, the preconceived idea is that we do not share something private to a stranger." (James: 130-135)

As a result, therapists reported adopting methods of adaptation of CBT depending on the client. Integration emerged during interviews as a means by which therapists negotiate with CBT and how knowledge is exchanged. 'Therapy congruency' highlighted therapists' experiences in adaptation, to get a closer look at what this might look like in relation to how aspects of CBT might be changed or utilised in addition with other methods of working during therapy with a client. James summarises this directly:

"…I use CBT in conjunction with other modalities, it's no different in terms of how you utilise it… CBT is a technique it's a method, it's how you utilise the method that encompasses the humanism within it. Then it could be CBT, psychoanalysis, person-centred, it could be acceptance commitment therapy or even sub-confession therapy." (James: 298-304)

James begins by describing his use of CBT along with other modalities and how this is best achieved. He seems to suggest that other modalities including person-centred and Acceptance and Commitment therapy (ACT) help to draw out humanism emphasising the whole person:

"…if you adapt it to the humanistic model then it encompasses disability, ethnicity, beliefs, gender…anything else that just encompasses it." (James: 314-316).

Reference to the humanism model, serves to incorporate meaningful experiences socio-cultural factors which James highlights as the key. Similar views were shared regarding the inclusion of humanism by another therapist:

"I've sort of moved on from doing Beckian CBT and I'm more into Acceptance and Commitment Therapy now so even though I say I'm a CBT Therapist I do more Acceptance and Commitment Therapy and third wave therapy because it's so humanistic." (Wendy: 177-181)

Wendy expounds on her preference of incorporating ACT into her work:

"Well another thing I have learned along the way, ACT is a Mindfulness-based CBT approach and when you are working…it's relational it's not saying 'you know I'm the expert and I'm doing this to you' you don't do ACT to people you do it with people." (Wendy: 199-204)

As part of this subcategory therapists also shared that part of the challenge of achieving therapy congruency with CBT in clients from Black African and Caribbean backgrounds was in managing preconceptions on both sides. Below Liz describes preconceptions that might be held by the therapist:

"…it's valuable not to assume you know if you are of the same culture; how the client is feeling or you know, in order for them to feel understood I think, even as a therapist I ask 'how does that fit in with your beliefs or culture?' because I think that's important as I may not know and that then is lost in therapy which is very important, so I will often ask if there's something I don't understand about a culture." (Liz: 63-66)

Liz emphasises the importance of querying from the position of the therapist, to glean understanding which she frames around culture. This experience of having assumption and the impact was personally shared by Jane as she reflected on a session:

"I felt like I should know because I shared a similar West Indian culture and upbringing, and felt guilty when I couldn't understand her…I should've been able to understand her being black too." (Jane: 168-171)

Wendy pointedly asserts as if in response to Jane:

"I can't say 'oh I've got all this training on cultural diversity or cultural competence now I know' I don't know how that person is experiencing their culture and what it means to them so it's just being with each person I see. Or I can't say 'oh I'm African so I know what an African thinks about, I'm black so I know…' I don't know where people are at" (Wendy: 301-307

Developing my Therapy Style

Throughout the interviews there was a universal sense that CBT can seem too structured and prescriptive, perhaps for the therapist in their preferred way of working with some BME clients where a humanistic position is preferred. Some therapists found that adapting CBT by assuming a non-purist CBT approach can help with maintaining therapy engagement thereby decreasing risk of dropout. Therapists seemed to feel frustrated with working in a singular CBT way and that drawing on their own professional experiences and other modalities provided an opportunity for therapists to find their own way to build on existing CBT principles and combine this with existential, ACT and person-centred positions. Three sub-categories *humanism, training and flexibility* were developed from therapists sharing such views as to what they felt were the most important aspects underlying their CBT work. Below Liz describes that as the CBT model is a 'one size fits all' the therapist must have the freedom to explore the best fit. There is responsibility for the therapist to take on the choice as to how to work with a protocol that can work for all:

"I think that's up to the therapist, because the protocol is written for everybody…so if it's a depression protocol if you do it strictly, then you're not asking. I can't think of which protocol includes culture in it (laughs) or to ask questions about it. I'm thinking about the Becks depression model. So the background, the assumptions, it doesn't ask about cultural experiences it just says 'experiences'" (Liz: 78-81).

This opens up the idea that there is perhaps something missing within formulation which does not clearly specify cultural factors.

On issues of flexibility Steph below describes the need to work flexibly in reducing methods of CBT such as tools, agenda and homework in favour of a relational focus in order to manage risk against dropout and maintain engagement:

"…thinking of the way I practiced with the Caribbean clients has impacted the way that I usually have to think flexibly in the way I present the treatment as a whole…so compared to how I would work with maybe somebody who was White British for example my experience of working with Black African or Caribbean backgrounds, they usually have difficulties engaging or with continuity in treatment so when you present the model in its strictest form whereby its very structured, its boundaried, agenda, homework, all of those things seem…erm…too much work for them should I say" (Steph: 49-65)

The issue of maintaining engagement and managing dropouts with her BA and BC clients in the past has been a factor and presenting CBT in its "strictest form" such as the agenda and homework does not perhaps meet with initial therapy expectations or might feel overwhelming. Steph continues to explain her views on the impact of homework:

"I have had feedback in that 'Oh I didn't have time to finish my homework…I forgot…I didn't remember…or I thought I could do it in session…I feel better talking with you in session rather than writing' yeah so comments like that the focus has been on how I engage them in treatment so that you reduce the risk of dropout so there has been that need to be flexible that's what I mean" (Steph: 65-72)

James below highlights thoughts records specifically as something that he does not use. He goes on to describe the impact of what it might feel like for the client not completing thought records:

"…and sometimes when they don't do it, they're so scared to come to the session because there are things that you're supposed to do for the session" (James: 235-239).

Liz shared similar views below:

There was some resistance in doing thought diaries, writing it, making it become more real, that kind of stuff. (Liz: 46)

Along with Steph, James and Liz, Jane also described a similar experience:

"I don't know, I feel that my overall CBT approach depends on who I'm working with but I just find that certainly BC clients I've worked with don't really do written homework. They want to talk about things. Often making behavioural changes is something more they can get their teeth into and see change." (Jane: 173-177).

Working flexibly seems to take the form of the therapist creativity in finding ways to explore the presenting problem along with the client to identify expectations for therapy. Moving away from traditional methods of homework, thought records and using the session time to focus on issues seems to be an important part of practice.

Curiosity

Throughout the interviews a clear category that emerged through the transcribing process were therapists' views on assuming a position of curiosity. This position is important to hold when working in psychotherapy as a whole but for therapists who shared their views during interviews, emphasis was placed on assuming a curious position in terms of culture and how this relates to their clients within the context of therapy.

Therapists also expressed that the model of CBT is very much centred on exploring the individual which could often be challenging for working with clients whose culture advocates viewing self through family and community contexts for which they have become used to. Wendy offers up a reason for this challenge by firstly reporting collectivist views held by clients and the role of community:

"…it's a community, experiences as a child, it's not about the individual it's about the collective, so the community sets pace of what you do and so if you are doing therapy, CBT for instance with somebody from African Caribbean or from BA origin maybe they might struggle." (Wendy 108-113)

Wendy states that those clients specific to African and Caribbean indigenous communities are more likely to view their problems from a collective perspective and as such this could be difficult to engage with the concept of CBT. Seb shared a similar view below when attempting to explain the CBT model in sessions by drawing on comparisons between African and western cultures:

"You know so perhaps the family is a lot more important, where say in Britain or America being an individual is more important perhaps, you know, so striving for the individual and bugger the family." (Seb: 156-162)

This supports the view where Cheek (1976) advised that although CBT can be used

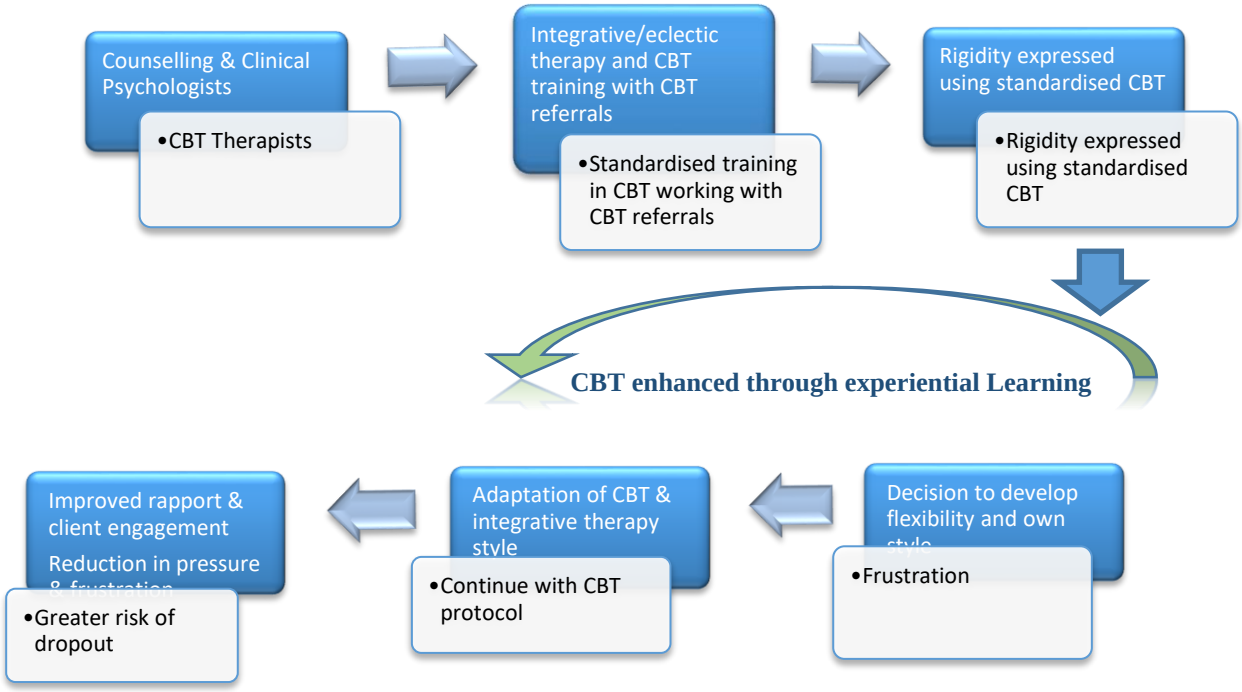
appropriately for different cultural-racial backgrounds, the caution and curiosity required of therapists could not be underestimated, who stressed that simply attempting to modify traditional forms of psychotherapy, is not all that is needed to work ethically and effectively with culturally diverse client groups but in the awareness of how contextual factors impact client's lives. In this study there were differences between the perspectives of Psychologists collectively and CBT therapists on issues relating to therapy style, where Psychologists ventured onto methods of adaptation to meet cultural need and CBT therapists keeping to stricter methods of CBT principles. One thing that was clear across all of the interviews was the importance of assuming a position that was open to understanding the client's perspective.

Discussion

This study aimed to explore how therapists experience working with Black clients using CBT. More specifically was the intention to understand how CBT might be adapted to suit the needs of the client as and when issues around cultural sensitivities might arise and what strategies, techniques or other modalities might be utilised in order to make CBT more applicable for the client. The purpose of this study was to get a personalised account from therapists themselves who have worked with Black African and Caribbean and Black British clients in order to generate a reliable view of first-hand experiences.

The findings from the study highlight the many factors therapists must be aware of and operate under to achieve therapy congruency. What became evident was that achieving therapy congruency meant stepping away from standardised CBT practice where therapists work mostly in an integrative way in order to meet the needs of clients from black ethnicities. Therapists mostly felt that CBT lacked a humanness and in its rigidity, exposed the risk of not developing sufficient therapy congruency therefore leading to leading client dropout. The relationship was expressed as fundamental to the success of therapy and that relying on a purely protocol driven approach of CBT was not enough to work in a way that kept Black clients engaged. Therapists shared aspects of adaptation of CBT in order to better meet client's needs. What became evident was that therapists who shared experiences of adaptation of CBT were Clinical and Counselling Psychologists with CBT Therapists working mostly within the CBT framework alone. CBT Therapists expressed experiencing frequent degrees of dropout with black clients that they had worked with, comparatively Clinical and Counselling Psychologists did not report client dropout over the course of their practice with their black clients. Clinical and Counselling Psychologists described the importance of specifically adopting a humanistic model as the most important approach for working in a CBT way with black clients. Studies have supported such a stance, advocating that humanism as a pluralistic position is the most appropriate foundation on which to establish CBT frameworks with clients from African and Caribbean backgrounds. Studies have found that a person's way of living in any cultural setting cannot be accounted for by the environment, cognitive or biological factors alone (Jenkins, 2001).

Figure 1. Conceptualisation of Emergent Theory: Process of Therapist experience of CBT with Black clients



The emergent theory identified in Figure 6 above captures the process of the therapist's emotions and strategies of working with CBT. This process identifies two processes occurring. The first process is about the therapist's own interaction with the CBT framework – frustration and confining and the subsequent development of an adapted style of therapy. There is also then the therapist's belief of how the client responds to this change in style. For therapists the emphasis of working from a humanistic model was seen as a significant addition to CBT work. Numerous studies have identified that CBT might conflict with cultural values (Hays & Iwamasa, 2006; Rathod et al. 2010; Bernal et al. 1995; Bennett-Levy, J. et al., 2014; Kingdon, 2015). A review of CBT conducted by Kantrowitz and Ballou as far back as 1992 found that the emphasis in CBT regarding cognitions, logic, and rational thinking strongly favours dominant cultural perspectives which includes definitions for rationality. In this study therapists described CBT as rigid and inflexible and that the materials often used in conjunction with homework contributed to rigidity and the therapeutic feeling that felt 'alien' for clients and indirectly for therapists also with this client group. This method leads to feelings of frustration for therapists. The critique is that this cognitive emphasis can easily lead to an undervaluing of the importance of spirituality in the face of cognitive rationality. In addition, CBT's focus on changing oneself can contribute to the neglect of cultural influences that can restrict a person's ability to create and in so doing affect implementing change. Consequently, Hays (2006) states that this internal focus, if not sufficiently balanced by a perspective that recognises the power of the environmental influences, may contribute to developing a sense of blame of the client for problems that are primarily environmentally based. This perspective, as shown in Figure 1, shows therapists adopting a integrative approach using a humanistic perspective into their CBT work. Some early studies supported the view that adopting a humanistic approach that does not ignore spirituality was the most appropriate perspective to consider for effective treatment. Maslow (1966) and Sutich (1976) on the humanistic movement acknowledging the experience of the fully functioning person, were dissatisfied with the idea of social transformation occurring without consideration of the spiritual.

As suggested above, therapists found that when working with Black clients using CBT, it felt rigid and inflexible as fully engaging with those from African and Caribbean backgrounds requires a greater relational approach, for which therapists felt CBT could not provide when utilised on its own. Although CBT therapists also expressed rigidity and some frustration, they continued to work in a standardised way using CBT, which as Figure 2shows, increased the risk of client dropout. Clinical and Counselling Psychologists who each expressed rigidity with the CBT framework found that developing their own style was important in their process of working, the emphasis of which was on the relationship, thus reducing client drop out and less frustration in therapeutic style for the therapist. In this study the personalised accounts of the appropriateness of CBT with Black African and Caribbean clients who may be less acculturated than Black British suggests that CBT must be adapted in order to be beneficial.

Therapists felt a strong sense of freedom to work flexibly to develop a more idiosyncratic approach and that at times a purist CBT position felt restrictive and impersonal with Black clients where sociocultural factors such as family, religion and identity might dominate. The need to combine elements of humanism, focusing on areas around self-actualisation, self-esteem, belonging and needs as a foundation to build on with working to explore the here and now of thoughts, feelings and behaviours appeared to be preferable.

Study Limitations

A limitation of this study was in the sampling size providing only 7 participants. From a constructivist perspective, truths are not based on generalisability from large sample sizes, instead they focus on how the phenomenon are constructed through personal experiences. So although reliable opinions were shared for the purpose of this study, a larger sample size could offer a richer contribution to overall theory. The consideration of this point is that a larger number of participants could have identified further information that was not highlighted by the current participants. In terms of variation among ethnicity, a strength within this study was that therapists were from varied ethnic backgrounds. A significant larger sample size was unfortunately not possible as this would make the size of this study unmanageable and therefore was not considered for practical reasons.

A further limitation to this study is the lack of generalisability due to its qualitative methodology. A vital step in future research would be to investigate and provide accurate statistics on comparative quantitative measures with more therapists. Quantitative data therefore could have served better in capturing the wider view of therapists across larger areas and psychotherapy services. However, it is important to note that the strength of grounded theory is the clinical applicability of the emerging theory as it can be integrated into training, practice and have real-life clinical applications (Teram et al., 2005). It is also important to note that in this study some categories have only been partially defined as far as their dimension due to not reaching complete 'saturation' (Corbin & Strauss, 2008). It is for this reason that further research could be carried out in the future with an aim to engage in further theoretical sampling to fully saturate the findings gathered so far.

Conclusions and Implications

The central challenge that therapists face when working with clients is gleaning an understanding of the different way that clients construct meaning, how they deal with challenges and what sources of strength or coping strategies help to sustain them through stressful life events. The findings of this study demonstrate some practical applications for successfully approaching CBT when working with clients who present from African and Caribbean ethnic backgrounds. Therapists shared their views on how they managed difficulties and barriers when clients struggled to engage with the concepts of CBT and how they managed this through developing a style of therapy which was more eclectic rather than purist. In so doing, therapists often 'adapted' CBT through a combination of other models and perspectives in order to present CBT as more 'humanistic' and relational for which they felt that it lacked and as a consequence could be the fundamental cause for client dropout. Previous research highlighting high dropout rates amongst Black clients reportedly expressing "*considerable dissatisfaction with the approaches in therapy they received*" (Fernando, 2004; Rathod, 2010).

In this study Counselling and Clinical Psychologists described their current practice as being integrative, even within IAPT services, as they incorporated therapeutic approaches other than pure manualised CBT, making them more flexible and adaptable. Both Clinical and Counselling Psychologists made adaptations based primarily on their own experience. These adaptations involved altering the cognitive and behavioural interventions to better suit the individual needs of the client. The adaptations took into account the client's culture, religion, language, psychological mindedness, acculturation to their host country, education and age. The therapists' confidence in CBT and their self-identity as therapists also influenced their overall practice of therapy. Historically counsellors and psychologists have spent much time debating the 'best' models or theories to use when working

with specific client groups (Ivey, 2002). However, therapists have increasingly come to realise that many ways exist in helping clients to deal with the challenges and problems that bring them to therapy. Studies have shown that this realisation in recent years has led many therapists to embrace a more eclectic approach to psychotherapy (D'Andrea & Daniels, 1994), as reflected in the approach that Psychologists took within this study. The view that this study offers is the benefit of Psychologists using an adaptive and eclectic approach of CBT with Black clients that rather than becoming locked into one particular psychotherapeutic theory, is the growing tendency to utilise strategies that might come from different theoretical models when working with people from diverse client populations and who manifest a broad range of concerns and problems in a counselling setting. This type of flexibility and open-mindedness appeared to be something desperately called for by therapists in this study who reflected pressure, a sense of rigidity, either feeling unable to practice with open-mindedness and flexibility or not having time enough to do so. Given the rapid increase of cultural-racial diversification within the UK and counselling services, the importance of maintaining a flexible and open-minded approach in psychotherapy has been underscored by many theorists and researchers, who have identified that traditional Western counselling theories requires a shift, as they are often not sufficiently helpful, or may even pose a threat, when used with culturally diverse clients who may have very different beliefs about mental health, psychological illness and helping strategies (D'Andrea & Daniels, in press; Sue & Sue, 1999).

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The models commonly referred to as those that therapists would adapt CBT, were ACT and humanistic models. Several articles investigating the use of ACT comparatively with CBT suggest that ACT is not hostile to traditional CBT and is not directly buoyed by whatever weaknesses traditional CBT might have and is therefore part of the larger behavioural and cognitive therapies perspective (Hofmann & Asmundson, 2009; Forman & Herbert, 2009; Hayes, Strosahl, et al., 1999). ACT however questions the validity where CBT needs to apply "*the cognitive model of a particular disorder with the use of a variety of techniques designed to modify dysfunctional beliefs and faulty information processing characteristic of each disorder"* (Beck, 1993, p. 194), or to identify distorted cognitions and then to challenge thinking to realign such distortions reflected in thought diaries. Therapists in this study often opted to omit thought diaries – the style of 'cognitive distortion analysis', 'dysfunctional belief modification' work due to being cognizant of cultural sensitivities and choosing to incorporate more acceptance and compassion work into the overall cognitive approach, with a focus on self, values and commitment to action. The holistic and contextual approach of humanism thus provides an approach that can be appealing to Black African and Caribbean clients. According to Kim & Gudykudst (1988) inter-cultural communication can be based on one of three traditions including Positivist, Humanist and Systems traditions. Here the emphasis of the humanistic tradition stresses the freedom of individuals and of the understanding of the course of actions taken by individuals (Maslow, 1966). The humanistic model therefore promotes the historical meaning of experience and its developmental and cumulative effects at both the individual and social levels, making it beneficial for collectivist views.

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