The experiences of psychological therapy: Perspectives from male Iranian survivors of torture

By

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Volume I

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Dedication

This project is dedicated to the memory of my father, who always encouraged me to follow my aspirations

Acknowledgement

Firstly I would like to thank the seven participants who kindly offered their time and for sharing their personal experiences.

I would like to thank my research supervisors, Dr Ruth Butterworth and Dr Michael Larkin for their support, encouragement, time and patience during the research process.

Thank you to Dr Sobia Khan for her enthusiasm and help during the research process. Your voice of how one Psychologist can make a difference will always stay with me. To the whole team at Freedom from Torture, thank you for being welcoming and for your help during the recruitment process.

A huge thank you to Savina for being incredibly supportive during the challenging times and for sharing (and often creating) the fun times.

Thank you to my mother and brother for their unconditional love, understanding and support during this journey. To my partner Edward, thank you for patiently sharing every moment with me, keeping me grounded and for being my constant source of strength and support.

Thesis Overview

This thesis is submitted in partial fulfilment of the requirements of the degree of Doctorate of Clinical Psychology at the University of Birmingham, comprising of both the research and clinical components of the course.

Volume I consists of the research component and incorporates of three papers. The first paper is a literature review, which explores the effectiveness of culturally adapted cognitive behavioural therapy (CA-CBT), and the adaptations made to CBT in both individual and group therapy. A total of 24 papers were included in the review. The methodologies and outcomes were critically evaluated using an adapted quality assessment tool, which was adapted by the author. The review discusses the mixed outcomes in the long-term effectiveness of CA-CBT, and the potential adaptations that clinicians could use in cognitive behavioural therapy. Limitations of the data are discussed and further research in this field is suggested.

The second paper is an empirical study, which explores the experiences of psychological therapy from the perspectives of male Iranian survivors of torture. Seven participants who were engaging in psychological therapy or had recently been discharged were interviewed about their experiences. Interpretative Phenomenological Analysis was used to analyse the data and four superordinate themes emerged. The participants described their experiences of distress, loss of control and their 'broken' sense of self before coming to therapy (Vulnerability, loss and uncontrolled distress); interpretations of fear in trusting the therapist and the development of trust once engaged in therapy (Exposing vulnerabilities and developing trust); the experience of being able to trust the therapist and

therapeutic alliance developed (Experiencing security and connectedness) and finally the fears of ending therapy, but also the regaining a new sense of self (Regaining resilience through control but fearing the loss of connectedness). The paper discusses the data in relation to existing literature, clinical implication and future research suggestions.

The third paper is a Public Domain Paper, which encapsulates the empirical study using language accessible to the general public.

Volume II includes the clinical component and comprises of five Clinical Practice Reports (CPRs), which are examples of clinical work completed over the course of training. CPR 1 illustrates the case of 25-year-old Amy who presents with anxiety regarding her health. The presenting difficulties are formulated from a psychodynamic and a cognitive behavioural perspective. The service evaluation for CPR 2 assessed the use of the patient experience questionnaire which is used in an adult mental health service. CPR 3 is a single-case experimental design evaluating a behavioural intervention with 18-year-old Jacob, a young person with autistic spectrum disorder and presenting with anger difficulties. CPR 4 describes the case study of Jeremy, a 68 year old male presenting with anxiety and depression following a stroke; the case was formulated using a cognitive behavioural formulation. An abstract is presented for CPR 5, which was a case study delivered as an oral presentation. The case describes a cognitive behavioural formulation and intervention of 42 year old Cece who presented with mixed depression and anxiety following the birth of her baby. To maintain anonymity, pseudonyms were used for all service-users.

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VOLUME I

I. LITERATURE REVIEW:

Culturally adapted cognitive behavioural therapy: A Systematic review

Paper to be edited and submitted to Clinical Psychology Review

ABSTRACT

Aim: To explore the effectiveness of culturally adapted cognitive behavioural therapy (CA-CBT) and the adaptations that were made for individual and group interventions.

Method: Bibliography databases EMBASE, Medline, ERIC, AMED, PsycArticles, EBSCO, CINAHL, ASSIA, PILOTS and Proquest were used to conduct the search. Studies included CBT interventions with at least one adapted component, which did not solely focus on adapting verbal or written language. Twenty-four studies were included and a narrative synthesis was conducted to review the studies.

Results: CA-CBT was shown to be effective in reducing psychological distress across a range presenting problems and diverse populations however mixed outcomes were reported on its long-term effectiveness. Cultural adaptations included relaxation/visualisation, somatically focused cognitive restructuring and the inclusion of family in behavioural interventions. These adaptations were determined by initially exploring family values, cultural beliefs of somatic symptoms and spirituality/religion.

Discussion: Further research in this field is warranted, as there are limited empirical studies to ascertain the effectiveness of CA-CBT. Adaptations within the review are not exhaustive but can give clinicians guidance to move towards delivering culturally competent CBT to diverse cultural populations.

1. INTRODUCTION

According to cognitive theory, maladaptive cognitions about the world, the self and the future, contribute to the maintenance of psychological distress and unhelpful patterns of behaviour (Beck, 1970). Cognitive behavioural therapists (CBT) aim to work collaboratively with individuals to help gain a shared understanding of the presenting problems. CBT has a number of disorder-specific formulations and treatment protocols for a range of mental health problems. Through utilising cognitive and behavioural intervention techniques CBT can reduce psychological distress and enhance mental well-being (Hofmann, 2011).

Extensive research evidence demonstrates that CBT is an effective therapeutic approach across diverse mental health presentations (Dobson, 2001; Sheldon, 2011), and is one of the nationally recommended psychological interventions in the United Kingdom (Roth & Pilling, 2008; NICE, 2011). However, the majority of research evidence does not represent diverse populations (Whitley, Rousseau, Carpenter, Song & Kirmayer, 2011). Many studies researching the effectiveness of psychological therapies have lacked data on ethnicity or have included a majority of participants from western cultures (Miranda et al., 2005; Mak, Law, Alvidrez & Perez-Stable, 2007). There is currently a lack of research on the use of CBT with diverse cultures,[a] therefore it can not be assumed that the approach will be as applicable and effective for individuals from non-western cultures (Voss Horrell, 2008).

[a] For the purpose of the review culture is defined as a "*a set of guidelines which individuals inherit as members of a particular society which tells them how to view the world, to experience it emotionally and to behave in relation to other people, supernatural forces or Gods and to the natural environment. Culture provides a way of transmitting these guidelines to the next generation by using symbols, language, art and ritual*" Helman (2014; p. 2-3).

One reason for including diverse cultural populations in therapy efficacy research is that the context of mental health and therapy differs across cultures (Fernando, 2010) and that psychological theory and treatment is not 'one size fits all'. Sue and Sue (2003) argue that 'etic' approaches imply that theory and therapeutic interventions are universal to all cultural populations. However, CBT is based on Western concepts and illness models, which may be incongruent with the cultural norms of non-western populations (Rathod, Kingdon, Phiri & Gobbi, 2009). Conversely, when applying an 'emic' approach (understanding that individuals experience mental health differently given their culture, life experience, and their understanding of these given their context), therapy needs to be adapted to be more accessible and feasible for clients (Hays & Iwamasa, 2006; Hofmann, 2006).

To move away from the notion that evidence based practice is 'one size fits all', it has been suggested that health organisations, therapists and training should aim towards becoming 'culturally competent' (Bhui, Warfa, Edonya, McKenzie & Bhugra, 2007; Whitley, 2007) i.e. to appropriately provide care to clients from diverse values, beliefs and behaviours to meet their social, cultural and linguistic needs (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003).

In clinical practice, it is recommended that psychologists should recognise and align with a client's culture, whilst applying culturally appropriate skills, as this is both ethical and best practice (American Psychological Association, 2003). In doing so evidence based therapies may need to be modified or adapted. The cultural adaptation of therapy has been defined as *"the systematic modification of an evidence-based treatment or intervention protocol to consider language,*

culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jimenez-Chafey, & Domenech-Rodriguez; 2009, p. 362). Barrera, Castro, Strycker and Toobert (2013) add that this should be achieved whilst maintaining the fidelity of the core elements of therapy to enhance the effectiveness of therapy.

There is emerging research of evidence-based therapies such as CBT being culturally adapted, varying from linguistic adaptations (Sue & Sue, 2003) to the use of theoretical frameworks (Hays & Iwamasa, 2006). There is currently a gap between research and practice for empirically supported therapies for ethnic minority groups (Sue & Zane, 2006). Previous meta-analyses and systematic reviews have evaluated a range of therapeutic approaches that have been culturally adapted (Chowdhary et al., 2014; Cabassa & Hansen, 2007; Voss Horrell, 2008; Griner & Smith, 2006). However, to the author's knowledge there are no systematic reviews that focus specifically on one therapeutic approach for a range of mental health presenting problems with both qualitative and quantitative research.

1.1. Aims of the review

The aims of the current systematic review were to identify and synthesise the literature on cultural adaptations to cognitive behavioural approaches for diverse cultural populations and presenting problems. This will be done by:

1) Evaluating the effectiveness of culturally adapted CBT (CA-CBT)
2) Describing the adaptations made to individual and group CBT (GCBT)

The current review did not attempt to generalise how CBT should be adapted to specific cultural populations, but does suggest areas to consider when adapting therapy for culturally diverse populations.

2. METHOD

2.1. Search Strategy

The following bibliography databases were searched in October 2014; Psychinfo, Embase, Medline, ERIC, AMED, PsycArticles, EBSCO, CINAHL, ASSIA, PILOTS and Proquest. Articles published between 2003 and 2014 were included in the search as in 2003 the APA guidelines first stipulated that psychologists should be offering psychological therapy whilst keeping the client's cultural context in mind to ensure best practice and ethical practice. In addition, the application of cultural competence for psychotherapy did not occur until the early 2000's (Office of Minority Health, 2001).

The following search terms were used and Boolean terms expanded these for culturally competent therapy, (Cultural competency, Cultural sensitivity, Cross-cultural comparison, Cross-cultural competency, cross-cultural treatment, Culturally adapted, Culturally responsive, Culturally appropriate, Cultural awareness, Culturally congruent) and Cognitive behavioural therapy (Cognitive behaviour therapy, behavior therapy, cognitive behaviour psychotherapy, Cognitive behavior psychotherapy, Cognitive therapy, Modified cognitive behaviour therapy, Modified cognitive behavior therapy, CBT). This resulted in a total of 911 studies.

2.2. Inclusion and Exclusion Criteria

Studies were examined against the following inclusion and exclusion criteria:

Inclusion criteria

1. CBT individually or in a group format
2. Having at least one adapted component of the CBT intervention
3. Any cultural group or mental health presentation
4. Participants aged 18 years and over
5. Reported the outcomes of the adapted CBT intervention including empirical measures and/or qualitative outcomes.
6. English language article
7. Any study design

Exclusion Criteria

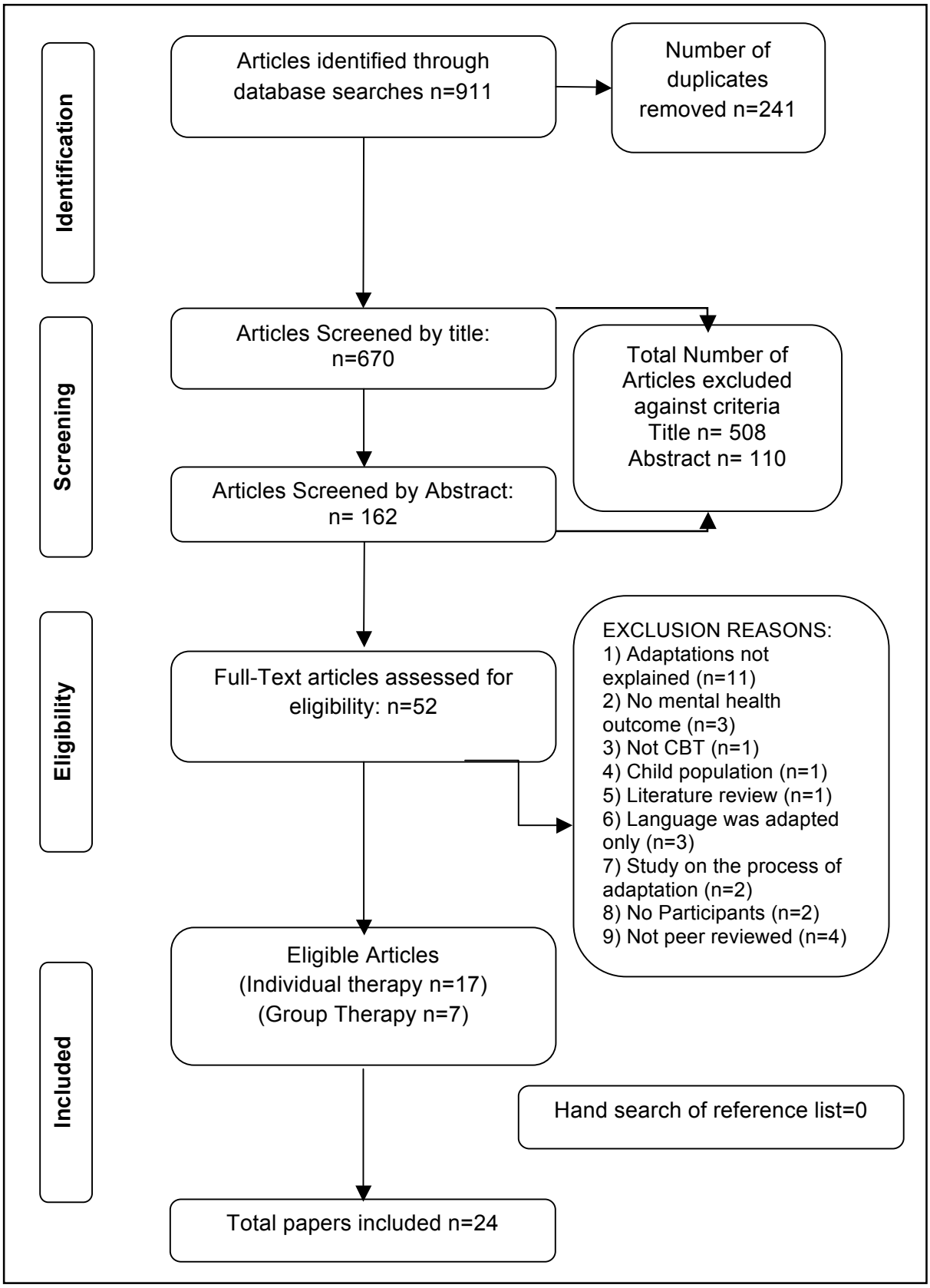
1. Studies that focussed solely on adapting the language of psychological measures and written materials
2. No explanation of adaptation provided
3. Where the focus or aim of the study was not regarding mental health presentation
4. Interventions conducted as part of therapy with other family members e.g. mother-infant, family therapy

2.3. Procedure

Once the studies were identified using the above search terms they were exported onto Reference Manager (Thompson Reuters, 2011, version 11). Duplicate papers were removed resulting in 670 studies, which were screened by title, abstract and then full-text in accordance with the inclusion and

exclusion criteria. In the case where no abstract was available or where a definitive answer to the inclusion of the study could not be given, then the article was reviewed in full-text. A hand search of the references from the eligible articles was conducted to identify any further additional articles. Figure 1 highlights the process of identifying the studies.

Figure 1: PRISMA Flowchart of Literature Search Procedure



2.4. Quality Assessment

A total of 24 studies with a range of designs were selected for the review. As there were no standard quality assessment frameworks to accommodate a range of study designs (Tacconelli, 2010), the author adapted existing quality assessment tools to offer a consistent and comparable range of quality criteria. To the author's knowledge there is no current consensus on how to incorporate or develop a quality framework tool for a variety of study designs (Tacconelli, 2010). The quality assessment tool was therefore created by amalgamating relevant components from Sale and Brazil's (2004) quality assessment framework for qualitative and quantitative study designs, Downs and Black's (1998) for randomised and non-randomised controlled trials and Atkins and Sampson's (2002) for case study designs (Appendix 1). Each study was given a score (very poor quality-excellent quality) against the subscales of truth-value, applicability, consistency and neutrality alongside a brief summary of the strengths and limitations of the study (Appendix 2). Although the quality framework has not been tested for validity and reliability like some standardised quality assessment tools, the adapted version best suited the current range of study designs. As recommended by the Centre for Reviews and Dissemination (Tacconelli, 2010) the modified checklist was piloted with two independent researchers to minimise bias and increase reliability.

A summary of the 24 studies, which were assessed for quality, can be seen in Table 1. Fifteen studies were classed as 'good quality' (Bennett, Flett & Babbage, 2014; Byrant et al., 2011; Habib, Dawood, Kingdon & Naeem, 2014; Fujisawa et al., 2010; Gonzalez-Prendes, Hindo & Pardo, 2011; Hinton et al.,

2005; Hinton, Hofmann, Pollack & Otto, 2009; Hinton, Hofmann, Rivera, Otto & Pollack, 2011; Interian, Allen, Gara & Escobar, 2006; Naeem, Waheed, Gobbi, Ayub & Kingdon, 2011; Naeem et al., 2014; Rathod, Kingdon, Phiri & Gobbi, 2010; Simoni et al., 2013; Penedo et al., 2007; Wong, 2008) whereby most of the quality criteria had been fulfilled and were very unlikely to impact on the overall quality or conclusions of the study. Six studies were classed at 'fair' (Hinton et al., 2004; Hinton, Safren, Pollack & Tran, 2006a; Hinton, Pich, Chhean, Safren, & Pollack, 2006b; Hovey, Hurtado & Seligman, 2014; McIndoo & Hopko, 2014; Weingarden et al., 2011) whereby some of the assessment criteria had been fulfilled and were unlikely to impact on the overall conclusions of the study. Two studies were classed as 'poor' (Otto et al., 2003; Weiss, Singh & Hope, 2011) as only a few of the assessment criteria were fulfilled which was likely to impact the quality and overall conclusions of the study. One study was classed as 'very poor' (Aguilera, Garza & Munoz, 2010) and was very likely to impact on the quality and overall conclusions of the study. Although three studies were judged to be of 'poor' and 'very poor' quality it was decided to include these in the current systematic review, due to the relatively small number of studies focussing on the topic of interest. To ensure the reliability of the quality assessment process, two clinical psychologists in training independently rated four studies and these were discussed for similarities and differences of the outcomes to ensure consistency in the scoring.

The summary in Table 1 shows that the subcategory of 'neutrality' was scored poorly by 5 studies (McIndoo & Hopko, 2014; Weingarden et al., 2011; Weiss et al., 2011; Aguilera et al., 2010; Otto et al., 2003), as there was a query as to whether the results were open to bias. 'Truth Value' was scored poorly in three

studies (Interian et al., 2006; Aguilera et al., 2010; Hovey et al., 2014) where the internal validity of the study design was questioned. One study (Aguilera et al., 2010) was scored as 'very poor' as the intervention was a rolling group program which lacked detailed description. It was difficult to ascertain the effectiveness as a majority of the participants did not complete the outcome measures. There was no description of limitations to the study design or intervention provided.

Table 1: Summary of Quality Assessment

INDIVIDUAL INTERVENTIONS (n=17) and GROUP INTERVENTIONS (n=7[b])					
	Sub-Categories from Quality Assessment Tool				
Author	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Overall Quality**
Bennett et al., (2009)	**	***	***	****	***
Byrant et al., (2011)	**	****	***	***	***
Fujisawa et al., (2010)	***	****	****	****	***
Gonzalez-Prendes et al., (2011)	**	****	***	**	***
Habib et al., (2014)	***	***	***	***	***
Hinton et al., (2004)	**	***	**	***	**
Hinton et al., (2005)	***	***	***	**	***
Hinton et al., (2006a)	**	**	**	**	**
Hinton et al., (2006b)	*	**	**	**	**
Interian et al., (2006)	*	***	***	***	***
McIndoo and Hopko (2014)	**	***	****	*	**
Naeem et al., (2011)	***	****	****	****	***
Naeem et al., (2014)	***	****	****	***	***
Rathod et al., (2013)	***	****	***	***	***
Simoni et al (2013)	***	****	****	****	***
Weingarden et al., (2011)	**	***	***	*	**
Weiss et al (2011)	**	**	*		*
[b] Aguilera et al., (2010)		*			
[b] Hinton et al., (2009)	***	***	**	***	***
[b] Hinton et al., (2011)	***	***	***	***	***
[b] Hovey et al., (2014)	*	**	**	***	**
[b] Otto et al., (2003)	**	*	**	*	*
[b] Penado et al., (2007)	**	***	***	***	***
[b] Wong (2008)	**	***	***	****	***

[b] =Studies that were delivered in a group format

NB: no stars=very poor quality; *=poor quality; **=fair quality; ***=good quality; ****=excellent quality.

3. RESULTS

3.1. Study Characteristics

Twenty-four published studies were included in the review and were written in the English language (Table 2). The study designs included 12 randomised control trials (Byrant et al., 2011; Habib et al., 2014; Hinton et al., 2004; Hinton et al., 2005; Hinton et al., 2009; Naeem et al., 2011; Naeem et al., 2014; Rathod et al., 2010; Simoni et al., 2013; Otto et al., 2003; Penado et al., 2007; Wong, 2008), 6 cohort studies (Bennett et al., 2014; Fujisawa et al., 2010; Interian et al., 2006; Aguilera et al., 2010; Hinton et al., 2011; Hovey et al., 2014), two case series designs (Hinton et al., 2006a; Hinton et al., 2006b) and 4 case studies (Gonzalez-Prendes et al., 2011; McIndoo & Hopko, 2014; Weingarden et al., 2011; Weiss et al., 2011). Of the 24 studies, 5 were pilot studies (Interian et al., 2008; Naeem et al., 2010; Otto et al., 2003; Hinton et al., 2004, 2009).

3.2. Study Population

In 17 studies, CBT was delivered individually for PTSD (Byrant et al., 2011), PTSD with panic attacks (Hinton et al., 2004; Hinton et al., 2005; Hinton et al., 2006a; Hinton et al., 2006b), depression (Bennett et al., 2014; Fujisawa, 2010; Gonzalez-Prendes, 2011; Interian et al., 2006; Naeem et al., 2011; Naeem et al., 2014; Simoni et al., 2013), social anxiety (McIndoo & Hopko, 2014; Weiss et al., 2011), schizophrenia (Rathod et al., 2010; Habib et al., 2014) and body dysmorphic disorder (Weingarden et al., 2011). In seven studies the CBT intervention was delivered through a group format focussing on presentations of depression (Aguilera et al., 2010; Wong, 2008), stress (Penado, 2007) and

depression and anxiety (Hovey et al., 2014), PTSD (Hinton et al., 2011; Otto et al., 2003), and PTSD & panic attacks (Hinton et al., 2009).

Most of the studies were conducted in the USA (n=15), three were conducted in Pakistan, and the remaining six studies were from around the globe (one each from New Zealand, Thailand, Japan, UK, Mexico and Hong Kong). A majority of the studies (n=20) were conducted in the participants' first language. In three studies where the intervention was not conducted in the participants' first language, it was reportedly conducted in English. One study did not specify the language in which the intervention was conducted (Bennett et al., 2014). The average number of sessions ranged between 4-22 sessions with a duration of between 50-60 minutes for individual therapy. For group therapy, a range of 6-16 sessions were offered with a duration of 60-150 minutes.

Table 2: Data Extraction Table of 24 Papers

INDIVIDUAL INTERVENTION n=17						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Bennett et al., (2014; *New Zealand)* Cohort	MDD Māori (Unknown)	CBT; n=16	Adaptation areas of Engagement, Spirituality, Family involvement and Metaphors.	*Pre, post & 6 month follow-up.* BDI-II (face validity to population) ATQ (not adapted).	Drop in depression scores and maintained at follow-up. Reduction in negative cognitions.	***
Byrant et al., (2011; *South Thailand)* RCT	PTSD Survivors of terrorist attacks (Thai)	CBT; n=16 TAU; n=12	Thai meditation techniques.	*Pre, completion and 3 month post follow-up.* PSS-I; BDI-II; ICG Measures translated & back translated.	Intervention shown to be beneficial however ended abruptly due to on-going terrorist threats.	***
Fujisawa et al., (2010; Japan) Cohort	MDD Japanese (Japanese)	CBT; n=27	Problem solving/solution focussed approach Incorporated family values	*Pre & Post measures.* BDI-II; DAS-24 Measures validated to Japanese population. HAMD-17; GAF; QIDS-SR SUBI Unclear whether the measures were translated or sensitive to the population.	Decrease in depressive symptoms on the BDI pre-post treatment. Minimal adaptations to therapy.	***

INDIVIDUAL INTERVENTION n=17						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Gonzalez-Prendes et al., (2011: USA) Case study	Depression Mexican Heritage (Spanish & English)	CBT; n=1	Integrated cultural values of familismo, Personalismo, respecto into cognitive and behavioural interventions (family values, trust warmth, attention and respect).	*Measures given each session.* BDI-II; BAI Measures showed validity and reliability to the population.	Clinical significant change in depression and anxiety scores.	***
Habib et al., (2014; *Pakistan)* RCT	Schizophrenia (Urdu)	CBT; n=21 TAU; n=21	Family members included in the treatment plan. Homework facilitated by family member. Formulation included an understanding of locally held beliefs related to health, religion and culture.	*Pre & Post measures.* PANSS; PSYRATS; Insight Scale All measures were not validated to the intended population.	Reduced psychotic symptoms and improved insight. (Adopted same protocol as Naeem et al., 2011).	***
Hinton et al., (2004; USA) RCT	PTSD & Co-Morbid Panic Attacks Vietnamese Refugees (Vietnamese)	I-CBT; n=6 D-CBT; n=6	Translated some measures to Vietnamese. Culturally appropriate visualisation (Asian cultural values of flexibility). Cognitive restructuring including cultural related fears of somatic symptoms.	*Pre, end of I-CBT intervention, end of D-CBT intervention.* HTQ; HSCL-25 Translated & validated for population ASI; H-PASS; O-PASS Good reliability.	Improved somatic symptoms (headache, orthostatic panic attacks).	**

INDIVIDUAL INTERVENTION n=17						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Hinton et al., (2005; *USA*) RCT	PTSD & comorbid panic attacks Cambodian refugees (Cambodian)	I-CBT; n=20 D-CBT; n=20	Culturally appropriate visualisation (same as Hinton et al., 2004). TCMIE model of panic & PTSD to help gain an understanding cultural context initially.	*Pre, end of I-CBT intervention, end of D-CBT intervention, 12 week follow-up.* ASI; CAPS; SCL; O-PASS; N-PASS; N-FSS; OFSS *GAD status*-use of SCID All measures translated & back-translated and tested for reliability.	I-CBT intervention showed significantly greater improvement of PTSD, somatic symptoms and anxiety than the wait-list group. Cultural related somatic symptoms include neck-focussed panic (of vessel rupture) and dizziness.	***
Hinton et al., (2006a; *USA*) Case Series	PTSD & Co-morbid panic attacks Vietnamese refugees (Vietnamese)	CBT; n=3	TCMIE model of panic & PTSD Culturally appropriate visualisation (Lotus bloom) teaching cognitive flexibility. Mindfulness. Focuses on somatic symptoms then to move onto psychological interventions.	*Baseline, every two weeks for 40 weeks.* H-PASS; O-PASS; HTQ; HSCL-25; ASI All measures had good inter rater reliability and test re-test reliability for the Vietnamese population.	Culturally specific context to somatic symptoms of PTSD & panic (trauma, illness or panic related). Improved headache and orthostatic associated panic attacks and PTSD.	**

INDIVIDUAL INTERVENTION n=17						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Hinton et al., (2006b; *USA*) Case Series	PTSD & Co-morbid panic attacks Cambodian refugees *(Cambodian)*	CBT; n=3	Used Hinton et al's (2005) treatment manual TCMIE model of panic & PTSD Included Loving kindness, mindfulness. Intervention initially focussed on somatic symptoms.	*Baseline, every two weeks for 40 weeks.* HTQ; N-PASS; N-FSS; HSCL-25; ASI Validated to the population and all measures had good inter-rater reliability and test re-test reliability for the Cambodian population.	Treatment utilises CBT approaches to panic Neck focussed panic and flashbacks reduced. Culturally specific somatic symptoms of neck and orthostatic panic.	**
Interian et al., (2006; USA) Cohort	MDD Hispanic (Spanish)	CBT; n=15	Therapy delivered in Spanish Ethno-cultural assessment. Adapting therapeutic interpersonal styles. Language considerations.	*Pre, post, 6 month follow up.* BDI-S; BAI; PHQ-15 Not all measures were culturally comparable.	Significant reductions in depression, anxiety and somatic symptoms at post-treatment and 6 month follow-up.	***
McIndoo & Hopko (2014; USA) Case Study	SAD Arab student (English)	CBT; n=1	Assessment of cultural background & acculturation in both Arab and American culture. Addressed cultural values, and Arab etiquette, gender roles and stigma related mental health.	*Pre & post measures.* ADIS-IV; BAI; BDI-II; SASCI All measures reported to have good psychometric properties.	Improvements in Social anxiety and depression when comparing pre to post treatment. Due to acculturation in both Arab and American culture little adaptation offered.	**

INDIVIDUAL INTERVENTION n=17						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Naeem et al., (2011; Pakistan) RCT	Depression Pakistani (Urdu)	CBT & AD; n=17 AD; n=17	Focussed initially on physical symptoms. Urdu equivalents of CBT jargon used in therapy. Culturally appropriate homework, encouraged to attend even if homework not completed. Involvement of family member. Folk stories and examples from the Prophet Muhammad and Quran used (use of religion).	*Pre, post & 3 month follow up.* HADS; BSI Measures Validated in Urdu.	Pilot study for further research (Naeem et al., 2014). Drop in depression scores Importance of how participants develop insight into their mental health-context of personal, family, social and religious values. Treatment manual developed from earlier consultation research.	***
Naeem et al., (2014; *Pakistan)* RCT	Depression Pakistani (Urdu)	GSH; n=94 TAU; n=89	Self-help material in Urdu using locally accepted idioms, phrases, stories and images. Family members recruited to facilitate the use of materials and as many had poor literacy.	*Pre & post measures.* HADS; BSI; BDQ Measures validated in Urdu.	A drop pre & post in depression scores.	***

INDIVIDUAL INTERVENTION n=17						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Rathod et al., (2010; *UK*) RCT	Schizophrenia African Caribbean/ Black African South Asian Muslim (English, unclear if interpreters were used)	CBT; n=16 TAU; n=17	African Caribbean: Suitable self-disclosure. South Asian Muslims: Prefer authoritative or paternalistic approach Importance of family values. Both Cultures: Seen at home or near place of worship. Formulate with cultural and spiritual beliefs.	*Baseline, post-treatment & 6 month follow-up.* CPRS; MADRS; SCS Brief Anxiety Rating Scale BRAINS; PEQ; Insight in psychosis scale Measures were not validated to the target population.	Statistically significant improvements in symptom reduction-but not maintained at 6 month follow-up. Scores on insight did not improve.	***
Simoni et al., (2013; *Mexico*) RCT	Depression (and adherence to HIV medication treatment) Mexican Heritage (Spanish/ Mexican)	CBT; n=20 TAU; n=20	Exploration module added to assess ways in which family, relationships, stigma and spirituality inform patient's experiences with depression and medication adherence (aimed to build a culturally valued sense of mutual trust).	*Pre, 6 month follow-up, 9 month follow up.* BDI-IA; MADRS Back translation by translator. Not tested for reliability with the proposed population.	Decrease in depression scores when comparing CBT group to TAU.	***

INDIVIDUAL INTERVENTION n=17						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Weingarden et al., (2011; *USA*) Two case studies	BDD Jewish Male & African-American Male (English)	CBT; N=2	Psychoeducation & formulation to incorporate their cultural context. Cognitive restructuring: validating experiences within their culture.	*Baseline & Post.* BDD-YBOCS; BABS; BDI-II Measures were not culturally adapted.	With one case study the outcome measure scores reduced. The case study with the Jewish male; outcomes improved on BDD but depressive symptoms worsened. Minimal adaptations were made with both interventions	**
Weiss et al., (2011; *USA*) Two case studies	SAD Central America & China (English)	CBT; n=2	Understandings of the role that family plays in culture (familisimo).	*Baseline & Post* ADIS-IV; BFNE; SIAS; SPS; SASCI Fear & avoidance Hierarchy	Minimal adaptations were needed and could adhere to the CBT protocol. Improvements in social anxiety symptoms.	*

GROUP INTERVENTIONS (n=7)						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Aguilera et al., 2010; *USA*) Cohort	Depression Latino (Spanish)	CBT; N=14	Flexible use of treatment manual. Patients received call reminder to attend. Culturally relevant sayings to convey core messages. Changed the language of homework to *Proyecto personal.* Incorporating family values identification and attitudes to the sessions. Exploration of intergenerational differences.	*Pre & post measures.* Centre for epidemiology studies-depression scale. Mood screener for depression.	Positive group cohesion, which may have helped with social isolation Outcome measures completed by two participants. Homework tasks were not completed Little change in depressive symptoms-researchers state a discrepancy between qualitative feedback as participants reported feeling better compared to the first session.	Very poor
Hinton et al., (2009; *USA*) RCT	PTSD and co-morbid panic attacks Cambodian (Khmer)	IT CBT; n=12 DT CBT; n=12	Measures translated and back translated to Khmer. Muscle relaxation, diaphragmatic breathing, guided imagery, mindfulness training (multi-sensory), and yoga like stretching linked to self-images of flexibility. Promotion of emotional regulation through physical exercises to promote	*Pre & Post Measures.* CAPS; Emotion regulation scale; Orthostatic PA Interview; OPASS OFSS; OCCSS All measures reported either good inter-rater and/or test-retest reliability).	Improvement in emotional regulation and orthostatic panic severity and orthostatic blood pressure. Decreased PTSD symptoms Scale for emotional regulation was not a published scale; created by authors.	***

GROUP INTERVENTIONS (n=7)						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
			emotional distancing.			
Hinton et al., (2011; *USA)* RCT	PTSD Caribbean-Latino (Spanish)	GCBT; n=12 AMR; n=12	Use of cultural idioms of distress and catastrophic misinterpretations. Use of imagery and analogies, which are culturally relevant. Use of traditional methods of emotional regulation. Decentring and applied stretching. Cultural Introspective exercises to encourage adherence to model.	*Pre & post measures; 12 week follow-up.* PTSD checklist; Anxiety subscale of the symptom checklist; Emotion regulation scale; Nervios scale All measures were validated for the Spanish speaking patients.	Participants improved in both groups in all measures however one GCBT was not superior to the AMR. Culturally specific fear of ataque de nervios (attack of nerves).	***
Hovey et al., (2014; *USA*) Cohort	Depression & Anxiety Mexican decent *(Spanish)*	GCBT; n=6	Explored acculturation gaps family related issues including nurturing, childrearing, and discipline. Culturally adapted assertiveness training cognitive strategies etc.	*Pre, post & 6 month follow-up.* MFWSI; PAI; CED-D; BHS; Rosenberg self-esteem inventory Adequate internal consistency and convergent validity.	Clinically significant change for improved depression, stress, self-esteem, anxiety and hopelessness, which was maintained at 6 month follow-up.	**

GROUP INTERVENTIONS (n=7)						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Otto et al., (2003; *USA*) RCT	PTSD Cambodian refugees *(Khmer)*	GCBT & ST; n=5 ST; n=5	Offered clarification between PTSD symptoms and culturally distinct fears of death associated with somatic symptoms. Groups held in local Buddhist temple.	*Baseline & post treatment.* CAPS; HSCL-25;ASI Adapted version of ASI specific to Khmer culture.	Cultural specific fears of death/disability (sore neck, weak arms cold hands, tinnitus, abdominal fullness or orthostatic hypotension). The combined group of sertraline and G-CBT proved better than Sertraline treatment alone. Reduction in depression scores was equally effective in both groups	*
Penedo et al., (2007; *USA*) RCT	Stress Hispanic men (Spanish)	GCBT; n=53 SM; n=40	Incorporated in the treatment goals, group discussions and exercises were values around family and non-confrontational social interactions, which are culturally relevant to the group.	*Baseline & post measures.* FACT-G; Sexual functioning Good reliability & validity.	Significant improvements on physical and emotional wellbeing compared to SM.	***

GROUP INTERVENTIONS (n=7)						
Author, year & country	**Presentation, Cultural Group & Language**	**Intervention**	**Adaptations to therapy**	**Outcome Measures**	**Key points**	**Quality**
Wong (2008; Hong Kong) RCT	Depression Chinese (Chinese)	GCBT; n=48 WL; n=48	Exploration and modification of dysfunctional rules relating to family and interpersonal relationships (as literature has shown that family and interpersonal relationships may become a source of stress for Chinese people).	*Pre & post treatment.* C-BDI; Emotions checklist; Cope Scale; DAS-A Only C-BDI was measured for reliability and validity.	Greater improvement in CBT group and had fewer symptoms of depression, dysfunctional rules, negative emotions and more adaptive coping skills compared with the control group. Positive emotions were shown to have no clinical significant improvement in group or WL.	***

Antidepressants (AD); Applied Muscle Relaxation (AMR); Cognitive Behavioural Therapy (CBT); Culturally adapted Cognitive Behavioural Therapy (CA-CBT); Delayed Cognitive Behavioural Therapy (DCBT); Group Cognitive Behavioural Therapy (GCBT); Guided Self-Help (GSH); Immediate Cognitive behavioural Therapy (ICBT); Initial treatment-cognitive behavioural therapy (IT-CBT); Major Depressive Disorder (MDD); Post traumatic stress disorder (PTSD); Stress Management (SM); Treatment as Usual (TAU); Randomised Controlled Trial (RCT); Social Anxiety Disorder (SAD); Sertraline (ST); Waitlist (WL).

Anxiety disorder interview schedule for DSM-IV (ADIS-IV; Brown, DiNardo & Barlow, 1994); Anxiety Sensitivity Index (ASI; Taylor, Koch & McNally, 1992; Reiss & McNally, 1985); Automatic Thought Questionnaire (ATQ; Hollon & Kendall, 1980); Beck Anxiety Inventory (BAI; Beck & Steer, 1990, 1993; Beck, Epstein, Brown et al., 1988); Beck Depression Inventory (BDI; Beck, Ward, Mendelson et al., 1961); Beck Depression Inventory-IA (BDI-IA Beck & Steer, 1993); Brown Assessment of Beliefs Scale (BABS; Eisen, 1998); Beck Depression Inventory-II (BDI-II; Kojima, 2002; Beck, Steer & Brown, 1996); Beck Depression Inventory-Spanish (BDI-S; Bonilla, Bernal, Santos et al., 2004); Beck hopelessness scale (BHS; Beck & Steer, 1988); Body Dysmorphic Disorder-Yale Brown Obsessive Compulsive Scale (BDD-YBOCS: Phillips, Hollander, Rasmussen, & Aronowitz, 1997); Fear of Negative Evaluation-Brief Version (BFNE; Leary, 1983); Bradford somatic inventory (BSI; Mumford, Bavington et al., 1991); Brief Anxiety Rating Scale (Tyrer et al., 1984); Brief Rating Instrument for Assessment of Negative Symptoms Scale (BRAINS; Hansen et al., 2003); Brief Disability Questionnaire (BDQ; Von Korff, Ustun, Ormel et al., 1996); Centre for epidemiologic studies depression scale (CED-D; Radloff, 1997); Chinese Beck Depression Inventory (C-BDI; Beck et al., 1961); Clinician-Administered PTSD scale (CAPS; Weathers, Keane & Davidson et al., 2001; Blake et al., 1990); Comprehensive psychopathological rating scale (CPRS; Asberg et al., 1978); Cope scale (Carver et al., 1989); Dysfunctional attitude scale-Form A

(DAS-A; Beck et al., 1991); Dysfunctional Attitude Scale-24 Item (DAS-24; Tajima, Numa, Kawamura et al., 2007); Emotions checklist (Cormier & Hackney, 1987); Emotion Regulation Scale (Hinton, Hofmann, Pollack et al., 2009); Functional Assessment of Cancer Therapy-General Module (FACT-G; Cella, Hernandez, Bonomi et al., 1998); Fear and avoidance hierarchy (Hope et al., 2000); Fear of negative evaluation-brief version (BFNE; Leary, 1983); Global Assessment of functioning (GAF; American Psychiatric Association, 1994); Harvard trauma questionnaire (HTQ; Mollica, Caspi-Yavin, Bollini et al., 1992); Hamilton Rating scale for depression (HAMD-17; Hamilton, 1960); Headache panic attack severity scale (H-PASS; Hinton, Pham, Tran et al., 2004); Hopkins Symptom Checklist-25 (HSCL-25; Mollica, Wyshak, de Marneffe, Khuon et al., 1987); Hopkins Symptom Checklist-25 (Indonesian HSCL-25; Mollica, Grace, Lavelle et al., 1990); Hospital Anxiety and Depression Scale (HADS; Mumford, Tareen, Bajwa et al., 1991; Zigmond & Snaith, 1983); Insight in psychosis scale (David, 1990) ; Inventory for complicated grief (ICG; Prigerson et al., 1995); Migrant farm worker stress inventory (MFWSI; Hovey, 2001); Montgomery-Asberg depression rating scale (MADRS; Montgomary & Asberg, 1979); Mood Screener for Depression (Munoz, 1998); Neck Panic Attack Severity Scale (N-PASS; Hinton, Chhean, Pich et al., 2006); Neck Panic Flashback Severity scale (N-FSS; Hinton, Chhean, Pich et al., 2005); Nervios Scale (Hinton, Lewis-Fernandez & Rivera & Pollack, 2009); Orthostatic-Panic Attack Catastrophic Cognition Severity Scale (OCCSS; Hinton et al., 2004); Orthostatic Panic Attack severity scale (O-PASS; Hinton, Pham, Tran et al., 2004); Orthostatic panic Flashback scale (O-FSS; Hinton, Chhean, Pich et al., 2005); Orthostatic Panic Attack Interview (Hinton, Hofmann, Pollack et al., 2009); Patient experience questionnaire (PEQ; IAPT, 2008); Patient Health Questionnaire-15 (PHQ-15; Kroenke, Spitzer & Williams, 2002); Personality assessment inventory (PAI; Morey, 1991); Positive and negative syndrome scale (PANSS; Kay, Fiszbein and Opfer, 1987); Psychotic symptom rating scale (PSYRATS; Haddock, McCarron, Tarrier and Faragher, 1999); Post Traumatic Stress Checklist-SCID (First et al., 1995); Post Traumatic Stress Disorder Symptom Scale Interview (PSS-I; Foa, Riggs, Dancu et al., 1993); Quick Inventory of Depressive Symptomatology Self-Rated (QIDS-SR; Rush et al., 2003); Quality of life: functional assessment of cancer therapy-general module (FACT-G; Cella et al., 1998); Rosenberg self-esteem inventory (Rosenberg, 1989); Structured Clinical Interview (SCID; First et al., 1995); Schedule for Assessment of Insight (SAI; David, Buchanan, Reed and Almeida, 1992); Schizophrenia Change Rating Scale (SCS; Mongomary et al., 1978); Social Anxiety Session Change Index (SASCI; Hayes, Miller, Hope et al., 2008); Social interaction anxiety scale (SAIS; Mattick & Clarke, 1998); Social phobia scale (SPS; Mattick & Clarke, 1998); Social Anxiety Session Change Index (SASCI; Hayes, Miller, Hope, Heimberg & Juster, 2008); Structured Clinical Interview for Positive and Negative Syndrome Scale (SCI-PANSS; Kay, 1991); Subjective Well-being Inventory (SUBI; Sell, 1994); Symptom Checklist-90-R scales (SCL-90-R; Derogatis, 1994).

3.3. The effectiveness of individual and group culturally adapted CBT

3.3.1. CA-CBT for individual therapy

Randomised controlled trials

Eight RCTs (Byrant et al., 2011; Simoni et al., 2013; Naeem et al., 2010; Naeem et al., 2014; Habib et al., 2014; Rathod et al., 2010; Hinton et al., 2004; Hinton et al., 2005) compared CA-CBT to treatment as usual (TAU), or a delayed treatment group. Self-reported outcome measures showed that CA-CBT was more effective in reducing psychological distress when compared to TAU, although this was not maintained across all studies at follow-up. Two studies (Hinton et al., 2005; Naeem et al., 2010) reported a maintained reduction in symptoms at follow-up. Three studies (Byrant et al., 2011; Simoni et al., 2013; Rathod et al., 2010) found that improvements in self-reported symptoms of psychological distress were not maintained at follow-up. Simoni et al., (2013) found a discrepancy in the self-reported measures for depression, (indicating a maintained reduction in scores) and therapist ratings, which showed no significant reduction. This may call into question the participant's understanding of the outcome measures, or the clinical sensitivity of the therapist's ratings. Three studies (Hinton et al., 2004; Naeem et al., 2014; Habib et al., 2014) conducted no follow-up making it impossible to ascertain whether the effects of symptom reduction were long term.

A number of study limitations may have impacted on the conclusion of the outcomes. These included therapist effects as the interventions were both conducted by the same therapist (Hinton et al., 2004, 2005), small sample sizes (Naeem et al., 2010) the lack of culturally sensitive outcome measures (Naeem et al., 2014) which may question the reliability of the outcomes, and confounding

variables, including family member involvement in therapy and the range of TAU interventions offered (Simoni et al., 2013; Rathod et al., 2010; Habib et al., 2014; Naeem et al., 2014).

Case Series Studies

Two case series studies (Hinton et al., 2006a; Hinton et al., 2006b) used the TCMIE protocol (Trauma associations, catastrophic cognitions, metaphoric associations and introceptive condition direct to fear and arousal-reactive sensations), for co-morbid PTSD and panic attacks, and reported improvements for anxiety, PTSD and somatic focussed symptoms. In both studies the rationale for the design and data analysis was unclear. The results reported the means and individual scores of the outcome measures rather than conducting a statistical analysis, therefore statistical significance of symptom reduction cannot be ascertained. Additionally, as there was no comparison group it cannot be ascertained whether the improved scores were due to the intervention alone. Outcomes were collated at staggered follow-up times, but not reported.

Cohort Studies

Two studies reported a statistical significant reduction in symptoms, which were maintained at 6-month follow-up (Bennett et al., 2014; Interian et al., 2006). Whilst Fujisawa et al., (2010) and Interian et al., (2006) reported a clinically significant reduction in symptoms of depression, Fujisawa et al., (2010) did not conduct a follow-up, and therefore the long-term effectiveness of treatment can not be ascertained. The studies showed promising outcomes as co-morbid

presentations were included in the study, which would typically be seen in clinical practice. The studies had several limitations which may have impacted on the reliability of the results including a lack of comparison group to reduce bias in the outcomes, the sensitivity of outcome measures used for the intended population, therapist effects, small sample sizes and the impact of drop out during treatment and follow-up (Interian et al., 2006).

Case Studies

Four case studies (Weingarden et al., 2011; Weiss et al., 2011; McIndoo & Hopko, 2014; Gonzalez-Prendes, 2011) reported a clinically significant reduction in psychological distress using disorder specific outcome measures. Only McIndoo and Hopko (2014) reported a statistically significant reduction in psychological distress. Gonzalez-Prendes (2011) was the only study to report that a significant reduction in psychological symptoms was maintained at one and two month follow-up. The case studies offered a detailed illustration of how CBT might be adapted in a clinical setting. The quality of the case studies was deemed as 'poor' (Weiss et al., 2011) and 'fair' (Weingarden et al., 2011, McIndoo & Hopko, 2014) as they did not adequately meet the quality framework for neutrality and were potentially subject to bias, therefore the results should be viewed with caution.

Summary

Although the studies reported that the CA-CBT was effective only seven studies collected follow-up measures, which led to lack of clarity regarding the long-term maintenance of symptom reduction and thus the lasting effectiveness of

CA-CBT. A range of quality of studies were included in the review therefore, although the outcomes were hopeful in terms of symptom reduction, they may need to be viewed with caution.

3.3.2. CA-CBT for group therapy

Randomised controlled trials

Five RCTs (Hinton et al., 2009; Hinton et al., 2011; Otto et al., 2003; Penado et al., 2004; Wong, 2008) suggested that CA-CBT was more effective in symptom reduction when compared to a control group. The control groups were either a WL or a treatment group. Two studies (Otto et al., 2003; Penado et al., 2007) found that symptoms reduced far greater for CA-CBT. However, Otto et al., (2003) reported that combined GCBT and medication (SSRI) was as effective as medication alone in symptom reduction for depression. Follow-up measures that were conducted in one study at 12 weeks suggested that symptom reduction was maintained (Hinton et al., 2011).

Limitations to these studies included therapist effects as the lead author conducted the interventions (Hinton et al., 2009, 2011), validity and reliability of outcome measures (Hinton et al., 2009) and treatment fidelity of the intervention (Hinton et al., 2011). Additionally, delivering treatment in the comparison group made it difficult to determine whether CA-CBT had an effect on symptomology (Penado et al., 2007; Hinton et al., 2011) and the process of randomisation and allocation of participants was not clearly reported (Otto et al., 2003; Wong, 2008). Furthermore, one study was deemed to be of 'poor' quality (Otto et al., 2003), which could have affected the concluding results. It should be noted that although three studies (Hinton et al., 2011, 2009; Otto et al., 2003) used GCBT for PTSD,

group intervention for PTSD is not currently recommended by the NICE guidelines (NICE, 2005).

Cohort Studies

Two cohort studies reported improvements in psychological symptoms for group CA-CBT (Hovey et al., 2014; Aguilera et al., 2010). Hovey et al., (2014) reported clinically significant reduction in symptom scores, which were maintained at 6 month follow-up. Aguilera et al., (2010) implemented a rolling group programme whereby participant attendance varied from week to week. There was little adherence to the completion of homework tasks and outcome measure and sporadic session attendance. The authors reported a one point drop in the depression score but believed this was inconsistent with the informal verbal feedback that was gathered from participants. The effectiveness of treatment was therefore inconclusive. Observational feedback from the authors reported that social cohesion was very valuable to participants who shared a similar context of cultural values. This study was deemed as 'very poor' quality therefore, the results should be viewed with caution.

Summary

All the studies reported that CA-GCBT was effective in symptom reduction of psychological distress. The variation in study designs and quality of methodology may compromise the reliability and validity of the outcomes reported. Three out of the 7 studies (Wong 2008; Hovey et al., 2014; Aguliera et al., 2010)

attributed the effectiveness to group dynamics, however this was not confirmed with the use of formal measures.

3.4. Outcome Measures

All studies used outcome measures to ascertain the effectiveness of therapy through the change of symptomology. Twelve studies (50%) reported that at least one of the measures had been validated or tested for reliability for the intended population. (Fujisawa, 2010; Gonzalez-Prendes et al., 2011; Hinton et al., 2004, 2006a, 2006b, 2009, 2011; Interian et al., 2008; Naeem et al., 2011, 2014; Otto et al., 2003; Wong, 2008). Four studies (Habib et al., 2014; Hinton et al., 2005, 2009; Hovey et al., 2014) reported using published guidelines to translate and back-translate outcome measures (using Mollica et al., 1987; Breslin et al., 1973; Ahmer, Faruqui and Aijaz, 2007 procedure manual). The remainder of the studies did not validate any of their measures for the intended population, which may question the validity and reliability of the results gathered.

Five studies (Hinton et al., 2004, 2005, 2006a, 2006b, 2009) created outcome measures ascertaining specific somatic symptoms of neck and orthostatic severity for panic attacks (NPASS and OPASS) and neck and orthostatic flashback severity (N-FSS and O-FSS) which were validated with the intended populations.

3.5. Cultural Adaptations made to CBT

3.5.1. The process of culturally adapting therapy

Six studies referred to previous formative mixed-method research studies to develop a new CA-CBT treatment manual. Three studies (Naeem et al., 2011, 2014; Habib et al., 2014) used the same treatment manual, which was developed with involvement from patients, their carers and health professionals. The main themes developed from this research included cultural and related issues, capacity and circumstances, cognition and beliefs and the use of the 'bio-psycho-social-spiritual' model which was used as a model of illness (Naeem, Ayub et al., 2009). Three studies (Hinton et al., 2005, 2006a, 2006b) used the TCMIE model, which was designed to culturally understand the meanings and experiences of somatic symptoms of panic. The TCMIE model was developed from an earlier study (Hinton et al., 2001) surveying participant's cultural context of panic and somatic symptoms.

Nine studies reported adapting existing treatment approaches to CBT (Bennett et al., 2014; Fujisawa et al., 2010; Gonzalez-Prendes et al., 2011; Interian et al., 2008; Penado et al., 2007; Rathod et al., 2013; Weiss et al., 2011; Aguilera et al., 2010; Wong, 2008), including Beck et al., (1979), Greenberger and Padesky (1995), Antoni, (2003), Kingdon and Turkington (2005), Hope et al., (2000) and Munoz et al., (2000). Two studies (Bennett et al., 2014; Penado et al., 2007) furthered these adaptations by consulting an advisory panel of professionals and other cultural influences in the field and using culturally relevant literature. The remaining 15 studies adapted CBT on an ad hoc basis. Minimal adaptations were made in the case studies which were reportedly based on a culturally

informed case conceptualisation (Weingarden et al., 2011; Weiss et al., 2011; McIndoo & Hopko 2014).

3.5.2. Adaptations to treatment components of CBT

Adaptations to written materials and language were described in 10 studies (Bennett et al., 2014; Interian et al., 2006; Naeem et al., 2011, 2014; Penado et al., 2007; Wong 2008; Aguilera et al., 2010; Hinton et al., 2009, 2011; Gonzalez-Prendes et al., 2011). 'Culturally appropriate' metaphors, phrases, proverbs and idioms that would typically be used within that culture, spirituality and/or religion were adapted to help convey and reinforce components of CBT. For example, folk stories and extracts from religious text were used. Homework was made culturally appropriate by changing the language of materials and through the use of idioms and metaphors. Typical CBT jargon was changed for example *homework* was changed to *Proyecto* (meaning personal project) to move away from the negative connotation of being like school, and *rational/irrational* was changed to *helpful/unhelpful.*

Ethnocultural assessment and the exploration of acculturation were specifically reported to understand the participant's cultural values and their context of presenting problems (Interian et al., 2006; McIndoo & Hopko, 2014; Gonzalez-Prendes et al., 2011; Hovey et al., 2014; Aguilera et al., 2010; Simoni et al., 2013; Weiss et al., 2011; Naeem et al., 2011; Hinton et al., 2004). This included social and family expectation, gender roles, mental health stigma, and traditional cultural values. Exploration on acculturation included the number of years that participants had lived in the migrated country and how they believe they

have adapted in the country. Social supports were also explored as participants may have migrated away from family.

Case-Conceptualisation

Formulation adaptations included the integration of locally held beliefs related to health, religion, spirituality and culture (Habib et al, 2014; Rathod et al., 2010; Weingarden et al., 2011; Weiss et al., 2011). Weiss et al., (2011) included the biopsychosocial model to incorporate the genetic and family history influences of the presenting problem.

Psychoeducation

Few adaptations were made for psycho-education aside from the written materials and the language. Hinton et al's team used their developed TCMIE model as part of the psycho-education component for participants to understand the maintenance of somatic focussed panic and PTSD.

Relaxation/Visualisation

Six studies adapted relaxation and visualisation techniques (Byrant et al., 2011; Hinton et al., 2004, 2005, 2006a, 2009, 2011). For example, in Asian cultures visualisation of a lotus bloom was incorporated to encourage the cultural value of flexibility. Relaxation and visualisation were also used as a way of distancing from one's thoughts and to reduce the preoccupation with catastrophic thinking. Other relaxation techniques included applied muscle relaxation, breathing retraining and mindfulness. Four studies by Hinton et al.'s team (2005,

2006a, 2006b, 2011) used the mindfulness technique of loving-kindness meditation. Within a group setting, yoga was used (Hinton et al., 2009). These techniques were used to manage the somatic symptoms of panic and PTSD and to help develop techniques of emotional regulation. For culturally related somatic symptoms introceptive techniques were used for example for neck pain, rotational exercises of the neck and head were implemented. (Hinton et al., 2004; Hinton et al., 2005; Hinton et al., 2006a; Hinton et al., 2009).

Approaches to cognitive restructuring

In 7 studies cognitive restructuring was adapted by focussing on culturally related fears of somatic sensations to reduce catastrophic misinterpretations (Hinton et al., 2004, 2005, 2006a, 2006b, 2009; Otto et al., 2003; Naeem et al., 2011). For example some Cambodian and Vietnamese cultures have culturally specific meanings and catastrophic interpretations of somatic sensations linked to distinct fears of death and disability. Hinton et al's team adopted the strategy of initially understanding the social construct of the somatic symptoms to later offer a cognitive intervention.

McIndoo and Hopko, (2014); Bennett et al., (2014); Naeem et al., (2011); Interian et al., (2008); Hovey et al., (2014); Gonzalez-Prendes et al., (2011) described how cultural beliefs and values may impact therapeutic change; for example, how the concept of assertiveness may prove contradictory to cultural beliefs and values of respect; and may be construed as being rude. Therefore, as a therapeutic approach, the therapist used a culturally sensitive assertiveness approach by understanding the cultural values to find a middle ground between

being assertive without being disrespectful (Gonzalez-Prendes et al., 2011). Weingarden et al., (2011) stated the importance of therapists being skilled in validating the participant's experience within the context of their culture whilst not validating the cognitive distortion. Weiss et al., (2011) highlighted the importance of conducting cognitive interventions in the participant's first language. The participant wrote homework tasks in their own language to ensure that no meaning was lost.

Behavioural Approaches

Three studies (Gonzalez-Prendes et al., 2011; Weingarden et al., 2011; Hinton et al., 2011) adapted behavioural interventions to promote accessibility and engagement in therapy. These included integrating culturally valued beliefs with behavioural activation (e.g. family values was integrated by engaging in more pleasurable activities with family members) and using culturally specific exercises for in-vivo exposure to elicit symptom specific feelings of anxiety (e.g. using piñata games with Caribbean-Latino cultures to elicit symptoms of dizziness).

3.5.3. Understanding of cultural values and beliefs

Spirituality and religion were integrated in four studies (Bennett et al., 2014; Habib et al., 2014; Hinton et al., 2011; Simoni et al., 2013) incorporating prayer and the use of religious text which was relevant to the areas discussed in session. For example Bennett et al., (2014) began and ended therapy session with a Maori prayer. Hinton et al., (2011) used text from the Bible to help with emotional regulation strategies.

Interpersonal relationships focussing upon the importance of respect (within culture, family and personal beliefs) and mutual respect between therapist and client was described in 5 studies (Interian et al., 2006; Fujisawa et al., 2010; Gonzalez-Prendes et al., 2011; Simoni et al., 2013; Weiss et al., 2011). For example studies with a Latino population described cultural values of *familismo, personalismo and respect*, which are cultural values of family orientation, personal interactions with therapist and others of warmth, trust, attention and respect. To develop a sound therapeutic relationship these values were discussed during the assessment phase before intervention commenced. In two studies (Bennett et al., 2014; Rathod et al., 2014) therapists used self-disclosure to encourage a positive therapeutic alliance and treatment outcomes with Maori and African-Caribbean cultures. Whereas, two studies (Naeem et al., 2011; Rathod et al., 2010) reported that south Asian Muslims preferred an authoritative and directive therapist. To ensure a good therapeutic relationship was maintained Weingarden et al., (2011) had an open dialogue with participants to check whether information discussed in sessions was misinterpreted or caused offence to the participant.

The importance of family values was explored and applied to the intervention sessions in seven studies (Fujisawa et al., 2010; Weiss et al., 2011; Interian et al., 2008; Aguilera et al., 2010; Hovey et al., 2014; Penado et al., 2007; Gonzalez-Prendes et al., 2011). Studies adapted therapy to incorporate how interpersonal relationships with family can be a source of both support and stress (Wong, 2008). For example, family may inhibit the participant's willingness to take time for themselves and engage in enjoyable activities (Interian et al., 2008). Four studies (Bennett et al., 2014; Naeem et al., 2011, 2014; Habib et al., 2014)

included the involvement of family/supportive member in treatment. Participants could invite a family member (with consent from the participant), to be involved in treatment planning and support in implementing therapy. This included facilitation with homework tasks, particularly if the participant had poor literacy.

3.5.4. Accessibility to treatment

In three studies participants were offered phone call reminders of sessions whilst emphasising the importance of regular attendance to facilitate mental health improvements (Interian et al., 2006; Aguilera, 2010; Naeem et al., 2014), as for example Pakistani patients tended to drop out of therapy when their somatic symptoms decreased (Naeem et al., 2010). In three studies (Rathod et al., 2013; Otto et al., 2003; Hovey et al., 2014) therapy was conducted in non-clinical venues (e.g. places of worship, or participants' homes) to increase accessibility to services in a non-threatening environment.

3.5.5. Adaptations to Group therapy

The adaptations to group therapy were not dissimilar to individual therapy. Ethnocultural background and values including family values and the strong identifications and attachment to them were explored (Aguilera et al., 2010; Hovey et al., 2014; Penado et al., 2007). Specifically, family issues related to intergenerational differences, nurturance and child-rearing, communication and acculturation gaps with their children were discussed. Once cultural values and beliefs were understood they were then incorporated into the intervention and treatment goals. Social cohesion and shared family values helped to promote

social interactions, particularly with those who may be disconnected from their cultural values and feel socially isolated (Aguilera et al., 2010). The benefits of a group format were discussed in three studies (Hovey et al., 2014; Wong, 2008; Aguilera et al., 2010) including offering a sense of group cohesion in reducing stigma of mental health, reducing problems of social isolation, increasing social connections and gaining emotional support. This was an observation from the authors of the group dynamics and was not formally measured.

4. DISCUSSION

4.1. Evaluation of the effectiveness of culturally adapted CBT

Overall, the current review found that CA-CBT was effective in symptom reduction, particularly in the short-term. When compared to a control group, CA-CBT was found to be more effective regardless of the mental health problem and therapy format (individual or group). In the long-term, however, there were mixed outcomes on the maintenance of symptom reduction. This concurred with previous studies reporting that culturally adapted interventions significantly improved mental health distress across diverse conditions and outcome measures (Griner & Smith, 2006; Chowdhary et al., 2014).

None of the studies in the review compared CBT to CA-CBT. Barrera et al., (2013) states that culturally adapted interventions are rarely compared directly to the original interventions; therefore, it is uncertain whether culturally adapted components add significant efficacy. Kohn, Oden, Munoz, Robinson and Leavitt (2002) compared GCBT and CA-GCBT with African American women with depression and found little difference in the effectiveness of therapy. There are, however, limitations to the study as participants self-selected for the intervention group, therefore there was little control from confounding variables between the two treatment groups.

Researchers argue that psychometric measures should be intended for target populations, as assessment tools are created and normed to European or American individuals (Dana, 1993; Malgady, 2011). Within the present review outcome measures were reliable and valid for the intended population in twelve studies; therefore querying the reliability of the outcomes reported in the remaining

studies. Translating existing measures into another language does not make measures culturally sensitive to that population (Alvidrez, Azocar & Miranda, 1996). The language used may not be culturally transferable and the expression of psychological distress in non-western cultures may differ to western cultures. To consider cultural constructs of somatic symptoms Hinton et al.'s team developed outcome measures, which could effectively monitor change in symptoms.

None of the case studies used a culturally adapted outcome measure, reportedly due to the participant being already acculturated; however, studies did not report on how acculturation was determined. Therefore, the studies did not clarify the circumstances in which culturally adapted measures should be used to ensure that change is recorded accurately.

As previously reported, the studies had a number of methodological limitations as well as potential subjectivity in their findings. RCTs are normally viewed as the 'gold standard' for evaluating the effectiveness of psychological therapies, as they are the least prone study design to bias or error. However, RCTs are not always directly applicable to clinical practice, due to issues such as restrictive inclusion criteria (e.g. no co-morbidity). Other study designs had their merits as case studies gave a detailed illustration of flexibly adapting CBT with the participant in mind. Six of the 24 studies (25%) were conducted by Hinton et al.'s team and of these 5 studies reported that the lead author conducted the treatment interventions. The authors acknowledge the bias of therapist effect.

4.2. Adaptations made to individual and group CBT

The process of adapting therapies ranged in the complexities of approaches from formal mixed-methods research to ad hoc changes during therapy. There are currently no explicit protocols or guidance on how researchers/therapists should culturally adapt evidence based therapy (Lau, 2006). Therefore, it is not surprising that the studies varied in their approaches to the adaptations. Bernal and Saez-Santiago (2006) propose an eight-element framework of culturally adapting psychological treatments for the Latino population. These elements centered on language, persons, metaphors, content, concepts, context, methods, and goals. The themes collated from the current review are presented within Bernal and Saez-Santiago's framework as part of the discussion section.

Language and cultural metaphors: Adaptations of the written materials and language were used most frequently in the studies to accommodate for cultural, spiritual and religious diversity. Adaptations such as these can increase therapy accessibility and draw culturally appropriate meanings for the client. These outcomes are consistent with a recent systematic review whereby colloquial languages, idioms, and metaphors were adapted (Chowdhary et al., 2014).

Person (Therapeutic relationship)*:* A positive therapeutic relationship is a key component to the effectiveness of outcomes regardless of treatment intervention (Castonguay, Constantino & Holtforth, 2006; Norcross, 2002; Roth & Fonagy, 2004; Ardito & Rabellino, 2011). CBT is a collaborative approach between client and therapist, which may be incongruent with some cultural norms and could ultimately affect engagement in therapy. Studies within the current

review reported on the differences in therapeutic styles (Naeem et al., 2011; Rathod et al., 2010). Echeverry (1997) suggests that therapists have an open dialogue about client expectation of therapy at the beginning of the therapeutic process. A number of studies (Interian et al., 2006; Fujisawa et al., 2010; Gonzalez-Prendes et al., 2011; Simoni et al., 2013; Weiss et al., 2011) described the importance of developing a warm, trusting, and respectful relationship with clients which may involve self-disclosure (Rathod et al., 2010; Bennett et al., 2014). Newman (2007) supports these outcomes suggesting that therapists must not stretch their normal professional boundaries, but instead add flexibility with some cultural groups to facilitate a therapeutic bond.

Understanding cultural beliefs and values: Gaining ethnocultural knowledge of the client's values, beliefs and traditions can develop an alignment with the client's perspective and thus increase therapeutic alliance (Smith, Rodriguez & Bernal, 2011). This should be incorporated throughout therapy to help understand the context of clients' experiences (Bernal & Saez-Santiago, 2006). Understanding cultural beliefs in non-western countries can help with barriers to therapy and can help to inform westernised approaches to psychological interventions (Habib et al., 2014). Some cultures may place strong values on family as a unitary construct rather than the client as an individual; e.g. putting the needs of family first over yourself (Pantalon, Iwamasa & Martell; 2010). The review found that family was a strong cultural construct across diverse cultures and included family members in the adapted therapy.

Concepts (cultural constructs): Once cultural values and beliefs are understood from the client's perspective, then the unique meanings that are

shared by cultural groups can help to conceptualise presenting problems in a way that is meaningful to the client. It is important to understand the client's perspectives and beliefs of illness/mental health as these can affect the adherence to treatment (Kleinman, Einsenberg & Good, 2006). Within the current review, for example Hinton et al.'s team explored the cultural context of somatic and physical symptoms of PTSD and panic, and developed a unique conceptualisation of this presentation for clients to implement in therapy. Traditionally some cultures may seek faith healers or religious figures to help them to understand and explain their psychological distress. Some individuals may believe that the cause of their distress is due to religious causes or material deprivation. Therefore the exploration of a client's understanding of the cause of their distress is important (Naeem et al., 2010).

Cultural values, spirituality and religious beliefs were incorporated into the formulation and therapy. In order to obtain a shared understanding of the conceptualisation the BPS (2011) suggests that formulations should be culturally adapted with the use of the Cultural Formulation model (Lewis-Fernandez & Diaz, 2002). The model aims to highlight the cultural identity of the client, use their preferred explanation of the difficulties, highlight the cultural factors to stresses and levels of support and the cultural elements of the relationship between the client and therapist.

Social, Economic and political Context: Studies in the review reported on the importance of the wider social economic and political stresses that could impact on mental health such as acculturation, migration and social support. Griner and Smith (2006) tentatively suggest that the less someone is acculturated

to a society the more cultural adaptations to therapy are required.

Goals and methods: Within the current review particular beliefs and values were identified including family, religion/spirituality and interpersonal relationships which were integrated and adapted within the cognitive behavioural components of psycho-education, relaxation/visualisation, cognitive restructuring and behavioural interventions to meet the client's goals for therapy. To improve accessibility to therapy therapists conducted the interventions in non-clinical settings, and telephoned clients to remind them to attend sessions. Habib et al., (2014) reported that some cultural populations somatise their presenting problems and noted that when somatic symptoms reduced clients were more likely to drop out of therapy as they reported feeling better.

Researchers have debated on an 'etic' approach to therapy and whether there should be a creation of new therapies for each cultural group to align with their beliefs, values and practices (Comas-Diaz, 2006; Wendt & Gone, 2012). Others have suggested an emic approach of implementing evidence based practices with minimal or no adaptations (Chambless & Ollendick, 2001). Lau (2006) considers a middle ground between culturally adapting evidence-based therapies, whilst maintaining the fidelity to the core treatment elements. The purpose of the cultural adaptation is to enhance the acceptability, accessibility, and effectiveness of treatment (Barrera et al., 2013). The results from the current review may have enhanced acceptability to therapy by accounting for cultural values, beliefs and understanding the client's context; however, this was not formally measured in the included studies. The core cognitive and behavioural

treatment elements did not appear to have been adapted, thus the fidelity of treatment is not likely to have been compromised.

Group therapy

Adaptations to group therapy were similar to those made to individual therapy. Limited information was gathered about group interventions and there was little discussion about the process of group therapy. Observations of the group dynamics of social cohesion and support, which may have been a contributing factor to outcomes, were not measured. Research has shown that applying GCBT can be effective in reducing symptomology (Whitfield, 2010) however there is little evidence to suggest that it is more effective than individual therapy (Tucker, 2007). Delivering the core components of cognitive behavioural concepts through group members can be the vehicle of change. Additionally, therapeutic factors including group cohesiveness, interpersonal learning, normalising thorough identification with others are a few of the benefits of GCBT (Whitfield, 2010).

4.3. Limitations of the current review

Although qualitative studies were part of the inclusion criteria the systematic search did not capture studies that were suitable for the current review apart from the case studies. This may be due to the search terms used in the review or that there is a paucity of research using qualitative methods. The review was limited to adults aged 18 and over, therefore this may have limited the variety of studies that could have been collated. Moreover, the review was limited to studies written in

English, however given the topic of interest there may have been studies of relevance that were excluded, thus limiting the generalisability of the findings.

4.4. Research consideration for culturally adapting CBT

As there were a small number of studies, further research in the area is warranted. For example additional research could extend data collection to determine the long-term effectiveness of treatment. Furthermore, conducting a component study may ascertain whether CBT needs to be adapted to culturally diverse populations i.e. through comparing CA-CBT with non-adapted CBT. However in doing so, further culturally appropriate outcomes measures are required to accurately capture the changes in mental health well-being. Furthermore, GCBT could measure the effectiveness through quantitative or qualitative feedback on the group process of therapy.

There is debate on how therapies can be culturally adapted and as previously noted this will inevitably differ according to the cultural group, socioeconomic status, acculturation, and personal meanings for individuals (amongst other reasons). It is recommended that researchers should clearly report their process of CBT adaptations to help inform others as to how these have been implemented for diverse cultures. Additionally, the publication of research that has not shown effectiveness in outcomes can also be of clinical worth for those of interest.

4.5. Clinical considerations for culturally adapting CBT

There is currently no guidance on how to explicitly adapt CBT to diverse cultural populations. However, there is a drive for therapists to move towards a flexible emic approach in delivering psychological treatments. It has been suggested that culturally competent therapists should focus on offering interventions to reduce health disparities, that the interventions are accessible and effective, and that the therapist has the knowledge, and skill set to effectively adapt therapy with the client's needs in mind (Bhui, Warfa, Edonya, McKenzie & Bhugra, 2007; Lie, Lee-Rey, Gomez, Bereknyei & Braddock, 2011).

The adaptations relied heavily on the therapist developing a cultural understanding and context of the clients' constructs of the presenting problems and their cultural values. The therapist can then be guided on what adaptations may be required in line with the client's treatment goals. The current review has found that the main themes focussed on family values, spirituality/religion and cultural beliefs of somatic symptoms. Minimal adaptations were made to the core cognitive and behavioural components of CBT. Of the adaptions that were made, these focussed on the client's beliefs, values and constructs. CBT was made more accessible by changing technical therapeutic language and using more culturally appropriate metaphors and idioms.

It is important to note that individuals are not just their culture and although the research gives a guidance regarding how particular cultures may respond to mental health presentations and therapy, this can not be generalised to everyone within that cultural group. The adaptation of therapy is not universal but a fluid process that takes into account what is important to clients based on their cultural

and social context**.** This review is not an exhaustive list of adaptations that may be implemented, nor is it a prescriptive outline on what should be done to culturally adapt CBT. These are areas that therapists and services may wish to keep in mind to make therapy accessible and effective.

5. REFERENCES

Aguilera, A., Garza, M. J., & Munoz, R. F. (2010). Group cognitive-behavioral therapy for depression in Spanish: Culture-sensitive manualised treatment in practice. *Journal of Clinical Psychology, Vol.66,* 857-867. Doi: 10.1002/jclp.20706

Alvidrez, J., Azocar, F., & Miranda, J. (1996). Demystifying the concept of ethnicity for psychotherapy researchers. *Journal of Consulting and Clinical Psychology, 64,* 903–908.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)* Washington DC: American Psychiatric Press

American Psychological Association (2003). Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. *The American psychologist*, *58* (5), 377.

Ardito, R.B., & Rabellino, D. (2011). Therapeutic Alliance and outcome of psychotherapy: Historical Excursus, Measurement and prospects for research. *Frontiers in Psychology. 2: 270.*

Atkins, C., & Sampson, J. (2002). Critical Appraisal Guidelines for single case study research. Proceeding of the 10th European Conference on Information Systems. 6-8, Gdansk, Poland.

Barrera, Jr, M., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: A progress report. *Journal of consulting and clinical psychology*, *81* (2), 196. Doi: 10.1037/a0027085

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An

inventory for measuring depression. *Archives General Psychiatry* 4:561–571.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology*, 56, 893–897.

Beck, A. T., & Steer, R. A. (1988). *Beck hopelessness scale: Manual*. San Antonio: The Psychological Corporation.

Beck, A. T., & Steer, R. A. (1990). *Beck Anxiety Inventory Manual*. New York, NY: The Psychological Corporation.

Beck, A.T., Brown, G., Steer, R.A., & Weissman, A.N. (1991). Factor analysis of the Dysfunctional Attitude Scale in a clinical population. *Psychological Assessment* 3:478–483.

Beck, A. T., & Steer, R. A. (1993). *Beck Anxiety Inventory: Manual* (2nd ed.). San Antonio, TX: Psychological Corporation.

Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

Bennett, S. T., Flett, R. A., & Babbage, D. R. (2014). Culturally adapted cognitive behaviour therapy for Māori with major depression. *The Cognitive Behaviour Therapist*, *7*, 20. Doi: 10.1017/S1754470X14000233

Bernal, G., & Saez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology.* 34 (2) 121-132. DOI: 10.1002/jcop.20096

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing

racial/ethnic disparities in health and health care. *Public Health Reports*, 118 (4), 293–302.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research*, 7, 15. doi:10.1186/1472-6963-7-15

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Klauminzer, G., Charney, D. S., & Keane, T. M. (1990). A clinician rating scale for assessing current and lifetime PTSD: the CAPS-1. *Behavior Therapist*, *13*, 187–188.

Bonilla, J., Bernal, G., Santos, A., & Santos, D. (2004). A revised Spanish version of the Beck Depression Inventory: Psychometric proper- ties with a Puerto Rican sample of college students. J*ournal of Clinical Psychology,* 60, 119–130.

British Psychological Society (2011). *Good Practice Guidelines on the use of psychological formulation.* Division of Clinical Psychology.

Brown, T. A., Di Nardo, P. A., & Barlow, D. H. (1994). *Anxiety disorders interview schedule for DSM-IV: Adult version*. Oxford University Press.

Bryant, R. A., Ekassawin, S., Chakkraband, M. L. S., Suwanmitri, S., Duangchun, O., & Chantaluckwong, T. (2011). A randomized controlled effectiveness trial of cognitive behavior therapy for post-traumatic stress disorder in terrorist-affected people in Thailand. *World Psychiatry, 10,* 205-209. Doi: 10.1002/j.2051-5545.2011.tb00058.x

Cabassa, L. J., & Hansen, M. C. (2007). A systematic review of depression treatments in primary care for Latino adults. *Research on Social Work Practice*, *17*(4), 494-503. Doi: 10.1177/1049731506297058

Carver, C.S., Scheier, MF., Weintraub, J.K. (1989). Assessing coping strategies: A theoretical based approach. *Journal of Personality and Social Psychology* 56:267–283.

Castonguay, L. G., Constantino, M. J., & Holtforth, M. (2006). The working alliance: where are we and where should we go? *Psychotherapy,* 43, 271–279 doi:10.1037/0033-3204.43.3.271

Cella, D., Hernandez, L., Bonomi, A. E., Corona, M., Vaquero, M., & Shiomoto, G. et al. (1998). Spanish language translation and initial validation of the functional assessment of cancer therapy quality of life instrument. *Medical Care, 36*, 1407–1418.

Chambless, D. L & Ollendick, T.H. (2001). Empirically supported psychological interventions: Controversies and Evidence. *Annual Review of Psychology.* 52:685-716. Doi: 10.1146/annurev.psych.52.1.685

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J. D & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychological medicine*, *44* (06), 1131-1146. Doi:10.1017/S0033291713001785

Comas-Diaz, L. (2006). Latino Healing: The integration of ethnic psychology into psychotherapy. *Psychotherapy: Theory, Research, Practice, Training. (*43) 4, 436-453.

Cormier, L.S., & Hackney, H. (1987). *The professional counselor: A process guide to helping*. New Jersey: Prentice Hall.

Dana, R. H. (1993). *Multicultural assessment perspectives for professional*

psychology. Boston: Allyn & Bacon.

David, A.S. (1990). Insight and psychosis. *British Journal of Psychiatry* 156, 798–808.

David, A., Buchanan, A., Reed, A. & Almeida, O. (1992). The assessment of insight in psychosis. *The British Journal of Psychiatry*, *161*, 599–602.

Derogatis, L.R. (1994). *SCL-90-R*. Minneapolis, MN: National Computer Systems.

Dobson, K. S. (2001). *Handbook of cognitive-behavioral therapies*, (2nd ed.). New York. Guilford Press

Downs, S.H and Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology Community Health.* 52:377-84. doi:10.1136/jech.52.6.377

Echeverry, J.J. (1997). *Treatment barriers: Assessing and accepting professional help.* In G. García & M.C. Zea (Eds.), *Psychological interventions and research with Latino populations* (pp. 94–124). Boston: Allyn and Bacon.

Eisen, J.L., Phillips, K.A., Baer, L., Beer, D.A., Atala, K.D., & Rasmussen, S.A. (1998). The Brown Assessment of Beliefs Scale: Reliability and validity. *American Journal of Psychiatry*.155 (1):102–108.

Fernando, S. (2010). *Mental health, race and culture*. Palgrave Macmillan.

First, M.B., Spitzer, R.L., & Gibbon, M. (1995). *Structured clinical interview for DSM-IV Axis I disorders.* New York: New York State Psychiatric Institute.

Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of traumatic stress*, *6*(4), 459-473

Fujisawa, D., Nakagawa, A., Tajima, M., Sado, M., Kikuchi, T., Hanaoka, M., & Ono, Y. (2010). Cognitive behavioral therapy for depression among adults in Japanese clinical settings: a single-group study. *BMC research notes*, *3* (1), 160.

González-Prendes, A. A., Hindo, C., & Pardo, Y. (2011). Cultural values integration in cognitive-behavioral therapy for a Latino with depression. *Clinical Case Studies*, *10* (5), 376-394.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training,* 43 (4), 531-548. Doi: 10.1037/0033-3204.43.4.531

Habib, N., Dawood, S., Kingdon, D., & Naeem, F. (2014). Preliminary Evaluation of Culturally Adapted CBT for Psychosis (CA-CBTp): Findings from Developing Culturally-Sensitive CBT Project (DCCP). *Behavioural and cognitive psychotherapy*, 1-9.

Haddock, G., McCarron, J., Tarrier, N., & Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: The Psychotic Symptom Rating Scales (PSYRATS). *Psychological Medicine*, *29*, 879–889. doi:10.1017/S0033291799008661

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry.* 23:56-62.

Hansen, L., Turkington, D., Kingdon, D., & Smith, P., (2003). Brief rating instrument for assessment of negative symptoms: Derived from the Comprehensive Psychopathological Rating Scale (CPRS). *Internal Journal of Psychiatry & Clinical Practice.* 7, 113–116.

Hays, P. A. & Iwamasa, G. Y. (2006). *Culturally Responsive Cognitive-Behavioral Therapy: assessment, practice, and supervision*. Washington, DC: American Psychological Association (Eds.).

Hayes, S. A., Miller, N. A., Hope, D. A., Heimberg, R. G., & Juster, H. A. (2008). Assessing client progress session-by-session in the treatment of social anxiety disorder: The Social Anxiety Session Change Index. *Cognitive and Behavioral Practice*, *15*, 203-211. doi:http://dx.doi.org/10.1016/j.cbpra.2007.02.010

Helman, C. G. (2014). *Culture, health and illness: An introduction for health professionals*. Butterworth-Heinemann.

Hinton, D. E., Pham, T., Tran, M., Safren, S. A., Otto, M. W., & Pollack, M. H. (2004). CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: A pilot study. *Journal of Traumatic Stress.17 (5)* 429-433. doi: 10.1023/B:JOTS.0000048956.03529.fa

Hinton, D.E., Pich, V., So, V., Pollack, M.H., Pitman, R.K., & Orr, S.P. (2004). The psychophysiology of orthostatic panic in Cambodian refugees attending a psychiatric clinic. *Journal Psychopathology Behaviour Assess*;26:1–13.

Hinton, D. E., Chhean, D., Pich, V., Safren, S. A., Hofmann, S. G., & Pollack, M. H. (2005). A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: a cross-over design. *Journal of traumatic stress.18 (6)* 617-629. Doi: 10.1002/jts.20070

Hinton, D. E., Safren, S. A., Pollack, M. H., & Tran, M. (2006a). Cognitive-Behavior Therapy for Vietnamese Refugees With PTSD and Comorbid Panic

Attacks. *Cognitive and Behavioral Practice.13 (4)* 271-281. doi:10.1016/j.cbpra.2006.04.008

Hinton, D. E., Pich, V., Chhean, D., Safren, S. A., & Pollack, M. H. (2006b). Somatic-focused therapy for traumatized refugees: treating posttraumatic stress disorder and comorbid neck-focused panic attacks among Cambodian refugees. *Psychotherapy: Theory, Research, Practice, Training, 43,* 491-505. Doi: 10.1037/0033-3204.43.4.491

Hinton, D. E., Hofmann, S. G., Pollack, M. H., & Otto, M. W. (2009). Mechanisms of efficacy of CBT for Cambodian refugees with PTSD: Improvement in emotion regulation and orthostatic blood pressure response. *CNS Neuroscience & Therapeutics, Vol.15,* 255-263. doi: 10.1111/j.1755-5949.2009.00100.x

Hinton, D. E., Lewis-Fernández, R., & Pollack, M. H. (2009). A model of the generation of ataque de nervios: the role of fear of negative affect and fear of arousal symptoms. *CNS Neuroscience and Therapeutics,* 15, 264-275.

Hinton, D. E., Hofmann, S. G., Rivera, E., Otto, M. W., & Pollack, M. H. (2011). Culturally adapted CBT (CA-CBT) for Latino women with treatment-resistant PTSD: a pilot study comparing CA-CBT to applied muscle relaxation. *Behaviour Research and Therapy, 49,* 275-280.doi:10.1016/j.brat.2011.01.005

Hofmann, S. G. (2006). The importance of culture in cognitive and behavioral practice. *Cognitive and Behavioral Practice*, *13*, 243–245. doi:10.1016/j.cbpra.2006.07.001

Hofmann, S. G. (2011). *An introduction to modern CBT: Psychological solutions to*

mental health problems. John Wiley & Sons.

Hollon, S.D., Kendall, P.C. (1980). Cognitive self-statements in depression: development of an automatic thoughts questionnaire. *Cognitive Therapy and Research* 4, 383–395.

Hope, D.A., Heimberg, R.G., Juster, H.R., & Turk, C. (2000). *Managing social anxiety: A cognitive-behavioral therapy approach (Client workbook).* The Psychological Corporation.

Hovey, J. D., Hurtado, G., & Seligman, L. D. (2014). Findings for a CBT support group for Latina migrant farmworkers in western Colorado. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues* 33:271-281. Doi: 10.1007/s12144-014-9212-y

Improving Access to Psychological Therapies (2008). IAPT Outcomes Toolkit 2008/9. Crown Copyright. Accessed at: http://ebookbrowse.com/iapt-outcomes-toolkit-2008- november-2-pdf-d54172229.

Interian, A., Allen, L. A., Gara, M. A., & Escobar, J. I. (2008). A Pilot Study of Culturally Adapted Cognitive Behavior Therapy for Hispanics with Major Depression. *Cognitive and Behavioral Practice.15 (1)* 67-75. Doi:10.1016/j.cbpra.2006.12.002

Kay, S. R., Fiszbein, A. & Opfer, L. A. (1987). The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, *13*, 261.

Kleinman, A., Eisenberg, L., & Good, B. (2006). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Culture*, *4* (1). Doi: 10.1176/foc.4.1.140

Kohn, L. P., Oden, T., Munoz, R. F., Robinson, A., & Leavitt, D. (2002). Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal, 38,* 497-504.

Kojima, M., Furukawa, T.A., Takahashi, H., Kawai, M., Nagaya, T., Tokudome, S. (2002): Cross-cultural validation of the Beck Depression Inventory-II in Japan. *Psychiatry Research.* 110(3): 291-299.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2002). The PHQ-15: Validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic Medicine,* 64, 258–266.

Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13,* 295- 310.

Leary, M.R. (1983). A brief version of the fear of negative evaluation scale. *Personality and Social Psychology Bulletin*. 9:371–375.

Lewis-Fernandez, R., & Diaz, N. (2002). The cultural formulation: A method for assessing cultural factors affecting the clinical encounter. *Psychiatric Quarterly, 73*, 271–295

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock, C. H., 3rd. (2011). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of General Internal Medicine*, 26 (3), 317-325.

Mak, W. W., Law, R. W., Alvidrez, J., & Pérez-Stable, E. J. (2007). Gender and ethnic diversity in NIMH-funded clinical trials: Review of a decade of published research. *Administration and Policy in Mental Health and Mental*

Health Services Research, *34* (6), 497-503. DOI: 10.1007/s10488-007-0133-z

Malgady, R.G. (2011). *Cultural Competence in Assessment, Diagnosis, And Intervention With Ethnic Minorities: Some Perspectives from Psychology, Social Work, and Education*. UAE: Bentham Science Publishers

Mattick, R.P., & Peters, L. (1988). Treatment of severe social phobia: Effects of guided exposure with and without cognitive restructuring. *Journal of Consulting and Clinical Psychology.* 56:251–260.

Mattick, R.P., & Clarke, J.C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy*. 36:455–470.

McIndoo, C. C. & Hopko, D. R. (2014). Cognitive-behavioral therapy for an Arab college student with social phobia and depression. *Clinical Case Studies.13 (2)* 128-145. Doi: 10.1177/1534650113504132

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W.C., & LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology* 1,113–142. Doi:10.1146/annurev.clinpsy.1.102803.143822

Mollica, R. F., Wyshak, G., de Marneffe, D., Khuon, F., & Lavelle, J. (1987). Indochinese versions of the Hopkins Symptom Checklist-25: a screening instrument for the psychiatric care of refugees. *American Journal of Psychiatry*, *144*, 497–500.

Mollica, R.F., Grace, W., Lavelle, J., Truong, T., Svang, T., & Yang, T. (1990) Assessing symptom change in Southeast Asian refugee survivors of mass

violence and torture. *American Journal of Psychiatry*. 147:83– 88.

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire. *Journal of Nervous and Mental Disease*. 180:111–116.

Montgomary, S.A., & Asberg, M. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry* 134, 382–389.

Morey, L. C. (1991). *Personality assessment inventory.* Odessa: PAR.

Mumford, D. B., Tareen, I. A., Bajwa, M. A., Bhatti, M. R. & Karim, R. (1991). The translation and evaluation of an Urdu version of the Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavia, 83*, 81–85.

Mumford, D. B., Bavington, J. T., Bhatnagar, K. S., Hussain, Y., Mirza, S., & Naraghi, M. M. (1991). The Bradford Somatic Inventory. A multi-ethnic inventory of somatic symptoms reported by anxious and depressed patients in Britain and the Indo-Pakistan subcontinent. *British Journal of Psychiatry, 158*, 379–86

Munoz, R.F. (1998). *The mood screener.* Retrieved from http://www. medschool.ucsf.edu/latino/manuals.aspx#MoodScreener. Cited in Aguilera, A., Garza, M. J., & Munoz, R. F. (2010). Group cognitive-behavioral therapy for depression in Spanish: Culture-sensitive manualised treatment in practice. *Journal of Clinical Psychology, Vol.66,* 857-867. DOI: 10.1002/jclp.20706

Naeem, F., Waheed, W., Gobbi, M., Ayub, M., & Kingdon, D. (2011). Preliminary evaluation of culturally sensitive CBT for depression in Pakistan: Findings from Developing Culturally-sensitive CBT Project (DCCP). *Behavioural and*

Cognitive Psychotherapy, Vol.39, 165-173. doi:10.1017/S1352465810000822

Naeem, F., Sarhandi, I., Gul, M., Khalid, M., Aslam, M., Anbrin, Saeed, S., Noor, M., Fatima, G., Minhas, F., Husain, N., & Ayub, M. (2014). A multicentre randomised controlled trial of a carer supervised Culturally adapted CBT (CaCBT) based self-help for depression in Pakistan. *Journal of Affective Disorders.156,* 224-227.Doi: 10.1016/j.jad.2013.10.051

National Institute for health and care excellence (2005). *Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care*. Guidance CG26.

National Institute for health and care excellence (2011). *Common mental health disorder: Identification & pathways to Care.* Guidance CG123.

National Institute for Health and Care Excellence (2012). *Process and Methods guides. Methods for the development of NICE public health guidance* (third Edition).http://www.nice.org.uk/aboutnice/howwework/developingnicepublic healthguidance/publichealthguidanceprocessandmethodguides/ public_health_guidance_process_and_method_guides.jsp

Newman, C.F. (2007). *The therapeutic relationship in cognitive therapy with difficult to engage clients*. In: Gilbert P & Leahy R.L (2007). *The therapeutic relationship in the cognitive behavioural therapies.* Routledge. Taylor & Francis. London and New York.

Norcross, J. C. (2002). *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients.* New York: Oxford University Press

Office of Minority Health (2001). *National standards for culturally and linguistically appropriate services in health care. Final report*. Washington DC: US Department of Health and Human Services.

Otto, M. W., Hinton, D., Korbly, N. B., Chea, A., Ba, P., Gershuny, B. S., & Pollack, M. H. (2003). Treatment of pharmacotherapy-refractory posttraumatic stress disorder among Cambodian refugees: a pilot study of combination treatment with cognitive-behavior therapy vs sertraline alone. *Behaviour research and therapy*, *41*(11), 1271-1276. doi:10.1016/S0005-7967(03)00032-9

Penedo, F. J., Traeger, L., Dahn, J., Molton, I., Gonzalez, J. S., Schneiderman, N., & Antoni, M.H. (2007). Cognitive behavioral stress management intervention improves quality of life in Spanish monolingual hispanic men treated for localized prostate cancer: Results of a randomized controlled trial. *International Journal of Behavioral Medicine.14 (3)* 164-172. Doi: 10.1007/BF03000188

Phillips, K.A., Hollander, E., Rasmussen, S.A., & Aronowitz, B.R. (1997). A severity rating scale for body dysmorphic disorder: Development, reliability, and validity of a modified version of the Yale-Brown Obsessive Compulsive Scale. *Psychopharmacology Bulletin*. 33(1): 17–22.

Prigerson, H.G., Maciejewski, P.K., & Reynolds, C.F. (1995). Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Research*; 59:65-79.

Radloff, L.S. (1977). The CES-D scale: A self-report depression scale for research in the general population. Applied Psychological Measurement, 1, 385–401.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by Exploration and Incorporation of Service Users' and Health Professionals' Views and Opinions. *Behavioural and Cognitive Psychotherapy.* 38, 511-533. Doi: 10.1017/S1352465810000378

Rathod, S., Phiri, P., Harris, S., Underwood, C., Thagadur, M., Padmanabi, U., & Kingdon, D. (2013). Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: a randomised controlled trial. *Schizophrenia Research, 143,* 319-326. Doi: 10.1016/j.schres.2012.11.007

Reference Manager (2011) [Thompson Reuters v 12.0.3] [Program Software] Available from www.refman.com

Reiss, S., & McNally, R.J. (1985). *The expectancy model of fear.* In: Reiss, S.; Bootzin, R., editors. *Theoretical issues in behavior therapy.* NewYork: Academic Press. p. 107-121.

Rosenberg, M. (1989). *Society and the adolescent self-image.* Middletown: Wesleyan University Press.

Roth, A., & Fonagy, P. (2004) *What Works for Whom?: A Critical Review of Psychotherapy Research,* New York: Guilford Press

Roth, A. D., & Pilling, S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy*, *36* (02), 129-147.

Rush, A.J., Trivedi, M.H., Ibrahim, H.M., Carmody, T.J., Arnow, B., Klein, D.N., Markowitz, J.C., Ninan, P.T., Kornstein, S., & Manber, R. (2003). The 16-

Item Quick Inventory of Depressive Symptomatology (QIDS), clinician rating (QIDS-C), and self-report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. *Biological Psychiatry*, 54(5):573-583.

Sale, J. E., & Brazil, K. (2004). A strategy to identify critical appraisal criteria for primary mixed-method studies. *Quality and Quantity*, *38*(4), 351-365.

Sell, H. (1994). The Subjective Well-Being Inventory (SUBI). *International Journal of Mental Health*. 23(3): 89-102.

Sheldon, B. (2011). Research on the effectiveness of cognitive-behavioural therapy. *Cognitive- behavioural therapy: research and practice in health and social care* (2nd ed., pp. 26-70). Abingdon, Oxon: Routledge.

Simoni, J. M., Wiebe, J. S., Sauceda, J. A., Huh, D., Sanchez, G., Longoria, V., Bedoya, C.A., & Safren, S.A. (2013). A preliminary RCT of CBT-AD for adherence and depression among HIV-positive Latinos on the U.S.-Mexico border: The Nuevo Dia study. *AIDS and Behavior, Vol.17,* 2816-2829. Doi: 10.1007/s10461-013-0538-5

Smith, T.B, Rodriguez, M.D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology. 67* 166-175.

Sue, D.W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice*. 4. Hoboken, NJ: John Wiley and Sons inc.

Sue, S., & Zane, N. (2006). How well do both evidence-based practices and treatment as usual satisfactorily address the various dimensions of diversity? In Norcross, J.C., Beutler, L.E., & Levant, R.F. (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental*

questions (pp. 329–374). Washington, DC: American Psychological Association

Tacconelli, E. (2010). Systematic reviews: CRD's guidance for undertaking reviews in health care. *The Lancet Infectious Diseases*, *10*(4), 226. doi:10.1016/S1473-3099(10)70065-7

Tajima, M,. Akiyama, T., Numa, H., Kawamura, Y., Okada, Y., Sakai, Y., Miyake, Y., & Ono, Y. (2007). Reliability and validity of the Japanese version of the 24-item Dysfunctional Attitude Scale. *Acta Neuropsychiatrica*. 19 (6): 362-367.

Taylor, S., Koch, W. J., & McNally, R. J. (1992). How does anxiety sensitivity vary across the anxiety disorders? *Journal of Anxiety Disorders*, *6*, 249–259. Doi: 10.1016/0887-6185(92)90037-8

Tyrer, P., Owen, R.T., & Cicchetti, D.V., (1984). The brief scale for anxiety: a subdivision of the comprehensive psychopathological rating scale. *Journal Neurology, Neurosurgery & Psychiatry* 47, 970–975.

Tucker, M., & Oei, T. (2007) Is group more cost-effective than individual cognitive behaviour therapy? The evidence is not solid yet. *Behavioural and Cognitive Psychotherapy* 35: 77–91

Von Korff, M., Ustun, T.B., Ormel, J., Kaplan, I., & Simon, G.E., (1996). Self-report disability in an international primary care study of psychological illness. *Journal Clinical Epidemiology* 49, 297–303

Voss Horrell, S.C. (2008). Effectiveness of Cognitive-Behavioural Therpay with adult ethnic minority clients: a review. *Professional Psychology.* 39 (2) 160-168. Doi: 10.1037/0735-7028.39.2.160

Weathers, F., Keane, T., & Davidson, J. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety*, 13, 132–156.

Weingarden, H., Marques, L., Fang, A., LeBlanc, N., Buhlmann, U., Phillips, K. A., & Wilhelm, S. (2011). Culturally adapted cognitive behavioral therapy for body dysmorphic disorder: Case examples. *International journal of cognitive therapy*, *4*(4), 381. doi:10.1521/ijct.2011.4.4.381

Weiss, B. J., Singh, J. S., & Hope, D. A. (2011). Cognitive-behavioral therapy for immigrants presenting with social anxiety disorder: Two case studies. *Clinical Case Studies.10 (4),* 324-342. doi:10.1177/1534650111420706

Wendt, D. C., & Gone, J. P. (2012). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry*, *49*(2), 206-222. Doi: 10.1177/1363461511425622

Whitfield, G. (2010). Group cognitive-behavioural therapy for anxiety and depression. *Advances in psychiatric treatment.* 16 219-227 doi: 10.1192/apt.bp.108.005744

Whitley, R. (2007). Cultural competence, evidence-based medicine, and evidence-based practices. *Psychiatric Services,* 58 (12), 1588–1590

Whitley, R., Rousseau, C., Carpenter Song, E., & Kirmayer, L. J. (2011). Evidence-based medicine: opportunities and challenges in a diverse society*. Canadian Journal of Psychiatry,* 56(9), 514-522.

Wong, D. F. K. (2008). Cognitive behavioral treatment groups for people with chronic depression in Hong Kong: a randomized wait-list control design. *Depression And Anxiety, 25,* 142-148. Doi: 10.1002/da.20286

Zigmond, A.S., & Snaith, R.P. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica*. 67, 361–370.

II. EMPIRICAL PAPER:

Experiences of psychological therapy: Perspectives from male Iranian Survivors of torture.

Paper to be edited for submission to Transcultural Psychiatry

ABSTRACT

Aim: To explore how male survivors of torture experienced being in psychological therapy.

Method: Seven Iranian men who had experienced torture were interviewed about their experiences of psychological therapy. All interviews were analysed using interpretative phenomenological analysis (IPA).

Results: Four super-ordinate themes emerged from the data. *'Vulnerability, loss and uncontrolled distress*' focussed on the participants' sense of self as being vulnerable to distress, lack of control, loss of identity and connectedness with others; ***'****Exposing vulnerabilities and developing trust'* focussed on the journey of exposing the vulnerable self and building trust with the therapist; *'Experiencing security and connectedness'* explored the experiences of therapy and the therapeutic alliance; and finally ***'****Regaining resilience through control but fearing the loss of connectedness'* focussed on the reconnection with the self and gaining a sense of agency, but also fearing the loss of therapeutic support and becoming vulnerable again.

Discussion: The participants' experiences of the sense of self following torture, the development of the therapeutic relationship through trust building and the fear of ending therapy have been well documented in literature. The implications of this research could further support clinical work, research and future training.

1. INTRODUCTION

It is estimated that there are nearly 42 million people worldwide who fall into the 'persons of concern' category, whose protection and needs are of interest to the United Nations High Commissioner for Refugees. They include asylum seekers, refugees, internally displaced, and stateless persons (United Nations High Commissioner for Refugees, 2015). It is estimated that between 5-35% of 'persons of concern' have been tortured (Basoglu, 1992). However, these figures may underestimate the true prevalence, as many individuals do not disclose their torture experience (Burnett & Peel, 2001). Torture is defined as,

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. (United Nations, 1995, pp. 294-300).

The impact on an individual following torture is diverse and multifaceted. Torture experiences may differ across the individual's context of the torture, the context of the recovery environment, their culture, and gender (Patel, Kellezi & Williams, 2014). The impact of torture can be psychological, physical, interpersonal, social, and altering of the individual's personal, political, cultural and spiritual beliefs (Williams & van der Merwe, 2013; Quiroga & Jaranson, 2005).

The psychological impacts may include Post Traumatic Stress Disorder

(PTSD), anxiety, phobias, and depression (Carlsson, Olsen, Mortensen & Kastrup, 2006; Patel, 2010; Williams & van der Merwe, 2013). Physical impacts of torture such as chronic pain can cause restricted functioning or disability, which can affect both health and psychological well-being (Williams & van der Merwe, 2013). Survivors of torture may also have altered beliefs about the world and others, which may influence their personal or political values (Turner, 2000). Interpersonal and familial relationships may suffer as a result of the above issues (Patel et al., 2014).

Aside from the experience of torture, individuals may experience mental health distress during the journey of escaping their home country in the fear of persecution (Quiroga & Jaranson, 2005). Individuals may seek asylum to legally remain in a host country as a refugee. Gerritsen et al., (2005) distinguishes the importance between the statuses of asylum seekers and refugees; asylum seekers may have added uncertainties about being unable to remain in the host country. Once a survivor of torture has moved from their country of origin, they may experience a lack of social support, poor living conditions, and difficulties adapting to language and cultural differences, which can impact on their quality of life (Williams & van der Merwe, 2013). Asylum seekers may have more difficulties with their physical health and be at a higher risk of mental health problems such as PTSD and depression/anxiety compared to refugees (Gerritsen et al., 2005; Ryan, Benson & Dooley, 2008).

In the United Kingdom, therapeutic treatment models such as trauma focussed cognitive behavioural therapy (TFCBT) and eye movement desensitisation and reprocessing (EMDR) are recommended as effective

treatments for PTSD (NICE, 2005). For survivors of torture in particular, emerging research has demonstrated that Cognitive Behaviour Therapy (CBT) and Narrative Exposure Therapy (NET) have moderate benefits in reducing psychological distress and PTSD 6-months after treatment, when compared to a control intervention (Patel et al., 2014; Neuner, 2004). However, access to psychological therapies has been shown to differ across gender and culture. Addis & Mahalik (2003) found that men are less likely to engage in psychological therapy due to perceived stigma and strong attitudes about mental health problems compared to women. The male role may be perceived as being strong and able to support their family, whereas seeking therapy can be experienced as being shameful and weak (Vogel, Wade & Hackler, 2007). Therefore, in some cultures, help-seeking is accessed within their community to protect the family from negative public opinion (Carolan et al., 2000). Additionally across cultures, barriers to engaging in therapy may include, language difficulties, stigma, culturally constructed beliefs about mental health problems and competing cultural practices (Saechao et al., 2012; Misra, Connolly & Majeed, 2006).

The use of psychological models to treat mental health problems has been largely developed from quantitative research using western participants and has generally demonstrated positive outcomes (Elsass, Carlsson, Jespersen & Phuntsok, 2009). However, the application of westernised psychological models to non-western cultures has shown mixed outcomes (Jaranson et al., 2001; Campbell, 2007). This may be due to the differences in the way that individuals socially and culturally construct and interpret mental health experiences across cultures (Raskin, 2002; Silove, 2004; Fernando, 2010). This could in turn be

influenced by factors such as spiritual meaning, political beliefs, resilience, and cultural context (Quiroga & Jaranson, 2005). Therefore therapists should attempt to gain an understanding of clients' sociocultural and political context, and their interpretations of their experiences (Turner, 2000; Williams & van der Merwe, 2013), as these may be incongruent with westernised social constructs. Failing to explore the client's own constructs may not only limit the understanding of the experiences of survivors of torture, but may also impact negatively on the therapeutic relationship (Silove, 2004; Turner 2000), and therefore the outcome of therapy, as a strong therapeutic alliance has been found to be one of the predictive factors of positive outcomes for individual therapy (Castonguay, Constantino & Grosse Holtforth, 2006; Norcross, 2002; Artito & Rabellino, 2011).

Given the complex needs of this marginalised group, survivors of torture may access mainstream primary or secondary care mental health services for psychological support; however services may struggle to meet their needs. Nonetheless, few researchers have explored torture survivors' expectations and experiences of therapy in order to gain a better understanding of whether, and how therapy needs to be adapted to best support their needs. There is limited qualitative research exploring the experiences of asylum seekers and/or refugees in engaging with psychological therapy. Vincent, Jenkins, Larkin and Clohessy (2012) interviewed asylum seekers (two of whom had experienced torture, amongst other traumatic events) to explore their experiences of engaging in TFCBT. Using Interpretative phenomenological analysis (IPA), the authors found that participants were initially ambivalent about therapy and stated the importance of the therapeutic relationship as an encouraging factor for engagement in

therapy. Additionally, Isakson and Jurkovic (2013) explored the process of recovery for survivors of torture using grounded theory methodology. Their results suggested that a holistic process of cognitive reframing and empowerment helped participants to recover from their traumatic experiences of torture. This included a focus on spiritual beliefs and values, personal and cultural strengths, and coping mechanisms, which allowed participants to move forward with their lives.

1.2. Research aims

Limited research has been conducted to explore asylum seekers' and refugees' experiences of therapy. To the author's knowledge there are no studies exploring male survivors of torture's experiences of psychological therapy. Given the gender differences in engagement with therapy, and the diverse constructs of mental health across cultures, it was decided to conduct the study using male participants from a non-western culture**.**

The rationale for conducting such research was to develop a better understanding of the shared meanings and lived experiences for survivors of torture with complex mental health problems. Specialised services such as the charity Freedom from Torture have been developed to specifically provide a holistic rehabilitation package of care suited to meet the complex needs of survivors of torture. Given the marginalised status of survivors of torture, it is important to understand their 'therapy experiences' in the context of the specialist service who are better equipped to engage with them. The recruitment site chosen for this study mainly provided support for Iranian participants, and this opportunistic sample group was used for the current research.

The study therefore aimed to:

'Explore how male survivors of torture experienced their journey of engaging in psychological therapy, within their own personal, social and cultural contexts.'

An Interpretative Phenomenological Analysis (IPA) was chosen opposed to other qualitative methodologies, as it was well suited to the study of individual's lived experiences of a particular phenomena, whilst enabling researchers to gather a thorough understanding of their experience (Smith & Osborn, 2008). IPA allows for a small number of participants to develop a focussed understanding of the person-in-context (Smith, Flowers & Larkin, 2009).

It is anticipated that the outcomes from the research would enable therapists and service providers to understand survivors of tortures' expectations and experiences of psychological therapy in order to gain a better understanding of whether therapy and services need to be adapted in ways to better support this population.

2. METHODOLOGY

Interpretative Phenomenological Analysis

The current study used IPA, which is a qualitative methodology aimed at exploring how individuals make sense of their lived experiences of a given phenomenon and the meanings that they attach to them (Smith & Osborn, 2008). IPA draws on the principles of phenomenology, hermeneutics and idiography. These principles identify the essential components of experiences, which are unique from the individual's point of view. Through this dynamic process of interpretation and meaning making the researcher is able to make sense of the participant's personal and social world and does not aim to make general claims about the causes of events (Smith & Osborn, 2008).

Context

Participants were recruited and interviewed at the human rights charity organisation Freedom from Torture. This national specialist organisation which enables survivors of torture and their families to engage in rehabilitation, including medical consultation, forensic documentation of torture, and psychological and physical therapies.

Freedom from torture work towards three aims within the service including *rehabilitation, protection* and *accountability* (where states are held responsible for torture and the human rights of survivors are guaranteed nationally and internationally). As previously described the journey for a survivor of torture is multifaceted and clients present with complex co-morbidities from multiple life events, in addition to the experience of torture. Clinicians initially focus on helping an individual to gain internal and external control. This may include the clinician

organising legal, social, housing and financial supports and case work and psychoeducation on the psychological presenting problems. Clinicians then draw upon a range of therapeutic models (e.g. cognitive behavioural therapy, eye movement desensitisation reprocessing, Gestalt) to provide targeted interventions to help reconstruct and reprocess the trauma in detail, to then later support survivors of torture to acculturate into society.

Without such specialised organisations, survivors of torture would typically access national health services for psychological therapies which may not be able to offer specialist long-term psychological and holistic support.

Sampling Strategy

Turpin et al., (1997) recommends that 6-8 participants are an appropriate number for an IPA study, as this offers the opportunity to examine similarities and differences between individuals. To ensure homogeneity of the sample the following inclusion and exclusion criteria were created:

1. To minimise researcher bias towards participant selection, treating clinicians recruited seven Iranian male participants over the age of 18.
2. Participants who had engaged in a sufficient number of therapeutic sessions whereby their therapist deemed that they were able to reflect upon the therapeutic process were included. This was to ensure that there would be minimal risk of the participant re-experiencing trauma (which is a characteristic symptom of PTSD) as a result of engaging in the research, and that they were able to safely manage their emotional distress.

3. Participants who were a risk to themselves or others were excluded from the study.

Participants

Two female clinicians from the site invited their clients for the study (Appendix 3) through opportunistic sampling (n=2 from a clinical psychologist; n=5 from a psychological therapist). Seven male Iranian participants agreed to take part and were aged between 23 and 46. Participants' engagement in therapy at the recruitment site ranged from 5 months to 2 years. Four participants had asylum seeker status, whilst three participants were granted indefinite leave to remain in the UK. All participants had been tortured by political officials in Iran. Table 1 highlights the demographic information and the pseudonyms allocated to each participant to maintain anonymity.

Table 1: Demographic Information

	Age	Level of education	Time in therapy	Time in UK	Asylum Status	Age of experience of initial torture	Previous engagement of therapy
Afzal	23	Bachelors degree	5 months	9 months	Asylum Seeker	18	Yes
Belaal	42	Bachelors degree	Over 1 year	16 months	Asylum seeker	30	No
Khalil	32	Bachelors degree	8 months	17 months	Refugee	27	Yes
Heba	34	A-Levels	2 years	2 years 6 months	Refugee	31	Yes
Nadim	21	Diploma	1 year	1 year 6 months	Asylum seeker	16	Yes
Hafaaz	46	University uncompleted	2 years	9 years	Refugee	16	Yes
Wassim	33	Bachelors degree	1 year	18 months	Asylum seeker	27	Yes

Interview Schedule

The semi-structured interview schedule (Appendix 7) was developed collaboratively with the three research supervisors to offer a flexible framework for the interview whilst ensuring that key areas of interest were covered. A pilot interview was conducted with a male trainee clinical psychologist to test the semi-structured interview format and feedback was gathered in relation to the process of the interview, and the language used in the schedule. Minor amendments were made to the language used, as it may have proved difficult for the interpreter and participant to understand.

Procedure

The interviews were conducted by the author between September 2014 and February 2015 at the recruitment site. Prior to taking part in the interview, an initial consent session was arranged with each participant to discuss the participant information sheet (Appendix 4) and to complete the consent form (Appendix 5). The consent session lasted up to 30 minutes without an interpreter, and one hour if an interpreter was required. During the completion of the consent session, participants were made aware by the researcher that if they were to disclose any criminal acts performed by others during the torture experience then this will not be taken further by the researcher. However if the participant disclosed criminal acts performed by themselves or others since the experience of torture then the researcher would inform their treating clinician who would take the appropriate risk procedures. Following the consent session a reflection period of two weeks was given for participants to withdraw from the study. This was arranged in order to enable participants to feel in control and not coerced into participating.

Audio informed consent was obtained prior to each interview, and was also obtained for an interpreter to be present for the interview. Demographic information (Appendix 6) was collated followed by the semi-structured interview (Appendix 7), which lasted for a maximum of one hour without an interpreter and a maximum of one hour and 30 minutes with an interpreter. At the end, participants were debriefed and given information on whom to contact should they feel distressed (Appendix 8). Participants were also informed that they had the option to withdraw from the research, up to two weeks following the interview. No one withdrew from the study.

Role of the interpreter

Six out of the seven interviews were conducted with an interpreter. Interpreters were enlisted from the recruitment site, as they were trained and experienced in interpreting in the context of mental health with this population group. Two different interpreters were used for the interview, and all the participants had requested their usual interpreter. Prior to the interview the author met with the interpreter for fifteen minutes to discuss the nature of the study, the interpreter's role, expectations from the session and to read through the interview schedule and discuss any issues with translation. At the end of the interview the interpreter was offered the option of being debriefed. None of the interpreters chose the option of the debrief.

IPA Data Analysis

The data analysis was conducted by the author, whereby all the interviews were audio-recorded, then transcribed verbatim and analysed in stages in accordance with the IPA guidelines by Smith, Flowers and Larkin (2009). The first stage involved reading the transcript and noting items of significance line-by-line at the descriptive phenomenological level (*coding*). Next, the interpretative stage involved going through the transcript again and noting the potential meanings and experiences of the participant's narrative (*themes*). An interpretative account was produced to illustrate the relationship between the themes. Reflections or further questions were noted. Following this process, the objects of concern and the experiential claims were transferred onto a word document. The codes were then clustered into emerging themes. This process was repeated for the remaining transcripts. Emerging themes across the seven transcripts were then clustered to develop super-ordinate themes (Appendix 9).

Validity and Quality Checks

As IPA is an interpretative method, validation strategies are suggested to check the credibility and plausibility of the analysis (Larkin & Thompson, 2012). Peer validation was implemented with two other clinical psychologists in training and the research supervisors. Sections from individual transcripts were coded independently and similarities and differences of the emerging themes were discussed.

One tape was back translated to check the quality of the interpreted data from the interpreter. A Farsi speaking PhD student with a background in Clinical

Psychology independently conducted the back-translation by transcribing Farsi into English. The transcription from the interpreter and the back-translation was compared to identify any differences in the language and narratives recorded. Where differences changed meanings of the narratives, then these were amended on the original transcript. Three amendments were made on the transcript. Two amendments were made to the transcript regarding an inaccurate translation of a question asked by the author.

Reflexivity of the researcher

Clancy (2013) suggests that the process of reflexivity provides credible and plausible analyses of participants' experiences to avoid bias. Prior to starting the clinical course, I had some academic and clinical experience working with refugees and asylum seekers from varying cultural backgrounds. Once commencing the Clinical Doctorate course, I was interested in pursuing this area of research further. I approached the idea of interviewing refugees and asylum seekers who had experienced trauma in collaboration with my clinical and research supervisors.

Although I have had clinical experience and research knowledge of psychological therapy with refugees and asylum seekers, I was curious in exploring the process of psychological therapy from the perspective of an individual, who had experienced multiple traumas, in order to find out whether theoretical knowledge was in line with the individual's lived experiences. My previous experiences may have influenced some of my interpretations of the data during the interview and analysis stages, particularly when linking the participants'

experiences to my knowledge of the literature base about the asylum seeker/refugee population group. To help minimise possible biases, I kept a reflective journal during the research process to note my own perceptions and processes and how these may influence the data analysis.

Ethical Approval

Ethical approval was granted by the University of Birmingham Ethics Review Committee (Appendix 10), and the Ethics Committee from Freedom From Torture.

3. RESULTS

During the analysis emergent themes were clustered into four super-ordinate themes and 20 sub-themes (Appendix 9), which naturally fitted the journey of participants' distress before therapy and during the process of psychological therapy.

3.1. Vulnerability, loss and uncontrolled distress

This theme explored participants' sense of self before coming to therapy. Participants described feeling vulnerable to distress which impacted on their self-identity, disconnectedness from others, and inability to trust those around them; and for some participants, feeling hopeless about the future. Following the torture experience participants reflected upon a vulnerable, broken sense of self.

"[…] they did that night and morning they were just lashing me….the next morning they just throw me into a room my lashed body..my dead body" (Hafaaz, Line 31-32)

Vulnerability to problems & lack of controlling distress

Participants experienced distressing mental health problems including depression, PTSD, fear and suicidal thoughts. They described upsetting ruminative thoughts and physical feelings such as feeling out of control and trapped by their trauma. Although at the time of the interview they were free from being tortured, there was a sense that they were unable to control the repetitiveness of the re-lived experiences of the torture.

“Nightmares um..[pause] you know just um…being afraid, being frightened, being scared, um…..[pause] attacking thoughts, um…[pause] not being able to sleep and this painful…" (Afzal, Line 4)

“[…] feeling upset sad, angry and bad sleeping these were some of the feelings. It it was very ermm…all of these caused bad sleeping, I couldn’t sleep and if I slept I had nightmares always and always.” (Khalil, Line 56)

Belaal attributed his experience of panic attacks being worse than the experiences of torture due to the uncontrollable nature of panic compared to the preparedness for torture.

“This experience of panic attack is even worse than this because that moment that they have, you have rope on your neck you are conscious of what’s happening around you but this experience is absolutely worse you’re unconscious as you don’t, it’s absolutely worse than that” (Belaal, Line 19).

Participants described that, whilst living in Iran they experienced a sense of disempowerment from the Iranian society, and that the sense of social oppression was incongruent with their own personal beliefs on gender and politics.

"They rule the women they try to just rule them that they stop them to come to the society. They are not allowed to wear whatever they want so you see how they separate women from society." (Belaal, Line 85)

"When we got women walking around half dressed decently they cause earthquake. If this this belief is true we would have earthquake in England every day every second every minute." (Hafaaz, Line 48)

A majority of participants expressed a sense of vulnerability to loneliness/aloneness, a loss of connectedness with others and not feeling valued as an individual.

"You see I'm very lonely, you see..you have a family, I don't, I don't have a family here. Here it's just me and me…" (Afzal, Line 51)

"Since the torture I didn't want to mix with anybody just wanted to be on my own just be with myself." (Heba, Line 60)

"I felt that nobody's listening to me, nobody's hearing me….and this was my biggest problem that no one was listening to me." (Nadim, Line 107)

A sense of hopelessness about the future was also experienced by a majority of participants. For some, participants this included thoughts of suicide whereby the participant experienced the distress of the torture as so unbearable that he could not contemplate a future.

"Yeah I felt that all of these nightmares anxiety are going to be with me for the rest of my life…" (Wassim, Line 119)

“Negative thoughts, negative thoughts errm..going back through same sort of tortures and umm…I had feelings that you know I’d rather finish things off and just get rid of all of this pain and torture than go through all those again.” (Heba, Line 22)

Loss of identity and new sense of self

Participants appeared to experience a negative and vulnerable perception of self, and a loss of their own identity. It appeared that these experiences occurred when both in Iran and during the transition from coming to the UK. Participants’ identity included their place in their family relational systems and their contribution to society.

"You have left life you left your family you left your job even I had to leave my girlfriend so when I arrived here even it it was disturbing for me …we had some phone contact with my girlfriend it was very disturbing to me that I had to leave her." (Khalil, Line 62)

For example Nadim compared his identity before and after the torture. He appeared to value a sense of worth by being ‘useful’. However since the torture he experienced a sense of 'uselessness' and as a result of being unable to provide a sense of worth, and experiencing this as a rejection from society.

"Before that I was very active and very positive person. When those situation happened I just felt useless." (Nadim, Line 6)

"The way I was treated here I felt I was I wasn't wanted here you know I'm a useless person here just living off the state." (Nadim, Line 89)

Participants experienced a sense of guilt and grief for leaving their family in Iran and fleeing the country, but also the loss of connectedness with the country in knowing that they would not be able to return to Iran safely. It appeared that family was strongly valued for most participants, and that this was experienced as a part of lost identity. For example Khalil experienced an internal debate about whether he could return to Iran to visit an unwell relative. There was a sense that he fought between his personal values of the importance of family and the valid fears of being arrested if he returned.

"If I go there again I will be in prison and there should be serious problems over there […] I said maybe this is the last chance to see her if something's happens to her," (Khalil, Line 56).

Distress visible/Help-seeking through others

Some participants' distress appeared to be noticeable to others and they were advised to seek help by professionals or family members. Participants had mixed views regarding what therapy could offer, including medicalised views about removing their distressing feelings, being 'fixed', being connected with their former sense of 'normality' before the torture and to have a future.

"My aim was to cure myself to get better, and her aim was to help me to get better." (Hafaaz, Line 135)

"I just wanted to live again and I was hoping that they would show me er..err the right way to get back into living again and be a normal person. I just wanted to be normal again." (Nadim, Line 84)

"*Obviously when you have a problem you you start to solve that problem. If you get cold you start to take some medication you want to treat that problem." (Belaal, Line 21).*

Beliefs and Hopes from therapy

Some participants expressed a sense of mistrust relating to their previous involvement with mental health services in the UK. Participants described a sense of distrust and vulnerability due to their lack of support.

"[…] when you hear that people have suggested certain things and they forgotten it themselves you lose faith and you lose trust." (Nadim, Line 38)

"[…] just had concerns that my story information I would give should be discussed somewhere else." (Wassim, Line 59)

The participants' sense of a changed and 'broken' self and their beliefs about engaging in therapy as a potential 'fix', links to the next theme, of participants fearing the exposure of their vulnerabilities to others.

3.2. Exposing vulnerabilities and developing trust

This theme focused on participants' transition from not trusting, which may have developed from their fear of being judged or appearing weak; to the development of trust with their therapist, which was expressed as feeling 'comfortable' in discussing their experiences of distress.

Fear of trusting

Due to their experiences of torture, many participants expressed a fear of trusting others and a view of the world as unsafe.

"*I wasn't able to talk about that person with other people and even if you want to open the information again they will arrest you and again there is big problem." (Belaal, Line 69)*

"*[…] because of what happened to me I couldn't trust anybody." (Wassim, Line 45)*

Determining whether to trust

Many participants appeared to experience an initial ambivalence about engaging in therapy. It seemed that participants did not feel forced to attend therapy but maintained an element of control in their decision about continuing with therapy. Some participants felt that they could trust other Farsi speaking males who accessed the service, which may suggest that participants experienced a sense of safety and solidarity in the 'untold story' of knowing that all other service-users accessing the service had also experienced torture.

"*I was 50/50 I wasn't sure if I was coming or not and when I saw this person is giving me advice and she is honest and you know and that experience I could make my own decision." (Belaal, Line 47)*

"I met somebody here who been through the therapy and he sort of said to me look you know keep coming because what it will get better it will get easier." (Wassim, Line 137)

In the initial appointment participants generally experienced not being able to focus during the session and were unable to retain the information discussed. This gave the sense of participants initially feeling highly anxious and hypervigalent to their surroundings. During this period, it appeared that there was a two way process between the participant and therapist. Whilst the therapist was determining whether the participant would benefit from therapy, the participants were determining whether to trust the therapist and analysing the therapist's capability.

"I wasn't really listening I was looking around you know just checking out the room, checking what, checking my surroundings." (Afzal, Line 26)

"When you are analysing me as a client I am analysing you as a therapist. So in one two sessions of wondering that I am considering the person in front of me to see what type of person is that." (Belaal, Line 38)

Wassim described seeing a male Iranian therapist from a previous service:

"*I have that feeling that you can't trust...Because of the problem I had I just couldn't trust anybody…I didn't know anybody I just got here and I just didn't know anything I didn't want to sort of share my personal experience with someone who speaks my language." (Wassim, Line 16).*

There was a sense that therapist matching to the client made the participant feel vulnerable and fearful of trusting him. This may have been due to the small Iranian community and the fear of his safety if information was disclosed.

Fear of judgement, showing weakness and shame.

Some participants experienced fearing judgement from their therapist as a consequence of showing their emotions and appearing weak, which were incongruent with their beliefs about masculinity.

"You have to be rough and tough you know, you have to be a MAN [participant raises voice and gestures]... and sometimes when you, feel like a man you know you feel really weak." (Afzal, Line 57)

"Discussing this with other people I just let them think that I'm weak and not able..you know managing my activities." (Hafaaz, Line 28)

Participants appeared to fear being judged by their therapist and others, which may have been influenced by their sense of personal and societal stigma associated with engaging in mental health services. Afzal and Khalil's beliefs appeared to be an initial barrier in disclosing personal experiences of the torture.

"Why I was reluctant to talk about it was because of that stigma that that something bad has happened to me er.. and.. I just and you know you don't want something which is abnormal to explain to someone." (Afzal, Line 42)

"I won't accept that cos I believe no, I'm not crazy or not mad. I don't need [previous therapist] […] you immediately imagine a hospital some…people with serious mental problem are there and sometimes they have to control theses people that are dangerous they may do anything and maybe also they have to tie them…to somewhere." (Khalil, Line 14-20)

Khalil had strong beliefs about the type of people who engage in therapy, and associated this with an image of someone being 'crazy' and so uncontrollably 'dangerous' that they would have to be tied down. This was completely incongruent with his beliefs of his problems. However as the therapeutic relationship developed, it appeared that his initial beliefs about mental health were de-stigmatised.

"[…] I realised that this is not about just mad or crazy people this is applicable to everyone." (Khalil, Line 12)

Transition from being guarded to trusting

As therapy progressed there was a sense that participants became less guarded and more trusting of the therapist. Overall it appeared that there were two ways that this was experienced. For some participants this was a gradual process, for example, there was a sense that Wassim reached out for support when he was ready to disclose his vulnerabilities and in return he experienced the therapist supporting that. Whereas for other participants (e.g. Afzal) a decision was made to take the risk to openly discuss their experiences.

"Slowly slowly talked, I got to know them better, I felt they are good to me, I gave them my hand and they hold my hand, they are kind to me." (Wassim, Line 44)
"[…] sometimes you just have to jump in the deep end." (Afzal, Line 22)

Building of trust through evidence

The majority of participants described trust building through the therapist helping them with related practical problems such as contacting the Home Office. It appeared that the 'advocacy' role of the therapist gave Belaal and Nadim a sense of being valued by being 'held in mind' and supported by the therapists.

"*[…] making contact with the legal team in the centre and making contact to my solicitor to see how the situation is going so you know that she is putting lots of energy and effort to support you and then gives you better feeling and making better trust of her." (Belaal, Line 54)*

"First thing [therapist] did was by contacting Home Office and let them know that what I was going through the situation with my wife and for myself and that was important to me that somebody is actually doing something, contacting doing something positive towards my problems." (Nadim, Line 110)

Humanising

Participants experienced a sense of connectedness with the therapists through their personal characteristics of warmth and the therapist's expertise. In addition, particular humanising values through the therapist made participants feel understood, listened to and of existence. The therapist taking adequate time to fully hear and understand the participants' personal context gave participants a sense of value and acknowledgement for being a person, and not just a person who experienced torture. For example Hafaaz described how important it was that his therapist got to know him as a person of existence, and that he had a life prior to the experience of torture.

"Just to know that you are Iranian and you've been tortured is not enough. They need to know your background which family you've grown in, they need to know what field you've been working in, what level is your education at, how many times you have been in prison, they need to know the whole thing" (Hafaaz, Line 168)

Experiencing therapy as painful/uncomfortable

Once trust was gradually developed between the participant and therapist, participants appeared willing to open up about their experiences of torture. The

trauma-focused therapy was experienced as a painful/uncomfortable process, which encompassed setbacks. The experience of discussing the torture felt real and present to participants, giving a sense of 'exposure' to their trauma experience.

"She opened up the wound she opened up the whole thing and gradually she dealt with every little every…you know..every little piece and helped me to open up about it and talk about it.." (Nadim, Line 193)

"Going through those experiences was making it so fresh that you are actually going through it and er…because of the effect it had on your mind you felt its so fresh in your body…" (Heba, Line 122)

"[...] the sessions I've had its kind of like a see-saw thing sometimes it was going well then suddenly something happened I had a dream and something happened and it knocked me back right to the beginning." (Heba, Line 114)

Nadim described his experience of disclosing his vulnerability using a metaphor related to a medical perspective. His distress as being a 'wound' which the therapist opened up and cleaned/dealt with gradually by talking. Heba uses the word 'fresh', which may have related to his physical feelings of re-living the trauma experiences.

Transition from pain to comfort

This painful process transitioned to a sense of comfort, increased trust and connectedness with the therapist. Participants still experienced the pain of talking about the torture experience. However, they felt that the more they spoke the more 'comfortable' and 'at peace' they felt, which for some encouraged continuation with therapy. For example:

"…every time I get here I was getting peace and support and the fact that you know I was here I was feeling comfortable I had peace." (Heba, Line 54)

"I keep coming back I saw a lot of good things happening ok a little bit was unhappy but there was a lot of good happening so I kept coming back. The fact that I was able to trust somebody and speak my mind just telling about what was going on in my mind was a big thing for me." (Nadim, Line 196)

"*[…] I feel, I don't know how if this is working but if you share something an experience or something with someone so it is easier for you. It's not you're carrying that everything on your shoulders alone. You have another person to share that and you feel better." (Belaal, Line 68)*

Some participants were unable to explain why the process of talking was making them feel better. There was a sense of sharing the experiences of torture with the therapist that became less burdensome on participants and a sense of feeling physically lighter.

This second super-ordinate theme was concerned with participants' fear of exposing their vulnerabilities and their development of trust towards the therapist. The development of trust included the therapists offering 'humanising' values to the participants, and by taking an 'advocacy' role. Once a therapeutic relationship developed participants took the 'risk' of 'exposing' their vulnerabilities which was initially experienced as being 'painful', however transitioned to feeling 'comfortable' in managing and exposing their distress. This leads on to the next theme about participants' experiences of being in a secure and trusting therapeutic relationship.

3.3. Experiencing security and connectedness

Therapy being gradual & guided

Therapy was experienced as being a gradual and guided process, and for some participants, this differed from their original beliefs about what therapy could offer. Therapy was experienced as a space to talk about anything distressing in addition to the torture experience, which was found to be helpful and supportive. Only a few participants however, specifically described the type of advice and techniques that were used in therapy.

"She was getting me deeper and deeper into our talking and I was giving answers into that. [therapist] know exactly what sort of questions to ask and she was taking me in that direction. She knew where to start and where it takes me." (Hafaaz, Line 117)

"One of the first things she did was put one of the problems on the board think it was about ten things that we needed to do she said if we try to do all of them in one go it wont happen but why don't we start doing one at a time and this is probably when things started rolling forward." (Nadim, Line 124)

Since engaging with therapy Khalil had adopted the understanding that recovery is a long-term process. He also reflected a sense of ownership over some of the problems that he discussed in therapy, acknowledging that some problems cannot be removed.

"By coming to the service its not like magic there is no magic or miracle that in one second everything changes. No they're they they don't solve the problem in that way." (Khalil, Line 101)

Trust being mutual

All participants appeared to develop a sense of mutual trust with their therapist, whereby participants clearly understood their role and their therapist's role. For some participants this was experienced as being a two-way process of attunement with one another. For example:

"When I sit in front of [therapist] before I open my mouth she knows what's going on in my mind she knows what I want to say and that's important to me." (Nadim, Line 115).

"[…] if you tell them the whole truth the therapist or or the person in front of you can assess and use more tools that is disposal to help you to get better. If he or she is a specialist she will know where to start the therapy or the recovery period." (Hafaaz, Line 166)

Developed sense of trust and safety

Trust appeared to develop the connectedness with the therapist but also a sense of a safe base within the service; which enabled participants to open up further about their experiences and to feel safe enough to remain engaged in the service.

"I know I have a safe place that I can talk, even if they are not able to do any help but at least there is a safe place that I can talk." (Khalil, Line 93)

"*Its like a shelter, I look at [service] like a shelter so if I, if I was running away from something again or I had a big problem I couldn't deal with I would seek help in [service]*." *(Afzal, Line 69)*

Some participants expressed a sense of trust and comfort as a result of seeing a female rather than a male therapist, which may be attributed to their beliefs about the 'softer' characteristics and non-judgemental approach of women. It seemed that there would be a barrier for Heba to openly trust a male therapist when discussing his marital problems.

"[…] sometimes you can't help thinking that when you talk about your family your wife and your children she is probably more sympathetic with the thoughts..with your thoughts because being a woman she could see what I was sort of going through." (Heba, Line 96)

This was interpreted by the author, as a sense of judgement from a male therapist of weakness and failure for not fulfilling his male role as a father and husband, whereas a female therapist would be more empathic.

Belaal, Khalil, Nadim and Afzal likened their connectedness with their therapist to a relationship with an elder sister or a friend, in feeling comfortable in 'opening up' to them.

"*Having an elder sister or brother it's a sweet experience, like it's a beautiful experience you have someone […] is a very beautiful experience when you feel like you're not alone, there is someone beside you this person is watching you and sometimes the person is able to give you some advices that maybe you're not aware of the situation." (Belaal, Line 58)*

"Cos you're more comfortable to talk to a friend about your feeling than your therapist. And you get more out of a friend talking than someone talking to a therapist." (Nadim, Line 209)

It appeared that participants experienced a sense of valuing their therapist's companionship during sessions and of not being as alone as they felt they once were prior to commencing therapy.

'Offloading' release of distress

Some participants experienced a sense of 'offloading' or 'releasing the pressure' of their distress, which was interpreted as a form of removal of physical feelings of distress from their system in order to feel more relaxed and at ease. For example:

"The more I was telling them the more relaxed I was getting because I was just offloading." (Wassim, Line 65)

"She was just removing the problems she reduces the pressure on me." (Nadim, Line 105)

"After the session you feel comfortable, you're better you …..have errmmm…you feel feel that you.. there is..it's not heavy anymore you're light, its better." (Belaal, Line 64)

"Every time that I spent time with [therapist] I felt good. Probably because I was pouring out what I had inside." (Hafaaz, Line 40)

Connectedness vs loneliness

Once participants finished their therapy session, for some there appeared to be a cyclical process of experiencing the vulnerability to distress and of aloneness upon their return home; and perhaps they returned back to therapy for a sense of connectedness and releasing of the 'pressure'.

"I leave here I have to go to my lonely place again on my own and I just can't escape going back to my thoughts and you know some of the things I'm trying to get rid of." (Nadim, Line 141)

"[…] then I go home then I was on my own again then I was back to myself and all the thoughts come back again." (Wassim, Line 152)

Overall this theme reflects the general sense that once a feeling of trust and safety is developed with the therapist that this can extend to the service. The more participants were willing to 'open up' and 'offload', the more their therapist could support them. The process of 'offloading' was experienced as a physical release of distress, which may have been experienced as a benefit of engaging in therapy. However, it seemed that some participants were unable to maintain the sense of the 'releasing of pressure' without the support from the therapist. This links to the final theme of participants' experience or envisaged experiences of 'going alone' without the therapist.

3.4. Regaining resilience through control but fearing the loss of connectedness

This theme focused on participants gaining a sense of control over their experiences of distress before therapy and being able to move towards feeling hopeful about the future. Some participants feared that the ending of therapy would lead to them becoming vulnerable to distress due to the ending of the sense of connectedness arising from the therapeutic relationship.

Fear of ending therapy and support

Hafaaz had recently completed therapy and experienced a sense of hopelessness and a loss of connectedness with his therapist. It appeared that he was unable to imagine an ending for therapy and experienced disappointment that his problems had not been 'cured', which was linked with his initial expectations from therapy.

"She succeeded to a certain extent but I still think she's left me unfinished job with me. The only fault I can find in this process is that fact that she left me unfinished…left me unfinished." (Hafaaz, Line 156)

"I just wanted a cure. I just wanted my depression to be sorted. I'm still suffering my depression and I know I feel it myself." (Hafaaz, Line 128)

"if I had more sessions I feel I would have probably got the whole thing out of my system and to get better quickly." (Hafaaz, Line 162)

This experience of the therapy ending seemed understandable given the description of the strong alliance built with the therapist and the perceived fear of managing these vulnerabilities alone. However as only one participant in the study had been discharged, it is unclear whether this would be a typical experience for participants.

Most participants were still engaged in therapy, however some feared that support would end, leaving them to feel exposed to becoming vulnerable again, and unable to manage alone and without the support from the therapist.

"I was built up to come to this level and if somebody were to withdraw this help from me… I don't know… I'm not sure whether I would collapse down or or stay where I am. I just need the support." (Nadim, Line 91)

"If I don't continue therapy I will go back to the state I was in, hopeless, helpless but less less less, all the lesses." (Afzal, Line 85)

Regaining control

Participants found that understanding their distress through learning coping skills and techniques, that they were able to regain a sense control over their distressing problems. This sense of having the knowledge and understanding of their distress appeared to help reduce their sense of vulnerability. For example:

"You get to know things like the breathing technique and..although you don't remember to do it at the time, eh its helpful to know, in case you remember you would use the techniques." (Afzal, Line 87)

"[…] be able to control these negative thoughts but more important to manage them rather than run away from them." (Heba, Line 24)

"This is very important for me, that I feel, and I think, and I can decide for myself […]." (Nadim, Line 98)

Some participants experienced a sense of disempowerment related to the cultural context of Iranian society. For example Belaal maintained his personal beliefs of gender inequality in Iran and remained hopeful about making future changes to Iranian societal beliefs. The author interpreted this as Belaal experiencing the sense of empowerment through disseminating his knowledge to his children about gender equality.

"*I learnt how men and women should balance power in the family. My son will learn from me, so this is like a chain that will go on from generation to the next generation." (Belaal, Line 83)*

Regaining a sense of self

A sense of acceptance of the torture and hope for the future was experienced by participants, which enabled a reconnection with their former self

and a start of a new life. For example, Heba initially appeared to experience his distress as being ‘bright’ and noticeable and that through therapy the distress had decreased, and helped him to move to a sense of acceptance of the trauma experience.

“[…] helped me to look at the whole thing and sort of take the shine…the pain away from some of those experiences that I had…that I was sort of so colourful that making the main reason for my situation eventually faded away and..then coming to terms with a lot of it [...] it helped me to come to terms with these experiences that I had it’s a healing process its understanding and just accepting it in a way that it’s helped me to move on.” (Heba, Lines 62-72)

For other participants this was experienced as being able to envisage moving forward with a positive outlook on life. This included relationships with their family and sense of being included within society.

“I’ve found myself again. I believe in myself now […] trying to build towards a lifestyle to build a future build a life for the future. I feel once I have settled here and I managed to get my visa […] I can bring my wife to me, and we can start living again.” (Nadim, Lines 185-186)

“[…] now that I am busy with college and I’m integrated into the society a little bit.” (Afzal, Line 83)

"[…] she was able to get me to get the pen back in my hand. That's what's important." (Hafaaz, Line 155)

This final super-ordinate theme described the dichotomy between some participants fearing the loss the support from the therapist who enabled a sense of control over their distress, and for others gaining a sense of agency over their feelings of distress and a hopeful future.

Table 2 highlights the prevalence of the participants' narratives being heard within each of the superordinate themes.

Table 2:Prevalence of Super-ordinate themes:

	Super-ordinate theme			
	Vulnerability, loss & uncontrolled distress	Exposing Vulnerabilities and developing trust	Experiencing security and connectedness	Regaining resilience through control, but fearing the loss of connectedness
1	Yes	Yes	Yes	Yes
2	Yes	Yes	Yes	Yes
3	Yes	Yes	Yes	Yes
4	Yes	Yes	Yes	Yes
5	Yes	Yes	Yes	Yes
6	Yes	Yes	Yes	Yes
7	Yes	Yes	Yes	Yes
Present in over half of the sample?	**Yes**	**Yes**	**Yes**	**Yes**

4. DISCUSSION

4.1. Main findings

The aim of the research was to explore how male survivors of torture experienced psychological therapy. The four super-ordinate themes appeared to lend itself to the sequential journey of the participants' experiences of engaging, continuing and the end of therapy. This may have been due to the nature of the questions asked during the interview. The super-ordinate themes were, '***Vulnerability, loss and uncontrolled distress'*** which focussed on the participants' sense of self as being vulnerable to distress, loss of identity, control, and connectedness with family and society; **'*Exposing vulnerabilities and developing trust'*** focussed on the journey of exposing the vulnerable self to the therapist through building trust; ***'Experiencing security and connectedness'*** explored the experiences of the therapeutic alliance therapy. Finally **'*Regaining resilience through control, but fearing the loss connectedness'*** focussed on regaining a sense of control of their distress to feeling reconnected with the self, but also fearing the loss of therapeutic support and becoming vulnerable again.

As previously highlighted as there is limited research on the survivors of torture's experiences of psychological therapy, the main findings will be discussed in relation to existing research on asylum seekers and refugees experiencing trauma.

Vulnerability, loss and uncontrolled distress

Within the first super-ordinate theme participants described themselves as being distressed, vulnerable and with a broken sense of identity. This resonates

with previous research on survivors of torture as the dehumanising nature of torture greatly impacts individuals' sense of 'personhood', locus of control, their social connectedness and their personal and political values (Gorman, 2001; Elhers & Clark, 2000). Furthermore, Silove (1999) explains how the experience of torture threatens an individuals' system of security and safety, attachment systems, loss of identity and role. Many participants experienced a sense of loneliness, through the loss of supports and family, which may reflect a collectivist culture of placing strong values on relationships (de Jong, 2004).

These multiple levels of losses understandably impact on an individual's wellbeing (Turner & Gorst-Unsworth, 1990). Ehlers and Clark (2000) suggest that refugees and asylum seekers presenting with complex trauma experience a sense of ongoing threat. This concurred with the current research whereby participants experienced hypervigilance and a sense of current threat through ruminative thinking and reliving of the trauma. The current sense of fear may have impacted on the experiences of withdrawal from society. The experience of being displaced from the country of origin is distressing in itself, particularly as there is a sense of threat to an individual's safety. To resettle into a new culture, survivors of torture must develop a new identity within the bounds of the host county's culture and contend with cultural, language, and societal differences (Ekblad & Jaranson, 2004; Silove, 2004). Within the current study this appeared to be experienced as a sense of not being valued by society, social isolation and vulnerability. Once an asylum seeker moves to the UK, they lack control over aspects of life that they once had in their home country e.g. choice of accommodation and employment. These could be experienced as a sense of disempowerment and a lack of agency,

which could prevent moving forwards with life and reconnecting with their previous identity. As a result these losses could impact on participants' trauma rehabilitation and may need addressing, in addition to the experiences of torture (Pettitt, 2013; Douglas, 2010).

Most participants described being advised to engage in therapy for support, which was interpreted as experiencing a lack of agency in seeking support. However, this could be due to the lack of knowledge about where and how to seek support, or due to the stigma around accessing therapeutic services. Research conducted around male help-seeking behaviours of psychological therapy has found strong stigma about engaging in services compared to women (Addis & Mahalik, 2003; Gonzalez, Alegria & Prihoda, 2005). Only some participants described their stigma related to engaging in therapy which appeared to be experienced as a sense of ambivalence and fear of judgment. Isakson and Jurkovic (2013) found that for survivors of torture, the stigma related to mental health was a barrier to empowerment. In the current study this was perceived as retaining a sense of control to make an informed decision regarding the continuation with therapy, which involved asking other Iranian males at the service for advice.

Exposure of vulnerabilities and developing trust/Experiencing security and connectedness

The second and third super-ordinate themes explore the process and development of trust and connectedness and the experience of engaging in therapy.

Research in this area demonstrates that a strong therapeutic alliance is a

key component for positive outcomes from therapy regardless of the therapeutic approach (Castonguay et al., 2006; Norcross, 2002). In the present study, there was a sense of ongoing vulnerability and lack of trust during the initial phases of engaging in therapy. For most participants, the development of a therapeutic alliance was experienced as a long process whereby therapists had to prove that they could be trusted by being seen to practically support participants. Fabri (2001) suggests that, should survivors of torture view their therapist as an authority figure, they often feel disempowered or controlled by others, which may impact negatively on the therapeutic relationship. Within the current study it appeared that participants initially experienced uncontrollable distress; however they developed a sense of agency during therapy by making the decision to not only come to therapy, but also what to disclose.

It seemed that the therapists delivered core 'humanising' values; being listened to, understood and valued, which supported participants to feel empowered as a human being. Gorman (2001) suggested that the act of torture removes the victims' voice and agency, and disempowers individuals. The development of safety within the therapeutic relationship can enable clients to reconstruct a sense of trust and security with another person, which had once been diminished through the acts of torture (Fabri, 2001; Herman, 1992). Behnia (2001) found that when professionals spent time in understanding and listening to the survivors of tortures' narratives in a culturally competent way that strong therapeutic relationships were developed. Therefore developing a strong therapeutic relationship is crucial in empowering oppressed survivors of torture to find their voice and to offer a sense of agency in telling their narrative; which in

itself appeared to be therapeutic to the participants.

The sense of ongoing threat can be maintained by the uncertainty of asylum status, and social factors such as inadequate housing (Grey & Young, 2008). Perhaps participants' level of perceived threat was reduced when therapists offered practical support, such as contacting services to help with their asylum status. The 'advocacy' role of the therapist appeared to be important in 'giving a voice' to the participant who may at that time be experiencing disempowerment from society. This role appeared to further strengthen the therapeutic relationship. Studies have shown that holistic psychosocial approaches to therapy are required for this population group, which may go beyond the role of many generic mental health services. Therefore service structures may need adapting to be adapted to meet the needs of survivors of torture (Patel et al., 2014).

Participants experienced a fear of judgement and shame, and described these to be an initial resistance to opening up to the therapist. Not many links were made to masculinity or gender differences unless prompted by the researcher. Some participants described their fear of showing their emotions to be attributed to weakness. This may be due to the social and cultural beliefs of interpersonal dominance, self-reliance and giving the appearance of being resistant to vulnerability (Addis & Mahalik, 2003). Good, Thomson and Brathwaite (2005) suggest that male clients start off at an unequal footing compared to women, as there is incongruence between the societal expectation of masculinity and the expectations from therapy. Therefore, if not within their social and cultural norms,

considerable time is needed to develop a sound therapeutic relationship to enable male clients to express vulnerability.

Some participants reported that they preferred having a female therapist despite previously having a male therapist, as they perceived them to be 'more empathic' and felt more comfortable to discuss their emotions. Some participants described having no preference regarding the gender of their therapist and therefore the gender of the therapist may not have been important to them. These findings concur with qualitative literature on the gender preference of therapist, whereby male and female clients experienced being more 'comfortable' in opening up to female therapists, and were perceived as having a 'softer' character compared male therapists (Gehart & Lyle, 2001). All participants described experiencing a very positive relationship with their therapist. There may have been possible bias in the participants' responses due to the researcher being female, and that the majority of participants were still engaged in therapy with their female therapist. There may have been a concern from participants that their responses may have been fed back to their therapist although confidentiality was explicitly discussed when obtaining consent.

The experience of 'offloading distress' was interpreted as being a cathartic process whereby participants described feeling 'lighter' from the release of the distress, which was also observed in Gilkinson's (2009) study with refugees receiving trauma focussed therapy. Mirdal, Ryding and Sondej's (2012) qualitative study compared therapists', interpreters' and refugees' perspectives of trauma focused psychotherapy to find that clients stressed the importance of being able to talk, and that it had a cathartic effect due to '*putting words on thoughts and*

feelings' to structure the aspects of their mental life. These experiences appeared to resonate with Herman's (1992) model of trauma rehabilitation whereby the process of client's detailing and modifying their trauma memories, becomes less anxiety provoking and more controllable. Some participants appeared to experience the benefits of feeling relaxed once releasing their distressing thoughts in session, but then experience a sense of loneliness and vulnerability once they returned home from their session. Research has suggested that the process of catharsis and reflective thinking alone is not a sufficient for lasting therapeutic change (Greenberg & Pascual-Leone, 2006).

The analysis appeared to show no difference in vulnerability, trust, control, and hope, between refugees and asylum seekers before or during experience of therapy. This may be due to methodological factors such as the focus, or the quality of the interview, as this may not have accounted specifically for these differences. Moreover, the current study had a small sample size with both refugees and asylum seekers. A larger sample and quantitative design may have been required to observe these possible differences.

Regaining resilience through control, but fearing the loss of connectedness

The fourth super-ordinate theme focussed on the development of hope and a sense of agency, in addition to the participants' fear of vulnerability from the ending of the therapeutic relationship.

Most participants were still engaged in therapy but some expressed fear about how they would manage once therapy ended. One participant had been discharged from therapy and experienced a sense of disconnectedness from the

therapist and of returning to feelings of vulnerability. Given that his expectation of therapy was to be 'cured', he understood that he felt 'unfinished' and appeared unable to envisage therapy coming to an end. Similar outcomes were identified in Vincent et al.'s (2012) study as one participant had also been discharged from therapy and found the ending of the therapeutic relationship to be distressing due to the lack of support outside of therapy. They suggest that therapists should carefully prepare treatment endings including identification and links to other forms of support. Although similarities between the current study and Vincent et al's research findings were identified, it would be premature to assume that all survivors of torture discharged from therapy would experience a similar level of disconnectedness and vulnerability.

Initially participants described experiencing a sense of identity loss and a broken sense of self. As therapy progressed, it appeared that participants gradually reconnected with their preferred sense of self and experienced hope for the future through developing a sense of agency. This included a sense of connectedness through social inclusion, and reconnecting with family. Research has shown that reconnecting with normal routines can help individuals regain self-respect, self-confidence and control (Turkovic, Hovens & Gregurek, 2004) and enable them to take responsibility for reducing their distress through therapy (Curling, 2005; Herman, 1992).

4.2. Methodological Considerations

IPA was a well-suited methodology for the current study, as it gathered the salient themes around the lived experiences of Iranian male survivors of torture in

relation to psychological therapy. The study attempted homogeneity in including participants from one gender group and the same cultural background.

All participants were invited by their treating therapists and had to be able to reflect on the therapy process. The results from the current study suggested that participants were at a stage where a positive therapeutic relationship was built as they had all 'opened up' about their trauma experiences, and were experiencing the benefits of therapy. However, if the participant sample had included those who had not disclosed their trauma experience then perhaps more negative and 'difficult' experiences may have been reported. This therefore suggests possible bias in the current sample.

Use of interpreters

Six participants required an interpreter, and all were familiar with the interpreters used. It was important to use a familiar interpreter in the research process as this is likely to enable participants to feel more comfortable to talk about their process of therapy. Two different interpreters were used, although it has been suggested that to maximise consistency in the translations and the reliability in the analysis, having one interpreter for a research study may be optimal (Twinn, 1997). Five of the participants who required an interpreter were still engaged in therapy. Therefore, there may have been some bias regarding disclosing negative experiences during the interview, out of concern that this information may reach their therapist and affect the therapeutic relationship.

One tape was back-translated to check the reliability of the interpretation. Upon comparing the two transcripts, differences were found in some of the words

translated. However, the main narratives were broadly similar. There were two instances towards the end of the interview where the interpreter inaccurately translated the questions asked by the researcher. However, the researcher identified this during the interview process, as they noticed that the answers were not congruent with the question asked. It is acknowledged that this is not a reliable approach to ensuring accurate translation.

The use of an interpreter meant that cultural nuances and language were not captured to enable a higher level of analysis of 'lived experience'. The interpreters' repeated words or hesitations did not appear to come from the participants' narrative (as indicated form the back-translation) and therefore this layer of interpretation was not as thorough, compared to an analysis without an interpreter, which may question the validity and level of interpretation of the lived experience. As part of Twinn's (1997) research, one interview in Chinese was interpreted into English by two independent translators and showed variations between the transcripts. This demonstrates that translation is open to interpretation as language is not a transparent medium, and that translating meanings and concepts is not always interchangeable from one language to another (Tribe, 1999). Therefore using an interpreter is likely to have a negative impact on the validity and reliability of the data. In order for the current study to retain the cultural language and context, the study would need to be conducted by a Farsi speaking researcher and written in the Farsi language, as the translation into English would inherently result in loss of validity and accuracy.

There are currently no specified methodologies on conducting IPA when using interpreters. It has been recommended that to address validity and reliability

with any rigor, then there should be a development of interview guides and data analysis when conducting IPA with interpreters (Twinn, 1997). Despite these challenges in cross-language research, it is unethical to exclude cultural groups that require an interpreter in research for this issue alone, as there is still a clear need for ethnic minorities to be represented in research (Murray & Wynne, 2001), to enable their experience of therapy to be heard, in order to offer culturally competent interventions. Therefore, whilst bearing in mind this limitation, it is believed that the current research still provides a useful contribution to the area.

4.3. Reflections on own research practice

Initially I found it challenging to not use my therapeutic skills as a trainee clinical psychologist in summarising and reflecting during the interview. The use of the reflective journal and supervision throughout the interview and analysis helped to develop skills, which were consistent with an IPA approach. Recording the reflections during these processes helped to identify any preconceptions, and experiences, which may have influenced the interview and analysis. During the interviews, I often queried whether the interpreter had correctly translated the information. At times I had the sense that the answers were not always congruent with the questions asked. Given my previous clinical experience of working with interpreters, I felt confident in challenging this by asking the interpreter to repeat the question again. However, it is noted that this approach was not methodologically robust, and back-translation was conducted to explore this further.

I was aware that being a western female myself, I may have influenced

some of the responses gathered from the participants. For example, questions regarding the therapist's gender may have been skewed given that I am a female researcher. Particularly as the data gathered suggested that there was a sense that the participants had a strong therapeutic relationship with their female therapist. It may have been viewed as a 'loaded question' as none of the participants reported having a stronger preference to see a male therapist.

The data suggested that there was a sense of disempowerment from the Iranian society and that this was incongruent with the participants' own beliefs on gender. This included the social oppression against women in Iran. These questions were not asked directly in the interview and yet had developed a theme in the data. Given that I am a western female, I had wondered whether this had influenced the discussion of disempowerment in relation to gender. Also, I wonder whether the data would have lent itself to the individual narratives of gender disempowerment and social oppression if the study was conducted by a male researcher.

Sample validation was considered whereby individuals who are eligible for the study (who did not take part) review the analysis, as this would have validated the trustworthiness of the analysis from the perception of an individual who had also experienced torture. However, due to the barriers of identifying further participants and the use of interpreters this method was not utilised. Therefore, peer validation via the research supervisor was conducted to achieve trustworthiness and plausibility of the analysis.

4.4. Clinical Implications

It is hoped that the outcomes of this research will provide therapists with an understanding of service-users' viewpoint of therapy; and lead to offering more attuned therapy approaches. The outcomes from the research suggested that some participants valued the advice about engaging in therapy from other service-users. Perhaps clients could adopt this supportive role for other survivors of torture and which may lead to social cohesion.

The outcomes of this research also suggested that psychological therapy needs to be long-term to enable the development of a therapeutic relationship and to re-integrate clients into society for a sense of connectedness. Research with asylum seekers and refugees have suggested that therapists offer diverse support and intervention (Grey & Young, 2008; Patel et al., 2014), including broader concerns such as accommodation to increase the likelihood of therapeutic engagement (Watters, 2001). However, it is questionable whether this is possible in current mainstream mental health services, given the limited resources and the reported benefit of the therapists being 'a voice' and an advocate for this marginalised population. The concern may be that if careful and considerable time is not spent developing a sound therapeutic relationship with survivors of torture and adequately supporting them, then there may be a risk of client's remaining vulnerable within society.

Connectedness with the therapist appeared to be a strong theme with participants. For some there was a fear of the loss of the connectedness with their therapist and the fear of becoming vulnerable to distress again. Perhaps there is scope for survivors of torture to be linked more within society to develop the sense

of connectedness outside of therapy, but more importantly to strengthen their sense of agency with respect to their difficulties. There is a need for connecting clients with community/voluntary sector services to enable engagement with psychosocial support.

4.5. Research Implications

The results add to the limited research base on survivors of torture and facilitate training for professionals. The current research opens further questions in terms of exploring how survivors of torture experience being discharged from therapy, or exploring the impact of supportive systems outside of therapy. For example, relatively little is known about how those who live with survivors of torture manage the impact of the trauma experiences.

4.6. Conclusions

The implications of the current study can aid professionals in understanding survivors of torture's perspectives of therapy. The outcomes suggested that survivors of torture benefit from a holistic rehabilitation service, including psychological therapy. Participants experienced a strong sense of connectedness with the therapist and described beginning to feel human again following the dehumanising experiences of torture. They regained a sense of identity and became more hopeful about the future. However, clients may still experience a sense of vulnerability once discharged from services due to the fear of managing their vulnerability without the support from a therapist. Encompassed in the role of the therapist working with survivors of torture, there is a role for confronting these

human rights violations by initially being the voice for survivors through different mediums such as advocacy and research to raise awareness. There is a need for more adequate long-term specialised rehabilitation services, as mainstream mental health services, currently may not be fully equipped to provide medico-legal and advocacy support, in addition to psychological therapy (Patel et al., 2014). There may be a need for more specialised rehabilitation services for additional training in the mainstream mental health services to effectively identify, signpost and support survivors of torture.

5. REFERENCES

Addis, M.E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American psychologist*, *58* (1), 5.

Ardito, R.B., & Rabellino, D. (2011). Therapeutic Alliance and outcome of psychotherapy: Historical Excursus, Measurement and prospects for research. *Frontiers in Psychology 2: 270.*

Basoglu, M. (1992). Torture and Its Consequences: Current Treatment Approaches. New York, NY: Cambridge University Press.

Behnia, B. (2004). Trust building from the perspective of survivors of war and torture. *Social Service Review*, *78* (1), 26-40.

Burnett, A., & Peel, M. (2001). The health of survivors of torture and organised violence. *British Medical Journal*. 322 (7286) 606-609

Campbell, T. A. (2007). Psychological assessment, diagnosis, and treatment of torture survivors: a review. *Clinical psychology review*, *27* (5), 628-641.

Carlsson, J. M., Olsen, D. R., Mortensen, E. L., & Kastrup, M. (2006). Mental health and health-related quality of life: a 10-year follow-up of tortured refugees. *The Journal of nervous and mental disease*, *194* (10), 725-731.

Castonguay, L. G., Constantino, M. J., & Grosse Holtforth, M. (2006). The working alliance: where are we and where should we go? Psychotherapy 43, doi: 271–27910.1037/0033-3204.43.3.271

Carolan, M. T., Bagherinia, G., Juhari, R., Himelright, J., & Mouton-Sanders, M. (2002). Contemporary Muslim families: Research and practice. *Contemporary Family Therapy, 22*, 67-79. Doi: dx.doi.org/10.1023/A:1007770532624

Clancy, M. (2013). Is reflexivity the key to minimising problems of interpretation in phenomenological research?. *Nurse researcher*, *20* (6), 12-16.

Curling, P. (2005). The effectiveness of empowerment workshops with torture survivors. *Torture*, 15, 9-15.

de C Williams, A. C., & van der Merwe, J. (2013). The psychological impact of torture. *British Journal of Pain*, *7* (2), 101-106.

de Jong, J. (2004). Public mental health and culture: Disasters as a challenge to Western mental health care models, the self, and PTSD. In Wilson, J.P., & Drozdek, B (Eds.), Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims (pp. 159-178). New York, New York: Brunner-Routledge.

Douglas, A. (2010). Identities in transition: living as an asylum seeker. *Advances in Psychiatric Treatment*, *16* (4), 238-244.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of post-traumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.

Ekblad, S., & Jaranson, J.M. (2004). Psychosocial rehabilitation. In Wilson, J.P., & Drozdek, B (Eds.), Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims (pp. 609-636). New York: Brunner-Routledge.

Elsass, P., Carlsson, J., Jespersen, K., & Phuntsok, K. (2009). Questioning Western assessment of trauma among Tibetan torture survivors: A quantitative assessment study with comments from Buddhist Lamas. *Torture, 19*, 194-203.

Fabri, M. R. (2001). Reconstructing safety: Adjustments to the therapeutic frame in

the treatment of survivors of political torture. *Professional Psychology: Research and Practice, 30*, 452-457.

Fernando, S. (2010). *Mental health, race and culture*. Palgrave Macmillan.

Gehart, D. R., & Lyle, R. R. (2001). Client Experience of Gender in Therapeutic Relationships: An Interpretive Ethnography. *Family process*, *40* (4), 443-458.

Gerritsen, A. A., Bramsen, I., Devillé, W., Van Willigen, L. H., Hovens, J. E., & Van Der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social psychiatry and psychiatric epidemiology*, *41* (1), 18-26.

Gilkinson, L. J. (2009). *An Interpretative Phenomenological of Refugees‟ Experiences of Psychological Therapy for Trauma* (Doctoral dissertation, University of Hertfordshire).

Gonzalez, J. M., Alegria, M., & Prihoda, T. J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults?. *Journal of Community Psychology*, *33* (5), 611-629.

Good, G. E., Thomson, D. A., & Brathwaite, A. D. (2005). Men and therapy: Critical concepts, theoretical frameworks, and research recommendations. *Journal of clinical psychology*, *61*(6), 699-711.

Gorman, W. (2001). Refugee survivors of torture: Trauma and treatment. *Professional Psychology: Research and Practice*, *32* (5), 443.

Greenberg, L. S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of clinical psychology*, *62* (5), 611-630.

Grey, N., & Young, K. (2008). Cognitive behaviour therapy with refugees and asylum seekers experiencing traumatic stress symptoms. *Behavioural and Cognitive Psychotherapy*, *36* (01), 3-19.

Herman, J. L. (1992). *Trauma and recovery*. NY: Basic Books.

Isakson, B. L., & Jurkovic, G. J. (2013). Healing After Torture The Role of Moving On. *Qualitative health research*, *23* (6), 749-761.

Jaranson, J. M., Kinzie, J. D., Friedman, M., Ortiz, S. D., Friedman, M. J., Southwick, S., & Mollica, R. (2001). Assessment, diagnosis, and intervention. In *The mental health consequences of torture* (pp. 249-275). Springer US.

Larkin, M., & Thompson, A. R. (2012). *Interpretative phenomenological analysis in mental health and psychotherapy research.* Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners, 99-116.

Lie, B. (2002). A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavica, 106,* 415-425.

Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Mirdal, G. M., Ryding, E., & Essendrop Sondej, M. (2012). Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, *85* (4), 436-455.

Misra, T., Connolly, A. M., & Majeed, A. (2006). Addressing mental health needs of asylum seekers and refugees in a London Borough: epidemiological and user perspectives. *Primary Health Care Research and Development*, *7*(03), 241-248.

Mollica, R. F., McInnes, K., Pham, T., Fawzi, M. C. S., Murphy, E., & Lin, L. (1998). The dose effect relationships between torture and psychiatric symptoms in Vietnamese ex-political detainees and a comparison group. *Journal of Nervous and Mental Disease, 186*, 543-553.

Murray, C. D., & Wynne, J. (2001). Researching community, work and family with an interpreter. *Community, Work & Family*, *4* (2), 157-171.

National Institute for Clinical Excellence (2005). NICE: Post Traumatic Stress Disorder. The Management of PTSD in adults and children in primary care and secondary care. National Clinical Practice Guideline number 26.

Norcross J. C. (2002). *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients.* New York: Oxford University Press

Patel, N., Kellezi, B., & Williams, A. C. D. C. (2014). Psychological, social and welfare interventions for psychological health and well-being of torture survivors. *The Cochrane Library*.

Patel, N., & Granville-Chapman, C. (2010). *Clinical guidelines for the health assessment and documentation of torture***.** London: Medical Foundation with the Department of Health (UK)

Patel, N., & Mahtani, A. (2007). The politics of working with refugee survivors of torture. *Psychologist*, *20* (3), 164-166.

Pettitt, J. (2013). The right to rehabilitate for survivors of torture in the UK. Retrieved 2015, from http://www.freedomfromtorture.org/sites/default/files/documents/Poverty report FINAL a4 web.pdf

Quiroga, J., & Jaranson, J. M. (2005). Politically-motivated torture and its survivors. *Torture*, *15*, 2-3.

Raskin, J. D. (2002). Constructivism in psychology: Personal construct psychology, radical constructivism, and social constructionism. *American communication journal*, *5* (3), 1-25.

Ryan, D. A., Benson, C. A., & Dooley, B. A. (2008). Psychological distress and the asylum process: a longitudinal study of forced migrants in Ireland. *The Journal of nervous and mental disease*, *196* (1), 37-45.

Saechao, F., Sharrock, S., Reicherter, D., Livingston, J. D., Aylward, A., Whisnant, J., Koopman, C., & Kohli, S. (2012). Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. *Community mental health journal*, *48* (1), 98-106.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. *The Journal of nervous and mental disease*, *187* (4), 200-207.

Silove, D. (2004). The global challenge of asylum. In Wilson J.P., & Drozdek, B (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. 13-31). New York: Brunner-Routledge.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, research, practice*. London: Sage

Smith, J.A., & Osborn, M (2008). *Interpretative Phenomenological Analysis*. In: Smith, J., Qualitative Psychology: A practical guide to research methods (pp. 53-80).

Tribe, R. (1999). Bridging the gap or damming the flow? Some observations on using interpreters/bicultural workers when working with refugee clients, many of whom have been tortured. *British Journal of Medical Psychology*, *72* (4), 567-576.

Turkovic, S., Hovens, J.E., & Gregurek, R. (2004). Strengthening psychological health in war victims and refugees. In J.P. Wilson & B. Drozdek (Eds.), Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims (pp. 221-243). New York: Brunner-Routledge.

Turner, S. (2000). Psychiatric help for survivors of torture. *Advances in Psychiatric Treatment*. 6. 295-303. DOI:10.1192/apt.6.4.295

Turner, S. W., & Gorst-Unsworth, C. (1990). Psychological sequelae of torture: a descriptive model. *British Journal of Psychiatry, 157*, 475–480.

Turpin, G., Barley, V., Neail, N., Scaife, J., Slade, P., Smith, J.A & Walsh, S (1997). Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum, 108,* 3-7.

Twinn, S. (1997). An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *Journal of advanced nursing*, *26*(2), 418-423.

United Nations (UN). (1995). Convention against torture and other cruel, inhuman or degrading treatment or punishment.10 December 1984. In Human Rights 1945 – 1995. Blue book series. Volume VII: Documents. (pp. 294-300). Geneva: United Nations.

Vincent, F., Jenkins, H., Larkin, M., & Clohessy, S. (2013). Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: a qualitative study. *Behavioural and cognitive psychotherapy*, *41*(05), 579-593.

Vogel, D., Wade, N., & Hackler, A. (2007). Perceived public stigma and the willingness to seek counselling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*, 40-50. Doi: dx.doi.org/10.1037/0022-0167.54.1.40

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine*, *52*(11), 1709-1718.

Williams, A. C. D. C., & van der Merwe, J. (2013). The psychological impact of torture. *British journal of pain*. *7*(2), 101-106.

III. PUBLIC DOMAIN PAPER

Experiences of psychological therapy: Perspectives from male Iranian Survivors of torture.

This document provides an overview of the literature review and research paper that was submitted as part of the requirements for the degree of Doctorate in Clinical Psychology at the University of Birmingham. There are two sections to the research.

SYSTEMATIC REVIEW:

AIM: The first section is a literature review, which explored the effectiveness of culturally adapted cognitive behavioural therapy (CA-CBT) and the specific adaptations made to CBT. **METHOD:** Ten journal article databases were searched for academic literature that was published between 2003 and 2014. Studies that reported on effectiveness of treatment and had adapted least one CBT component, which was not solely focussed on adapting verbal or written language were included in the review. **RESULTS:** The review comprised of twenty-four studies and included a range of psychological presenting problems and diverse cultures. The results suggested that CA-CBT was effective at reducing psychological distress across different presenting problems and diverse cultural populations. However there were mixed findings the long-term effectiveness of CA-CBT. Adaptations to CBT were made once the participants' family values, cultural beliefs of physical symptoms and their spirituality/religion were explored. The cultural adaptations to CBT included relaxation and visualisation techniques, cognitive interventions, which focussed on physical symptoms and the inclusion of family to support participants with behavioural interventions.

DISCUSSION: Further research in this field is warranted, as there are limited empirical studies exploring the effectiveness of CA-CBT. In particular there is limited research comparing CA-CBT to CBT to explore whether cultural adaptations are more effective than CBT. The implication of the study offers guidance for clinicians in moving towards delivering culturally competent CBT to diverse cultural groups.

RESEARCH PROJECT:

AIM: The second section is the research project, which explored the experiences psychological therapy, from the perspective of male Iranian survivors of torture. **METHOD:** Seven men were invited to the take part in the study by their treating therapist from a specialist rehabilitation service for survivors of torture. Participants were interviewed about their experiences of therapy. The interviews were analysed using Interpretative Phenomenological Analysis (IPA), which explores the meanings of the interviewed accounts, to better understand the experiences from the perspective of the individual.

RESULTS: Following the analysis of the data, four main themes emerged. The first theme '*Vulnerability, loss and uncontrolled distress*' focussed on how participants experienced their lives following the trauma of torture and before they came to see their therapist. This included feeling vulnerable, experiencing uncontrolled feelings of distress, the losses of identity and relationships with family and society. The second theme ***'****Exposing vulnerabilities and developing trust'* focussed on the journey of 'opening up' their distressing feelings and the experiences of developing a trusting relationship with their therapist. '*Experiencing security and connectedness'* was the third theme highlighting participants'

experiences of the therapeutic relationship and the benefits of therapy. Finally *'Regaining resilience through control but fearing the loss connectedness*' focussed on participants' feelings of a hopeful future and becoming more in control of their feelings of distress to reconnect with their former self. There was also a fear of losing therapeutic support and becoming vulnerable again.

DISCUSSION: The outcomes were linked to existing research on client-therapist relationships and the sense of feeling 'broken' and threatened following the experience of torture. The slow and gradual development of trust building between participants and therapist was required for participants to feel 'safe' to disclose their vulnerabilities and traumatic experiences. Participants highlighted that they valued how their therapist made them feel of 'existence' through listening and understanding them; in comparison to the acts of torture which made them feel 'dehumanised'. In addition participants experienced that the role of the therapist enabled the development of trust, safety and advocated for the participants at a time when they were most vulnerable. Some participants made reference to feeling more 'comfortable' about disclosing their emotions to a female therapist compared to a male therapist due to their pre-conceived beliefs that male therapists may 'judge' them, and the stigma around expressing emotions. Participants had a strong connection of companionship with their therapist whereby they did not feel alone. Some struggled to feel in control of their distressing feelings outside of therapy and feared that they may be unable to manage without the support of the therapist. Whereas other participants reported to feel more hopeful for the future and felt that they were reconnected with their life again.

IMPLICATIONS: The implication of this research project offers valuable insight into the lived experiences of survivors of torture whilst being in psychological therapy. The outcomes from the current research suggested that survivors of torture may require long-term specialist services to help develop a trusting therapeutic relationship which is the basis for most therapies, but is particularly important within this population given their shattered sense of trust in others and the world. The outcomes from the study could be used to develop clinician's understanding of the therapeutic processes for this population to better support survivors of torture. This may include planned endings to therapy in helping to develop a sense of relational supports which participants experienced losing. These may be from other agencies or community groups to help reduce the sense of vulnerability. Further research is warranted to gain a further understanding of how survivors of torture manage distress outside of therapy, as it appeared that some participants were unable to implement their own sense of control. Training professionals within mainstream mental health services would be beneficial to highlight the complex presentation of this population group and the diverse supports that are required from the clinician and other statutory and non-statutory services. Given the current economical climate of national health services, one wonders whether it would be feasible to offer diverse long-term supports to survivors of torture. Therefore the need for specialised rehabilitation services are essential to ensure that survivors of torture receive an adequate rehabilitation package and do not remain vulnerable and alone in society.

Appendix 1: Adapted Quality Assessment Tool

	Quantitative Research	Yes/Partially/ Can't Tell/No
TRUTH VALUE (Internal Validity)	Extraneous/confounding variables identified? OR Baseline differences controlled for in the analysis?	
	Statement about comparability group treated equally to aside from intervention	
	Ethics: Ethical review undertaken? Confidentiality protected?	
	RCTs Only: Was an attempt made to blind *study participants* to the intervention? Was an attempt made to blind *researchers* measuring the outcomes of the intervention? Description of random allocation? Description of concealment?	
APPLICABILITY (External validity/ generalisability)	Description of intervention (if appropriate)	
	Outcome measures defined	
	Assessment of outcome blinded	
	Description of setting/conditions under which data collected	
	Design explicitly stated	
	Sample randomly selected (*n/a for non-randomised trials)*	
	Description of: -Subject recruitment/sampling -Inclusion & exclusion criteria for participant selection -Study population -Source of participants -Control/comparison group -Non-respondents -Missing data -Data gathering procedures -Data collection instruments or source of data -Drop-outs -Limitations to the study -Participant losses at follow-up	
	Power calculation to assess adequacy of sample size/sample size calculated for adequate power	
	Statistical procedures referenced or described	
	P values stated	
	Confidence intervals given for main results	
	At least one hypothesis stated	
	Both statistical and clinical significance acknowledged	

	Quantitative Research	Yes/Partially/Can't Tell/No
CONSISTENCY (Reliability)	Do the findings of the study map onto the proposed hypothesis of the study? **Standardisation of observers described:** -Is the study standardised to the proposed population? -Are the measures used reliable? -Was there fidelity of the treatment/intervention? -Are the results reported accurately? ***Notes:***	
NEUTRALITY (Objectivity)	**Standardisation of observers described:** -Were significant and non-significant results reported? -Are the limitations to the study explained? -Are any biases observed? ***Notes:***	

	Qualitative Research	Yes/partially/Can't tell/No
TRUTH VALUE (Credibility)	**Description of Triangulation:** -Of sources -Of methods -Of investigators -Theory/perspective	
	Are the findings meaningful?	
	Ethics: -Informed consent -Ethical review/human subject review -Statement of confidentiality -Consent procedures described	
	Peer debriefing	
	Use of quotations	
APPLICABILITY (Transferability/ fittingness)	Rationale for use of qualitative methods/case study methods	
	Sampling: -Procedure described -Justification/rationale for sampling strategy	
	Clear Description of: -Study and context -Participants -Data gathering procedures -Field note procedures -Data analysis -Raw data -Limitations to the study	
	Case Studies: If there is a formulation is it supported by assessment data/linked to wider theory or literature? If there is an intervention, is it clearly described & appropriate? Is the conceptual framework for the research explicitly described? Does the study suggest if & how findings could be transferable to other settings? Does the report identify questions or issues for future research?	

CONSISTENCY (Dependability) How plausible is the process	External audit process **Triangulation of investigators/researchers (***through the triangulation did the different people involved in the analysis highly agree in the results or did they disagree? If they disagreed, how did they resolve their differences in opinion/interpretation?***)** *In addition to Case studies:* *-Reliability of measures and assessment information.* ***Notes:***	
NEUTRALITY (Reflexivity)	External audit of data and reconstructions of data	
	Bracketing *(mitigate effects of preconceptions that may taint research process)*	
	Statement of researcher's assumptions/statement of researchers perspective	
	In addition to CASE STUDIES (unless otherwise stated): -Has the role of the researcher and relationship to the participant clearly described? -Is there evidence that any bias is taken into account when performing data analysis? ***Notes:***	

Appendix 2: Quality Assessment Ratings

INDIVIDUAL INTERVENTIONS (n=17)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Year	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of the Paper**
Bennett et al., (2009)	**	***	***	****	Description of adaptations to therapy. Clear rationale for use of measures and statistical analysis.	Intervention delivered by the primary researcher (potential source of bias). Treatment fidelity not reported. Unclear inclusion/exclusion criteria	***
Byrant et al., (2011)	**	****	***	***	Clear description of methodology and treatment protocol.	Formal supervision was not offered to the therapists during the trial. Therefore the fidelity of the intervention could be questioned as this was not being monitored. Can't tell if blinding of the researchers measuring outcomes. No description of concealment.	***
Fujisawa et al., (2010)	***	****	****	****	Ensured treatment fidelity by fortnightly supervision Clear description of methodology and non-completers (and intention to treat analysis conducted). Inter-rater reliability of measures with this population.	The outcome measures were not blinded to the therapists (could have led to bias from the therapist? Author reports on this). Therapist effect, usual therapist offered CA-CBT. Pre-existing therapeutic relationship. Large effect size however could have been due to lack of control group. Self-report measure may have been bias of improvement.	***

INDIVIDUAL INTERVENTIONS (n=17)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Year	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of the Paper**
Gonzalez-Prendes et al., (2011)	**	****	***	**	Very clear description of the study including referencing throughout to explain the evidence base for the clinical decisions made. Gives explanations as to why results can not be generalised but what to keep in mind within this cultural group. Measures were reliable and valid to the intended population.	No mention of ethics/informed consent/confidentiality. No statement of whether there was any subjectivity or bias to the outcomes.	***
Habib et al., (2014)	***	***	***	***	Clear description of intervention and control group and the intervention offered. Flexibility offered to how therapists met the participant's needs.	Analysis of outcomes were not done blindly. No description of concealment. Unclear on whether there were any drop-outs. Study states that anyone who attended less than 8 session were considered as drop outs, however unclear on whether this data was included or excluded from the results. Reported that the measures used were not standardised to the local population.	***
Hinton et al., (2004)	**	***	**	***	Main core elements of the intervention described. Extraneous variables were identified which included	This pilot study does not explain how participants were identified and how participants were randomly assigned. Same individual provided the treatment,	**

INDIVIDUAL INTERVENTIONS (n=17)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Year	Truth Value	Applicability	Consistency	Neutrality	Strengths	Limitations	Overall Quality of the Paper
					medication. Baseline differences controlled for. Limitation of therapist effects were reported on among other limitations of the study.	potential therapist effect (has been highlighted in limitations. No inclusion/exclusion criteria included. Intervention delivered by lead author and Social workers/other team members interpreted the sessions (therapist effect?) Ethics not reported on, and whether consent was gathered particularly with the interpreter's involvement. All participants had SSRI medication-unclear whether the improved scores were due to the intervention or a combination with medication treatment. Delay group was offered TAU of supportive counselling.	
Hinton et al., (2005)	***	***	***	**	Main core elements of treatment intervention described. Detailed methodology of the study.	Treatment conducted by the same therapist and there was no supervision given to assess treatment fidelity. Unclear on what the 'supportive counselling' entailed. No description of concealment No power calculation, no explanation of respondents/non-respondents.	***
Hinton et al., (2006a)	**	**	**	**	Outcome measures were blinded from the researcher although not an RCT.	No explanation how the participants were selected. No clear inclusion/exclusion criteria. Limitations of potential therapist effect	**

INDIVIDUAL INTERVENTIONS (n=17)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Year	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of the Paper**
					Detailed description of intervention.	reported. No report on treatment fidelity -States that there were significant improvements in scores but no detail of how this was calculated (not statistically significant). Reports on individual score changes per participant. Could have perhaps conducted autocorrelations. Unclear why staggered study designs were implemented.	
Hinton et al., (2006b)	*	**	**	**	Details of culturally adapted intervention described.	Statistical analysis involved means & Standard deviation to illustrate significant drop in scores given however due to small sample size. uncertain of reliability of results No advanced statistics completed e.g. autocorrelations/bootstrapping. Unclear on how the participants were selected. No report on the length of sessions. Treatment fidelity not reported/or report of therapist effect. No report of potential confounding variables. Unclear why the staggered study designs was implemented.	**
Interian et al., (2006)	*	***	***	***	The study reports on the limitations of the study including treatment fidelity,	Explains about using ethnocultural assessment but does not go into detail on what this entails.	***

INDIVIDUAL INTERVENTIONS (n=17)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Year	Truth Value	Applicability	Consistency	Neutrality	Strengths	Limitations	Overall Quality of the Paper
					small sample size and no control group to test for spontaneous recovery. Good analysis of results and description. Report both clinical and statistical significance.	Baseline difference not controlled. Measures were not culturally sensitive. Dropouts from treatment (n=4) & follow-up (n=6). Intention to treat analysis conducted however. No report of ethics/confidentiality. Outcomes were not blinded by the treating therapist but were reported in the paper. Potential therapist effect.	
McIndoo & Hopko (2014)	**	***	****	*	Generalisable to clinical practice as was given to a typical co-morbid presentation. Detailed statistical analysis and how this is applicable to clinical practice. Reports limitations to the study.	No reflexivity and stance of therapist. Unclear if during supervision there was adherence to the treatment model. Therefore there could be a negative impact on the quality of the paper. Ethics and confidentiality not reported on.	**
Naeem et al., (2011)	***	****	****	****	Well detailed pilot study and operationalized well. Thorough explanation of the method and treatment fidelity. Detailed description of adaptations to therapy and was reliable to the proposed population.	Did not report on concealment of randomisation. Unclear whether participants were blinded to the intervention. No power calculation to assess sample size.	***

INDIVIDUAL INTERVENTIONS (n=17)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Year	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of the Paper**
Naeem et al., (2014)	***	****	****	***	Well-described and well-executed study. Measures validated for the intended population.	Minimal limitations reported. Supervision was offered but unclear about the fidelity of treatment. No description of concealment.	***
Rathod et al., (2013)	***	****	***	***	The study is applicable to the target population and the adaptions were reported from a previous study. Very detailed description of intervention and could be replicated. Baseline differences controlled for at baseline.	The TAU widely varied and in terms of intervention this may not have been controlled for. Concealment of randomisation not reported. Does not report whether interpreters were used (suggested that this was offered) and if so any protocol/reliability with their interpreting? Measures not validated to the population therefore the outcomes should be viewed with caution.	***
Simoni et al., (2013)	***	****	****	****	Justified the study and explained how this could be implemented and replicated sufficiently again. Through treatment fidelity and use of back translation.	Reported a small sample size and can not account or statistical. significance but clinical significance. This study would have got an 'excellent rating' however due to the outcome measures not being validated to the intended population. It is unclear to ascertain whether the quality of the conclusions is accurate.	***

INDIVIDUAL INTERVENTIONS (n=17)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Year	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of the Paper**
Weingarden et al., (2011)	**	***	***	*	In depth description of intervention to see how this was adapted for the participant. Reports of confounding variables and that this could not be controlled for. Linked to the evidence base of the literature to support intervention and outcomes.	Unclear how participants were chosen. Unclear on what the therapist's stance was. Qualitative feedback from the participant was given though this was not done independently but reported to the treating therapist (bias?). No description of ethics.	**
Weiss et al., (2011)	**	**	*		Clear description of intervention and measures were reliable. Links to evidence based literature to explain rationale of intervention. Case conceptualisations given.	No limitations or potential bias reported. Role of researcher or relationship with participant not reported. No explanation of how the participant was chosen.	*

GROUP INTERVENTIONS (n=7)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Study Type	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of Paper**
Aguilera et al., (2010)		*			Describes the benefits of group therapy and the gains of group cohesion. Reports of the importance of understanding cultural values for ethnicities.	No truth value. A rolling program so participants could join the group at any point of the program. Authors claim that the measures may not be measuring the improvement of symptoms. This might be of bias a perhaps the measures were but there was no change. There was qualitative feedback but informally gathered. No limitations to the study were provided. Participants did not complete measures therefore no outcomes reported. Discussion mainly explores recommendations of how computerised technology could be used in the future.	Very poor quality
Hinton et al., (2009)	***	***	**	***	The researchers were blinded to assessment, outcomes and treatment conditions.	Reports on clinical significance but not from a psychological/therapeutic perspective. Measure for emotional regulation was created that had face validity but not inter-rater reliability. No mention of treatment fidelity. No description of concealment. Therapist effect, the treatment was led by author of paper. No report of treatment fidelity.	***
Hinton et al.,	***	***	***	***	Explained that applicability of the study and could be	No statement of how the participants were randomly selected.	***

GROUP INTERVENTIONS (n=7)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Study Type	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of Paper**
(2011)					replicated. Authors report on the limitations of therapy and potential biases to outcomes.	The nervios Scale was created for the study and was shown to have good inter-rater reliability however done with 20 participants-may need further validity/reliability exploration. No report on the implications of delivering in a group format. Control was a treatment group therefore unable to ascertain what were the effective components of treatment.	
Hovey et al., (2014)	*	**	**	***	Reported on procedures of translating and back translating outcome measures. Limitations and potential biases reported on.	No specific treatment protocol described.No control group or comparison group to identify effectiveness of the intervention. Small sample size (n=6) with 2 drop-outs at follow-up. Due to small sample size perhaps the results could not be generalised.	**
Otto et al., (2003)	**	*	**	*	Measures validated to the Khmer population. The aim of the study was to measure effect sizes of the population.	Although a pilot study limited details were given of the procedure and method. It is unclear how participants were recruited, if they were blinded to the study, and how they were randomly assigned. Unclear who conducted the treatment, and for how long No report of drop outs. No limitations reported, treatment fidelity. Clinical significance was not reported.	*

GROUP INTERVENTIONS (n=7)							
	Sub-Categories from Quality Assessment Tool				Evaluation		
Author & Study Type	**Truth Value**	**Applicability**	**Consistency**	**Neutrality**	**Strengths**	**Limitations**	**Overall Quality of Paper**
Penado et al., (2007)	**	***	***	***	Thorough process described of how the measures were validated. Limitations to the study reported. Baseline differences controlled for at baseline. Drop-out rates and intention to treat analysis was conducted appropriately (22% GCBT; 25% control group).	No report on treatment fidelity or whether supervision was provided to ensure no bias. Small sample size although the results were statistically supported.	***
Wong (2008)	**	***	***	****	Good discussion points on whether the group effects were a factor for improved scores and future recommendations for research to explore. Statistical procedures described. Clinical and statistical outcomes reported.	The C-BDI was standardised for Chinese culture but had only been validated with a small sample size. Could impact the validity of the results. No clear description of how participants were randomised/concealment or whether the researchers were blinded to the outcome measures.	***

Quality rating	Quality rating definition
****	All of the criteria within the category have been fulfilled, and are **very unlikely** to impact on the quality or overall conclusions of the study.
***	Most of the criteria have been fulfilled. Criteria that have not been fulfilled are thought **very unlikely** to impact on the quality or overall conclusions of the study.
**	Some of the criteria have been fulfilled. Criteria that have not been fulfilled or not adequately described are thought **unlikely** to impact on the quality or overall conclusions of the study.
*	Few criteria were fulfilled. The unfulfilled criteria are thought **likely** to have an impact on the quality or overall conclusions of the study.
	No criteria were fulfilled and are likely to have an impact on the quality and overall conclusions of the study.

Adapted from NICE (2012)

Appendix 3: Advertising for Recruitment

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DClinPsy Thesis Project: How do male survivors of torture experience psychological therapy?

WHY? I am interested in exploring whether there are any similarities or differences in the experience of engaging in psychological therapy from the perspective of men who have experienced torture. This research is particularly important as there is very limited research in this area, which can aid in shaping future treatment for survivors of torture.

WHO? I am currently looking for male participants from Iran, Iraq or Sri Lanka (>18 years old) to discuss their experiences of engaging in psychological therapy. Below are the inclusion and exclusion criteria for the study:

INCLUSION	**EXCLUSION**
Participants who have had substantial sessions of therapy or have completed therapy Participants who are able to reflect on the process of therapy	Participants who show a level of risk to self and others
Male Participants >18 years of age	Participants who are not in a *stable* condition and have a high risk of becoming re-traumatised through the interview process of the study
Initially 6 men from Iran (If this can not be met then a mix of 10 Sri Lankan and/or Iraqi men)	
English and non-English speaking participants (an interpreter shall be provided if needed).	

WHAT WILL HAPPEN? If you currently have or have had clients who meet the above criteria and they are interested in participating then please forward their contact details to myself (Neena Ramful email: **XXXX**), or Dr Sobia Khan who is my clinical supervisor for this project (**XXXX**).

Participants will be invited to meet with me initially to discuss the study and answer any questions. If they are happy to proceed I will arrange a meeting to conduct the interview. The interviews will be conducted at the Freedom from Torture centre. The interview be audio-recorded and will remain confidential and anonymous. The interview will last for 1 hour without an interpreter and 1.5 hours with an interpreter, and I will ask a series of questions about their experience of therapy. Participants have the right to withdraw from the interview at any time without any reason. Once participants have completed the interview they have two weeks to

withdraw, without giving any reason. As per the system at Freedom From Torture, participants will be receive a public transport travel card to participate in the study.

Appendix 4: Participant information Form

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Participant Information Sheet

Title of Project: How do male survivors of torture make sense of psychological therapy?
Researcher: Neena Ramful
Clinical Supervisor: Dr Sobia Khan

What is the purpose of this research?

The purpose of this study is to explore how men who have experienced torture understand their psychological therapy. A maximum of 10 participants who have experienced torture will take part in the study.

Why have I been invited to take part?

We would like to take the opportunity to meet with you to talk about how you have experienced therapy.

What will happen to me if I agree to take part?

You will be invited to meet with the researcher (Neena Ramful) at the Freedom From Torture Centre and we will meet for up to 1 hour (1.5 hours if an interpreter is needed). The researcher will ask you some questions about your experiences of engaging in therapy. The meeting will be audio-recorded but it will be kept confidential. This means that the recording will be kept secure on a password protected memory stick. No identifiable information will be used in the study.
As this is a research study, the researcher will not directly provide you with therapy for your rehabilitation or be able to help you with any legal matters. If you require support with these please contact your allocated therapist or your solicitor.

What will happen if I do not want to carry on with the study?

Participation in this study is voluntary, and you have the right to change your mind even if you initially agree to participate. If you decided to not carry on with the study at any point before, during or two weeks after our meeting, please inform the researcher or Clinical Supervisor (Dr Sobia Khan). You do not have to give us a reason for leaving the study. By not participating in the study you and your family member's healthcare and legal rights will not be affected.

Risks

The interviews are not intended to be upsetting or distressing. However in taking part in the interview, it is possible that you may become upset or distressed from some of the information we discuss. If you do become upset or distressed during the meeting then you can decide on whether you would like to continue with the

interview. If you do not want to answer some of the questions asked in the meeting you have the right to refuse. We can arrange for you to meet with a therapist from Freedom From Torture, if you wish to discuss how you are feeling.
As when you engaged in therapy at the centre, should you report that you are a risk to yourself or others we will need to let your therapist and other third parties know. However, we will let you know this before going through this procedure. If you do disclose any criminal acts performed by others then this will not be taken further by the researcher. Should you wish to discuss this further then please contact your solicitor or your therapist for advice.

Expenses and payments

You will be paid travel expenses to come to Freedom from Torture for our meeting.

What will happen to the results of the research study?

The recording from the meeting will be transcribed and some quotes may be used in the write up on the study-these will not be identifiable and will remain anonymous. As part of the Doctoral Thesis, the results will be published and accessible at the Birmingham University library and online.
In the results of the study your contribution will be anonymised. Any identifiable information will be removed or changed. Apart from your demographic information and the recording from the meeting no other information will be gathered.

If you would like to have feedback of the results after the completion of data collection please tick here ☐

What happens if I have any further concerns?

If you would like to speak to the researcher, Neena Ramful directly please call **XXXX**
Alternatively if you would like to speak with the Clinical supervisor Dr Sobia Khan please call **XXXX**.

Appendix 5: Consent Form

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Consent Form

Research site: Freedom from Torture (Birmingham)
Title of Project: 'How do male survivors of torture make sense of psychological therapy?'
Researcher: Neena Ramful
On-site Supervisor: Dr Sobia Khan
Participant Identification Number:

Please tick box

Neena Ramful has explained the study and what it involves	☐
I confirm that I have understood the Participant Information Sheet for the above study.	☐
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I consent to the presence of an interpreter during the research process (if applicable).	☐
I understand that my participation is voluntary and that I am free to withdraw from the study at *any time during* the research interview, without giving any reason, without my own or my loved one's medical/social care or legal rights being affected.	☐
I understand that the research interview will be audio-recorded and transcribed and this information will be kept secure and anonymous.	☐
I understand that after the research interview I will have up to two-weeks to withdraw from the study. I understand that I can either contact the Researcher or the Freedom from Torture Centre at which point I may withdraw my interview entirely or in part, without giving any reason, without my own or my loved one's medical/social care or legal rights being affected.	☐
I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.	☐
I understand that if I disclose any risk to myself or others then parts of the information gathered at the interview may be made available to third parties.	☐

I understand that direct quotes from my interview may be published in any write-up of the data. My name will not be linked to any quotes and I will not be identifiable by my comments. ☐

I agree to take part in the above study by signing this consent form and giving audio-recorded consent. ☐

.....	.....	.....
Name of participant (IN BLOCK LETTERS)	Date	Signature

Neena Ramful	.....
Name of researcher	Date Signature

Appendix 6: Demographic Information

Demographic Information

1) **How old are you?**
2) **Which country were you born in?**
3) **What level of education do you have?**
4) **How long have/had you been in therapy for?**
5) **How long have you been in the UK?**
6) **What is your asylum status?**
7) **How old were you when you initially experienced torture?**
8) **Before engaging in therapy with Freedom from Torture, had you engaged in therapy prior to this?**

Appendix 7: Interview Schedule

PREVIOUS THERAPY

1. **Before you started seeing your therapist in [x] what problems were you experiencing?**
    a. How did you make sense of these problems at the time?
    b. How did you come to see a therapist in [x]?
    c. Can you tell me more about that?
2. **Before you started therapy…What did you hope therapy would be like? Fears?**
    a. What did you think the therapist was going to be like?
    b. What did you think your therapist would do?
    c. What did you think therapy would be like?
    d. Where do you think those beliefs came from?
3. **What was therapy like in [x]?**
    a. Did therapy meet your hopes? Worries/surprises
    b. What was it like to talk about your feelings?
4. **What was your relationship with your therapist like?**
5. **When you completed therapy how did you make sense of that process?**
    a. In what ways was therapy helpful/unhelpful?
    b. What changes had you noticed at the end of therapy?
6. **Is there anything else you would like to add about your previous therapy?**

A: BEFORE THERAPY:

1) **Before you started seeing [therapist], what problems were you experiencing?**
    a. Can you tell me more about this?
    b. What did you think was happening?
    c. What sense did you make of it at the time?
2) **Why did you engage in therapy?**
3) **What were your initial expectations of therapy? (What were your hopes for therapy?)**
    a. What did you think was going to happen?
    b. What did you think therapy was going to be like?
    c. What did you expect your therapist to be like?
    d. What did you think your therapist would do?

B: DURING THERAPY:

4) **Tell me about what happened in your first session**
    a. Were your initial expectations met?
    b. Or was it different to what you expected?
        i. (Is that what you thought might happen?)

ii. (What were your hopes for your first session?)

5) **When you first started therapy how did you feel about coming to talk about your feelings?**
    a. Can you tell me more about this?
    b. (What does it mean for you?)
6) **How did you feel about talking about your experiences to someone you did not know?**
7) **What was your relationship like with your therapist?**
8) **How did you feel about seeing a female therapist?**
    a. Can you think how it would have been like to have seen a male therapist?
    b. Where do you think that belief comes from?
    c. Why would it be difficult/easy to see a male therapist?
9) **Now that you have been seeing your therapist for some time now, how has the therapy developed?**
    a. How is life now?
    b. In what ways if any, do you think therapy has helped with that?
    c. Has there been times when therapy has been challenging?
        i. Can you tell me more about that?
        ii. What do you think could have been done differently?
10) **What made you continue with therapy?**

C: AFTER THERAPY:

11) **How would you advise someone who is seeking psychological support?**
    a. What would you tell them to expect?

Appendix 8: Participant Debriefing Information

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Debriefing Information sheet to Participants

Title of Project: How do male survivors of torture experience of psychological therapy? **Researcher:** Neena Ramful **Clinical Supervisor:** Dr Sobia Khan

The purpose of the study

This study explored how men who had experienced torture in the past understood the process of engaging in therapy. We are interested in exploring a number of areas. In particular we are interested in:

- What it was like to engage in therapy given your gender, culture and past experiences.
- Seeing how you found the concept of engaging in therapy in the UK, a place where psychological therapy in now on the increase.
- Whether there are any similarities or differences in your responses compared to the other participants that we interviewed.

It is hoped that this research will give clinicians information and guidance into how they can best support male survivors of torture, when delivering therapy. By offering a personal voice to your experiences of therapy, it is also hoped that other men from the same or maybe even different cultural backgrounds can access this research if they are unsure about engaging in therapy.

What happens now?

The information that you gave will be kept anonymous and confidential. The audio-recordings will be listened to by the researcher who will type up the interview. This anonymous typed version will be read by the three supervisors (Michael Larkin, Ruth Butterworth and Sobia Khan). This information will help us to understand your experiences and to look for any similarities or differences in the responses gathered.

The research will then be written up as part of the researcher's doctoral thesis and for publication. The research will also be used for teaching and training purposes. For these some quotes will be used from the recordings; however there will be no identifiable information to link you personally to these quotes.

If you have any concerns?

After the interview, should you feel distressed and wished to talk to someone, you may call **XXXX**. You can either speak with the therapist that you saw at the centre for therapy, or you may speak with **XXXX** who is a **XXXX** at **XXXX**. Alternatively you can contact your GP (if you are registered with a GP) or attend Accident & Emergency if you wish to speak with someone.

If you have any further questions about the study you may contact either:

- Neena Ramful (Lead Researcher) on **XXXX** (please leave a message with the administrator).
- Dr Michael Larkin at University of Birmingham **XXXX**

Thank you again for your participation in the study.

Appendix 9: Examples of the stages of analysis

Example of initial coding for interview 4

Initial Noting	Transcript Excerpt	Objects of concern
Pain Healing Positive Less distressed Benefits from therapy Sense of identity Control Learning/understanding Acceptance Future Engagement	The experience is like going to the doctor, you know you are going to have an injection, you know it is going to hurt but it's the thought of.. after the injection its going to be a healing process and you're going to get better. I was coming here and I was talking to my counselor and I was getting a lot of vibes that I knew just coming out and talking about my experience its painful but it fine if you're getting the positive vibes from here I was sure all the way back home it's help me come to terms and it was sort of calming me down eventually. I felt that that was the reason why I was coming to these sessions. Victims of torture, people like myself that constantly thinking through the negative thoughts of being tortured and everything else that its generated in my mind. When I come here talking to somebody else it help me to come to terms with these experiences that they had it's a healing process its understanding and just accepting it in a way that its helped me to move on and I wanted to come more and more	**Preparing for therapy** -Expectations -Trust in therapist **Vulnerabilities to disclosing torture** -Short term pain -Medicalised? -two sided pain/good vibes **After talking** -healing process -Improvements -a sense of progress & reflection on improvements? **Vulnerabilities** -New sense of identity? -lack of control of traumatic thoughts **Therapy** -sense of control through understanding repetitive thoughts? -supported process of acceptance -continued engagement **Control** -not feeling stuck with thoughts? -seeing a future

Extract from the table of codes for interview 4

Object of Concern	**Codes**
Therapy	Painful (L: 70, 124, 128) Pain & peace (L: 124, 126. 70) Healing process (L:76, 62, 54) Progress & setbacks (L: 144, 116, 130) Sense of agency (L:88, 94, 24, 52, 66,) Moving forwards (L: 46, 72, 75, 78) Resistance to change (L: 64)
Vulnerabilities	Repetitive distressing thoughts (L:20) Sense of self/identity (L: 48, 122, 130) Vulnerability of problems (L: 29, 46) Lack of control of distress (L: 18, 72, 22) Weakness (L: 48, 80)

Extract from the table of clusters/emerging themes for all interviews:

Experiencing Therapy as painful/uncomfortable	"You remember all those moments, you remember everything, everything becomes fresh and its especially difficult in the session" (Belaal, Line 64) "The more I talk about what happened to the more its going to hurt me" (Nadim, Line 20) **"**She opened up the wound she opened up the whole thing and gradually she dealt with every little every…you know..every little piece and helped me to open up about it and talk about it" (Nadim, Line 193) "She could penetrate to your hot button and get information out." (Hafaaz, Line 151) "When you understand more, you become less afraid…. before I didn't know I was a bit nervous" (Afzal, Line 65) "..Some made me feel very uncomfortable that made me uptight and anxious again". (Wassim, Line 128) "…Those are the sort of things that you know is hurting you the cause of your problems..and sometimes…its not as comfortable to talk about it as freely" (Heba, Line, 128)
Lack of controlling Distress	"These thoughts were always with me you know before and after you know I was experiencing those sort of thoughts." (Heba, Line 20) "You feel so light and it's like your spirit is flying from your body out" (Belaal, Line 5) "When I first came I was disorientated I was confused, I was helpless, hopeless" (Afzal, Line 56) "Before I came to see [therapist] everytime I had errm.. a vision or thought about my experience and and the past err…it was kind of worrying me" (Hafaaz, Line 68)

Emerging Themes

Fear of trusting others	Transition from being guarded to trusting
Trust being Mutual	Regaining Control
Developed Trust and safety in (therapist, therapy & service)	Transition from pain to comfort
Fear of ending/relapse	Distress visible/Help-seeking through others
Connectedness vs loneliness	Loss of identity and new sense of self
Vulnerability to problems & lack of controlling distress	Beliefs and Hopes from therapy
Experiencing therapy being painful/uncomfortable	Therapy being gradual & guided
Determining whether to trust	Humanising
Regaining sense of self	Building of trust through evidence
Fear of judgement, showing weakness & shame	Offloading' release of distress

Extract from the table of clustering themes & superordinate themes

SUPERORDINATE THEME	THEMES	EXAMPLES OF EXTRACTS
Exposing Vulnerabilities and developing trust	Fear of trusting	*"I wasn't able to talk about that person with other people and even if you want to open the information again they will arrest you and again there is big problem". (Belaal, Line 69)* "Sometimes there's something in there that you want to talk to someone about it but you don't want to" (*Heba, Line* 128).
	Determining whether to trust	*"I am considering the person in front of me to see what type of person is that" (Belaal; Line 30)* "Sometimes you have to look through people and you could to see she meant to help you and she's she trying to help" (*Hafaaz, Line* 96)
	Fear of judgement, Showing weakness & shame	*"Discussing this with other people I just let them think that I'm weak and not able..you know managing my activities." (Hafaaz, Line 28)* *"I was reluctant to talk about it was because of that stigma that that something bad has happened to me"* (Afzal, Line *42)*
	Transition from being guarded to trusting	"So I was protected about what I say and what I do, but gradually I got to know [therapist] and I was able to sort of offload" (Hafaaz, Line 84) "*Gradually I started sort of believing that they are trying to help me" (Wassim, Line* 47)
	Building of trust through evidence	"*First thing [therapist] did was by contacting homeoffice and let them know that what I was going through the situation with my wife and for myself and that was important to me that somebody is actually doing something"*

		(Nadim, Line 110) "*She is putting lots of energy and effort to support you and then gives you better feeling and making better trust of her"* (Belaal, Line 54)
	Humanising	*"Somebody knows about me, somebody cares about me"* (Nadim, Line 115) *"When you know that someone cares and its sometimes when [therapist] is kind to me and I cry" (Afzal, Line 93)*
	Experiencing therapy being painful/uncomfortable	*"You remember all those moments, you remember everything, everything becomes fresh and its especially difficult in the session"* (Belaal, Line 64) *"..Some made me feel very uncomfortable that made me uptight and anxious again".* (Wassim, Line 128)
	Transition from pain to comfort	*"I felt comfortable after a while you know that the more I talk I said you know its making me feel more comfortable" (Wassim, Line 150)* *"I started trusting her. And helped me to open up and tell me about my other problems"* (Hafaaz, Line 112) *"My understanding was the comfort she was giving me. I was feeling at peace"* (Hafaaz, Line 135)
Experiencing security and connectedness	Therapy being gradual & guided	*"I just explained the very basic things that I experienced"* (Afzal, Line 36)
	Trust being Mutual	*"I trust her and she trusts me. She's got that belief in me and I've got that belief in her"* (Nadim, Line 178) *"We need a good relationship between client and psychologist and be able to work together and to become efficient and effective" (Khalil, Line* 75)
	Developed Trust and	*"The fact that I was able to trust*

	safety	*somebody and speak my mind just telling about what was going on in my mind was a big thing for me" (Nadim, Line* 196) *"Trust her and comfortable to come out with my experience and thoughts I could share my thoughts, I could ask her anything, I could tell her anything"* (Heba, Line 112)
	‘Offloading’ release of distress (Cathartic)	*"She was just removing the problems she reduces the pressure on me." (Nadim, Line 105)* *"Every time that I spent time with [therapist] I felt good. Probably because I was pouring out what I had inside." (Hafaaz, Line 40)*
	Connectedness vs loneliness	*“I leave here I have to go to my lonely place again on my own and I just can’t escape going back to my thoughts and you know some of the things I’m trying to get rid of.” (Nadim, Line 141)* *“In Iran I had my wife my parents, but here I’ve got nobody. I leave this surgery here and I’m straight back into my flat my place and I’m on my own”* (Nadim, Line 141) *“And when I was alone when I was alone in my own room I started a new experience here and something I told myself what am I doing here?”* (Khalil, Line 66)

Super-ordinate themes

Vulnerability, loss and uncontrolled distress	Vulnerability to problems & lack of controlling distress
	Loss of identity and new sense of self
	Distress visible/Help-seeking through others
	Beliefs and Hopes from therapy
Exposing Vulnerabilities and developing trust	Fear of trusting
	Determining whether to trust
	Fear of judgement, Showing weakness & shame
	Transition from being guarded to trusting
	Building of trust through evidence
	Humanising
	Experiencing therapy being painful/uncomfortable
	Transition from pain to comfort
Experiencing security and connectedness	Therapy being gradual & guided
	Trust being Mutual
	Developed Trust and safety
	'Offloading' release of distress (Cathartic)
	Connectedness vs loneliness
Regaining resilience through control, but fearing the loss of connectedness	Fear of ending therapy and support
	Regaining Control
	Regaining sense of self

Appendix 10: University of Birmingham Ethics Approval

Dear Dr Larkin and Dr Butterworth

Re: "How do male survivors of torture make sense of engaging in psychological therapy?"
Application for Ethical Review ERN_13-1346

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I can confirm the conditions of approval for the study have been met and this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly bought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards

Research Ethics Officer Research Support Group

Appendix 11: Guidelines for authors Clinical Psychology Review

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Appendix 12: Guidelines for Authors Transcultural Psychiatry

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