

**The Influence of Language and Culture on Improving  
Access to Psychological Therapy (IAPT) for Pakistani,  
Somali, and Yemeni Patients in Sheffield: Spiritual Beliefs  
and Emotions**

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## Contents

<b>GLOSSARY</b>	<b>XII</b>
<b>ABSTRACT</b>	<b>I</b>
<b>1. INTRODUCTION</b>	<b>1</b>
1.1 Study Justification and Reflection on My Experience	3
1.2 Rationale of the Study	5
1.3 Research Question and Sub Questions	7
1.4 Outline of the Thesis	9
<b>CHAPTER TWO</b>	<b>12</b>
<b>BACKGROUND TO IAPT SERVICE</b>	<b>12</b>
2.0 Introduction	12
2.1 Background to Improving Access to Psychological Therapy (IAPT)	12
2.2 What Does Therapy Mean?	15
2.2.1 What is CBT?	15
2.2.2 What is Counselling?	16
2.3 Sheffield City as Culturally Diverse City	17
2.3.1 Background to the Influx of Immigrants from Pakistani, Somali and Yemeni Groups to Sheffield	18
2.3.2 The Similarities That Bring These Groups Together	19
<b>CHAPTER THREE</b>	<b>21</b>
<b>THE ROLE OF LANGUAGE AND CULTURE IN THERAPEUTIC INTERVENTION</b>	<b>21</b>
3.0 Introduction	21
3.1 The Concept of Mental Health	21
3.1.1 The Concept of Mental Health in the Western and Islamic Worlds	22
3.1.2 Summary	25
3.2 Definitions of Language and Discourse	26

3.2.1	Language as a Means of Communication	27
<b>3.3</b>	<b>Communication Difficulties</b>	<b>32</b>
3.3.1	Translation and Interpretation in Therapeutic Encounters	32
3.3.2	Communication of Emotional Expressions in Therapy	38
3.3.3	Non-Verbal Communication	39
3.3.4	Language and Power Relations between Therapists and Patients	41
3.3.5	Meeting Patients' Needs within IAPT Service	44
<b>3.4</b>	<b>Definitions of Culture</b>	<b>46</b>
<b>3.5</b>	<b>Culture in Therapy</b>	<b>47</b>
3.5.1	Religious Beliefs	49
3.5.2	Cultural Beliefs and Norms	52
3.5.3	Family Values	53
3.5.4	Perceived Similarity between Patients and Therapists	55
3.5.5	Patient-Therapist Relationship	56
3.5.6	Perception of Therapy	57
<b>3.6</b>	<b>Researching Patients' Encounters vs. Patient-centred Research</b>	<b>58</b>
<b>3.7</b>	<b>What is learnt from Previous Research and the Direction of this Study</b>	<b>67</b>
<b>3.8</b>	<b>Summary</b>	<b>71</b>
	<b>CHAPTER FOUR</b>	<b>74</b>
	<b>METHODOLOGY</b>	<b>74</b>
<b>4.0</b>	<b>Introduction</b>	<b>74</b>
<b>4.1</b>	<b>Philosophical Underpinning of the Research</b>	<b>74</b>
<b>4.2</b>	<b>Reasons for Using Qualitative Research Methods</b>	<b>76</b>
<b>4.3</b>	<b>Challenges Encountered in Conducting this Research</b>	<b>77</b>
4.3.1	Researcher's Positionality and Reflexivity	79
<b>4.4</b>	<b>Research Design</b>	<b>84</b>
<b>4.5</b>	<b>Research Methodology</b>	<b>84</b>
4.5.1	Setting and Participants Characteristics	84
4.5.2	Research Ethics	87
4.5.3	Piloting Information and Informed Consent Forms	88
<b>4.6</b>	<b>Research Methods/Tools</b>	<b>92</b>

4.6.1	Questionnaire	92
4.6.2	Participant Observation	98
4.6.3	In-depth Semi-structured Interviews	105
<b>4.7</b>	<b>Validity and Trustworthiness</b>	<b>119</b>
<b>4.8</b>	<b>Summary</b>	<b>121</b>
<b>CHAPTER FIVE</b>		<b>122</b>
<b>OVERVIEW RESULTS FROM RESEARCH TOOLS AND DATA COLLECTION METHODS</b>		<b>122</b>
<b>5.0</b>	<b>Introduction</b>	<b>122</b>
<b>5.1</b>	<b>Data Collection Timeline</b>	<b>122</b>
<b>5.2</b>	<b>Questionnaire Distribution Context and Initial Findings</b>	<b>125</b>
<b>5.3</b>	<b>Participant Observation</b>	<b>127</b>
<b>5.4</b>	<b>Semi-Structured Interviews</b>	<b>134</b>
<b>5.5</b>	<b>Pre-theme verses Post-theme Findings from Research Methods</b>	<b>143</b>
<b>5.6</b>	<b>Explanation and Justification for the Selection of the Cases Presented in the Subsequent Chapters</b>	<b>144</b>
<b>5.7</b>	<b>Summary</b>	<b>145</b>
<b>CHAPTER SIX</b>		<b>147</b>
<b>PERCEPTIONS AND BELIEFS ABOUT THERAPY</b>		<b>147</b>
<b>6.0</b>	<b>Introduction</b>	<b>147</b>
<b>6.1</b>	<b>Articulation of Therapy</b>	<b>147</b>
6.1.1	What is Therapy	147
6.1.2	Confidentiality	148
6.1.3	Perception of Talking Therapy	149
6.1.4	Sources of Help	152
6.1.5	Expectation of Therapy – What Therapy can do	155
<b>6.2</b>	<b>Stages of Therapy</b>	<b>158</b>
6.2.1	Assessment Stage	158
6.2.2	Administration of the Patient Health Questionnaire	159

6.2.3	Therapeutic Tasks and Challenges	161
6.2.4	Therapeutic Approaches	166
6.2.5	Case 1: Implementation of the Online Computerised Programme:	170
<b>6.3</b>	<b>Summary</b>	<b>173</b>
<b>CHAPTER SEVEN</b>		<b>175</b>
<b>CULTURAL AND RELIGIOUS BELIEFS</b>		<b>175</b>
<b>7.0</b>	<b>INTRODUCTION</b>	<b>175</b>
<b>7.1</b>	<b>Cultural Beliefs and Perceptions Surrounding Seeking Help</b>	<b>175</b>
7.1.1	PSY Groups Perception of the Term ' <i>Depression</i> '	179
7.1.2	The Misunderstanding between Cultural Beliefs and Religious Values and their Influences on the Access to Therapy	183
7.1.3	Cultural/Ethnic Match: Advantages and Disadvantages	188
7.1.4	Therapists' Cultural Understanding	194
7.1.5	Case 2: Implications of Therapists' Cultural Understanding	196
7.1.6	Case 3: Implications of Therapists' Cultural Understanding	202
<b>7.2</b>	<b>The Role of Religion in Therapy</b>	<b>206</b>
7.2.1	Religion and Emotional Well-being	206
7.2.2	The Influences of Religious Beliefs on Patients' Access to Therapy	208
7.2.3	Participants' Religious Beliefs and Practices and Their Influences on Access to Therapy	214
7.2.4	Case 4: Implications of Therapist's Religious Understanding on Access to Therapy	221
<b>7.3</b>	<b>Summary</b>	<b>225</b>
<b>CHAPTER EIGHT</b>		<b>227</b>
<b>COMMUNICATING EMOTIONS IN THERAPEUTIC ENCOUNTERS</b>		<b>227</b>
<b>8.0</b>	<b>INTRODUCTION</b>	<b>227</b>
<b>8.1</b>	<b>Language as a Tool of Communication in Therapeutic Settings</b>	<b>228</b>
8.1.1	Language and the Description of Physical Symptoms	228
8.1.2	The Expression of Emotions through Paralanguage and Non-verbal Communication	230
8.1.3	Emotional Expressions and their Meanings	235
8.1.4	Communication of Emotion and the Development of Identity	241

<b>8.2</b>	<b>Language Facilitating or Suppressing the Communication of Emotions</b>	<b>245</b>
8.2.1	Language Brings People Together	245
8.2.2	Language Pulls People Apart	246
8.2.3	Language as an Expression of Power	249
<b>8.3</b>	<b>Barriers in the Communication of Emotions</b>	<b>252</b>
8.3.1	English as a Second Language (ESL) and the Limited Knowledge of Vocabulary	252
8.3.2	The Use of Code- Switching	258
8.3.3	Borrowed Words	260
8.3.4	The Role of Interpreters in Therapeutic Encounters	265
<b>8.4</b>	<b>Summary</b>	<b>280</b>
	<b>CHAPTER NINE</b>	<b>282</b>
	<b>DISCUSSION</b>	<b>282</b>
<b>9.0</b>	<b>INTRODUCTION</b>	<b>282</b>
<b>9.1</b>	<b>Research Question 1</b>	<b>282</b>
	<i><b>How do PSY Patients Articulate their Understanding of IAPT?</b></i>	<b>282</b>
9.1.1	Participants' Definition of Therapy	282
9.1.2	Sources of Help	284
9.1.3	Perceptions and Attitudes towards Seeking Help	285
<b>9.2</b>	<b>Research Question 2</b>	<b>288</b>
	<i><b>How do PSY Patients Articulate their Emotions?</b></i>	<b>288</b>
<b>9.3</b>	<b>Research Question 3</b>	<b>292</b>
	<i><b>Do PSY Participants Feel that Language and Cultural Issues Impact on their Experiences of Therapy, and if so, How?</b></i>	<b>292</b>
9.3.1	Language as Influencing the Communication of Emotions	292
9.3.2	Cultural and Religious Beliefs	298
<b>9.4</b>	<b>Research Question 4</b>	<b>301</b>
	<i><b>Do PSY Patients Feel their Emotions are Being Explored by Therapists, and if so, How?</b></i>	<b>301</b>
<b>9.5</b>	<b>Summary</b>	<b>304</b>

<b>CHAPTER TEN</b>	<b>306</b>
<b>CONCLUSION</b>	<b>306</b>
<b>10.0 INTRODUCTION</b>	<b>306</b>
<b>10.1 Key Findings</b>	<b>306</b>
10.1.1 Perception of Therapy	306
10.1.2 The Communication of Emotions and the Complex Relationship between Language and Culture	307
10.1.3 Understanding Cultural and Religious Beliefs and the Integration of Religious Practices as a Source of Help	308
10.1.4 Language as a Barrier for Effective Communication of Emotions	308
<b>10.2 The Implications of the Current Study</b>	<b>308</b>
10.2.1 Language and Intercultural Communication Studies	309
10.2.2 Multilingual Research	309
10.2.3 Teaching and Training Programmes for Therapists Working with PSY Groups	311
10.2.4 Translation and Interpreting Teaching Programmes	312
10.2.5 Policymakers and Decision-Makers	313
<b>10.3 Strengths and Limitations of the Study</b>	<b>314</b>
<b>10.4 Recommendations</b>	<b>315</b>
<b>10.6 Opportunities for Further Research</b>	<b>317</b>
<b>10.7 Conclusion</b>	<b>317</b>
<b>REFERENCES</b>	<b>319</b>
<b>APPENDIX 1</b>	<b>353</b>
<b>QUESTIONNAIRE</b>	<b>353</b>
<b>APPENDIX 2</b>	<b>354</b>
<b>What to Observe during Participant’s Observation</b>	<b>354</b>
<b>APPENDIX 3</b>	<b>357</b>
<b>Observed Sessions – Participant’s Consent Form</b>	<b>357</b>

<b>APPENDIX 4</b>	<b>358</b>
<b>Interview Topic Guide</b>	<b>358</b>
<b>APPENDIX 6</b>	<b>362</b>
<b>Role of GP</b>	<b>362</b>
<b>APPENDIX 7</b>	<b>363</b>
<b>Check List of Documents Sent with First REC Application</b>	<b>363</b>
<b>APPENDIX 8</b>	<b>365</b>
<b>First letter from REC</b>	<b>365</b>
<b>APPENDIX 9</b>	<b>368</b>
<b>Check List of Documents Sent with Second REC Application</b>	<b>368</b>
<b>APPENDIX 10</b>	<b>371</b>
<b>Approval Letter from REC</b>	<b>371</b>
<b>APPENDIX 11</b>	<b>372</b>
<b>Patient Health Questionnaire</b>	<b>372</b>
<b>APPENDIX 12</b>	<b>373</b>
<b>EXAMPLE OF PARTICIPANT OBSERVATION ANALYSIS</b>	<b>373</b>
	<b>375</b>
<b>APPENDIX 13</b>	<b>377</b>
<b>Examples from my Reflective Dairy of Work as an Interpreter and as a Mental Health Worker</b>	<b>377</b>
<b>APPENDIX 14</b>	<b>380</b>
<b>Example of Initial Coding of Questionnaire Data</b>	<b>380</b>
<b>APPENDIX 15</b>	<b>381</b>



<b>Semi-Structure Interviews Coding Using Nvivo Nodes</b>	<b>381</b>
<b>APPENDIX 16</b>	<b>383</b>
<b>Example of Initial Interview Coding- Extracts from Noor's Interview</b>	<b>383</b>

## List of Tables

Table 1 Planning Matrix of the Study.....	85
Table 2 Bryman's Questionnaire Design Techniques (2004) .....	92
Table 3 Research Questions Addressed by the Questionnaire .....	93
Table 4 Research Questions Addressed by Participant Observation .....	99
Table 5 Research Questions Addressed by Semi-Structured Interview .....	106
Table 6 Overview of Participants' Characteristics .....	111
Table 7 Transcription Rules to Ensure Consistency in Transcribing Interviews .	113
Table 8 Example of the Process Involved to Ensure Decision Making in Translation.....	115
Table 9 Example of Using Idioms which have Roots in the Original Culture .....	116
Table 10 Approach used in this Research to rule out Validity threat .....	120
Table 11 Data Collection Timeline.....	124
Table 12 Preview of Questionnaire Content Analysis' Findings .....	127
Table 13 Summary of Participant Observation Process and Findings.....	128
Table 14 List of Participant Observation Sessions Attended.....	130
Table 15 Participant Observation Background Information .....	133
Table 16 Interview Timeline and Setting .....	134
Table 17 Interviewee Background Information and Reason for attending Therapy .....	142
Table 18 Explanation and Justification for the Use of Particular Cases .....	145
Table 19 Religious Practices and Their Influence on Access to Therapy .....	215
Table 20 Mental Health as Crazy .....	236
Table 21 Articulations of Depression.....	237
Table 22 Feelings of Despair.....	237
Table 23 Acknowledging Experiences of Discomfort.....	238
Table 24 Difficulty Opening Up and Dealing with Psychological Wounds .....	239
Table 25 Spirituality and Emotions .....	240
Table 26 List of Arabic Words Used by Somali and Pakistani Participants .....	261

## List of Figures

Figure 1 Stepped care pathway for the IAPT service .....	14
Figure 2 Braun and Clarke (2006) Six Steps of Data Analysis Approach .....	97
Figure 3 Spradley's (1980) Main Dimensions of Research Observation .....	101
Figure 4 Study Process: Recruitment and Data Collection Stages.....	123
Figure 5 New Timeline for Data Collection Methods .....	125
Figure 6 Ratio of Males to Females in Research Collection Methods .....	131
Figure 7 Research Methods Pre-Themes .....	143
Figure 8 Research Methods Post Themes .....	143
Figure 9 Summary of Research Finding themes .....	146

## List of Abbreviations

BME	Black and Minority Ethnic
CBT	Cognitive Behavioural Therapy
ESL	English as a Second Language
IAPT	Improving Access to Psychological Therapy
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PHQ	Patient Health Questionnaire
PPI	Public Patient Involvement
PSY	Pakistani, Somali and Yemeni
PWP	Professional Wellbeing Practitioner
REC	Research Ethics Committee
SL	Source Language
ST	Source Text
TL	Target Language
TT	Target Text

## Glossary

The following Arabic transliteration system is used for Standard Arabic words:

### Transliteration System for Standard Arabic

Arabic letter	ا	ب	ت	ث	ج	ح	خ	د	ذ	ر	ز	س	ش	ص	ض	ظ	ع	غ	ف	ق	ك	ل	م	ن	ه	و	ي		
Trans-literation	ʾ	b	t	ṯ	J	ḥ	x	d	ḏ	R	z	s	š	ṣ	ḍ	ṭ	ḍ	ġ	f	q	k	l	m	n	h	w	y	ʾ	
	ā																									or	or		
	ā																										ū	ī	

### The Following is a list of all loan words used and their meanings

Word	Meaning
Allah	Arabic Word Meaning God
Arbaš	Out of control
Darood Sharif	Urdu word meaning blessing, prayers and praise sent to the Prophet Mohammed, peace and prayers be upon him
Daʿwa	Calling non-Muslims towards Allah and to enter in the religion of Islam which is the religion of all prophets. It also means to call all Muslims to remain firm with their religion and to abide with its commandments and to avoid all the prohibitions.
Ḍikr	Remembrance of Allah through praising Him and reading His book. In addition to the ritual acts of worship, it covers an array of activities of the tongue and heart. It involves thinking and making mention of Allah all the times and in every area of our lives. Muslims believe that by remembering Allah, Allah in return, will remember them, and the angels will surround them with mercy, and tranquility will cover and descend upon them. Ḍikr can be done when one is on one's own or when one is amongst a group of people.
Duʿa – Dua'	The act of supplication, calling out to God, communicating and conversing with the Creator, the knowing and the Powerful. It is one of the most powerful and effective act of worship a human being can engage in. It is the submission to God and a manifestation of a person's need to God.
Dwra Quran	The recitation of the whole Quran
Ḥajj	It is one of the five pillars of Islam. The greatest Muslim pilgrimage to Mecca which a Muslim is expected to carry out at least once during their lifetime.
Ḥalal	Permissible in accordance with the Islamic rules and regulations
Ḥaq mehr	Islam has made the determination and presenting of the dowry to the woman on marriage an absolute obligatory condition but Islam did not specify the amount of dowry to be presented. Rather. It should be agreed between the two parties.

<b>Word</b>	<b>Meaning</b>
Haram	Anything that is prohibited by the faith
Hiba	A gift
Hijab	Means barrier or partition but in Islam it has a broader meaning. It is the principle of modesty and includes behaviour as well as dress for both male and females. Here it means the visible head covering that many Muslim women wear.
Hirz	Refers to Quranic verses, ḍikr and narrated supplications that are recited in order to protect one's life
Imām	The person who leads prayers in a mosque and usually offers support to his fellow Muslims. He is also supposed to have undertaken certain training in Islamic thoughts
Iṣṭmad	Self-reliance is considered a virtue in Islam. The word also means a state of being completely dependent and having complete trust in God.
Kalima	Refers to the six significant parts of one's religious belief which are: word of purity 'there is none worthy of worship except Allah and Mohammed is the messenger of Allah, the word of testimony, the word of glorification, believing in the Unity of Allah, the words of forgiveness, the words of rejecting disbelief.
Madrasa	An Arabic word for any type of education but it is used by Urdu speakers to refer to a school where people go to learn about religious and Islamic teaching
Maqam	Related to a position that can be achieved by a person. It can also mean a physical place where a saint has revealed an occasional presence and then developed to be a shrine
Mašallah	An Arabic word to express appreciation, joy and thankfulness.
Mašgūl	Occupied, busy
Qadar	The concept of divine destiny in Islam and one of the main six articles of belief of faith. These are the belief in one God, the angles of God, the books of God especially the Quran, the prophets of God, Especially Mohammed, the day of Judgment, and the supremacy of God's Will .
Qiyam ul Layl	Spending the night or part of it performing a voluntary night prayer, reading Quran and remembering Allah. The best time for this prayer is usually the last third portion of the night. There is no maximum limit to the number of prayers one has to perform
Ramaḍan	The month where Muslims observe fasting from dawn until sunset
Ruqyah	Arabic word consisting of specific portion of Quran or contains a praise of Allah's words as an invocation of his help, protection or cure against the evil eye, black magic, touch of Satan and other ailments
Şaber	Endurance and persistence and the ability to be patient with life difficulty
Şadaqah	The voluntary giving and a sign of sincere faith in Islam for a good cause. It is not obligatory and it encompasses any act of charitable giving done out of compassion, love, friendship or

<b>Word</b>	<b>Meaning</b>
	generosity. It can be given to anyone and has no limits or guidelines
Sajdah	Kneeling in prayers but it demonstrates the act of humbleness in front of the creator of the world of worlds and shows gratitude to Allah in the form of prostration.
Ṣalat	The ritual prayers of Muslims performed five times daily and one of the pillars of Islam
Ṣayx (Sheikh)	A man respected for his religious learning
Ṣirk	The sin of worshipping anyone besides God which is considered a major sin
Skūn	Peacefulness or tranquility
Ṣufi	A lover of God. A person proves their love to God by constant remembering of Allah
Sunnah	The way of life which the Prophet - peace and prayers be upon him- taught the people in theory and practice and for which, in his capacity as a teacher of Islamic law, he laid down ideal standards of leading a life which one should meet to earn Allah's approval through complete submission to His Commandments. On the other hand, Hadith implies the narration of a saying or of an act of the Prophet peace and prayers be upon him, irrespective of if the matter is authenticated or still disputed and it is usually derived from Sunnah
Tajweed	The rules governing the way the Quran should be read during recitation
Tasbeeh	Form of ḍikr and remembrance of Allah
Tawakul	A Muslim's trust in Allah and the importance of accepting His will
Tawākul	The word indicates laziness and expecting Allah to take care of the person's affairs while they do nothing
Turjuman	Translator/interpreter
Walī	Derived from the Arabic word walī Allāh meaning friend of Allah. The lexical meaning of the word is supporter, guardian or protector.
Wuḍu	The ritual of cleansing the face and body organs that are always in contact with things before daily prayers. It is expected to give Muslims peace in heart and spiritual power in preparation for worshipping. Also, Muslims expect their sins to be washed away as they make wudu in preparation for worshipping.
Xutbā	The public preaching in Islam tradition which is performed during Friday's prayer
Zamzam water	A well located in Mecca near Kaʿba in Saudi Arabia and was miraculously generated from God. Many Muslims around the world believe. It is a blessed water and has curative effect
Ḥmrah – Umrah	An Islamic pilgrimage to Mecca which can take place any time during the year

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## **Abstract**

Improving Access to Psychological Therapy (IAPT) is an initiative implemented by the Department of Health in 2006 to achieve better health objectives for patients who suffer from depression and anxiety disorders. According to studies undertaken by the Department of Health and the National Institute of Health Research in 2009 and 2011, Black and Minority Ethnic (BME) populations face additional barriers involving language, culture or faith that prevent them from fully benefiting from psychological therapies. The current study was designed to expand the knowledge base and explore Pakistani, Somali and Yemeni (PSY) patients' articulations of therapy in the Sheffield area, in order to better understand the language and cultural challenges that they may face when accessing IAPT. An interpretive approach using qualitative data collection methods including questionnaire, direct observations and in-depth semi-structured interviews has been used in order to understand the meaning of the intercultural communication encounter. Each method has been planned to unfold specific dimensions of the research questions and generate different meanings and understanding of the phenomenon under study. The results were interpreted using content and thematic analysis. The present study shows variations in the groups' perceptions of therapy linked to the use of negative vocabularies which appeared to influence the attitudes towards seeking help. Additionally, the different communication methods used to express emotional feelings unfolded layers of cultural and religious beliefs that were not easily conveyed or translated in some cases. More importantly, religion was found to be an important source of help for PSY groups and represented a significant challenge for Non-Muslim therapists as they were often entangled with cultural views. Achieving successful communication with patients appears to involve engaging with their different perspectives and negotiating the making of meaning and language in context as well as reviewing positive practice guidelines in order to address the culturally specific issues outlined in the current study.

**Key Words:** IAPT – Communication – Emotions – Culture – Religion – language - Depression



# 1. Introduction

“Language, any language, has a dual character: it is both a means of communication and a carrier of culture”

Ngũgĩ (1986:13).

“Language, especially the mother tongue is not merely an instrument but it is a source of human pride and dignity. Everyone is entitled to the right to use the language(s), she/he chooses to speak and this right should be honoured in all forms of communication”

Tsuda, in Nakayama and Halualani (2010:261).

“Culture is the struggle over meaning... Culture is never merely a set of practices, technologies or message, objects whose meaning and identity can be guaranteed by their origin or their essence”

Grossberg (1997:157).

These quotes encapsulate the main purpose of this research where the focus is on understanding Pakistani, Somali, and Yemeni (PSY) patients’<sup>1</sup> narratives<sup>2</sup> to reveal important language and cultural issues when accessing psychological therapy (IAPT). Language forms the main medium through which patients express their emotional distress and convey their meanings, and through which therapists obtain and give information as well as deliver treatment. Yet, to provide therapeutic interventions that are effective and reflective of patients’ perspectives, both patients and therapists need to establish an understanding which is often communicated through the use of language.

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<sup>1</sup> According to the Royal College of Psychiatrists, a resolution in 2013 was reached to use the word ‘patient’ in all official documents since the word ‘patient’ emphasised the equality between mental and physical health condition. Available at: <https://www.independent.ie/life/health-wellbeing/healthy-eating/patient-service-user-or-client-whats-in-a-name-34904915.html>. For that reason, the term will be used throughout the thesis when referring to the literature review and participant observation.

<sup>2</sup> Refer to section 4.6.3.1 for explanation for the use of the term ‘narrative’ in this thesis

Language and cultural difficulties in therapeutic sessions often stem from the inability to translate one's emotional expressions in another language or in the difficulty of finding equivalent terms that are reflective of specific cultural meanings (Wierzbicka 2009). Of course, this can have a negative effect on access to therapy. The American Psychological Association (APA, 1990), the Department of Health (DoH, 2009), and the National Institute for Clinical Excellence guidelines (NICE, 2011) support this argument and acknowledge that language and culture including religious, spiritual, and world views are important considerations when working with Black & Minority Ethnic (BME) patients. The APA also approved certain guidelines in order to work effectively with diverse ethnic groups based on being respectful of BME peoples' cultural and spiritual beliefs and promoting sensitive consideration and flexibility of treatment when working cross-culturally in order to deliver good quality care.

Despite a growing interest in the importance of language and culture in the development and provision of mental health services for BME communities, little attention has been paid to the therapeutic encounter itself, the concept of culture or to 'language as a powerful vehicle for expressing emotions' as argued by many authors (Bhugra and Bhui, 1998; Guarnaccia and Rodriguez, 1996; Simich et al., 2009; Tribe, 2014). Simich et al. (2009) argue that cultural issues of BME communities are not taken seriously and insufficient attention is paid to the fact that these communities are influenced by the collective ethos, which tends to shape their interpretation of mental health problems. Tribe (2014) contends that the transfer of Western mental health models and the generalisation of them around the world can undermine other peoples' conception of mental health, and these models may not be able to account for cultural diversity. Failure to understand BME expressions of distress or their concepts of illness can mean that people from diverse minority and ethnic backgrounds will have limited choices or options available for seeking help.

It follows that having an in-depth understanding of the concept of culture and how it is conveyed through the use of language is important for the provision

of mental health services. Language is a powerful tool for expressing emotions, embedded within social and cultural contexts. In addition, there should be an acknowledgement of language issues encountered in therapeutic settings because they not only cause difficulties in translating the emotional experiences of patients, but can also elicit different meanings that are developed across languages and cultures. Therefore, the main focuses of this research will be on understanding PSY patients' articulations and emotional expressions when making cultural and religious inferences, and on how these expressions are conveyed through the use of language in IAPT sessions.

## **1.1 Study Justification and Reflection on My Experience**

My interest in this subject area started during my experience in transcultural mental health working with BME patients from diverse cultural and ethnic backgrounds. My suitability for this position centred on my language skills as an Arabic native speaker and a qualified interpreter/translator, where I came to value the importance of acquiring another language as means for communication. Alongside my language skills, I developed my cultural knowledge of the diverse BME groups by being actively involved in delivering 'Understanding of Equality and Diversity' training to hospital workers to ensure that the cultural needs of BME groups are understood. While working in the mental health field, I have come to realise some of the difficulties patients from BME backgrounds face when they access mental health services. One of these difficulties stems from the fact that many of these patients are unable to speak or communicate their distress using English as a second language. In addition, while the provision of interpreting services is intended to facilitate language and communication issues, patients often feel it is difficult to speak using a voice that is not their own and to describe their emotions in a language that is not easily translated. It can also mean that the interpreter will render the information into serviceable English words that are understandable to the worker but might leave the patient wondering whether it states exactly what he/she feels or wants to say. Moreover, even when

some patients can communicate using a few words in English, they often struggle to convey exactly the intended messages.

While the issues of language and culture are understandably complex, working as a transcultural mental health worker has equipped me with the desire to offer good quality services to patients who are unable to communicate the details of their mental health. Furthermore, it developed my interest in understanding how language operates and affects relationships in social settings. These topics were the ones I took up in a Master's (MA) dissertation where my focus was on identifying the language and cultural barriers facing health and social care professionals in mental health. However, I felt that I had only scratched the surface of these issues, and I was keen to explore patients' articulations of their experiences to provide an essential perspective to the testimonies of the health care professionals. Besides, the lack of culturally sensitive BME services (Bhui and Bhugra, 2004; Bhui, 2013; Kai and Hedges, 1999; Kareem and Littlewood, 1989; Keynejad, 2008) and resources for care and treatments, which are often built around Western approaches to health care (Lago, 2011; Lopez et al., 2014; Netto, 2006; Tribe, 2014) has developed my interest in increasing awareness of BME cultural views. Moreover, I want to expand the knowledge of the structural forms and meanings of language where the emphasis is on how language is used, in order to make therapeutic intervention appealing and convincing for BME patients.

This latter issue has been my main driver, motivating me to undertake a Doctorate in Philosophy (PhD) focusing on understanding language as being the main link to patient's thoughts and emotional experiences. Another reason is the fact that when I offer BME patients psychoeducation<sup>3</sup> - a key component of psychological therapy - they are often more able to understand the situation and deal with their distress properly. When exploring this issue further, I have noticed that BME patients have a poor understanding of the

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<sup>3</sup> Psychoeducation is an important component of any psychotherapy programme where the patient is given education about a certain condition or situation that causes psychological distress. The main goal is to educate patients and their carers by giving them information so they are able to understand more about the symptoms, causes and treatments enabling them to be more equipped to deal with the problem. (AIPC, 2014 available at: <http://www.aipc.net.au/articles/psychoeducation-definition-goals-and-methods/>)

concept of therapy and what it involves and are unwilling to engage with psychological therapies because of the challenges surrounding language and cultural perspectives. As an outsider, I felt that if I was to learn more about BME patients' experiences and gain an understanding of the language and cultural issues they may face when accessing psychological therapies, I could enable their voices to be heard and give them the opportunity to share their experiences. Meanwhile, I needed to listen to their accounts in order to learn and gain the understanding I need.

## **1.2 Rationale of the Study**

With the increasing number of BME immigrants and refugees to the UK who have left their home country either searching for better job opportunities or forced by political tensions and conflict, many have been confronted with emotional distress and the need to talk to someone about their suffering. One of the common causes of distress for migrants and refugees is the arrival to a new culture that is quite different from their own and having to adjust and go through the process of acculturation. As a minority group, they have to learn the new culture's practices and values as well as the new language patterns of the dominant group (Organista et al., 2010). The cultural differences and poor command of the new language can limit opportunities for socialisation and integration in the new society, thus furthering their suffering and impacting negatively on their mental health and wellbeing. Taking these issues into consideration, Sheffield Health Trust has realised the importance of meeting the mental health needs for these groups and has taken steps to improve their access to mental health services based on the current UK NICE guidelines (NICE, 2004, 2009, and 2011). This mainly consists of offering psychological therapies for a range of depression and anxiety disorders to help people from all communities understand the disorders and receive care and treatment promptly.

IAPT is a governmental initiative implemented in 2006 by the Department of Health based on disseminating cognitive behavioural therapy (CBT) and delivering evidence-based interventions to people who suffer from depression and anxiety disorders in primary care. The initiative intended to

achieve better health objectives by giving more attention and positive care to those who are experiencing mental health problems. The plan “No Health without Mental Health” focuses on the importance of mental health wellbeing provision as it will not only impact positively on the individual’s life but will also improve the outcomes for the nation as a whole. This plan is based on improving access to services, achieving improvements in clinical care and recovery, improving the economic situation through helping people come off sick pay and benefits, and finally, offering self-guided support which will increase patients’ satisfaction (DoH, 2011).

There have been many recent studies and researchers involved in evaluating the IAPT services to ensure that BME patients are having equal opportunities in accessing psychological intervention. One of the studies undertaken by the Department of Health in 2009 acknowledged that BME populations face additional barriers involving language and culture that prevent them from accessing psychological therapies (DH, 2009). Another study carried out by NHS North West addressed the specific concerns raised by the BME, Gypsy & Traveller, and the ageing population, and recognised the importance of building closer links between the IAPT services and community groups (University of Central Lancashire, 2009). Additional independent research was commissioned in 2011 to evaluate the IAPT service model in the demonstration sites<sup>4</sup> (Parry et al., 2011) and one of the recommendations of this research was to conduct further in-depth exploratory research of patients’ views to improve communication with patients. Also, it highlighted the need to have more responsive and flexible psychological wellbeing practitioners who are able to tailor the IAPT programme to accommodate the patients’ needs (Parry et al., 2011).

Given the diversity of cultural backgrounds and the breadth of language issues, additional research took place to explore the benefits of psychological therapies for BME groups. This research has highlighted the difficulties BME individuals often encounter when expressing themselves using a different

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<sup>4</sup> IAPT service was initiated in 2006. The first phase of the programme was established and demonstrated in two sites: Doncaster and Newham. This was mainly to increase the availability of psychological therapies for those who need it and evaluate the outcomes of the service provision

language, pointing out how this can restrict their abilities to fully express their feelings and emotions (Bhui and Bhugra, 2004; Bhui, 2013; Costa and Dewale, 2012; Eleftheriadou, 2010; Miller et al., 2005; Pavlenko, 2006;). Similarly, other scholars have drawn attention to the importance of addressing the complexity of culture when delivering psychological therapies as, not only can culture create an obstacle in understanding the different expressions used in therapy, but it can also impact on the patient-therapist relationship (Loewenthal et al., 2012; Loon et al., 2013; Lopez, 2013; Rathod and Kingdon, 2009; Springer et al., 2011). Yet, little is known about the BME patients' perspectives regarding the understanding and access of IAPT services or how to improve their engagement through the provision of culturally appropriate treatment.

### **1.3 Research Question and Sub Questions**

As demonstrated in the introduction, previous research has identified that the concept of mental health may manifest differently in different cultures and language differences can affect the expression of emotions in therapeutic encounters. This thesis contributes to understanding the cultural experiences of mental health and studies language-use in therapeutic settings by focusing on PSY patients' perspectives of IAPT. In particular, the study aims at understanding how cultural and religious beliefs may influence therapeutic encounters and prevent patients from fully benefiting from these psychological therapies.

A central focus in all therapeutic work is to understand patients' emotions. Some work has already been undertaken to understand the relationship between language, culture and emotions, such as understanding the challenges bilinguals may face during the process of translation to express their emotions or find equivalences to their cultural beliefs (Pavlenko, 2006). Also, Weirzbicka (1999) pointed out that if we use only one language to express emotional concepts, then we are lessening the broader range of emotions which can be articulated in different ways across languages and cultures. Moreover, the process of conceptualising mental health is commonly grounded in Western biomedical models (Tribe, 2014). The basis

of such approaches leaves little space for alternative explanations of the mind/body relationship, or supernatural influences, for example. Individuals coming from different cultural traditions may understand the concept of mental health differently and their reactions to mental distress may be culturally dependent, as they are often dependent on past experiences, which took place elsewhere, or within a family with a different cultural heritage, and/or where a language other than English is spoken. On top of this, mental health therapy requires patients to communicate their emotions, often in a state of distress, to therapists who may not share their idea of therapy, and who patients feel has not shared their experiences, which may have led to their mental health state (see Section 3.7)

Consequently, it is clear from these examples that language and culture play a key role in understanding patients' emotions in therapeutic encounters (see Section 3.3.2), and the aim of this thesis is to offer a more holistic view of the perspective of PSY patients themselves. More importantly, this thesis seeks to understand how patients experience the role of language and culture can impact on their therapeutic encounter with the IAPT service, which the researcher argues later cannot be separated from the persons themselves and their social/cultural background. Thus, the study aims to address these issues by answering the following main research question:

**How do PSY patients articulate their experiences of IAPT with particular reference to culture and emotions?**

In order to address this question properly, the following sub-questions will need to be asked:

- **How do PSY patients articulate their understanding of IAPT?**
- **How do PSY patients articulate their emotions?**
- **Do PSY patients feel that language and cultural issues influence their experiences of therapy, and if so, how?**
- **Do PSY patients feel their emotions are being explored by therapists, and if so, how?**



The data that comes from PSY patients' narratives of how they articulate their emotions is hoped to contribute to a better understanding of the language-use and cultural issues that can influence the engagement with IAPT services for these groups. It is also hoped to encourage linguists involved in future research to focus from a linguistic/cultural perspective on the cultural dynamic of translation in the field of mental health in order to raise the profile of PSY communities and ease their integration into the wider society.

#### **1.4 Outline of the Thesis**

This thesis consists of ten main chapters including this introductory chapter. The reason behind this structure is that understanding patients' perspectives and how language and culture are related not only to the therapeutic process, but to patients' different backgrounds as well, requires necessarily longer pieces of explanation than some other theses. This thesis offers not only case studies to allow the reader to understand the whole person but also an overview of the result analysis process.

**Chapter Two** starts with some background about the IAPT service, the care pathway, and the definitions of the different therapeutic models used within the IAPT care pathway. The chapter concludes with the rationale for choosing the three ethnic groups (Pakistani, Somali, and Yemeni) in the city of Sheffield.

**Chapter Three** considers the key concepts of mental health, theoretical approaches to language and cultural studies, theories and approaches to translation and interpretation and the main communication difficulties involved in therapeutic intervention as understood in the research literature on mental health and beyond. It also explains the reason for the shift from researching patients' encounters, a term used by the researcher to make a distinction between research, which involves mental health professionals commenting on their practices and experiences, and patient-centred research. Patient-centred research focuses on understanding the patient's world, explore their views on the kind of care they receive, and how services should be developed to accommodate their health needs. This type of

research uses different approaches, such as interviews, focus group discussions, and questionnaire, story-telling and narrative approaches.

**Chapter Four** details the conceptual framework that informs the research design. This includes mapping out the data collection methods and the analytical procedures. Then, a discussion about the reasons for using qualitative research methods and the ethical issues involved in undertaking this research are described, followed by a reflection on the researcher's positionality and how this may influence the researcher's subjectivity in the research process. Next, a discussion, explanation, and justification of the choice of methods and what research question(s) each method is expected to answer is outlined. The chapter concludes with details on how the data is analysed, validated and presented.

**Chapter Five** overviews the types of data that are yielded from the different methods and summarises the data collection timeline clearly and logically. The chapter introduces six case studies before a discussion of themes and also includes a summary of participants' backgrounds and their reasons for accessing therapy. This is particularly important for the reader to understand the complex issues discussed in the interviews.

**Chapters Six, Seven and Eight** present the results of the research. Three main themes emerged from the data collection: perceptions of therapy, cultural and religious beliefs and communicating emotions in therapeutic encounters. Each of these is addressed in depth in each chapter, in which the focus is on analysing and evaluating the main themes and sub-themes that emerged from the data.

**Chapter Nine** addresses the four main research sub-questions based on the findings of the research. The chapter concludes with a summary of the research findings and the contribution it has in understanding the research problem.

**Chapter Ten** shows the complexity of this approach where patients' perspectives revealed layers of cultural and religious beliefs that were not easily conveyed or translated. Achieving successful communication with

patients appears to involve engaging with their perspectives and thus, the research recommends reviewing positive practice guidelines to address the culturally specific issues outlined in the study.

## **Chapter Two**

### **Background to IAPT Service**

#### **2.0 Introduction**

This chapter starts with background information on IAPT and the stepped care pathway to the service. In keeping with the interest of this research, the discussion begins with the meaning of therapy and a definition of both Cognitive Behavioural Therapy (CBT) and Counselling, which are the main types of therapy offered by the IAPT service. The terms will be explained to assist the reader in understanding what psychological treatments involve and how language and cultural issues can impact on the delivery of the service. Next, a detailed justification for choosing the Pakistani, Somali and Yemeni (PSY) groups in the Sheffield area will be given. This will mainly focus on the cultural and social background of these groups and the characteristics they have in common.

#### **2.1 Background to Improving Access to Psychological Therapy (IAPT)**

In 2006, the National Institute for Health and Clinical Excellence (NICE), within the Department of Health, recognised the importance of counselling and psychological intervention in preventing the deterioration of mental illnesses and improving health and wellbeing (NICE, 2009). Subsequently, they introduced a new initiative – Improving Access to Psychological Therapy (IAPT) – to address the limited availability of psychological therapies and to improve their access to people who suffer from depression and anxiety disorders (DoH, 2011).

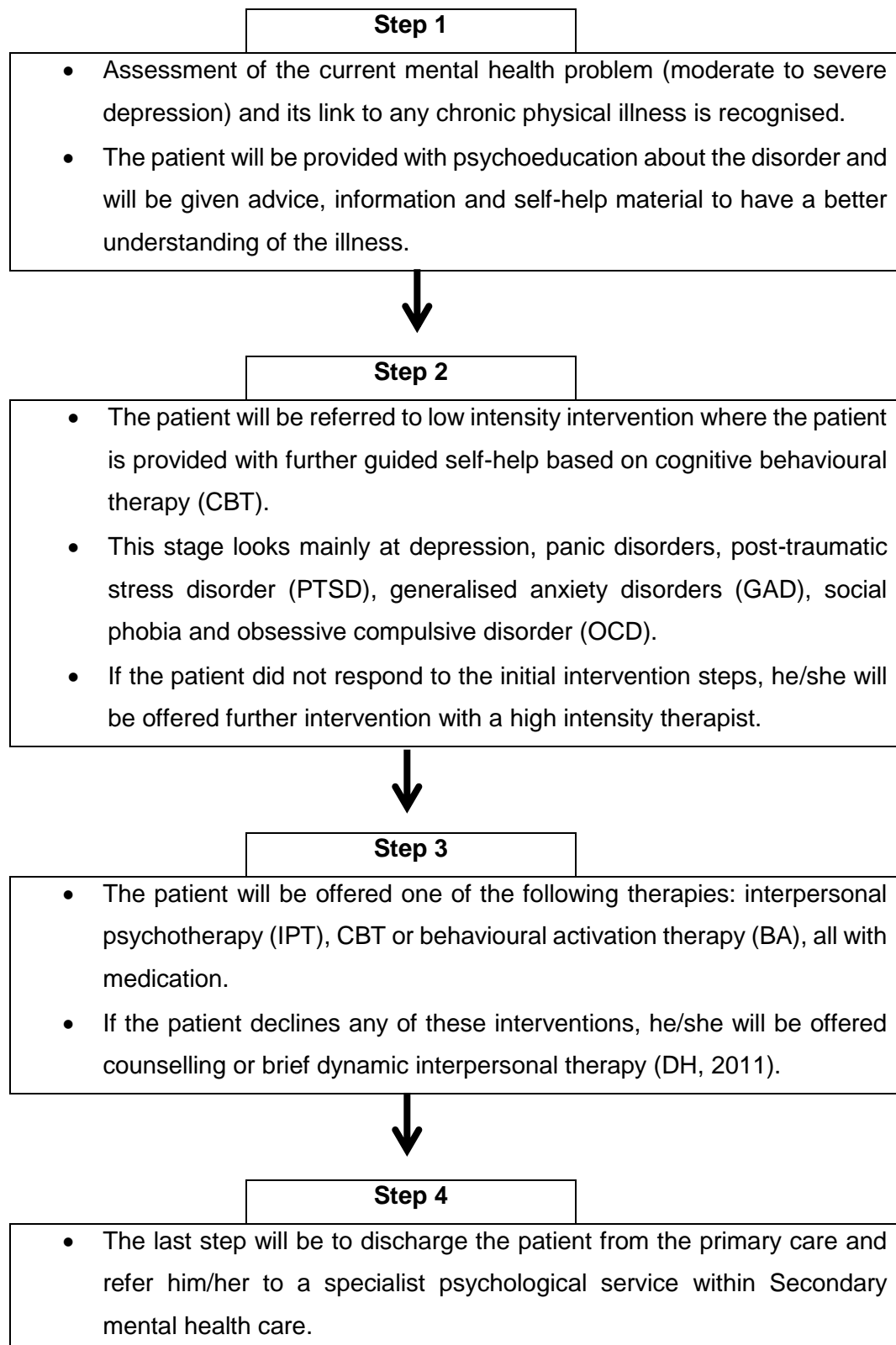
The IAPT programme was implemented to offer patients a first-line treatment for depression and anxiety disorders in combination with the prescription of medication. Together, these treatments are based on a plan that is centred on providing access to talking therapies where patients are better informed about the services they are receiving. The plan was also initiated due to the shortage of CBT practitioners, which was believed to be the main reason

preventing the National Health Services (NHS) from delivering the NICE guidelines (DoH, 2011).

The programme was first trialled in two demonstration sites and this provided a valuable insight into the outcomes of implementing the service and the factors that might hinder its utilisation (Parry et al., 2011). The results of these trials also demonstrated the effectiveness of CBT therapy as treatment to help people with depression and anxiety disorders. However, in order to fully implement the programme, the shortage of qualified and skilful therapists to offer such services have to be addressed and further training programmes would have to be delivered to ensure equity of access. This particular element means that services should focus on the different care needs of different individuals and should not assume that the same treatment model will be appropriate to all patients who suffer from depression and anxiety disorders. Accordingly, the mental health strategy 'No Health without Mental Health' has taken this into consideration to ensure the government's commitment to involve service users in having a say on how services are delivered. The IAPT services plan of action included the following statement: "...it is important for services to obtain feedback from a wide range of local stakeholders, especially groups that are difficult to engage, so that services are delivered in the ways that they can receive" (DoH, 2011:16). Furthermore, the BME positive practice guide, published in 2009, emphasised that services should take into consideration the racial and cultural diversity of our society and ensure therapies are appropriately adapted to be effectual (DoH, 2009).

The stepped care pathway for the IAPT services consists of four steps as detailed in figure (1), and involves providing psychoeducation and therapeutic intervention to patients. Psychoeducation is mainly provided at the first steps of the care pathway where guided self-help information, computerised CBT intervention and brief psychological intervention is provided to help motivate, support and actively monitor patients at the initial stages. If patients did not respond to the initial intervention steps, further assessment and treatment will be offered. This usually consists of CBT therapy and counselling.

## Stepped care pathway for the IAPT services



**Figure 1 Stepped care pathway for the IAPT service**

## **2.2 What Does Therapy Mean?**

Jerome Frank (1993) defined therapy as the treatment carried out by a healer to enhance a person's sense of wellbeing. This usually involves a healer (a trained therapist), a sufferer (the person seeking help) and the series of encounters between the therapist and the patient in order to establish a good relationship and produce a change in the sufferer's emotional and behavioural state. According to Frank, therapy involves talking with another person about one's thoughts and emotions in a way that the other person can understand. It also involves both therapist and patient communicating effectively with one another to establish a good working relationship. During these encounters, patients will be able to establish meanings of their past experiences and change their behavioural patterns.

Therapy involves the use of language both as means of expression and as a tool for healing. While patients use language to talk about their emotional experiences and describe their symptoms and thoughts, therapists employ language to have a better understanding of patients' accounts to give information and to deliver their therapeutic intervention.

There are different types of therapy that look at managing depression and anxiety disorders. These includes CBT, counselling, group therapy and computerised online programmes. IAPT services are particularly focused on delivering CBT and counselling interventions as recommended by NICE guidelines (NICE, 2004, 2006).

### **2.2.1 What is CBT?**

CBT is a type of talking therapy that focuses on thinking patterns (cognition) and behaviour. According to Kinsella and Gerland (2008:1) CBT is defined as:

“A highly structured evidence based treatment that aims to address patient's current problems. The treatment is goal oriented in that the goals are agreed between patients and clinicians usually in terms of

improving the patient's distressing emotional state and unhelpful patterns of thinking and behaviour”.

This means that therapists will work with patients on how they can change their behaviour or way of thinking to eliminate the negative thoughts because the way people think affects how they feel. A therapist helps a patient break down their problem into smaller components – the situation, thoughts, emotions, physical feelings and actions - and identifies particularly problematic thoughts and behaviours which enable the patient to understand the current problem (Royal College of Psychiatrists, 2015). Therapists also focus on the here and now and working with patients to identify practical ways – usually homework tasks undertaken by the patients – to solve the problem rather than centring on past events.

### **2.2.2 What is Counselling?**

Counselling is defined as:

“A purposeful private conversation arising from the intention of one person (couple or family) to reflect on and resolve a problem in living, and the willingness of another person to assist in that endeavour” (Mcleod, 2013: 7).

Counselling is aimed at helping people who have experienced traumatic incidents or conflict in their life to explore their emotions and talk about these feelings freely in a confidential setting without being judged (Feltham, 1995). The counsellor tends to adopt a 'non-directive' approach where he does not offer advice or specific techniques to overcome the problem. Counselling necessitates the counsellor to be an attentive listener, be able to build trusting and empathetic relationships with the client, and help them to develop an understanding of the problem and come up with their own conclusion on how best to identify a practical solution to the problem (NHS Choices, 2014). Some people will only need one session in order to make a difference in their life; others may need to see the counsellor on a regular basis.



Despite the achievement of IAPT services and the evidence-based practice of the effectiveness of CBT for depression and anxiety disorders, BME groups continue to have poorer access to mental health services and low uptake of psychological interventions (Brown et al., 2014; DH, 2009; Loewenthal et al., 2012; Lopez et al., 2014; Netto, 2006). A number of research studies have outlined how the use of emotional words can help patients recognise and express their emotions in therapy, and acknowledged the significance of understanding the way language is actually used in order to deliver psychological interventions that take into account the different communication styles (DoH, 2009; Keynejad, 2008; Loewenthal et al., 2012; Lopez et al., 2014). Other researchers have emphasized the need to understand the cultural background of BME groups and the variations of world views between BME patients and therapists in order to ‘develop a shared understanding’ (Bassey and Melluish, 2012) and familiarity of specific views and expressions of distress (Bhui and Morgan, 2007; Costa and Dewaele, 2012; Netto, 2006; Nezu, 2010; Rathod and Kingdon, 2009; Springer et al., 2011; Tribe, 2014).

In order to gain a better insight into the language and cultural issues that may impact on the access to IAPT services, current research is directed towards involving more BME groups in research consultations to share and establish a good understanding of their experiences (Kalathid, 2013; Kennedy, 2015). Taking this into consideration, this research focuses on the three largest BME groups – Pakistani, Somali and Yemeni – in Sheffield. An exploration into the historical context of the immigration of these groups to Sheffield will be underlined, followed by a rationale for choosing these communities and a highlight of the similarities that bring these communities together.

### **2.3 Sheffield City as Culturally Diverse City**

Sheffield has become a diverse city with 19.2% of its population being from BME groups (Sheffield City Council, 2014), and with over 128 languages spoken in its schools, universities and other community and voluntary sector organisations. The largest of these BME groups is the Pakistani community, followed by the Black and African communities that derive mainly from

Somalia and Yemen. In addition to these communities, Sheffield has large groups of Irish, Black and African Caribbean, Indian, Bangladeshi, Kurds, Iranian and Chinese communities. For the purpose of this study, the latter groups will not be included as involving all ethnic groups living in Sheffield would over extend the study. The reasons for focusing on the PSY groups are outlined below.

### **2.3.1 Background to the Influx of Immigrants from Pakistani, Somali and Yemeni Groups to Sheffield**

Due to the historical background of the steel industry in Sheffield, a large number of immigrants, mainly Pakistani, Somali and Yemenis, left their own countries – encouraged by the British government – in search of better employment, financial, and living conditions (Mahamadallie, 2007). While the Pakistani and Somali groups are considered the largest in Sheffield, the Yemeni population is the longest established in the city of Sheffield. Yemenis have been settling in Britain since the late 19<sup>th</sup> century after the port of Aden was captured and was ruled as a British crown colony from 1837 to 1963.

Consequently, many Yemeni people left their countries through the port of Aden during this period and travelled to the shores of Britain to work as seamen on ships (Mahamadallie, 2007). The outbreak of the First World War increased the demand for Yemeni and Somali seamen, however, when the war ended, the situation changed for these groups and they were discriminated against and forced to leave their jobs so that they could be reclaimed by British sailors. Many were also stripped of their rights as British citizens and were sent back to their homelands (Mahamadallie, 2007). After the Second World War, a further influx of Yemenis arrived to take up jobs in Sheffield's steel industry and Pakistanis were encouraged by the British government to come to the UK to alleviate a shortage of labour. Initially, Pakistani men came to the UK driven by the desire to earn money before returning to their own countries (Runnymede, 2012). However, numerous members of these groups decided to settle in the city permanently and brought their families over. In 1988, when the civil war erupted in Somaliland, large numbers of refugees fled the country and, with the aid of the British

government, they were reunited with their families and relatives who had moved previously to Sheffield to work in the steel industry.

### **2.3.2 The Similarities That Bring These Groups Together**

As a result of the high demand for cheap labour, a lack of knowledge of the English language was not at that time considered to be an issue by the British government (Mahamadallie, 2007). Therefore, a large number of people from the Pakistani, Somali and Yemeni populations who originally settled in Sheffield have difficulties or an inability to communicate in the English language. Many immigrants from these groups are also unable to read or write in their native languages because they did not attend any formal education (Sheffield Safe Guarding Children Board, 2013). In addition, the majority of these groups established their own communities, lived and worked closely together, and are concentrated in inner city areas like Burngreave, Page Hall, Firth Park, Pitsmoor, Darnall, Netheredge and Broomhall where housing is relatively cheap and poor (Burngreave Messenger, 2008; Sheffield City Council, 2014). These areas are also considered to be some of the most deprived areas in Sheffield and the resulting high rates of unemployment, low income, educational disadvantage, homelessness and overcrowding in the household can lead to social exclusion, poor engagement with community services and their health may suffer due to high levels of stress (Rae, 2011).

Furthermore, these groups are mainly Muslims, and the growing media and political focus on fighting Islamic extremism and terrorism has predisposed a general fear among these communities and created a sense of suspicion of Western clinicians or mental health services (Dunning, 2011; Ibrahim and Dykeman, 2011). In addition, there is a lack of acknowledgement amongst the local support services of the importance of faith for these communities where an understanding of religious beliefs is an essential step in order to gain the trust of these groups. For example, many of these groups believe that mental illnesses intertwine with supernatural entities, freeing the affected person from any responsibilities for unusual behaviour and prevents them from being actively involved in psychotherapy (Dwairy, 2006).

Moreover, most of these groups exist in a collective cultural background in which social approval or sanctions of the family, tribe or nation must be adhered to. Individuals from these groups retain their dependency within their families where familial authorities still play an important role in the individual's life and allow the individual limited scope for privacy (Dawiry, 2006). Finally, it is common among these groups to feel embarrassed and ashamed to talk about their mental health publicly. They consider mental health a taboo subject and a stigma that will jeopardise their families' relationships within the community (ICAR, 2007). For all the above reasons, these community groups might adopt a different approach to problems related to mental health. These issues will be explored in detail in the next chapter.

## **Chapter Three**

# **The Role of Language and Culture in Therapeutic Intervention**

### **3.0 Introduction**

This chapter offers the reader an overview of the literature concerning the role of language and culture in therapeutic interventions. The chapter starts with a discussion of the concept of mental health and how it relates to the concepts of culture in the context of this research. Following this, the theories of what language is and how it relates to language-use in therapy settings are outlined. Afterwards, the communication difficulties involved in therapeutic intervention as illustrated in previous research are explored. The next section discusses the definitions of culture and religion, and their possible influences on an individual's way of conveying or expressing emotional feelings. Finally, a reflection on research which focuses on researching patients' encounters compared with patient-centred research concludes this chapter and draws on the key aspects that will be researched in this thesis in order to address some of the gaps identified in the literature review.

### **3.1 The Concept of Mental Health**

The number of people with experience of mental health and emotional distress, which can range from mild to moderate mental illnesses, such as depression and anxiety disorders, or severely disabling disorders such as schizophrenia and personality disorders are on the rise (DoH, 2011). The experience of mental health may involve disturbance in the thoughts and emotions, which can prevent people from carrying out usual activities. This can cause some people functional impairment and in some extreme cases, violations of their human rights.

According to the national 'No Health without Mental Health' policy (DoH, 2009:18), mental health is defined as "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people,

communities and the wider environment. Levels of mental health are influenced by the conditions people are born into, grown up in, live and work in”.

It is evident from this definition that acknowledging individuals’ subjective experiences about their illnesses and understanding of the ‘self’ is an important component to achieve better health and wellbeing outcomes. Mental health often has its roots shaped by the complex interaction between individuals’ biological, social and cultural factors. Social and cultural factors are important to mental health since explanatory models of mental health are often grounded in the cultural system and governed by the ethos of the society (Valliant, 2012). So although, societal differences exist, this does not mean that the explanation of mental health in one culture is superior to the other. Rather, this draws attention to the importance of understanding the variations in the concept of mental health from one culture to another because culture can affect the individual’s coping options and finding appropriate supporting channels. Yet as pointed out by Tribe (2014), the beliefs and understanding of mental health remain a complex issue since the interpretations of aetiology vary considerably amongst the different societies.

### **3.1.1 The Concept of Mental Health in the Western and Islamic Worlds**

Of the different approaches to mental health and psychology that have been developed across the world, particularly pertinent to this thesis are those from Islamic backgrounds and Western psychology models. Broadly speaking, the Islamic approach has focused on the non-separation of mind and body (Haque and Keshavarzi, 2013; Skinner, 2010), and were blended with Islamic philosophy and religious beliefs in order to help patients understand and give meaning to their experiences (Abu-Raiya and Porgament, 2010; Haque, 2004). Some Muslim scholars sought to address mental health issues by invoking traditional Islamic concepts such as Jinn, black magic and evil eye. Others invoked natural and social sciences (Haque, 2004; Sabry and Vohra, 2013; Skinner, 2010). On the other hand, the Western approaches appear to centre on understanding the nature and causes of mental health disorders,

based on biological and cognitive enhancement, and treating mental illness cases with anti-depressants and CBT (Deacon, 2013; Skinner, 2010).

In approaches for mental health in the Islamic tradition ‘the secular and religious sciences have never split’ (Skinner, 2010:548). Even though the early work of Muslim thinkers was markedly influenced by the Greek philosophy and thought, the main contributions of Muslim scholars were inspired primarily from Islamic theology (Haque, 2004). A typical Islamic approach when looking at mental health historically from 980 to 1240AD involved psychotherapy and evidence-based treatments to help patients (Haque, 2004). For example, Avicenna (980-1037), drawing from his investigation into the metaphysical principles<sup>5</sup>, integrated the psychological aspects into theoretical and practical medicine to address the causes of mental illnesses. He explained to his patients how the negative emotions can affect the functions of an individual and highlighted the key role of life-style and behaviour modification in preserving health (Hajar, 2013, Khan et al., 2015). Other approaches included dietary advice and the use of herbal medicines (Skinner, 2010) or differentiated between physical and spiritual diseases and focused more on helping individuals understand themselves and identify the mental stimuli and despicable acts that cause psychological problems (Haque and Keshavarzi, 2014). For instance, Al-Ghazali focused on increasing the individuals’ awareness of behaviours linked to positive values in order to achieve purification of the heart and cleansing the soul from ill thoughts (Haque, 2004).

Among the Western paradigms for addressing mental health in practices was the biomedical model, which posits that mental illnesses are caused by biological abnormalities or biochemical imbalances in the body (Deacon, 2013). Although there is value in seeking a physical explanation of mental

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<sup>5</sup> According to Ibn Sina, “health is a dynamic state in which the temperament and structure of human body are such that all its functions are carried out in a correct and wholesome manner”. This means that the state of equilibrium which, a human being enjoys, has a certain range with an upper and a lower limit. Disease, therefore, is an abnormal state of human body, which disturbs normal functions. Disease may, thus, be a disorder of temperament or structure. (Khan et al., 2015. Ibn Sina and the roots of the seven doctrines of preservation of health. *Acta Medico-Historica Adriatica* [online] 13, (2), pp. 87-102. Available at: [https://www.researchgate.net/publication/295400187\\_Ibn\\_Sina\\_and\\_the\\_Roots\\_of\\_the\\_Seven\\_Doctrines\\_of\\_Preservation\\_of\\_Health](https://www.researchgate.net/publication/295400187_Ibn_Sina_and_the_Roots_of_the_Seven_Doctrines_of_Preservation_of_Health)

disorders, categorising symptoms of mental health illnesses and classifying them into diagnostic labels to manage them 'leaves no room... for social, psychological, and behavioural dimensions of illness' (Engel, 1977:130). When application of the biomedical model, for example by means of prescribing anti-depressants to rectify the purported imbalance in brain chemicals, failed to give long lasting recovery in many patients, it became necessary to search for alternative approaches based on alternative perspectives on the cause of mental illness. The CBT approach pioneered by Beck (2011) aimed at helping patients identify problematic thoughts (psychological factors) and explore possible behavioural changes (social factors) that may influence the biological functioning (mental illness) of a person before making a diagnosis.

However, it is far too easy to make this distinction between Islamic tradition and Western practices, or to assume that there is no overlap. Recently there have been some moves in the direction of CBT by some Islamic scholars who adapted CBT by integrating an Islamic perspective to offer a better compatibility with Muslim individuals' world views and ensure Muslim patients can get an effective treatment (Dwairy, 2006; Abu-Raiya and Porgament, 2010). If we try to make a distinction between the different traditions, we might point to the focus in Islamic tradition on spiritual matters and their effect on peace of mind, or lack of. However, the Avicenian notion of the non-separation of the mind and body leads is contiguous with the Modern Western view of the mind as the brain chemical alterations can cause mental illness. Despite cultural differences between the two approaches, they are not totally separated because many of the Western models began where Muslim scholars left off, who in turn had been influenced by the ancient Greek thought.

The use of therapy techniques such as CBT does not currently cover the link between mind and body, and it does not appear to cover all the beliefs, attitudes, norms, and religious influences that can offer an explanation into mental illnesses, and which may have a supernatural aetiology such as Jinn, evil eye and black magic. A number of researchers have commented on the



contrast between Western counselling in which individualism is the basis, and the values of Islamic cultures, in which collectivism is predominant (Bhui, 2013; Dwairy, 2006; Eleftheriadou, 2010). Thus, a significant minority of clinicians trained in the Western tradition assert that mental illness cannot stay isolated from the individual's social and cultural factors and question the effectiveness or appropriateness of directly applying therapeutic interventions such as CBT to these groups (Abu Raiya and Pargament, 2010; Bhui, 2013; Tribe, 2014, Loewenthal et al., 2012f). Their argument is based on the fact that such therapies do not address the wider problems in systems or families that have a significant impact on an individual's meaning of mental distress (Bassey and Melluish, 2012; Lopez et al., 2014; Rathod et al., 2010).

### **3.1.2 Summary**

It is clear that there are different perceptions of mental illnesses, which can be discernible at times, but they are not mutually exclusive and depend on historical change over time. Either of these interpretative frames, however, would indicate that culture (a key focus of this thesis) is important to understanding mental illness. Therefore, this thesis centres on the importance of understanding contexts when defining mental health. These contexts are not always clearly 'defined', as this thesis will show, and the researcher will be considering patients with influences from different cultural traditions accessing the IAPT service, which is set up under a 'Western' tradition. Language, cultural expectations, social backgrounds and religious beliefs all have implications, which will be considered later.

Inspired by the last two sentences and the researcher's aims to understand how patients articulate their emotional distress in specific social contexts, the research question(s) are approached with the intention of allowing patients the opportunity to talk about their understanding of their emotional distress. Because conceptions of mental health are often shaped by cultural determinants during social interactions between groups of individuals, these conceptions are usually developed by each individual during the process of communication and social interactions. Thus, language is the means by which people express their feelings and construct their understanding of

mental health. Given that BME people may be experiencing considerable cultural differences both linguistically and culturally in moments of distress, it is important to consider the role of these cultural references may make for people. Therefore, the use of language in therapeutic encounters is not only a way to express the self, but more importantly, when people engage in therapy, they construct knowledge of their worlds, reorganise their internal self, and develop meanings of their emotional distress within their cultural context. These social constructionist elements are built into the conceptual framework of this research which uses different qualitative research methods to collect linguistic and textual data in order to understand participants' articulations that are rooted in cultural assumptions and/or group practices (see Section 4.1).

In the next section the researcher will present some definitions of language and explicate the concepts of language applied in this study, which are theories of language as communication and translation, and theories related to discourse and analysing conversation.

### **3.2 Definitions of Language and Discourse**

According to Schwartz (1982) and Barber (2000) language is defined as a set of vocal symbols governed by a system of rules that are learned by speakers as members of a social group and participants in its culture. Through the use of these vocal symbolic rules (semantic, syntactic and phonological), both the speaker and the hearer show their knowledge of these rules and convey their messages. According to Chomsky (2000), messages are conveyed through a hierarchical structure consisting of two layers of meaning: lexical structure and expression structure. Hence, the recognition of word meaning and interpretation is an important step in understanding the role of language in therapeutic encounters. However, the use of language as a means of communication in this research is not simply a set of symbolic codes or a mechanistic model of encoding and decoding messages transmitted between a sender and a recipient, as stated by Shannon and Weaver (1949) and Berlo (1960). That model does not feature the possibility of negotiation of meanings; the meaning of a code is fixed.

Rather, in this research, language is considered as an interactive process in which the symbolic codes may have a variety of meanings depending on the context, such as social setting, and in which knowledge, including non-linguistic backgrounds and any relevant external beliefs, is essential to allow both the speaker and the hearer to understand the intended meaning. The language use incorporated in these social interactions is referred to as 'discourse'. Discourse as defined by Burr (2003) refers to instances of language-use in social settings where people from different backgrounds engage in talk about a given topic. In this process, the meaning of the discourse is dependent on the conversational context.

### **3.2.1 Language as a Means of Communication**

As demonstrated by Costa (2010) and Kennedy (2015), language plays an important role in accessing patients' feelings and emotions in therapeutic encounters. During the process of communication, therapists often ask questions, convey information, and deliver treatment. In return, patients describe their emotions and express their distress in order to make sense of their experience. The discourse taking place in these settings is dependent on the sender's (patient) presupposition that the recipient (therapist) has knowledge about the subject matter, and understand the meaning of the discourse. Discourse in these situations refers not only to instances of language use often incorporated in conversation and social interactions but as clarified by Burr (2003:64), refers to "a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events". However, as Burr (2003) and Van Dijk (2011) argued, the context is of paramount importance to determine the meaning of the discourse, which is a fundamental notion of the linguistic theory of pragmatics. As this research seeks to make meaning of what is said in therapeutic settings, the pragmatic view taken by Van Dijk to study the language in use as a social phenomenon is ideal for analysing patients' discourse in a qualitative research framework. Moreover, by differentiating between both the semantic meaning of the words (what is said) and the pragmatic use of language (what is implicated), then as outlined by

Grice (1967), we can discern the intended meaning behind patients' language use.

Employing language as a means of communication involves looking at how language helps individuals to express their cultures, establish and display their identity, and generate influence and control by revealing the power behind the speaker, which is discussed below.

### **3.2.1.1 Language and Culture**

Patients employ language as a medium of communication to make social connections, and draw on their knowledge of their culture, which is often made explicit in negotiating their meanings with therapists in therapeutic contexts. The patient's discourse is determined by social constructs, i.e. ideas, which are formed during interaction with their society and culture. Context is crucial in these interactions as it not only determines what the speaker intends to express by a particular utterance – as outlined by Craige (2004) – but context can also influence the interpretation of the message (Van Dijk, 1977:11). By studying the cultural references and commonly used words or phrases in patients' from a given cultural background, we can be more able to determine the meaning of an utterance. From a more theoretical perspective, studying the processes, products and consequences of language use within a cultural system can give insight into the role of words, for instance, in the constructions and emergence of one's identity (Howarth, 2011) or as an instrument of power (Fairclough, 2010).

### **3.2.1.2 Language and Identity**

The emergence of one's identity is determined by social and political practices, many of which involve discourse. (Fairclough, 1989). This means that when people interact with each other, they often create meaning of their previous experiences and behaviours of others, and display social and cultural influences by which they engage with and, reject or accept, and/or negotiate as part of developing their sense of self in relation to themselves and others (Faulkner and Hecht, 2011). Thus, discourse helps people

establish versions of the social world, negotiate their identity, and gain knowledge of others in a given context.

Gender, social class, religion, race, and ethnicity are some of the categories that can play part in forming one's personal identity. They were noted by many researchers (Burman et al., 2003; Karasaz, 2005; Keynejad, 2008; Lawrence et al., 2006; Netto, 2006, Simich et al., 2009) to be influencing factors in the expression of emotions in therapeutic encounters (See Section 3.6). These researchers' position is that identities are not only presented in discourse, but portrayed in linguistic, non-verbal and conventional styles and aspects. Furthermore as Jenkins (2014:18) pointed out, 'identity can be understood as the process of being or becoming', and it involves a degree of reflection to recognise the similarities or differences between individuals or groups. This can consist of categorising others depending on several cues such as the use of pronouns in language, the meanings encoded in items of clothing, and any information gathered from the people.

As argued by Scollon and Scollon (1995, 2001), it is not possible to separate identity from language and culture, since the notion of identity in discourse is a complex issue. In this research, participants present their perception of therapy through the use of language, reflecting their social, religious and cultural aspects of their identities in their communication. Hence, one purpose of this study is to be able to understand how individuals from the PSY groups use language, what cultural references they make, and what these cultural references mean. Another purpose is to determine how this is going to contribute to the understanding of the role of language and culture in therapy.

Regardless of any language or cultural backgrounds, the aim of therapy is to improve the mental health of the patient. Sometimes the emotional problem is culturally and socially embedded, and on other occasions, it can be understood within a broader religious or political framework. Yet, at the heart of all therapeutic encounters, the person is the central subject for enquiry, and the core construct is the personal self-schema, which encompasses the person's beliefs about themselves, others and the world.

Language and culture are the main construct of identity, particularly in the context of therapeutic encounters, where the therapeutic intervention focuses on the individual and the identity of the individual. Through talk, some patients may engage with the treatment and develop the meaning of their distress, so that they can recognise their internal-self and re-establish their identity. For others, the process of therapy may further open up insecurities and the patient may find it threatening to their identity (Gilbert and Procter, 2006), which can increase their vulnerability.

### **3.2.1.3 Language and Power Relations**

Language is not merely a vehicle for communicating information, but rather, there is a strong connection between language, power and inequalities that arise from therapeutic interactions (Fairclough, 1989). Here, the researcher views patients, therapists and therapeutic practices as having their own 'ideological discursive norms' (Fairclough, 2010), in which the way they interact with each other depends on these norms. Taking critical discourse analysis (CDA) into account as illustrated by Fairclough (2010), this research seeks to critically analyse patients and therapists' language use during therapeutic encounters to determine the relationship between the linguistic elements inferred by patients and therapists, and the social constructs that determine the meaning of these linguistic events. Insight is given into the social constructs (e.g. cultural beliefs, social identity and class, and constraints by governmental institutions) that may frame the ways both patients and therapists talk as part of the development of language awareness in such encounters (see Sections 6.2.2.1, 6.2.3, 6.2.4, 7.1, 7.2.2, 8.1.4.3).

Language in therapy is not just the speech that takes place in the encounter but also includes therapists showing the desire to be with the other person and listening attentively to their issues. Barden and Williams (2007) differentiated between three types of language taking place in therapeutic encounters. These are: the openness, the technical, and the monologue. The openness occurs at the start of the encounter and seldom uses of words. It comprises reacting to people's emotions through bodily movements, such as

the wringing of hands or a paleness displaying symptoms of anxiety or even the reaction to racial differences and facial features (Jensen, 2014; Nezu, 2010). The technical language (content) is the main exercise of obtaining the necessary information from patients and focuses on the words that are spoken. It also involves explaining the rationale of therapy to patients and encouraging them to engage in the healing process by identifying the problem and defining objective goals (Bhugra and Bhui, 1998). The monologue is the true willingness to help others by listening attentively to patients' problems and showing empathy and compassion for their difficulties (Barden and Williams, 2007; Nezu, 2010).

While the content has formed the focus for therapists in therapy, the openness of therapeutic encounters and the monologue (showing empathy and compassion to patients' difficulties) have been highlighted to aid the understanding of the social interaction (Barden and Williams, 2007; Jensen, 2014; Nezu, 2010). Scholars such as Brown and Levinson (1978) developed a theory in which they propose that negative and positive politeness strategies are a universal component of human interactions. They draw attention to the concept termed 'face' that manifests itself in social contexts and how a person may either feel valued and appreciated (positive face) by being shown friendliness for example, or feeling threatened or imposed upon (negative face) by being shown indifference. This may have the potential to impact on the setting even before it begins, such as in the way some therapists insensitively address patients or stereotype them (Costa, 2010; Fairclough, 2010; Majid, 2012; Nezu, 2010). This can be observed by some patients not only as a repetition of oppression or acts of racism, particularly if the therapist is a white person and the patient is from a different race, but can also be damaging to the relationship and may lead to negative reactions.

#### **3.2.1.4 Summary**

To summarise, this section offered theoretical insights into the use of language as a means of communication and argued how it is not merely a mechanical message transmitted between speakers. It gave some examples of the use of language as a means of communication taking into account

critical discourse analysis methods that can offer knowledge of how social and cultural backgrounds determine the intended meaning of discourse in therapeutic interactions. More importantly, the section emphasised the value of politeness strategies in achieving successful communication between therapists and patients. Also in this section the influences of culture on therapeutic interactions and the verbal and non-verbal structures that are culturally specific are demonstrated.

In the next section, some of the language and cultural communication difficulties that stop BME patients from being involved in therapeutic treatments as outlined in previous research, are examined.

### **3.3 Communication Difficulties**

As discussed in Section 3.2, prior research confirms that the interpretation and negotiation of meaning can influence the communications in therapeutic settings. Using verbal and non-verbal communication as well as emotional expressions that are shaped by cultural and social constructs can on one hand, help people represent the kind of emotion that is felt in a particular situation, and on the other hand, can create a discrepancy between intended and understood meaning between therapists and patients. Therefore, the definition of interpretation and approaches towards translation that are applicable to this research are reviewed in order to gain insight into the communication difficulties that can be experienced in therapeutic settings.

#### **3.3.1 Translation and Interpretation in Therapeutic Encounters**

Having discussed the role of language in general, the researcher is going to look at the role of languages. 'Translation' as a term has been employed to cover both translation and interpreting studies, where the purpose is to render the meaning of a message from one language text (referred to as the source language SL) into another language (the target language TL) (Newmark, 1988). The interpreting process, as illustrated by Pöchhacker (2009), features more adherence to 'orality, immediacy, simultaneity and irrevocability'. Thus, interpreters are required to have high familiarity with the source and target languages as well as cultural knowledge in order to decode



the messages. Unlike the process of translation in which the source is pure text, in interpreting the source text is conveyed through a person in tandem with non-verbal forms of language, and so interpreters are required to understand the socio-cultural dimensions of conveyed messages to unfold the full meaning of discourse. As a result, interpreting studies centred on improving the subject knowledge and developing training programmes to enhance the quality and performance of interpreters. Given that the quality of interpreters' output and knowledge of the social contexts receives a lot of attention in interpreting studies, one of the main interests of this research is to understand how interpreters' output and language-use influence the understanding of patients' mental distress and the communication of emotions in therapeutic settings.

With the ever increasing demand for improving intercultural communication in the world, the need to consider the cultural role in the transfer of meaning 'beyond the narrowly linguistic approach' (Bassnett, 1980) during translation was stressed. Due to the centrality of Bible translation in the West, literary texts were based on word for word translation and adherence to linguistic syntactic rules rather than sense for sense translation (Munday, 2009). Such a fixed nature of translation induced some academics to pay attention to what is really meant by the word 'translation'. For instance, Nida and Taber (1974:22) clarified "languages are different in meaning" and in order to facilitate the processing of the message in the recipient language, one must "[choose] carefully the particular basic meaning which is intended" (Nida and Taber, 1974:82). Thus, the science of translation evolved to feature deduction of the intended meaning in the context and produce equivalent effects between the ST sender and TT receiver. Other researchers such as Newmark (1981), Venuti (1995) and Nord (1997) argued that in order to produce texts that enable the TT readers to engage properly with the ST, knowledge of the cultural markers and social contexts are essential. As well as highlighting the importance of retaining the specific cultural meaning of a text in the SL, the authors pointed out some of the issues related to translated texts and suggested some strategies to operate in a manner appropriate to the culture of the TT readers.

This discussion of language, cultural influences, and context in translation will help to understand how expressing emotions can be appropriately translated between languages belonging to different cultures. In what follows, the communication problems that are related to interpretation and translation in therapeutic settings, as reported in previous research are discussed.

### **3.3.1.1 Interpreters' Influence on Therapeutic Encounters**

Using interpreters in therapeutic encounters is not without its limitations and challenges because a large amount of information and emotional expressions have to be processed and understood through the interpreter. As argued by Costa (2013), this can disempower patients from being fully involved in therapy.

According to Brune et al. (2011) using interpreters in therapeutic encounters is far from an ideal situation because they may influence the content of narrations. He clarified what he meant by giving examples of the ways in which interpreters may inject their own opinions or persuade patients against therapy or even omit some of the patients' comments, which can affect the expression of patients' meanings. Costa and Briggs (2014) and Miller et al. (2005) took the argument further in suggesting that interpreters' reactions and their non-verbal behaviour towards patients' traumatic experiences, such as their movements, facial expressions, apparent feelings of indifference, or perceptions of their being judgemental, can have a negative impact on the healing process and therapeutic alliance with therapists. Finally, the fact that some interpreters may have dealt with emotionally difficult situations themselves and have to deal with the hostilities of the situations they are thrown into, can be quite detrimental to therapeutic assignments. Miller et al. (2005) gave an example of how some interpreters may become quite upset, where the flow of the session can be interrupted and can leave the therapist wondering what has happened. This becomes an issue mainly in contexts in which interpreters are not provided with the help and counselling support they themselves need. The discussions of the aforementioned researchers motivate several questions about the interpersonal interactions between interpreters, therapists and patients, with a particular focus on the

interpreter's position 'in between'. This position is carefully observed and discussed with patients in this research.

Another issue of interpreters' influences on therapeutic encounters is the interpreters' ability to process, de-verbalise and transcode the messages. Lee (1997) and Loewenthal et al. (2012) gave some examples whereby the inability to process the information simultaneously affected the interpreter's performance. The misinterpretation of information can lead to misdiagnoses and the inability to recognise traumatic experiences. Moreover, interpreters need to cope with processing memory constraints, where they are usually required to instantly decide what patients mean in order to deliver the right meaning (Drennan and Swartz, 2002). As explained by Jackson et al. (2008), such challenges can stem from the difficulty for the interpreter to formulate questions addressed by therapists, or distractions by patients, for example an attempt to explain their perceptions of illnesses mid-sentence. The authors take the argument further in adding that some interpreters may approach patients with uncertainty or exasperation, For example when the patients' communications make no sense, and rather than explaining and describing the form and content of the dialogue, they adapt the text to comply with linguistic rules and fulfil the purpose of translation. These situations contribute to the struggle to build a rapport between therapists and patients and the interruption of the flow of communication by the interpreter can negatively affect the dynamic of therapy. Therefore, it is no quirk that in his definition of interpreting, Pöchhacker (1999) emphasised the quality of interpreters' performance.

One final and major challenge in community interpreting is the difficulty of disclosing confidential or intimate trauma information in the presence of interpreters, which is continually voiced by BME patients, who in some cases feel that an interpreter is likely to leak sensitive information, as pointed out by many researchers (Bhui and Morgen, 2007; Keynejad, 2008; Loewenthal et al., 2012; Rathod and Naeem, 2013). As a result, patients might resist the use of interpreters, which might influence their ability to participate in therapy (Bhui, 2013; Rathod et al., 2010). There is sometimes no evidence given to

support patients' claims of interpreters disclosing confidential information and we cannot say whether the conclusions patients reach about an interpreter's breach of confidentiality are in fact true or not. However, the issue of confidentiality in interpreting settings needs to be addressed as it may contribute to the understanding of patients' articulations of therapy.

### **3.3.1.2 The Non-availability or Untranslatability of Equivalent Words**

The equivalence issue in therapeutic encounters is the challenge of finding the exact meanings of words, cultural concepts to understand and explain nature and causes of illnesses, as well as identifying the different concepts of diagnosis available in the second language. The lack of availability of a semantic equivalence between two languages can affect all those involved in the triadic encounter. The interpreter in this case is not only struggling to find an equivalent word to denote the same meaning, but as Baker and Perez-Gonzalez (2011) argued, is also under tremendous pressure to render the message to the closest possible equivalence in order to achieve the same communicative purpose for both patients and therapists.

According to Grice (1967), it is somewhat difficult to interpret the meaning between what is said and what is meant. Particularly, in therapeutic contexts finding a suitable equivalent to the emotional expressions can be quite challenging for both interpreters and patients. For instance, the concept of 'sameness' in social relationships and emotions is not always possible, mainly when two different cultures are involved (Catford, 1965; Patel et al., 1995; Swartz et al., 2014). Therefore, Nida and Taber (1969: 12) gave emphasis to "reproducing in the receptor language the closest natural equivalent of the source language message, first in terms of meaning, secondly in terms of style". Hence, the most important point is that it should lead to the comprehension of the interaction between therapists and patients. As Fairclough (1989) points out, however, it seems to be necessary to look at the context as words and their lexical meanings can have either a single meaning, in the absence of other words, or a cluster of meanings, when associated with other words.

Another problem regarding equivalence is that while interpretation of assessment questionnaires used in therapeutic encounters can facilitate patients' understanding, merely translating these questions might not lead to accurate responses. As explained by Haque and Keshavarzi (2014) and Lu et al. (1995), the questions are based on Western psychological theories that have been conceptualised within a Eurocentric model and as a result, they might not be suitable for BME patients. Drawing on the variety of cultural meanings of idioms of distress, the authors illustrated the ways in which different cultures can describe mental health and argued that the inability to realise the equivalent meaning of symptom presentations can generate inaccurate responses from patients. To clarify these points, Haque and Keshavarzi (2014) draw on language-use by many Muslims when referring to "the sinking heart" or saying "the heart is sick" to indicate the meaning of feeling low and depressed. According to the authors, the heart in the Islamic perspective is intertwined with the human being as a whole and the argument is therefore, that simple translation may not recognise the cultural differences and may lead to patients being misunderstood.

The untranslatability of words or concepts that are unique to Muslim patients or that have been developed exclusively in other societies or cultures is another challenge. For example, the belief in supernatural causes of distress such as 'Jinn' is somewhat a difficult concept to be understood by a non-Muslim therapists (Loewenthal et al., 2012). Likewise, Haque and Keshavarzi (2014) and Rathod et al. (2010) found that Muslims may often make a prayer to God, but if their prayers are not answered immediately for reasons unknown to the person, the individuals believe they are being punished. As the authors pointed out, cultural norms and religious concepts play an important role in defining or labelling the causes of distress. As a result, they can be difficult to translate because they are often embedded within the norms of society and religious contexts.

Words of emotion or emotional terms are also rich with feelings and they may not have a linguistic counterpart in another language. As a leader in the study of bilingualism, Pavlenko (2006) explained that the expression of an

emotional term is usually related to a unique cultural experience and an equivalent word in the target language may not be sufficient to match the exact meaning of the word in the different cultural context. Similarly, Loue and Sayatovic (2008) found that whatever is implied by one word in one language may account for a long explanation in another. This suggests that merely translating the word might not necessarily convey the same connotation of the word or link it to its cultural context.

### **3.3.2 Communication of Emotional Expressions in Therapy**

Emotions are usually channelled using a combination of physical signs and linguistic components (Berry, 2007). For that reason, when patients use a particular word to describe their distress, it can be more than just a descriptive word reflecting their physical feelings; it may help patients fashion their feelings, perceive them, and articulate their experience. Accordingly, expressing one's thoughts about a certain experience or life event can be quite challenging.

Talking about emotional feelings of distressing events can be quite difficult as patients believe they might either have to summarise their long tales of sadness in a few words or struggle to find the words to describe their deep emotions. For that reason, Eleftheriadou (2010) pointed out that people in distress frequently tend to avoid talking about their emotional feelings or may sometimes choose not to speak in their native languages to avoid the exposure of their traumatic feelings in front of strangers.

However, recent research in the field shows that patients might use native words in their mother tongue that are culturally linked to the language of sorrow, unconsciously revealing the true meanings of the inner self that are of high importance for the purpose of communicating their emotions (Drolet et al., 2014; Pavlenko, 2006; Wilson, 2012). For example, idioms of distress are one way of describing individuals' feelings that affect the individuals' attitudes and emotions. They often relate to a certain culture and are usually socially inherited. For instance, Al-Kernawi and Graham (2000) found Arabic people describe depression as a "dark life" to indicate their confusion or

inability to make decisions. Somali people, on the other hand, as illustrated by Bentley and Owens (2008), use metaphorical expressions or proverbs such as “Nin madaxa laga haayo, meeli uma fiyooba” which means: ‘If a person has a sickness or pain in their head, no other parts will work’. The authors explain that such an expression is normally associated with mechanical devices that cannot be fixed, but in this instance, it is used metaphorically to show that the person is really unwell. Casual interpretations of the meaning of these metaphorical expressions or idioms of distress may not enable therapists to realise the multi-layered meanings. As explained by Westland (2009), these emotional expressions are closely related to alternative modes of expressing distress and the lack of consideration for or the inability to respond to, these expressions can influence the communication process during therapy. Overall, these studies outline the need to recognise the meanings of emotional expressions and to pay close attention to their implications, which is the central focus of this research.

In (1949 and 1979), Reich reported that different languages can have different representations of emotions. While some languages are rich with emotion, others convey feelings in a subtle way and without words. He clarified that “language in the process of word formation, depends on the perception of inner movements and organ sensation, and that words which describe emotional states render, in an immediate way, the corresponding expressive movements of the living matter”. However, not all forms of expression can be put into words. Individuals may use these expressions differently depending on their personal experience and/or cultural meaning, which may not be easily understood or may be misinterpreted by the therapist. This particular issue is further explored in the next section.

### **3.3.3 Non-Verbal Communication**

Non-verbal communication can assist in the understanding of meaning, and if missed or misinterpreted, key aspects of the therapeutic relationship between therapists and patients can be affected. Therefore, Lu et al. (1995) highlighted the relevance of showing empathy during therapeutic encounters to patients’ willingness to talk about their emotional feelings and prompting

them to talk about their illnesses. He pointed out that by listening to patients attentively and relating to their narratives, therapists can build trusting relationships with patients. Thus, the way therapists attend to patients' needs can both empower patients and engage them in therapy, or as argued by Patterson (1996) can affect their engagement and speed their drop-out from therapy. Showing indifference or aloofness can cause the patients to fear therapists. Therefore, it is essential to pay special attention to the first encounter between therapists and patients and create a positive impact, as patients are often able to notice the facial and body language of therapists and they can easily sense a therapist's lack of interest or sympathy (Eleftheriadou, 2010; Loewenthal et al., 2012). According to Suresh and Bhui (2006) and Eleftheriadou (2010), knowing that therapists can understand their emotional expressions is important to patients' ability to discuss their emotional feelings and therefore, therapists need to familiarise and relate these non-verbal expressions to their meaningful cultural elements.

Counter-transference<sup>6</sup> is one example of how therapists can relate to patients' emotional feelings. It is a useful tool in therapy, which can assist therapists to comprehend their patients' experiences when they are unable to understand their language. This allows therapists to attend to patients as a whole, showing interest in what they say and feel, living their experience, and allowing themselves to consider how they would have felt or reacted had they been in the same situation (Eleftheriadou, 2010). Although the evidence suggests that countertransference can be seen as a useful tool in therapy, the presence of a third party – the interpreter – has been argued by some researchers to be the cause of non-verbal communication being missed in the midst of clinical encounters (Bhui and Morgen, 2007; Svenberg et al., 2013). These studies outline the importance of non-verbal communication and the need to understand how different emotions are expressed in different cultures and the manner in which language acts in therapeutic settings

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<sup>6</sup> Counter-transference is the unconscious feeling of the therapist that emerges as a result of working with the client. It enhances the empathy that counsellors feel for clients (Murphy, S.N., (2013) Attending to counter-transference. *Counselling today*. Available from: <http://ct.counselling.org/2013/09/attending-to-countertransference/>



because social encounters rarely occur without a presence of non-verbal communication (Majid, 2012; Jensen, 2014).

Commenting on the need to pay attention to paralanguage and non-verbal communications in therapeutic encounters, Foley and Gentile (2010) argue that non-verbal communication will not only assist therapists in understanding what is said, but will also explain unconscious feelings and areas of concern that may result as a consequence of unfamiliarity with the non-verbal behaviour. To clarify this point, Al Krenawi and Graham (2000) choose the example of female Arab clients and Western therapists, particularly male professionals, pointing to the clients revealing little emotion to strangers (including mental health professionals), and maintaining a distance and minimal eye contact, which could be misinterpreted as resistance to treatment. This example draws attention to the different social conventions about when, what, and how much should be revealed and suggest the need for therapists to pay attention to how people express themselves.

The evidence presented in this section suggests that attitudes endorsed by therapists can either empower patients or negatively impact on their relationship with patients (Schiffrin et al., 2001). Therefore, these studies provide important insight into the form and function of the different communication styles articulated by the different cultural groups and draw attention to the need to appropriately interpret these non-verbal communications in order to work more effectively with patients.

#### **3.3.4 Language and Power Relations between Therapists and Patients**

According to Fairclough (1989), the dominant language used by the majority in any one society can have an effect on the social relations among the population of that society. One of the established examples of such an effect is the relationship between medical professionals and patients in the consultation room, mainly within BME groups who believe that white middleclass doctors and/or therapists are authoritative experts who should give advice, make decisions, and control the course of treatment (Patterson, 1996; Tse et al., 2012). Eleftheriadou (2010), for one, pointed out that BME

patients who regard the medical profession as the authoritative hierarchy can feel quite inhibited in the consultation room and will have great difficulty in using words properly or thinking appropriately, undermining their ability to communicate effectively with their therapists.

Power inequalities as well as issues of racism and cultural differences between BME patients and therapists may continue to be ignored as argued by Bhui and Sashidharan (2003), Burman et al. (2003), and Netto (2006), due to the lack of research on the impact of racism or the difficulty to address such issues within therapeutic encounters. Therapists' lack of awareness of such issues are additional external factors that can impact therapeutic settings and contribute to BME patients' psychological suffering. Chang and Yoon's (2011) research demonstrated that the majority of BME patients who had a therapeutic encounter with white therapists felt that the white therapists were unable to understand the issue of racial differences experienced by these minority patients or how such concerns affected their lives. This view is supported by Keynejad (2008) who provided in-depth analysis of the barriers stopping ethnic groups from accessing therapy showing its relevance to racial or religious issues related to immigrants. The evidence presented in this section suggests that BME patients tend to be reluctant, fearful, and suspicious of approaching or seeking help from a service derived from a dominantly Western culture, which they believe could strip them of their rights.

It is believed by some BME patients that institutional racism exists in therapeutic environments whereby they are subjected to a negative stereotypical image that may result in discriminatory practices against them (Schiffrin et al., 2001). For instance, the inability to speak the majority's language can undermine BME patients' rights to access the appropriate services and they might be deemed as unsuitable for talking therapy (Drennan and Swartz, 2002). As explained by Atdjian and Vega (2005) and Bhugra and Gupta (2010), using language barriers as a justification for the fewer referrals and underrepresentation of BME patients in therapeutic

treatments constitutes a fundamental deficit in equal rights to access quality care. Mumby and Clair further clarified:

“Power is not simply expressed and reproduced through discourse; rather there is a complex and dynamic process of ideological struggle in which different and competing groups attempt to shape and influence the way in which social reality is constructed” (1997:187).

The authors suggest that the social interactions are products of socially dominant cultural groups, who through the use of hidden language and/or practices can control members of other cultural groups. Dominant cultural groups (i.e. therapists) are likely to subtly impose a certain discourse type upon patients by the use of language that the patient may not understand, which may affect their engagement with therapy.

It is often assumed that Western psychiatric ideas and the diagnostic classification system that has been developed in the West are applicable to all people around the world. However, while the diagnostic manuals provide good mental health objectives (Netto, 2006), Tribe (2014: 253) argued that the manuals “are not neutral documents, [as] they carry a range of assumptions which reflect a western biomedical model and represent a range of interest groups”. To demonstrate institutional racism, Isaac (2013), Tribe (2014) and Turner and Bhugra (2010) gave some examples showing how BME groups, when seeking help and assistance from psychological services, are either faced with one model of therapy, which might not apply or fit with their cultural and world beliefs, or are identified as unsuitable for therapy due to language barriers and the inability to speak using the dominant language.

Finally, words can be a source of hope or they can generate fear and hostility (Lynn, 2010). For example, patients prefer the use of words such as “emotional wellbeing” and “unwell” than using the words “mental health” or “relapse”. While the first words imply the ability to understand the value of emotion and the ability to move forward in a positive direction, the second terms affect engagement due to the stigma or the negativity associated with mental health (Keynejad, 2008). The author also found the power of language

and creation of new words related to negative images of Islam and Muslims in the media to be a possible sign of discrimination or social exclusion. For instance, “third world” and “Islamophobia” are words implying negativity and can carry a certain antagonistic attitude against BME patients, which can stop them from seeking help and lead them to become suspicious of the services. In view of all that has been mentioned, Ashcraft and Anthony (2006) and Schiffrin et al. (2001) remarked on the importance of changing and replacing clinicians’ technical words with more humane words to reflect the lived world of patients and promote acceptance and respect. Collectively, the evidence suggests that while positive language-use in therapeutic settings is likely to improve patients’ engagement with the services, power relations can contribute to health disparities and access to appropriate care. A critical examination of patients’ discourse in this research can contribute to the wealth of knowledge in this field.

### **3.3.5 Meeting Patients’ Needs within IAPT Service**

According to the Department of Health (2009), language differences between therapists and patients are one of the main barriers to effective communication in therapy. Not all patients are proficient in the English language, which may cause an inability to relate traumatic life events or convey their emotional feelings as they do when they use their native languages (DH, 2009; Drolet et al., 2014). Due to the importance of bridging language barriers and achieving effective communication between therapists and BME patients, the need for a dedicated interpreting services for mental health is clear. The NHS framework for mental health and Delivering Race Equality (DRE) plans require that services should not be discriminatory and that patients should access psychological therapy in their own languages (DoH, 2009). As a result, NICE updated their guidelines on September 2011 to add the requirement of providing a pool of trained interpreters working in as illustrated whatever languages that are needed locally to work effectively with patients (Costa and Briggs, 2014). Nevertheless, as illustrated in (Section 3.3.1.1), research has shown that interpreting in mental health settings demands much understanding, a high level of linguistic competency,

and a professional training qualification (Costa and Briggs, 2014; Lee, 1997; Putsch, 1985; Tribe and Morrissey, 2004; Tribe and Ravel, 2003; Westermeyer and Janca, 1997). Overall, the evidence suggests that the use of interpreters may improve the access to therapy. However, steps are to be taken to minimise the negative and maximise the positive effects of using interpreters in therapeutic settings, which are addressed during the interviews in the current study.

Another issue of the IAPT service is in its reliance on providing information and self-help materials about mental health so that patients can understand their illnesses better. These materials are often written in the majority language with no availability of translated counterparts, and as a result, patients with Poor English proficiency are unable to access information about the service or understand what their services involve (DH, 2009; Eleftheriadou, 2010; Keynejad, 2008; Loewenthal et al., 2012). As observed by Drolet et al. (2014) and Lowenthal et al. (2012), even in the presence of translated information, some patients are in fact illiterate and as a result, they may be unable to access the IAPT service and complete therapeutic homework or use computer-based resources (Bhui, 2013; Suresh and Bhui, 2006). This means that many of these community groups will not be able to achieve the tasks of therapy or acknowledge their benefits (Bhui and Morgan, 2007; DH, 2009; Rathod et al., 2010).

Amidst the growing awareness of the need to address language and cultural issues and other requirements in therapeutic encounters, some scholars have recognised that there are few trained BME specialist psychologists who can communicate effectively with these patients or are sensitive to their needs (Burman et al., 2003; Eleftheriadou, 2010; Patterson, 1996). Reasons for a shortage of such specialists, as pointed out by Bhui and Sashidharan (2003), pertain to the presence of institutional racism and inequalities preventing BME professionals from gaining admission to training programmes in this field. Bhui and Sashidharan (2003) pointed out that while there has been a shift in policy and awareness of the need to address these issues, existing statutory services are still facing difficulty in employing

specialist BME workers or developing specialist services for BME groups. They also highlighted that specialist BME practitioners are either excluded from decision-making or have no power to influence change, such as introducing new services and language resources for BME groups. Therefore, if engaging BME therapists in services is to improve the access of BME patients to therapy, then it may be essential to consult with patients to ensure equal access to services that can meet their needs.

Since it is now clear how culture affects patients' communication in therapy, it is important to understand it further. Therefore, in the next section, the researcher presents the definition of culture in this study and discuss how cultural and religious backgrounds may influence the description of distress and communication of feelings in therapeutic settings.

### **3.4 Definitions of Culture**

Despite the many attempts to define culture, there is no overwhelming consensus amongst theorists. This is mainly due to the different usage of the term by anthropologists, linguistics, sociologists and psychologists. For instance, Rohner (1984:119–120) defined culture as:

“The totality of equivalent and complementary learned meanings maintained by a human population, or by identifiable segments of a population, and transmitted from one generation to the next”.

Matsumoto (1994: 18) in his definition of culture, clarified that while culture is learned and shared amongst a group of people, individuals interpret and engage with the cultural system differently. Therefore, culture is both an individual as well as a social construct:

“Culture is as much an individual, psychological construct as it is a social construct... Individual differences in culture can be observed among people in the degree to which they adopt and engage in the attitudes, values, beliefs and behaviours that, by consensus constitute their culture”.

Finally, in her definition of culture, Spencer-Oatey (2008: 3) emphasised the interconnections between language–use and the individual’s behaviour, how the cultural system can influence the interpretations of the individual’s behaviour, and the meanings held against other people’s behaviour:

“Culture is a fuzzy set of base assumptions and values, orientations to life beliefs, policies, procedures and behavioural conventions, that are shared by a group of people and that influence (but do not determine) each member’s behaviour and his/her interpretation of the meanings of other people’s behaviour”.

On the concept of culture, the authors agree that any cultural system is tied to members of social groups, who may agree that culture has a variety of components, such as beliefs, values, norms, and behaviours, that are learned and shared by almost all members of the group. Furthermore, the authors explained that the meaning of a cultural system is understood according to either the individual subjective experience or relative to other cultural groups (La Roche and Maxie, 2003). On this well researched basis, culture and communication appear to be interrelated. Culture can influence communication, and through communication we can learn how to participate in the web of meaning to improve the knowledge of those we communicate with, and make sense of ourselves by identifying ourselves in relation to others. Culture is not only composed of shared beliefs and value systems but is also learned and created through our interactions with other people. This draws a similarity between culture and both language and religion. This is because language as a medium of communication can enable group members to share their experiences and perception of the world, and help them relate to other cultures. Religion in turn is embedded in culture and cannot be understood in isolation from it, since the interpretations of the belief system are often shaped by and based on the local culture.

### **3.5 Culture in Therapy**

Cultural influences in describing emotional disorders and explaining symptoms of mental health continue to be one of the main challenges in the

process of psychotherapy for BME populations in therapeutic encounters (Bassegy and Melluish, 2012; Bhui, 2013; Lu et al., 1995; Bhui and Bhugra, 2004; Cardemil, 2010; Chang and Yoon, 2011; Eleftheriadou, 2010; El-Islam, 2008; Lopez et al., 2014; Nezu, 2010; Park et al., 2011; Rathod and Kingdon, 2009; Shefer et al., 2012). In view of this, it is essential, as chosen as the purpose of this study, to understand the concept of culture, especially as Nakayama and Halualani (2010: 6) argued that culture is:

“...not just a variable, nor being socially constructed, but a site of struggle where various communication meaning are constructed...”

According to the authors, the meaning of any given communication is constructed within a culture by exchange of viewpoints between individuals in society who occupy various positions of power, the final meaning favouring that of the more powerful. As such, culture becomes a site of struggle over the intended meanings. This suggests that the concept of culture and communication are closely related, in the sense that, an individual cannot learn the meaning of the situational contexts, social practices, discourse and non-discourses without going through the process of communication. As it stands, communication offers us an opportunity to engage with the different perspectives of the world as a result of which, individuals become better prepared to engage in intercultural interactions.

The different perspectives individuals from dissimilar cultures hold are going to be referred to in this thesis as cultural norms and beliefs, which reflect the individuals' values and can influence their subsequent relationship with others. Therefore, in therapeutic encounters, it is important to acknowledge the cultural heritage of the patient, and be aware of the cultural dimensions of the different ethnic groups, to be able to work efficiently and effectively with them.

By illustration, the PSY groups – the subjects of this research – are Muslims and their culture is guided by and intertwined with the teachings of Islam. Religion for these groups is a way of life that arranges people's relationship with God, provides a framework within which people relate to each other, and



offers a set of principles by which people deal with challenges and life events (Loewenthal, 2006; Ali, 2013). In view of that, it is possible that attending to the Islamic teachings of Muslim patients can offer them protection from ill health, which as noted by Haque and Keshavarzi (2014) and Ibrahim and Dykeman (2011) can offer people guidance to manage and understand mental health. Ting-Toomey (2010) argues that the most powerful cultural dimensions in explaining the attitudes and behaviours of people is the individualism vs collectivism. Consistent with Hofstede (2001), collective societies are tightly integrated, in which individuals see themselves as part of the group and their interests and human activities are linked together and emphasised. Dwairy (2006) and Ibrahim and Dykeman (2011) found that the collective ethos of the tribal Bedouin system appears to constitute the lifestyle and norms of a large number of BME groups and plays a central role in establishing and influencing their behaviours and attitudes. As a result, the centrality of familial authority, gender roles, and honourable behaviours considered to be important for maintaining group unity, continue to regulate individuals' behaviours and promote group cohesion within these societies (Dwairy, 2006; El Islam, 2008).

The examples presented in this section provide important insights into the influences of religious and cultural norms in shaping not only BME groups' understanding of emotional distress, but also how they may express their emotions. For that reason, I will shed light in the following sections on some of these cultural values and religious beliefs.

### **3.5.1 Religious Beliefs**

The way individuals from BME groups cope with their illness is generally shaped by their belief system, which can involve engagement in religious rituals or social activities appropriate to their world views in order to reach recovery (Bhui and Morgan, 2007). According to Haque and Kamil (2012) and Weich et al. (2012), a majority of Muslims tend to have a religious component to their belief system, which they consider a source of strength and support through which they face the many challenges of life. Additionally, many will consent to the fact that everything happening in life is taking place according

to God's will and that their destiny or fate (Qadar) is established even before they are born. Many Muslims interpret the idea of Qadar by accepting that it is their responsibility to thrive to achieve the best outcomes in their life, and yet if an outcome is not the desired one, they will feel content to put complete trust in God's mercy and forgiveness because everything is under His control. This gives an example of how "closeness to God" as Haque and Keshavarzi (2014) noted, can give people the strength and resilience to handle difficulties in life.

Religion and cultural beliefs provide individuals with meanings about their suffering and offer explanation of distress as well as helping people to find appropriate support and reach recovery (Ali, 2013; Keynejad, 2008; Lawrence et al., 2006). For example, Haque and Kamil (2012) noted many Muslim patients' reluctance to engage in therapeutic processes because they might perceive their illness as a punishment from God for their real or imagined bad behaviour. Some believe that if they endure pain patiently and resist whims and desires, they will be rewarded in the afterlife and all their sins will be forgiven (El-Islam, 2008; Loewenthal, 2006; Utz, 2012). But as argued by Bhui and Bhugra (2004), the lack of knowledge or appreciation of how Muslims arrive at these perspectives by some therapists can be problematic in therapeutic encounters, mainly if therapists have different world views from patients or lack knowledge of how to respond to such beliefs.

To illustrate this last point, Gater et al. (2010), Khalifa et al. (2011) and Rathod et al. (2010) provided some examples of some BME patients' understanding about the nature and causes of their distress and how they may refer to supernatural phenomena such as Jinn, evil eye<sup>7</sup>, and black magic<sup>8</sup> as possible causes for unexplained emotional suffering. As explained by the authors, Muslims on the whole refer to the existence of Jinn, and their abilities

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<sup>7</sup> When a person harms another with envious looks or feelings against a desirous object of attribute of another person. By repeated looks at the objects of their jealousy, the other person could be harmed. More information is available at: <https://islamqa.info/en/20954>

<sup>8</sup> When a person experience unexplained behaviour without an obvious reason such as a sudden dislike to his spouse, frequent miscarriages or complete loss of interest in life. Although such issues could be related to psychological distress, the Quran recommended certain steps to cure these conditions. Available at: <https://islamqa.info/en/240>

to conceal themselves from mankind from the many verses in the Quran. As stated in the Quran, Jinn can harm mankind either by causing them psychological distress: (From the evil of the retreating whisper who whispers [evil] into the breast of mankind<sup>9</sup>) or through possession and teaching people black magic. This, as believed by many Muslims, can cause people misfortune or disappointment in life: (From the evil of the darkness when it settles, And from the evil of the blowers in knots, And from the evil of an envier when he envies<sup>10</sup>). It may be for these reasons that some BME patients might seek spiritual and religious healers' support as a first line of treatment for mental health problems because they are believed to have extra powers to help them (Lago, 1996).

Muslims notions of possession by evil spirits, evil eye, and black magic are rarely recognised within statutory services, which can cause conflict with non-Muslim therapists who have limited understanding or skills to deal with such beliefs (Haque and Keshavarzi, 2014; Khalifa et al., 2011; Shefer et al., 2012). Despite the fact that some religious and cultural beliefs are the norm within these cultural groups, there has been no research performed to study the effectiveness of traditional healings or their disadvantages in comparison with the Western biomedical models, as pointed out by Eleftheriadou (2010), Shefer et al. (2012) and Tribe (2014). This raises the critical question of why some therapists seem to ignore cultural differences and instead over-generalise the factors that should be considered in therapeutic encounters. As noted by Revollo (2013), the ability to understand the belief system of BME patients can not only gain the trust of these groups, but can also generate a better understanding of individuals' world views to intervene in a culturally sensitive fashion. Therefore, these studies offer valuable insights and a starting point to research how PSY patients are likely to interpret their emotions from a religious perspective and cope with their mental distress.

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<sup>9</sup> Surah an Nas verses 4 and 5

<sup>10</sup> Surah al Falaq verses 3,4 and 5

### 3.5.2 Cultural Beliefs and Norms

Cultural norms are another factor that can influence the way individuals from different BME groups express their emotional distress and encourage or discourage certain behaviours to deal with mental distress. Dwairy (2006), Eleftheriadou (2010) and Ibrahim and Dykeman (2011) listed two cultural norms that repeatedly discourage individuals from talking about their private life or emotional distress. Primarily, patients are unable to recognise how talking alone can improve the situation. Secondly, patients may feel ashamed about revealing information about topics such as sexual orientation, which are considered either inappropriate to share with anyone or taboo subjects that could bring shame to the family. Where the latter is the case, Keynejad (2008) has reported that often Pakistani women struggle to seek help from therapists because it could harm the family's reputation and affect possible marriage prospects for other members of the family.

The restricted interaction between women and men, which is enforced by Islamic rules, can be another barrier that can limit access to therapy by both genders. This is further reinforced by traditional norms which limit the self-disclosure of in-depth emotions between people of different genders and regulate the level of modesty and eye contact allowed during these encounters. For example, El-Islam (2008) noted that Arabic women in some cultures are not allowed to talk about their emotions in front of strangers, including health professionals. Dwairy (2006), Keynejad (2009) and Shefer et al. (2012) found that in addition to restricted interactions, a further two factors affect women's attendance in therapy. First, whereas the attitudes towards mental health issues in men are more forgiving, for example assuming stress at work or home, a woman with mental health problems is more likely to be perceived as 'crazy'. Secondly, men are more able to attend therapy without the knowledge of others, whereas women, who men are sometimes considered to have authority over, would find it more difficult to seek help without the knowledge of others or permission from their husbands.

Finally, within BME community groups, talking about emotional and psychological distress is often discouraged and may evoke criticism, while

complaints about bodily symptoms on the other hand, is considered quite acceptable and worthy of attention, and can generate help and sympathy (Dwairy, 2006; Keynejad, 2008; El-Islam, 2008). As a result, BME patients were noted to express their emotional distress using terms of physical pain and metaphorical expression such as “the heart is sinking”, “my head is exploding” or “I can’t breathe”. This is known as “somatisation”, which is a socially recognised behaviour within BME groups. Somatisation occurs when individuals express their distress through bodily complaints, which are experienced as a response to stressful events, despite the absence of any pathophysiology of the organs alluded to (Dwairy, 2006; Patel et al., 1995).

To sum up, cultural norms and rules can offer us insights into patients’ values and beliefs, and predict their behaviours. Because cultural norms can be represented symbolically, patients can reflect the various aspects of their identity, and make references which reveal their sense of their world, whether through making references to large cultural groups, such as being Muslims or Pakistani, Somali and Yemeni, or smaller groups, such as those who are able to speak English and those who speaks basic English (see Sections 7.1, 7.2, 8.1.4.2, 8.3.1). In this research, these noteworthy topics will receive particular attention during observations of and communication with study participants.

### **3.5.3 Family Values**

Typically, PSY groups, the subjects of this research, come from a collectivist society, who consider the individual as part of a group, which may be family, tribe, community, religious organisation, or social networks (Dwairy, 2006; Ibrahim and Dykeman, 2011; Rathod and Kingdon, 2009). In collectivist cultures, the family is perceived as the main authoritative figure to whom the individual performs his duties and obligations, and sacrifices his own self-interests (Dwairy, 2006; Ibrahim and Dykeman, 2011; Keynejad, 2008). As pointed out by these authors, family integrity, harmony, interdependence, and core values are key principles within the collectivist culture. For most of these groups, family plays an important role in the individual’s life, and if the

individual is encouraged towards independence in therapy sessions, this may affect the attendance and can cause confusion for the patient.

As a consequence, BME groups normally seek help within the family circle because they believe the family will offer encouragement and support along with a sense of security during difficult times (Kai and Hedges, 1999; Park et al., 2011; Weich et al., 2012). Generally, family members' involvement in therapeutic sessions is often appreciated by therapists because they encourage the individual to seek professional help and ensure the patient's interest in and engagement with therapy. Nevertheless, to ensure the protection of family welfare, family members from BME communities, when involved in the session, often discourage patients from disclosing various confidential facts about family life (El-Eslam, 2008; Rathod and Kingdon, 2009) and prevent the individual from having their own voice (Dwairy, 2006; Haque and Keshavarzi, 2014; Martin, 2014; Rahiem and Hamid, 2012; Rathod and Kindgon, 2009). As a result, this impacts negatively on the person's thoughts and feelings, causing emotional distress and impairing their engagement in therapeutic sessions.

Another factor that can affect therapy attendance is the individual's fear of discussing topics related to substance misuse, domestic violence, sexuality, or suicide in front of their own family (Rahiem and Hamid, 2012). Dwairy (2006) and Keynejad (2008) further illustrated that a large number of BME family members fear the reaction of community gossip and the stigma around mental health; therefore, in order to hide mental health illnesses from others and avoid the exposure of secret family problems that could damage the family reputation, they stop the individual from seeking help. Finally, a number of authors reported that because families sometimes have a different concept of mental distress in which they devalue talking therapies, they deny or discourage the individual from accessing these services (Cairns, 2013; Eleftheriadou, 2010; Gater et al., 2010). Therefore, one of the objectives of this research is understanding the patient within their family, social and cultural networks as it may involve learning about the influential components of these networks on an individual's life.

### **3.5.4 Perceived Similarity between Patients and Therapists**

Another factor that can impact therapeutic sessions is the perceived similarities between patients and therapists such as ethnic, cultural or language matching, as perceived similarities are considered culturally and socially more appropriate. Generally speaking, when patients from BME backgrounds come across therapists of similar backgrounds, they feel better able to achieve improved communication and positive outcomes of therapy (Bhui and Sashidharan, 2003; Burman et al., 2003; Kai and Hedges, 1999; Lopez et al., 2014; Netto, 2006; Nezu, 2010; Park et al., 2011; Smich et al., 2009; Swartz et al., 2014). Previous research has shown that patients who are able to take part in therapy in their mother tongue remain longer as they are more able to express themselves properly and will feel more comfortable discussing their difficulties with people who share the same language (Lopez et al., 2014; Loue and Sajatovic, 2008; Nagayama-Hall, 2001; Smich et al., 2009). Moreover, recent studies have indicated that BME patients believe sharing similar experiences and cultural backgrounds with therapists enable the latter to provide more culturally appropriate services and offer proper advice for working and engaging with BME groups (Loewental et al., 2012; Lopez et al., 2014). Additionally, they are more aware of BME cultural values and beliefs and demonstrate greater competence in assessing specific areas of concern (Bhui and Morgan, 2007; Chang and Yoon, 2011; Netto, 2006). The studies presented thus, provide evidence that perceived similarities between patients and therapists enable the latter to generally deal with BME individuals in a considerate manner and address their needs in a more sensitive way (Chang and Yoon, 2011; Kai and Hedges, 1999; Nezu, 2010).

Conversely, mismatching can be perceived as a significant barrier as BME groups can feel that Western therapists are unable to understand their experiences as people of colour. However, several researchers have argued that matching in therapy can and does present its own challenges in therapeutic encounters (Bhui and Sashidharan, 2003; Chang and Yoon, 2011; Kai and Hedges, 1999; Keynejad, 2008; Nezu, 2010). The researchers drew attention to the problems associated with disclosing issues related to

sexuality or subjects that are considered taboo within BME communities. Furthermore, they explained that such issues could be worrying for the younger generations, who feel the need to integrate different cultural perspectives, and seek help outside the circle of the local community. This latter issue demonstrates the negative experiences that some BME groups may go through when working with people from their own community and the impact this may have on attendance of therapy and developing trusting relationships (Eleftheriadou, 2010; Kai and Hedges, 1999). Considering the different outcomes from these studies regarding ethnic/cultural and religious matching, the use of interviews in this research is hoped to contribute to a more nuanced understanding of the complexity behind ethnic/cultural and religious matching in therapy.

### **3.5.5 Patient-Therapist Relationship**

Positive outcomes of therapy are very much reliant on therapists' skills and awareness of how to approach patient's views about health and wellness and the manner in which to address the symptoms that are related to norms and/or religion. Therefore, several researchers have pointed out that therapists who have little understanding or appreciation for patients' beliefs and cultural systems, including religious and spiritual coping mechanisms, might not be able to relate to clients or provide them with appropriate meanings of their worries to overcome their difficulties (Bhui, 2013; Ibrahim and Dykeman, 2011; Haque and Keshavarzi, 2014).

The studies have also shown that therapists should have the ability to face any hidden feelings towards minority groups and develop an openness towards their cultural backgrounds with a real intention to accept BME patients as they are and without having pre-judgemental or stereotypical prejudices about their ethnic or racial background, or norms (Lago, 1996; Abu Baker, 1999). As declared by Chang and Yoon (2001) it is quite important to acknowledge the impact of racial and cultural attitudes between Western therapists and BME groups because the latter often feel that Western therapists are unable to perceive their experiences or show willingness to discuss the social racism they encounter in their daily life with them.



According to Khan and Ecklund (2012), these reactions appear to have affected some Muslim populations following the post 9/11 events, where they became reluctant to seek help from dominantly Western services. The authors clarified that the power dynamic that normally exist between therapists and patients can be compounded by power relations between Western therapists and BME patients, which if not acknowledged by therapists, can lead to negative reactions or may recreate power imbalance experienced outside of therapy.

### **3.5.6 Perception of Therapy**

The concept of therapy is quite alien to some BME groups, who may be unable to perceive how talk alone can cure them and think therapy is a waste of time. Consistent with Dwairy (2006), Lawrence et al. (2006) and Nezu (2010), BME patients normally attend therapy without prior knowledge or familiarity with the concept of therapy or have difficulty in conceptualising the process and its outcome. For that reason, many fear the discomfort related to the experience and tend to not accept therapy alone as a model of treatment (Loewenthal et al., 2012; Loue and Sajatovic, 2008). BME patients also usually look for a quick fix and expect to see immediate results, which can affect their involvements in any “homework” tasks that are considered common tools for CBT (El-Islam, 2008). Such behaviour might be interpreted by Western therapists as failure to comply with treatment and/or unwillingness to engage in therapy.

As explained by Haque and Keshavarzi (2014) and Sverberg et al. (2013) and as discussed in Section 3.5.1, many BME patients believe that the spiritual and physical are intertwined, so that closeness to God is most likely to lead to healthy wellbeing whereas distance from God can cause difficulty to cope with adversity. For these patients, the concept of therapy is very much associated with Islamic teaching and spirituality, and finding the balance between mind and body (Haque and Keshavarzi, 2014). Such teachings direct the individual's behaviours to positive values in order to achieve purification of the heart and cleansing of the soul from ill thoughts. It's for this

reason that some BME patients repeatedly seek help from spiritual healers such as Sheiks or Imams rather than attending therapy.

Another issue, as mentioned by Kai and Hedges (1999), Martin (2014) and Netto (2006), is the fact that BME groups tend to understand therapy as a short term measure to be accessed in crisis, such as bereavement in the family, to allow the individual the opportunity to take the weight off their mind and speak about any emotional distress (Kai and Hedges, 1999; Loewenthal et al., 2012). Therapy is not sought for apparently more trivial issues, which may lead BME individuals to conceal their mental health and as a result, develop into more serious mental health problems (Keynejad, 2008; Loewenthal et al., 2012). Furthermore, therapy is not considered a long term collaborative process as it should be (Martin 2014)

To summarise, these relatively common perceptions of therapy create the grounding for this research. Several questions remain unanswered by the studies mentioned in this review. Therefore, this research strives to explain the various implications of the emotional expressions in order to understand the relationship between individuals' behaviour and social contexts. Moreover, regarding the role of language and culture in therapy, it is apparent from the literature review that the two different research avenues examined contribute differently to enquiries in this field. Hence, in what follows the researcher will compare in chronological order between research in this area where the focus was on researching patients' encounters and patient-centred research. Then, she will examine and reflect on both types of research and determine the direction that guides this research.

### **3.6 Researching Patients' Encounters vs. Patient-centred Research**

Researching patients' encounters is a term used by the researcher to explore research on patient-professional interactions in therapeutic settings. This research involves mental health professionals studying, commenting on, and analysing their practices and interactions with patients. Although mental health professionals worked competently with patients' illness and were able to enhance their understanding of issues related to language and culture in

these settings, there was a growing emphasis to focus the attention on patients' engagement and perspectives. Balint (1969) was the first to introduce the term 'patient-centred care' arguing that it was the missing piece that is necessary to focus more on 'understanding the patient as a unique human being'. Patient-centred research is a complementary approach to patient-centred care and emerged from the idea that engaging patients as partners in healthcare research would help bring about a more comprehensive understanding of patients' perspectives and improve their engagements (Concannon, 2015; DoH, 1999; Royle et al., 2001). Patient-centred research focused on understanding the patient's world and explored their views and perspectives of psychological distress. This type of research uses different approaches, such as interviews, focus group discussions, story-telling and narrative approaches where the focus is to allow patients the opportunity to talk about their experiences and voice their concerns.

In the late 90s, the researching of patients' encounters involved studying therapist-patient interactions and examined the role of culture, race, and ethnicity in these relationships. (Abu Baker, 1999; Bhugra and Bhui, 1998; Lago, 1996; Petal et al., 1995).

Researchers highlighted the importance of working cross-culturally for both ethnic groups and therapists, as some believed working with minorities would not only benefit BME groups, but would also expand Western therapists' knowledge of the different health concepts, healing processes, as well as the explanatory models of illness. The cross-cultural interactions as discerned by Comas-Dias (1992), create a "pluralistic perspective", which can enhance therapy. Therefore, these encounters illuminated the need to conceptualise patients' distress and have a better understanding of their religious beliefs and the social context of their mental illness. Accordingly, the focus of therapy was directed towards adhering to the cultural meanings and world views of patients and their explanations of what constitutes mental illness (Lago, 1996). This meant that therapists should realise the importance of translating not only plain content of the message but also paying close attention to the way through which this message is being expressed – ensuring it is in a

manner that is consistent with the patient's explanatory model of illness and cultural belief system (Bhugra and Bhui, 1998; Patel et al., 1995). The attention was directed towards understanding the different concepts of culture, particularly as pointed out by Guarnaccia and Rodriguez (1996), the focus on culture being not only a process but also a product of both the combination of group values, beliefs, norms, and the individuals' experiences.

Researchers also emphasised the need to have BME therapists and therapists who are trained to be both more aware of BME issues and are willing to work with diverse populations in order to study the impact of cultural variables on the outcome of therapy and to tackle issues of racism. Studies have mentioned the need for therapists working with BME groups to be aware of their own existing cultural views and how these might function as a "cultural filter" and affect their attitudes towards minorities (Abu Baker, 1999). For example, some Western therapists believe the non-attendance or non-engagement of some Pakistani Muslim women who are distressed is related to conflicts with the family and/or Islamic rules. This stereotyping attitude may affect the interaction and lead to barriers to understanding patients. Hence, such issues merit further research as they can offer realisation of how such issues may influence the communication process.

Along with progress in incorporating outcomes from researching patients' encounters into the delivery of therapy, studies have also concentrated on further understanding the cross-cultural issues and developing recommendations for therapy from patient-centred research. Patient-centred research focuses on patients' views and concentrates on exploring BME patients' perception of psychological distress. The studies drew attention to the need to engage effectively with BME community groups and explore the group experience as well as the individual experience, in order to overcome any generalisations or unsuitable treatment and provision of health care (Rait and Burns, 1997). The consultations were intended to address the issues related to inequality of service provision to BME groups and other possible misunderstandings or misinterpretations of the different community groups'

needs (Clive and Hedges, 1999). As highlighted by Kareem and Littlewood (1992) and Tribe (1999), issues such as racial differences and language barriers, were found to impact on the consultation encounter, and showed that BME patients can feel comfortable when working with therapists who share the same cultural background, knowledge of language, and understanding of mental health. These similarities help patients build trusting relationships and achieve positive outcomes. The studies confirmed the points previously raised in researchers' encounters although they drew more on the need to understand communication difficulties and work towards developing a better intercultural therapeutic experience that is not based on a universal model.

At the beginning of the 21<sup>st</sup> century both research avenues – researching patients' encounters and patient-centred research – argued whether BME patients should have specialised services to ensure therapists' understanding of cultural, spiritual, and religious beliefs or whether mainstream services should ensure the inclusion of trained BME therapists to guarantee the capability of services to respond to all culturally diverse groups.

Research that focused on patients' encounters pointed out that the inclusion of BME therapists or having specialised services for BME groups ensures that the different cultural and linguistic variables, which some BME groups may encounter in cross-cultural therapeutic encounters are being identified and addressed (Bhui and Bhugra, 2004). For instance, Pavlenko (2006) reasoned that speaking the native language allows the person to feel comfortable in relaying their feelings and in fully expressing themselves. Dwairy (2006), who has been trained as a Western psychologist, believed that therapists should work within the patients' belief system and their collective nature and adapt their therapeutic techniques to be more culturally appropriate. Moreover, El Islam (2008) pointed out that the lack of knowledge or appreciation of how Muslims arrive at their perceptions or the inability to understand the belief system of BME groups may increase the gap of misunderstanding between these groups and affect their uptake of

therapeutic interventions. For these reasons, researching patients' encounters highlighted the need to focus on studying the expression of distress in different cultures and to have an open dialogue with the different BME groups. This kind of research can validate the effectiveness of similarities between therapists and patients such as, culture, language, religious beliefs and/or ethnicity in therapy, and provide insight into the different minorities' therapeutic experiences to enable a better understanding of the kind of care they receive and how services should be developed to accommodate their health needs (Nagayama Hall, 2001, Bhui and Sashidharan, 2003).

Patient-centred research undertaken at the beginning of the 21<sup>st</sup> century focused on exploring patients' views and offered a more complex picture to the ongoing debate about the provision of mainstream services and the separation of services for BME groups. The 'One Size Fits All' approach, the culturally contextual variables, and the need to focus on the social context outside therapy, were all issues whose value in cross-cultural therapeutic encounters received increasing recognition because of their crucial impact on the relationship between therapists and patients (Burman et al., 2003; Keynejad, 2008; Netto, 2006). Therefore, patient-centred research sought to gather information about how patients describe their distress and the role of social and cultural factors in coping with and experiencing mental health problems, rather than assuming that patients from certain cultural and language backgrounds will have certain needs (Karasaz, 2005; Keynejad, 2008; Netto, 2006). Patient-centred research focused not only on understanding culture as a set of practices and beliefs but also as a process of interpreting meaning. The outcome of this research suggested a collaborative work to be undertaken between mainstream services and the specific BME services as supplementary service providers. This would complement mainstream services' work, respond to the different cultural variables, and ensure patients' needs are met (Keynejad, 2008; Netto, 2006; Simich et al., 2009).

In addition to the above, patient-centred research raised issues similar to research focusing on therapists' encounters with patients, such as the concept of mental health and cultural values, the lack of knowledge or understanding of the culture of the other, and the inability within mental health services to speak minorities' languages ((Burman et al., 2003; Karasz, 2005; Simich et al., 2009). But the major developments of patient-centred research were to explore the different coping and help-seeking strategies amongst the different BME groups, the lack of understanding or the insufficient information about the services available, as well as providing recommendations to improve service provision. Such developments were fairly important as they aimed at increasing the mutual education of therapists' understanding of the barriers that may hinder mental health promotion amongst BME patients as well as ensuring that patients are empowered with knowledge of how to access services and collaborative work necessary between patients and therapists Keynejad, 2008; Simich et al., 2009).

Recent research studies that focused on patients' encounters and proceeded until late 2014 centred on understanding the impact of language on the way people express their distress and further examined the existing knowledge about cultural beliefs of BME patients. Psychotherapists and clinical psychologists continued to reflect on their encounters with BME patients and concentrated on their own experiences and awareness of communication differences and how this might impact on therapy. In particular, researchers highlighted that cultural knowledge is a life-long learning process that should be recognised. For instance, Nezu (2010), a clinical psychotherapist, reflected on his ethnicity as a factor that may have influenced his clinical practice and affected his approach to understanding human behaviour in a better way. He concluded that being from a minority ethnic background allowed him to be aware of non-verbal cultural communication and understand differences appropriately. Additionally, other researchers believed that educating BME patients about the different models of therapy available is important in improving access to services (Bassegy and Melluish, 2012; Eleftheriadou, 2010; Ibrahim and Dykeman, 2011). Studies have also acknowledged the different concepts of mental health in the different cultural

traditions of healing and touched on the need to allow room for BME patients to be understood within their racial and cultural contexts (Bassey and Melluish, 2012; Eleftheriadou, 2010; Nezu, 2010).

One main outcome resulting from researching patients' encounters was the importance of understanding the views of Muslims, who identify strongly with Islamic values and believe that all the solutions to their problems exist in the revelations of the Quran. According to Haque and Keshavarzi (2014), the culturally competent therapist must work on a relationship that encompasses an understanding of the patients' belief system. Another important outcome of these studies emphasised the need for the therapist's personal development and emotional engagement of therapists with patients. These studies addressed a number of issues that future research needs to take into consideration – in particular, the need to reconcile Western clinical dialogue with the non-Western by being more sensitive to BME's traditional healing models and working on incorporating some of these traditional thoughts in therapy (Haque and Keshavarzi, 2014; Nezu, 2010). Moreover, therapists need to understand patients' culture as this may lead to a better understanding of patients' suffering (Isaac, 2013).

In addition to the above issues, a wide range of researchers have centred their studies on the difficulties encountered when using an interpreter, which is often considered far from the ideal situation in therapeutic encounters. For example, Bhui (2013) highlighted the difficulties patients may experience in expressing deep emotional experiences, which while challenging in a shared language, is even more so across languages and cultures. Thus, involving an interpreter in psychotherapy can undermine the therapeutic alliance between patients and therapists. Despite interpreters and patients sharing a common language, problems may arise due to dialect and variations in language-use causing misunderstanding (Eleftheriadou, 2010). In addition, the presence of an interpreter in therapeutic encounters may impact on patients and they may feel reluctant to share their problems. Hence, in order to work effectively with interpreters in a mental health setting, one of the main outcomes of this research was developing training programmes for



interpreters to improve their performances. As further problems were reported, Tribe (2011) recommended training that included some guidelines for therapists and health clinicians on how to work through interpreters in an efficient way. These were incorporated into the 2013 NHS/NICE guidelines to enhance service delivery and ensure that language should not prevent those with limited proficiency from accessing psychological therapy in the host country.

Although there has been considerable research conducted regarding developing training programmes to enhance the performance of interpreters and train therapists to establish a good working relationship with interpreters, much of the focus has been centred on developing new skills for both interpreters and therapists that can ensure effective communication between therapists and patients. Little systematic research has considered the impact of using interpreters from the patients' perspective.

Taking this into consideration, patient-centred research recently examined the consequences of using interpreters in therapeutic encounters and their influences on the expression of mental distress, focusing mainly on patients' experiences of interpreters rather than therapists' (Costa and Briggs, 2014). Similar to the results of researching patients' encounters, a difficulty of engaging effectively with therapists was attributed to the presence of an interpreter (Brune et al., 2011; Loewenthal et al., 2012). As a result, the chief executive officer of the organisation *Mothertongue* in the UK developed a dedicated Mental Health Interpreting Service which is delivered by the organisation and commissioned by the Local Health Trust to overcome some of these language issues. The organisation aims at providing in-house training for interpreters by increasing their awareness of mental health issues, and is built on developing the relationship between the therapist and the interpreter as well as providing continuity and consistency by using the same interpreter for a series of consultations (Costa and Briggs, 2014). Reported benefits of this model included working in a triadic system as opposed to dyadic, whereby there is inclusion of the interpreter as a conduit for therapy. In addition, patients have increased satisfaction with the

therapeutic session as the interpreter is more aware of language and cultural issues facilitating a more positive outcome of therapy (Costa and Briggs, 2014).

Other themes that echoed previous studies on researching patients' encounters were the perceptions of depression and emotional distress, how this may influence the decision towards seeking help (Bristow et al., 2011) as well as relating the concept of therapy to Islamic teaching principles (see Sections 3.5.1, 3.5.3, 3.5.6). Hence, the health beliefs and practices of Muslims have received a lot of consideration and attention and have been much debated up to the present date. Much of this debate may be due to beliefs that tend to relate the nature and causes of distress to supernatural phenomena, such as Jinn, black magic, and evil eye, which remain relatively unexplored. Therefore, researchers in this domain believed that while linguistic barriers can affect the communication and interaction between patients and therapists, religious and cultural differences and the lack of understanding of these differences are the main factors that can lead to health disparities in the quality of received care between BME groups and UK population (Khalifa et al., 2011; Loewenthal et al., 2012; Weich et al., 2012). Similar outcomes of these studies such as the relationship between symptoms of distress and patients' stories, the influences of spiritual and traditional healing systems, and the unsuitability of therapeutic tasks for BME patients' culture needs, echoed previous researchers' encounters with patients (Bassegy and Melluish, 2012; Ibrahim and Dykeman, 2011; Nezu, 2010).

A new area that has emerged from patient-centred research and received considerable thought, but remains relatively unexplored, in therapeutic encounters is the issue of race and the relationship between BME patients and therapists (Chang and Yoon, 2011). The outcomes of these studies showed the reluctance of some BME patients to discuss racial issues in therapy because they believed White therapists might not understand perceived disadvantages or hidden historical racial thoughts. Moreover, feelings held by both BME patients and therapists can affect the therapeutic

alliance in therapeutic encounters if not explored or shared (Chang and Yoon, 2011). Mismatches, perceived differences, inequalities in the provision of mental health and patients' lack of trust in the health care system, were other factors believed to have adverse effects on some BME patients and their abilities to discuss issues such as the "other" or the "dissimilar" (Chang and Yoon, 2011; Tse et al., 2012; Weich et al., 2012).

The growing media attention towards content that fuels discriminatory attitudes towards Muslims since 9/11 events and the racially offensive attitudes towards them has become another area of concern in more recent years. This is mainly because Muslim patients who are exposed to such offensive attitudes have shown an increased rate of stress, which has had consequences on mental health such as depression and anxiety (Abu-Ras and Abu-Bader, 2009). Many Muslim patients were reluctant to report the harassment and were fearful of approaching and seeking help from dominantly Western services which might show indifference to patients' experiences and generate a negative stereotypical image of them (Khan and Ecklund, 2012). The outcome of this research suggested the need for therapists to be more concerned with any potentially negative remarks during therapeutic interactions and be more aware of the prejudicial views against Muslims (Husain, 2015). In addition, patients' views contributed further to the counselling settings by emphasising the need for therapists to be more culturally sensitive and aware of the multiplicity of factors that may impact on the therapeutic relationship with BME patients.

### **3.7 What is learnt from Previous Research and the Direction of this Study**

On examining previous literature that has focused on researching patients' encounters in addition to patient-centred research, four main themes have emerged. These themes are: cultural backgrounds and views, religious and spiritual beliefs, emotional expressions, and the concept of therapy.

The two research avenues discussed above considered the recognition of culture as defined in Section 3.4 as an important factor that may impact on

building a good rapport with patients and in facilitating an understanding of patients' concept of distress, but from two different points of view. Researching patients' encounters made an effort to draw attention to the factors that may influence the building of helpful bond with patients. The role of culture emerged as an important factor because awareness of a patient's culture can not only increase therapists' awareness of the patients' cultural meaning of distress but can also develop an empathetic understanding, openness, and sincerity of how to approach and engage with the patient appropriately. Patient-centred research, on the other hand, focused on patients' views in order to be able to accommodate their needs. Accordingly, attending to patients' meanings of distress is considered a primary concern as it opens a window into understanding the patients' culture and seeing the world through their eyes. The combination of both points of view can contribute to a better understanding of how culture shapes everyday practices and can help identify the meaning of an experience. Therefore, this research, while focusing on understanding how patients articulate their cultural experiences of therapeutic encounters, will raise questions about how patients feel their cultural issues are being understood by therapists.

Religion and spirituality were also highlighted within both types of research, although patient-centred research has focused more on religion as a coping mechanism and offering a description for the meaning of distress. Hence, patient-centred research described the role of religion, particularly for Muslim community groups, as critical, and stressed the need to consider the applicability of Islamic intervention in dealing with mental distress. This is an area that will be explored with participants<sup>11</sup> in this research and questions will be asked on how they understand and apply their religious beliefs to address mental health problems. Similarly, attention will be given to patients' articulations when making religious references in order to gain an in-depth understanding of the role of religion in therapy.

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<sup>11</sup> The term 'participant' is used to describe those involved in the interviews to promote equality and emphasise the importance of patients' active participation, involvement, and engagement in research.

Another interesting issue raised in both types of research and impacting on therapeutic encounters is that of language barriers, when language expressions are seen not only as a means of communication but in fact are very much dependent on culture, which shapes the understanding of such expressions. Due to the non-proficiency in the English language, patients may not be able to communicate with therapists and express their feelings or convey their thoughts, because the meaning of distress can be expressed differently from one culture to another. In addition, while using interpreters was meant to facilitate the communication and promote the understanding of cultural differences between therapists and patients, using interpreters in therapeutic sessions has its own limitations if interpreters may not be able to convey the meaning of the message or exhibit patients' affective states in a subtle way. As a result, therapists may fail to connect with patients and the latter become unable to comprehend the meaning of therapy. Furthermore, using interpreters in therapeutic encounters, while being quite valuable for both therapists and patients, has been experienced by both therapists and patients as disempowering. The difficulty in describing one's emotional feelings using a voice that is not one's own, with the inability to know whether one's words state exactly what one wants to say or feel, is quite frustrating for patients (see Section 3.3.1.1). Equally, therapists have voiced that, often, emotional expressions seem to be missed or not fully interpreted. For that reason, interpreters, particularly the inexperienced, constitute a huge barrier to recognising hot spots in patients' memories about certain events. The proposed study will further investigate whether it is possible to carry out meaningful therapy through interpreters. This is mainly because CBT is very much dependent on the subtle distinction between thoughts and physical sensations (see Section, 2.2.1) and if interpreters are unable to relay information correctly, therapists will be unable to understand and communicate effectively with patients.

A number of factors may also affect the communication of emotion between therapists and patients. One important and relatively unexplored area is the capacity of patients' vocabularies for expressing emotions and the language of distress. It is believed that the difficulty in interpreting emotional

expressions between two languages stems from the unavailability of or difficulty in finding suitable equivalents. It has been also highlighted that culture impacts on the way patients express themselves. As stated earlier in previous research, emotional terms are not always usefully translated by other emotional expressions. As outlined in the preceding paragraph, the use of interpreters, while being of immense help to both therapists and patients in therapeutic encounters, has also been recognised as being somewhat complex and unable to offer the same working relationship as when both therapist and patient speak the same language. Equally complex is the question of ethnic matching with therapists. Although this has been voiced by some BME patients as beneficial and preferred, other patients have raised concerns about confidentiality issues and have commented on the need to seek help outside the circle of the local community to enrich the relationship between Western therapists and BME patients. To sum up, it is absolutely central within this complex situation that we hear the voices of the patients in relation to emotional experiences in therapeutic encounters. This will be of particular interest to this research and will offer the opportunity to learn more about how emotions are expressed differently between cultures.

Emotions are at the heart of any therapeutic encounter and are of primary interest in psychological settings. Articulating the emotional experience not only helps patients to understand their emotions and make sense of their feelings, but also enables therapists to offer the appropriate help needed. The practice of therapy is mainly dependent on helping patients understand their emotions and increase their awareness of the emotional experience. This will enable patients learn how to regulate and/or identify unhelpful emotions in order to develop better ways of coping with distress. Therapists' true willingness to help patients and to have empathy and compassion is a key ingredient of successful patient-therapist relationships in these encounters (Barden and Williams, 2007). The centrality of emotions and the articulations of patients' emotions has been shown in the discussion earlier in this chapter (in particular, Sections 3.2.1.3, 3.3.2 and 3.3.3). It is evident that we cannot research language and culture in therapeutic encounters without researching emotions. Therefore, understanding patients' emotions

is fundamental to this research. The proposed study will build on the fact that people in different cultures use different languages to express their emotional distress, assessing the extent to which patients feel that their emotions are received and explored by therapists. Further, it will explore patients' opinion of both verbal and non-verbal language used by therapists to explore their emotional distress, and whether or not therapists are displaying appropriate emotions to their distress and how this impacts on the patient. Additionally, the research will pay particular consideration to how patients use language to talk about their distress and what language they use to describe their emotions.

Finally, there is an indication in both research avenues that the concept of therapy is not entirely understood by some BME patients and they are more likely to turn to family, considering them the most appropriate channels when seeking help. The proposed study will explore patients' experiences of the concept of therapy and what it means for them to seek it. Furthermore, the study will ask patients to talk about their expectations when attending therapy and how these expectations affect their interactions and understanding of it. By asking these questions, the research will draw on how language use impacts on the purpose of therapy.

### **3.8 Summary**

In summary, this chapter has offered the reader an overview of the literature about the concept of mental health and various theories related to language-use and discourse in therapy, translation, interpretation, and the communication difficulties involved in therapeutic intervention, as well as a discussion about the possible influences of cultural and religious beliefs in the way BME individuals convey or express their emotions. Following earlier research on patients' encounters and patient-centred studies, it was noted that both research avenues called for the need to pay close attention to understanding patients' cultural backgrounds, their belief system, and the emotional experiences of mental distress. However, most of the initial studies of issues facing BME patients that are accessing therapy have considered the need for therapists to view the role of culture to ease the understanding

of patients' emotional distress. They must be aware of how this might impact on their relationship with patients. In addition, most existing patient-centred research has focused on patients' views and perceptions of mental distress and how this may impact on their decision-making in seeking help, in order to accommodate their needs. This has led to the development of recommendations and guidelines in order for therapists to work effectively with interpreters with the objective of increasing their understanding of patients' emotional meanings. While aiming to have better outcomes for patients, the aspect of this earlier research has given little attention to patients' voicing of their experiences of psychological distress. Attending to patients' articulations allows them to define and better understand their emotions. Moreover, patients' declarations can provide a thorough description of their awareness, allowing therapists to focus more on the hidden aspects of the communication.

Based on the outcomes of this literature from researching patients' encounters and patient-centred research, key areas were identified for developing research within this field in which patients' cultural backgrounds and emotional expressions are the focus. This study aims to focus on patients' perspectives of therapy and how they express their emotions in order to learn more of how emotions may be expressed differently by people of other languages and cultural backgrounds. The recent studies of Loewenthal et al. (2012) and Lopez et al.'s (2014) centred on evaluating IAPT interventions for BME patients, specifically conceptualisation of mental distress coping, in the former, and exploring the effectiveness of adaptation for different cultures in the latter. Here the focus is almost exclusively on the patients' articulations of IAPT services and the language and cultural backgrounds that can influence the access to these services.

Despite the recognition of the importance of understanding patients' perspectives on language barriers, including the use of interpreters in therapeutic encounters and cultural backgrounds, it appears that less attention has been paid to BME patients' own voices. Involving patients in research contributes to the wealth of knowledge in the mental health field and



ensures that research will impact on and benefit people. Despite the Department of Health (2005) stating that members of the public and patients should be involved in the 'design, conduct, analysis and reporting of research', the involvement of patients in research can at times be seen as a "box-ticking" exercise and often does not go beyond seeking knowledge about their experiences and how they can play a role in shaping and developing policies and practices. However, the methodology of this research believes that patients have a critical role in determining the research focus as well as an "equal footing" in the production of knowledge as pointed to by Staddon, (2015). Therefore, this research intends to involve patients at the early stages of research design and development of topics that are related to the research information and which are considered important and a priority for them (see Section 4.5.3).

The next chapter will be looking at the methods and approaches taken to collect the information required to answer the main research questions as outlined in Chapter One, Section 1.3.

# Chapter Four

## Methodology

### 4.0 Introduction

The chapter starts by outlining the research approach and defining the conceptual framework and philosophical underpinning of the research. Then it provides reasons for using qualitative methods and the challenges faced undertaking such an approach in this research. The subsequent sections focus on the role of the researcher and describe the design of the research study, the setting and characteristics of participants, and the process of obtaining approval from the NHS research ethical committee. This is followed by a detailed discussion of the research methods and data collection procedures used to answer the main research questions and the reasons for choosing each method, highlighting any complexities or limitations encountered in conducting this research.

### 4.1 Philosophical Underpinning of the Research

The main research question for this study focuses on (1) understanding PSY patients' articulations of their experiences of IAPT. This implies that patients' subjective experiences are of paramount importance in order to understand (2) how they communicate their distress as well as to explore their perspectives on (3) how language-use and culture may influence their experiences of therapy. The study aims to represent, understand, and analyse participants' articulations of their emotions in therapeutic settings to reveal important elements of their thoughts and experiences.

Because mental health conceptions are shaped by cultural determinants between groups of individuals in specific social contexts (see Sections 3.1 and 3.1.2), a number of authors argued that homogenizing classification and diagnostic manuals of mental health across cultures would not represent reality because such manuals may fail to account for the different cultural explanatory models and ignore an individual's possible avenues towards a cure and treatment (Fee, 2000; Gergen, 1994; Sampson, 1993; Walker,

2006). The authors argued that a social constructionist perspective to explain the phenomenon of mental health would allow us to recognise the distinct way an individual of a different culture creates their meanings of distress, responds to similar illness, and attaches a socially constructed meaning to their suffering (Gergen, 1994; Sampson, 1993; Walker 2006). This would enable us to understand how the sociocultural context may influence an individual's behaviour (Fee, 2000; Parker et al., 1995), and understand the additional layers of meaning of an individual's mental health (Valliant, 2012). The recognition of the importance of the patient's perspective is in line with the position taken in this thesis, which focuses on developing an understanding of how people who suffer from mental health problems establish meanings of their distress, and how the somatic and emotional suffering are entangled with language and culture. Also, this research aims to discuss and reflect on these realities in their full complexity.

Taking a social constructionist approach, in this thesis each participant has an opportunity to consider language and cultural issues from their own perspective and they construct their version(s) of knowledge and meanings of these social perspectives in a different way. As a result, language in the interactions between patients and therapists, both in terms of its forms and use, is essential to the making of meanings and understanding of such interactions, which is also a keystone of social constructionism as discussed by Burr (2003). The use of language according to social constructionism, not only allows participants' thoughts and feelings to be shared, but also through the interactions with them, one is able to reach out and explore their subjective experiences that otherwise would have remained inaccessible. Language also provides participants with a way to construct their own experiences using specific meanings and symbolic systems which are often tied up with their cultural context of norms, beliefs, and values of their society. For example, talking about emotional illness is not simply a matter of describing the pathological symptoms; it involves culture-specific manners which are socially derived and are created and shared by the same cultural group (Burr, 2003). Hence, Saussure (1974:116) defines language as a system of differences, and argues, "If words stood for pre-existing concepts,

they would all have exact equivalents in meaning from one language to the next but this is not true". In fact Wierzbicka (1999) highlighted that it would be virtually impossible to translate and consider some basic concepts such as anger as a universal standard to describe human emotions, since it is only reflective of the English cultural models.

As shown above, this thesis focuses on the articulation of participants and understanding the implicit content of what they say about therapy. This will help our engagement, as researchers, with new ways of learning, guide our process of thinking, and expand our knowledge of therapeutic interactions (Hall, 1986b). To explore these topics, a qualitative research approach and its interpretive traditions are followed in order to capture the accounts of patients in therapeutic setting. Participants' reflections and reports of their subjective opinions will enrich our understanding, particularly in the areas of distinguishing the interplay of language and culture. The data that comes from participants' real experiences not only will yield different types of understanding, but can shape and advance our understanding of the different world's views and meanings with which people communicate their emotions. (Scotland, 2012).

## **4.2 Reasons for Using Qualitative Research Methods**

Qualitative research involves engaging with people and revolves around describing, understanding, and interpreting the expression of the human experience and interaction in the social world. It allows the researcher to explicate and deal with human differences and gain new insights and knowledge into the emotions and cognitive experiences relevant to the practices of counselling and psychotherapy. This can contribute to the field of psychology and enable the understanding of emotional expressions in a meaningful way (Britten, 2011; Crowe et al., 2015; Harper and Thomson, 2011; Ponterotto et al., 2008).

According to Barker et al. (2002) and Kreps (2011), qualitative research can increase the awareness of the challenges that health professionals may encounter in the provision of treatments in mental health and care settings.

Hence, qualitative research looks at answering the 'why, what, how' questions of the phenomena under investigation in health and communication research, and can produce new insights into culturally specific areas and contextually meaningful data (Britten, 2011; Mack et al., 2005). This allows the researcher to understand the complexity and nuances of the social context and focuses on the interactions between participants, the meanings they bring into the social setting, and how these are created or might change over time (Denzin and Lincoln, 2005). Moreover, as reported by Riessman (2009), qualitative research allows those interested in linguistic/cultural studies to be more sensitively attuned to people's accounts in order to understand and construct meaning from their experiences. Focusing on patients' accounts and empowering their voices not only extends our knowledge about specific topics related to research questions, but also advances our understanding of the social practices and dynamics of the human meanings that emerge from different cultural settings.

### **4.3 Challenges Encountered in Conducting this Research**

Despite the fact that qualitative research can provide an in-depth understanding of the phenomenon under investigation and act as a key tool to improve policy and practice, in the case of this research project, it does not provide researchers with straightforward guidelines or rules in tackling research challenges. One of these challenges was the formal procedures that had to be navigated to gain access to institutions and/or organisations. Recruiting key participants in the practice field and gaining their approval to conduct interviews was also challenging, and has been reported by Choudhuri (2003) and Kapoulas and Mitici (2012) as being a common issue in research inquiry. Since the challenges encountered were in the field of mental health, such complexities were anticipated due to the sensitive nature of topics discussed and the ethical concerns regarding data confidentiality.

Involving GP practices and NHS practitioners in the recruitment process was the first challenge encountered. The procedure involved providing patients with details regarding the research process. Despite initial agreement to take part in the study, the time constraints of medical consultations and practical

work constraints may have caused GP practices to withdraw from taking part in the study. NHS practitioners (therapists and counsellors) also appeared to block access to potential participants for patient protection on the one hand, and on the other hand to control access to knowledge of their practices. The changes in the IAPT service structure during the study was another issue that affected the process of data collection. In order to minimise the waiting list and offer help to those who were in urgent need of seeing a psychologist, the IAPT service was in the process of becoming more digitally accessible through telephone and Skype appointments (NHS Sheffield Commission Group, 2017). This meant that when patients were referred to therapy, a professional wellbeing practitioner (PWP) would arrange a telephone assessment with patients to decide on the right therapy for them. They would discuss what the patient would like to change so that they could direct the patient to group therapy, wellbeing sessions, or face-to-face therapy. However, if a patient struggled to communicate and requested a face-to-face assessment, then an assessment consultation appointment would be arranged to discuss the best option for the patient. Accordingly, it became more difficult to access patients and recruit them directly through face to face therapeutic sessions.

Similarly, recruiting key participants from the three community groups and engaging with community members to collect the data required to answer the research questions were also challenging tasks to achieve. The ethical concerns that necessitated an in-depth explanation of research procedures and confidentiality policies to convince participants to take part in the interviews sometimes produced adverse effects and caused participants to withdraw at the last minute. On the other hand, in a number of cases when patients were directly approached to take part in the interviews, they declined. Patients said they were hesitant to share information regarding mental health due to the cultural sensitivity surrounding the issue. Also, a community leader and a psychiatrist who had invited patients to take part in the study said that the different explanatory belief systems surrounding mental health issues affected participation because patients either did not want to acknowledge their mental health or their families did not give

permission to contact the patients. The Somali community, in particular, was the most difficult group to reach and this was quite evident from the limited number of participants in the questionnaire, participant observations, and interviews. In order to recruit four participants, it was necessary to communicate with six Somali community leaders in Sheffield, continually providing them with information about participation and explaining the data confidentiality policy, which was quite time-consuming.

In addition to the above, the researcher's role, her background, and position were also a challenge in this research, which is discussed below.

#### **4.3.1 Researcher's Positionality and Reflexivity**

Performing this research meant negotiating my positionality as an ethnic minority female researcher, and my preconceptions, based on my previous experience as a mental health worker, interpreter/translator and a PhD researcher. In order to undertake ethical research, Salutana (2007:380) recommends to critically "pay attention to positionality, reflexivity, the production of knowledge and the power relations that are inherent in research processes". According to Pillow (2003), reflexivity requires developing a sense of where we belong in the social context that we inhabit, and to expect as researchers to have different views, stances and/or backgrounds from the researched, which may shape our understanding and affect the research process. In particular, recognition of identity as emphasised by England (1994), and the acknowledgment of emic and etic stances are not intended to eliminate any biases, but mainly to be aware of, acknowledge, and consider their influences on the whole research process (Fook, 1999; Kezar, 2002; May and Perry, 2011).

In preparing to conduct this research, I expected being a mental health worker to be a clear advantage when negotiating access to the field. Especially, I was able to contact the IAPT manager directly, who considered the work undeniably of significant impact on the service to such an extent that he offered to attend the NHS Research Ethic Committee (REC) meeting to lend his full support to this work. Despite the fact that his involvement and

attendance at the REC meeting was important, it developed my awareness of the potential influence of institutional power and possible tensions or limitations in terms of acceptance as a researcher in therapeutic settings. To demonstrate, while being an insider in the health system allowed me the potential to contact therapists to participate in the research, some CBT therapists and counsellors were uncomfortable in my presence as an observer and blocked access to the opportunity to hear the authentic voices of PSY individuals. It seems that I might have taken my insider qualities for granted, overlooking therapists' possible perception of me as challenging to their practices and as a stranger, an outsider. This was demonstrated either by many Western therapists turning me down for observation of therapeutic encounters because they assumed that BME therapists would accept, or the reticence of some BME therapists to participate, which was often grounded on assumptions or an obligation to safeguard their community members' confidentiality. Consequently, many therapists responded that PSY patients did not feel comfortable having a third party in therapeutic sessions. Because interpreting the data consists of accounting for participants' experiences and deducing how participants make meaning of their experiences, such excuses helped me to be aware of my subjectivity when entering the consultation room and to focus on reporting patients' personal experiences using their direct quotes as shown in Section 6.2.5 and 7.1.6.

This aloofness was also encountered when I was meeting participants from the different communities at the different community centres. Being bilingual and sharing similar language and cultural backgrounds afforded certain advantages. However, it took me time to establish contact with participants and at other instances I was blocked from making contact with community group members. This is why I continued to attend community group gatherings and start building relationships with women who showed interest in participating in my research. After a couple of visits, the community groups were welcoming and I was recognised as "one of them". While this took time, being an outsider gave me the opportunity to understand the intimate relationships in the community and to have an insight into how community members related to each other and viewed the "other" who was an outsider.



For instance, while being an outsider, I shared certain commonality with the group and inhabited an insider identity as a woman. This brought me inside the women groups' circle and allowed me the opportunity to observe their interactions without being tied to a specific group or habits. In addition, depending on how I was introduced by the group leaders, the women would either welcome me more or be inclined to keep a distance. Although the women treated me with respect, they viewed me as the "other" at the initial recruitment stages of the research. Through my placing importance on their views, there was a shift in how the women saw me as someone interested in their stories and in what they thought. This has made me realise my multiple identities and their possible impacts on the research context. Moreover, this particular feeling of being the "other" raised my awareness of moments when participants drew distinctions between themselves and others (see Section 8.1.4.4).

Conversely, as an insider in the health system I was able to engage well with patients' emotional experiences and realise how valuable such skills were, as they allowed me the opportunity to enter spaces that would otherwise have remained hidden. I felt privileged as participants shared stories that were quite touching and often even quite complex and challenging. Listening to patients' stories made me realise how difficult it was for a number of them to cope with the barriers of language on their own. This in turn brought to the fore the issue of faithfulness to participants' voices and their experiences, the language to be used to report the results, and whether to include their quotes and keep them as said or to edit them. Engaging in the process of negotiating these issues left a feeling of vulnerability at times, particularly as there were no easy answers to these questions. Yet, as I began reflecting on the research questions of the role of language in enabling us to know what we mean, I recognised the importance of understanding language-use in multilingual settings. Accordingly, I decided to focus more on my participants' voices and aimed at using them to interpret the data.

It must be mentioned also that by being a Muslim, I became an insider in the research process. To develop an understanding of patients' perspectives,

respect their knowledge, and to avoid making assumptions about their beliefs, I continuously checked what participants meant when talking about Islamic beliefs. Moreover, removing researcher's bias is somewhat difficult. However, to maintain transparency, I ensured that all the different views raised by participants are included in the research findings, even if these views opposed my own beliefs (see Section 7.2.2).

The translation/interpretation process brought with it additional ethical issues. As Evans-Pritchard's stated, "to understand a people's thought one has to think in their symbols" (1951: 79), and my experience as an interpreter/translator and transcultural mental health worker lent me a sensitivity to the cultural meanings associated with specific instances of language-use, which was applied before producing the final version of the transcript. However, this incurred issues of linguistic positionality and power.

As a multilingual researcher, I encountered a number of challenges due to being an active participant in the interpretation process. For instance, following the non-attendance of an interpreter in three therapy sessions, both therapists and patients required me to act as an interpreter. Hence, I became a participant in the observation. This affected the role as an observer and impacted on the amount of data collected due to the limited ability to take notes. Yet, without participating in these interactions and having a sensation of patients' reactions, a complete understanding of patients' experiences would not have been possible.

Equally, translating the interview scripts involved undertaking ultimate decisions about the choice of words and equivalence of translations. As pointed out by Temple and Young (2004:167-168), the translation process can be a form of linguistic power, but "that power tends to rest in how translation is executed and integrated into research design and not just in the act of translation per se". With this in mind, I undertook careful steps using my training and experience as a translator to achieve the best translation possible in the translation tasks undertaken as explained in Section 4.6.3.6. In addition, a number of professional translators were consulted to ensure the right lexical terms were used in order to arrive at participants' intended

meanings. Although the translation process may have been slower than that of other researchers, by being mindful of the translation dilemmas, this approach aimed at achieving the best translation possible for the recorded texts. In addition, through my own experience in undertaking interpreting and translation roles, I have come to learn the importance of reporting the process of translation and explaining how the conclusions have been derived. This can provide readers with a better insight into the way the data was interpreted, and losses of any potential meanings of participants' perceptions were avoided.

Finally, in recording observations, I took field notes (see Appendix 12) whereby I recorded participants' verbal and non-verbal articulations of their emotional distress as well as my own comments, thoughts and insights into the context in which it took place (Flick, 2014). I used these field notes in conjunction with a reflective diary of my own practices both as an interpreter and as a mental health worker (see Appendix 13). In this reflective diary, I jotted down my reflection on my practices, addressing some of the issues encountered in order to be aware of my own views and methodological decisions that may arise as a response to participants' accounts (Montgomery and Bailey, 2007; Palaganas et al., 2017). Using Fook and Gardner's (2007) model of practicing critical reflection, the reflective diary helped me to consider how my assumptions may influence my practice and afforded ways to manage future experiences more effectively in participant observation. Moreover, I often made post-observational notes on problems coming from 'telling moments' in therapeutic encounters, which sparked off questions in relation to my beliefs and assumptions regarding my research that as a researcher I could not help myself from exploring. Although I didn't share my field notes with therapists, I shared my thoughts and discussed specific therapeutic encounters with them. By focusing on therapists' perspectives of the encounter, therapists gained more self-awareness in understanding patients' needs, and I gained a more nuanced perspective of the language and cultural issues encountered in the setting.

In sum, I have articulated my positionality and subjectivities in this section to allow readers to better understand the filters through which the research questions were asked, the data were analysed, and the findings were reported. In the following sections the research design methodology that guided the execution of this study is discussed.

## **4.4 Research Design**

The objectives of this study were to empower participants' voices and facilitate awareness of their perceptions of service provision. These objectives could only be achieved by a study that aims to explore patients' views, which are expressed by words, and which cannot be measured accurately on a scale. Studying the views of patients who were referred to, or accessed the IAPT service can reveal answers to the main research questions and sub-questions. The planning matrix of the study as shown in Table (1) below provides a summary of the most appropriate research methods undertaken to answer these questions and the characteristics of the participants and the setting of this study.

Each method was intended to contribute to the argument and add richness and depth to the inquiry. Following a reading of Thorne et al. (2004), multiple data collection tools were used since reliance on only one method could result in an incomplete explanation and interpretation of the subject under investigation.

## **4.5 Research Methodology**

### **4.5.1 Setting and Participants Characteristics**

This research was conducted within the Sheffield Primary Care service. Participants in the study were aged between 18 and 65 years and were of Pakistani, Somali and Yemeni origin, including a combination of those born outside and inside the UK. All participants lived in Sheffield at the time of the study. Participants who took part in the research were identified by the IAPT tool measures for anxiety and depression (patient Health Questionnaire PH9

Research Methods	Qualitative Research Methodology
<b>Stage 1: Self-administered Questionnaire</b>	The questionnaire was used at the early stages of the study to generate themes to be further discussed with patients in the interviews (see Appendix 1 for a copy of the questionnaire).
<b>Participants</b>	Patients who are at the point of referral by GP.
<b>Distribution</b>	GP is to distribute the questionnaire in the three languages (Urdu, Somali and Arabic).
<b>Consent</b>	The questionnaire included written consent.
<b>Stage 2: Participant Observations</b>	To identify certain patterns of behaviour (language use and actions) and report on the dynamic of the session as well as to understand the context of consultation from another perspective (See Appendix 2 for an observation field note form).
<b>Participants</b>	Patients who are at the point of assessment or having a follow-up appointment.
<b>Recruitment</b>	Therapists: Professional well-being practitioners (PWP), Cognitive behavioural therapist (CBT) or counsellor through IAPT Manager. Patients were recruited through therapists.
<b>Consent</b>	A written consent form was initially prepared (see Appendix 3) but due to time constraints of therapeutic sessions, verbal consent was taken from both therapists and patients.
<b>Stage 3: In-depth Semi-Structured Interviews</b>	To further explore in detail patients' articulations about their experiences of therapy (see Appendix 4 for the topic guide used for the interviews).
<b>Participants</b>	Patients who are currently accessing or accessed the service.
<b>Recruitment</b>	Purposeful sampling through IAPT observational sessions and community organisations.
<b>Consent</b>	All patients had to sign a written consent form (see Appendix 5)

**Table 1 Planning Matrix of the Study**

and Generalised Anxiety Disorder GAD7, see Appendix 11) as having mild to moderate anxiety and depressive disorders. Participants were at the point of access, in the middle, or at the end of therapeutic sessions. This gave the

researcher the ability to obtain an overview of the process of therapy as well as ensure good coverage of patients' perspectives. All participants were considered to have the capacity to consent to participation and the ability to understand the questions asked. Participants who were not proficient in the English language were also included in the study to ensure their voices were heard and interpreters were booked to facilitate communication.

Participants who suffered from severe conditions and more complex needs were excluded from the study due to either their perceived inability to give consent to participate and/or the inability to comprehend the questions. Participants from other ethnic backgrounds were also excluded due to research project time and budget constraints making involvement of all ethnic groups not possible. The choice of these ethnic groups for the study is explained in Chapter Two.

Since participants from the groups identified were hard to reach, contact was initially established through multiple gatekeepers (Reeves, 2010; Saunders, 2006); in this case these were the IAPT manager, GP practice managers, and community leaders. Without direct access to participants, as in this case, gatekeepers are useful as they can control research access to a setting and the potential participants in a study. They can help or hinder the research progress depending on their personal opinions on the validity and usefulness of the research to their services. As explained in Section 4.3.1, working in the field of mental health has been of immense help as it was possible to approach the IAPT manager directly with an overview of the research project. The IAPT manager helped in suggesting suitable ways of approaching potential participants, narrowing down the list of GP practices that had a greater number of PSY patients and identifying other potential gatekeepers (Holloway and Wheeler, 2002). The IAPT manager also suggested preparing an easy flow chart that outlined the role of the GP at first contact with potential participants (see Appendix 6).

However, there are potential issues with using gatekeepers, such as the possible coercion of participants to take part in the research. While the IAPT manager was quite supportive and helpful, and contacted therapists on the

researcher's behalf, this did not grant sufficient access to potential participants (Hennink et al., 2010) as some therapists behaved evasively and it was felt that they did not wish to participate but they felt obliged to do so by their manager. There was therefore a responsibility to ensure participants had been properly informed and were aware of their right of refusal to participate. Finally, the gatekeepers were community leaders with responsibilities and to whom the research was not perceived as a priority. As a result, the recruitment process was prolonged, impacting on the research time constraints and compromising the likelihood of achieving the desired target number of participants.

In this study, each participant did not necessarily take part in every data collection method. Each data collection method was intended to target a different group of participants at different stages of their access to IAPT in order to contribute to a different aspect of the argument (see Table 1 above). The use of different data collection methods was intended to capture patients' perspectives from the point of referral through the process of therapy to the discharge or exit from services. These data collection methods are discussed in further detail in Section 4.6.

#### **4.5.2 Research Ethics**

This research involves potentially vulnerable participants with mild to moderate anxiety and depressive disorders. Therefore, the main ethical issues anticipated while planning this study determined the approvals needed from institutional organisations and communicating the information to the participants in an easy and effective way to ensure they fully understood the consequences of participating. An ethical application was first submitted with supporting documents to Sheffield University Research Ethics Committee and was approved by March 2015.

In addition to obtaining approval from the Sheffield University Ethics Committee, it was required to obtain NHS Research Ethical Committee (REC) approval because the research involved working with vulnerable adult patients with mental health issues and was carried out at NHS premises such as GP practices. The application for the ethical approval from the NHS was

complex and required a long online process. Initially advice was sought from colleagues who had been in a similar situation to consider their expertise. Once the application was completed, it was submitted online with a large amount of supporting documentation as listed in Appendix 7. However, the application gained unfavourable opinion because the Committee was of the unequivocal opinion that the research proposal as submitted had major inadequacies in its design and planned execution. Therefore, they decided that it was highly unlikely that it would achieve its objectives, yet, it was acknowledged that the proposal contained value and as such listed a number of recommendations prior to REC re-submission (see Appendix 8). Following careful consideration of the REC response, it was realised that a number of the required changes requested were not initially considered, and consequently different aspects of the research had to be refined in line with these requirements.

Once all the documentation was ready another application was submitted with another list of supporting documentation (see Appendix 9) and a provisional opinion was received with suggested minor changes (see Appendix 10). Following the amendments and after fulfilling all the REC requirements, a letter was received confirming the approval of the application. In addition, permission from research and development management department was obtained from each host NHS organisation prior to the start of the study.

#### **4.5.3 Piloting Information and Informed Consent Forms**

The importance of involving members of the public, including patients, 'in the design, conduct, analysis, and reporting of research' has been explicitly stated by the Department of Health (DH, 2005). Therefore, the involvement of and consultation with potential research participants from the different PSY community groups and SUN: RISE Public and Patients Involvement Group<sup>12</sup>

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<sup>12</sup> SUN: RISE (Service User Network) is a monthly forum network consisting of service users and carers within Sheffield Health and Social Care NHS Foundation Trust (SHSC) which enables service users to be informed, involved and engaged in Trust business. SUN: RISE has a consultation role within Public and Patient involvement group where members get to be involved in developing services and many issues related to service users of mental health.



(PPI) were sought at the early stages of exploring topics related to the research questions as it was considered an important step to enable good research practice. The groups were consulted in order to ensure the process of the study and the methods used would empower research participants and treat them with respect (Faulkner, 2011). The participation in these patient-led discussions not only provided insights into patients' experiences, but also their active participation was considered crucial in ensuring their voices were heard.

In this study, PSY patients and PPI group who were involved in this process were asked about the wording of the information sheet and informed consent forms in order to ensure the language was clear and easy to understand to a layperson. PSY patients commented that the translated information sheets and consent forms read well and were written in language that was easy to follow. One patient was quite pleased to be able to read the consent form in her own language and to be fully able to comprehend her rights as she normally signs forms without being able to understand the whole content. Another patient, by using an interpreter to facilitate the understanding of the content, enabled the researcher to estimate the time needed to explain the information and purpose of the study. PPI group, while confirming the ability to understand the contents, recommended shortening the participant information sheet as they felt it was too long. However, the researcher explained that the detailed information was a requirement by the REC and could not be shortened. Therefore, they suggested sending out an invitation letter with brief details about the study instead. Giving out the detailed information sheet on the first encounter would then allow participants to ask for any clarifications before taking part. Hence, an invitation letter was prepared, translated and sent to GP practices, therapists and community organisations.

PPI group raised other issues that were taken into consideration, such as gender-matching the researcher and/or interpreters. This was carefully considered prior to interviews taking place. While gender-matching was a potential issue, it was not feasible in the case of the researcher (interviewer)

due to the data collection methods used. First, taking into consideration the researcher's background as a transcultural mental health worker, which was critical for lending the ability to observe and assess counselling sessions, it was not feasible to train an outside person in a short period of time to exhibit similar awareness in observational sessions. Moreover, due to the semi-structured nature of interviews, it was again harder to train an outside person as they might be unable to operate when more probing was needed or if they were to elicit the right type of responses. The cost that would be incurred to train someone to carry out this work was also beyond the capacity of this research. Therefore, while recognising the advantages of gender-matching, its lack was a constraint to be accepted. However, gender-matching of interpreters was offered to both male and female participants and, where possible, this was fulfilled when requested. PPI group also enquired the possibility for participants to use emoji like symbols as a means of expressing themselves. While this recommendation supported the questions raised in this research, particularly for those who were unable to communicate in the English language, none of the study participants resorted to this alternative. Most importantly, the process helped to ensure that the study was accessible to the participants involved and ensured that the qualitative research had the potential to empower participants by taking their opinions into consideration and communicating their own words, which was considered an important factor in this research.

In addition to the PSY patients and PPI group's involvement in the research design and following from the REC recommendations and reading of Rosaline (2008) to make the research as ethical and appropriate as possible, an advisory group was set up. This comprised of two managers, a psychotherapist, a psychologist, a Pakistani approved mental health professional, and a Somali mental health worker. They gave expertise on the clinical issues surrounding conducting research in the NHS. The involvement of the advisory group was sought throughout the planning and design process of research to ensure the right questions were posed and a relevant topic guide for the interview schedule was developed. The advisory group members were briefed about the research project and met in small groups as

well as individually. Discussion with the advisory group focused on the design and execution plan to ensure the research methodology would achieve the intended objectives from this work. They also helped in developing the topic guide, recommended high-quality resources and contacts for interpretation and translation services, and highlighted the importance of taking into consideration the safeguarding of and potential risks to both patients and the researcher. Additionally, they recommended having a supporting letter from the University to be sent to potential PSY voluntary and community organisations to ensure their full support of the research prior to meeting with them.

Information sheets were given to all participants – therapists and patients – prior to the commencement of the research process, to give them more details about the study. The information sheets in the translated languages were first circulated electronically to the IAPT manager and all GP practices who agreed to take part in the study. While the GPs were expected to hand the information sheets to potential participants upon referral to therapy, the IAPT manager, following initial communication, emailed the information sheets to IAPT sector managers outlining the aim of the research and requesting their support to distribute the information to all therapists. In addition, the researcher was invited to attend a meeting with the IAPT West and North teams, where the research and distributed copies of both the information sheets and consent forms were explained further. Therapists who agreed to take part consented by arranging mutual times and dates for the observation sessions. Further meetings were arranged with community organisation leaders, where copies of the information sheets and translated documents were provided to be distributed by the leaders to potential participants.

Patients who agreed to presence of the researcher in the observation session with the therapist were given a brief verbal summary about the study at the start of the session. Due to time constraints, most of the patients observed gave verbal consent. Towards the end of the session, they were approached by the researcher and given further details about the study. Conversely,

patients who took part in the interview were given the information sheet in the requested language prior to starting the interview. They were given time to read the information sheet and ask for any clarification. All participants were asked to sign a written informed consent form and were handed a copy of the form to take away with them.

## 4.6 Research Methods/Tools

### 4.6.1 Questionnaire

A crucial part of designing a questionnaire involves ensuring that it will address the aims and objectives of the research. Accordingly, the questionnaire was designed using Bryman’s (2004) techniques, as shown in Table (2), to generate preliminary data prior to using other methods to gain further insight.

<b>Bryman’s (2004) Questionnaire Design Techniques</b>
1. Questions should be geared towards answering research question(s)
2. Consider what exactly you need to know
3. Ask yourself the question to know if you are able to respond
4. Avoid ambiguous words/terms
5. Avoid long and general questions
6. Avoid leading questions
7. Keep open questions to the minimum
8. Avoid questions that are actually asking two questions
9. Give clear instructions on how questions should be answered

**Table 2 Bryman's Questionnaire Design Techniques (2004)**

Open questions were used to allow participants to list concerns they might have about therapy, language, culture and/or religion. They were also used to allow respondents the ability to provide detailed information in their own words about their perspective of IAPT service. Closed questions were not used because they would have limited the responses to choosing from a

predetermined dropdown list or statements, as has also been reported by Bradburn et al. (2004).

The questionnaire was short in nature and had only three questions as outlined in Table (3) below.

Research Question(s)	What Specific Question(s) on the Questionnaire will be used to Answer Each Research Question
Do patients feel that language and cultural issues impact on their experience of therapy and if so, how?	Question 1 <i>'Have you any concerns about language and communication?'</i>  Question 2 <i>'Have you any concerns about culture and religion?'</i>
How do PSY patients articulate their understanding of talking therapy?	Question 3 <i>'Have you any concerns about the IAPT services?'</i>

**Table 3 Research Questions Addressed by the Questionnaire**

Although the questionnaire consisted of only three questions, it was geared towards answering the research question(s) and tailored to address participants' views about therapy, language and cultural concerns. In addition, the questions were intended to be brief, taking into consideration patients' time constraints at GP surgeries and the level of education of some respondents who might require the help of a family member to complete the questionnaire. For that reason, and following reading of both Brace (2008) and Rosaline (2008), the advisory group, patients and PPI were consulted to ensure the right questions were asked and that they were presented using appropriate language, enabling participants to provide the information required, gaining an optimum response.

As the questionnaire was supposed to be distributed by GPs at their first encounter with patients, self-administered questionnaires were utilised as they had the ability to obtain feedback from a wider group of participants and avoid the possible influence of the researcher's bias. However, due to the difficulties encountered in getting GPs involved, the questionnaire had to be either emailed to other health and voluntary organisations or distributed at community centres.

#### **4.6.1.1 Translation and Piloting the Questionnaire**

Language difficulties can be a significant barrier for non-English speaking individuals in voicing their concerns about health service provision and can discourage them from taking part in research settings (Esposito, 2001). The inclusion criteria for this research considered that some participants from PSY groups have insufficient English proficiency. Therefore, the questionnaire was translated into the community group languages (Urdu, Somali and Arabic) to ensure that participants fully comprehended the purpose of the research. Three translation agencies (WordPerfect, Accent and One Hour translation) were consulted and approached. After further communication WordPerfect, an established translation agency, was chosen as it had more experienced translators in the languages required.

Clear instructions were given to the agency involved in translating the documents in both Urdu and Somali to present the information in a way that was easy, clear, and could be read as naturally as possible in order to avoid any misunderstandings that might produce inaccurate data. But being a native speaker of Arabic as well as a professional translator, I carried out the Arabic translations.

Before presenting the translated questionnaire to potential participants, the translations were reviewed with three transcultural colleagues in the mental health profession who were proficient in the target languages in order to check the accuracy, readability, and conceptual equivalence of the translations. The main reason for requesting the support of transcultural mental health workers was their understanding of the potential cultural barriers for patients. In addition, it provided an editorial check for errors and yielded a second opinion on the translated material in order to increase the credibility and readability of the translation process as also suggested by Ingvardotter et al., (2010). The Urdu translation contained a few spelling mistakes and lexical errors. The whole translation did not read well, as the script was written in non-traditional Urdu. This was considered difficult for some Pakistani participants to read and was amended accordingly. The Somali translation seemed to have been carried out by a translator from the

south of Somalia, which appeared to be a different dialect from the Northern region, but the language would be clear to all Somali respondents. Finally, the Arabic translation contained minor grammatical mistakes which were amended.

Before circulating and distributing the questionnaire to potential respondents, it was piloted to ensure that it elicited the type of responses aimed for (Gardner et al., 2003; Stone, 1993). Hence, three patients from PSY groups were requested to read the translated questionnaire and provide comments on any ambiguities related to the information provided and/or the relevance of questions to the research topics and the time needed to complete the questionnaire. Participants provided valuable feedback and suggested the following comments:

- a. To correct the typographical mistakes that had been identified
- b. To edit some of the sentences to conform to the target language sentence structure.
- c. To provide clearer instructions on how to leave personal details for those wishing to take part in the interview process and how they would be approached by the researcher.

All these comments were taken into consideration and the amendments and modifications were completed before the process of recruitment and distribution took place.

#### **4.6.1.2 Distribution of the Questionnaire and Collection Process**

Questionnaires were circulated in all three languages (Urdu, Arabic, and Somali) as well as in English. In total, twenty questionnaires were collected from the different sources that were approached during the process of this research. Four questionnaires were received in Arabic and the remaining were in English. No questionnaires were received from the GP practices, five questionnaires were collected through the help of the IAPT therapists, eleven from the different community organisations, and four through the University of Sheffield mailing list.

The initial plan for distributing the questionnaire was that when a GP considered a patient for a referral to IAPT service, he/she was expected to hand the questionnaire to the patient. The patient then should complete the questionnaire and hand it in at the reception on the same day. Consultations with nearly fifteen GP surgeries were carried out and the research outline and purpose were further explained. Meetings were held with GP surgeries who showed interest in taking part to provide further information about participation and answer any queries about the value of the research to their patients. The information sheet for patients and translated questionnaire versions were emailed to GP practice managers and pre-paid, pre-addressed envelopes were also provided to return completed questionnaires. Regrettably, the six GP surgeries who initially expressed interest made no further contact with the researcher despite repeated attempts (see Section 4.3).

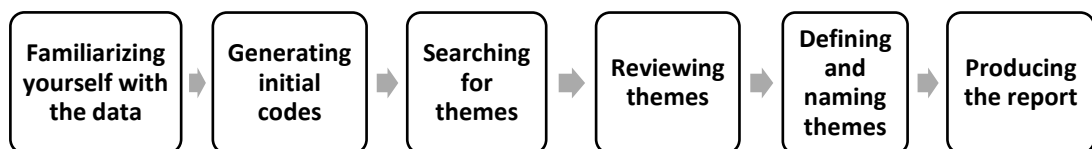
A change of plan was implemented and IAPT sector managers were contacted who in turn sent emails to all therapists, informing them about the study and encouraging them to take part as explained in Section 4.3. IAPT therapists were asked to hand in the questionnaire and a self-addressed stamped envelope to patients at the first assessment session so that information would be collected about possible areas of concern. At the time of distribution, major structural changes were taking place within the IAPT service as explained in Section 4.3. Hence, it was decided to contact the different voluntary and community organisations and their assistance to circulate the questionnaire was sought. The following community centres were approached: St Cuthbert's Church, Sheffield Asian Women Resource Centre, Pakistani Muslim Centre, Yemeni Community Centre, Fatma and Al-Risaalah Mosques, Somali Mental Health Sheffield, Somali Women Carer Group, ISRACC Somali Community and Cultural Association and Darnall Wellbeing. The researcher attended the different voluntary and community organisation events and explained the purpose of research and distributed the questionnaire to potential participants who accessed the IAPT service. Finally, as there was continued difficulty in distributing the questionnaire to these hard to reach groups, an email through the University of Sheffield



mailing list was sent after consulting with the main supervisors and seeking approval from the University. All four questionnaires received via this route were from Yemeni students. Because of the changes in the distribution process, it was not possible to reach those patients who were at the point of referral to IAPT, which might have yielded different responses.

#### 4.6.1.3 Questionnaire Analysis Methods

The data derived from the questionnaire is qualitative in nature because it focuses on describing the area of concerns mentioned by participants. Therefore, the frequency and recurrence of responses about these areas of concerns were searched in order to interpret the results. A qualitative content analysis method was subsequently applied because it provided insight into the number of instances when particular text was repeated and it extracted knowledge and understanding directly from participants' responses (Hsieh and Shannon, 2005). Guided by the literature review and using the research questions as a starting point, the researcher used the 'six steps of data analysis' approach as outlined by Braun and Clarke (2006) and as shown in



**Figure 2 Braun and Clarke (2006) Six Steps of Data Analysis Approach**

Figure 2 below. Investigation started by formulating initial codes, keeping in mind the secondary and main research questions (Section 1.3). This process was performed manually and carried out by carefully examining the responses (see Appendix 14). As recommended by Marke and Yardley (2004), the codes were then reformulated before organising them into specific categories, paying close attention to codes that may represent and yield different data or be of great relevance to answering the specific research question(s) (see Table 12). The use of coding allowed simplification of the data to provide meaningful interpretations of the research question(s). Following this step, these codes were further modified and reviewed before defining them under specifically named themes.

Themes were appropriately identified and described before being interpreted with support from extracts from the questionnaire texts taking into consideration Crowe et al.'s (2015) recommendations in this respect. The last process was producing the final report.

These steps provided further details about the study, allowed reflection and comparison of the different themes, and the establishment of the meaning of the data collected. Enough questionnaires were collected to be able to spot recurring themes that were common or meaningful in this context and to offer a practical approach to developing an understanding and knowledge of PSY patients' articulations. In addition, the knowledge from the questionnaire allowed better informed conduction of the semi-structured interviews as well as to triangulate between the different methods/tools used in this research.

#### **4.6.2 Participant Observation**

Participant observation is a data collection method that is normally associated with ethnography, as it allows the researcher to unfold the practices of individuals as they take place in social settings (Jupp, 2006). In this research, and following from the reading of Desai and Potter (2006) and Jupp (2006), the participant observation method was used for the following reasons: to share the experience of participants; to record their articulation of therapy and how they described their emotional distress; to observe the kind of words and language terms and any cultural references used by participants to convey their distress and explain their feelings; finally, to gain a detailed description of the interactions taking place between therapists and patients to enrich the researcher's understanding of the scene. For example, the way therapists approached patients, the type of questions they asked, and use of other techniques such as drawing diagrams to communicate with patients were noted. Likewise, close attention was paid to the way participants responded to the questions and communicated with therapists with or without an interpreter or family member present in the session. This provided an insight into people's social world and refined the understanding of linguistic and cultural practices (Holloway and Wheeler, 1996) as outlined in Table (4).

Research Question(s)	What Specific Question(s) on the Participant Observation Field Note Will Be Used to Answer Each Question
How do PSY articulate their understanding of IAPT?	Item 6: Do patients appear to understand the purpose of therapy?
How do PSY patients articulate their emotions?	Item 2: Describing the acts taking place in therapy; Item 3: describing the activity taking place; Item 5: Who is present in therapy? Item 7: How do patients use non-verbal communication?
Do patients feel that emotions are being explored by therapists and if so, how?	Item 1: Describing the setting; Item 4: Can you describe the event in details? Item 8: The language used by the actors.

**Table 4 Research Questions Addressed by Participant Observation**

#### 4.6.2.1 Types of Observation

It has been claimed that there are four levels of observation ranging from being a complete participant to being a complete observer (Gobo, 2008; Holloway and Wheeler, 1996; Ritchie et al., 2014). The “complete participant” observes the setting from within the research field, e.g. a nurse studying patients’ interactions with medical staff in a hospital setting. The “participant as observer” entails active participation with individuals or groups who are under study, which allows him/her more ease in building a relationship with participants. The researcher always obtains permission from gatekeepers and participants to enter the field of research. The “observer as participant” on the other hand, observes a research social setting and collects information without interference or interaction with subjects, to avoid any disturbance to the workforce. The researcher must obtain permission from gatekeepers and announce his/her role to participants. Even though the researcher does not play a key role in the social setting, he/she is more likely to be accepted and treated as a valued colleague and researcher. Finally, the “complete observer” is usually placed behind the scenes and is detached from the study location. The researcher often uses static devices such as cameras to record the events taking place in the research field.

Also, observation can be either “open” or “closed”. While the former usually takes place in public settings where the researcher does not need to have gained permission, the latter involves the researcher’s negotiating access and obtaining permission from both gatekeepers and participants to enter the social setting. Most of the observations in this study were closed and took place in GP settings, where permission was given by gatekeepers and verbal consent was also obtained from both therapists and patients.

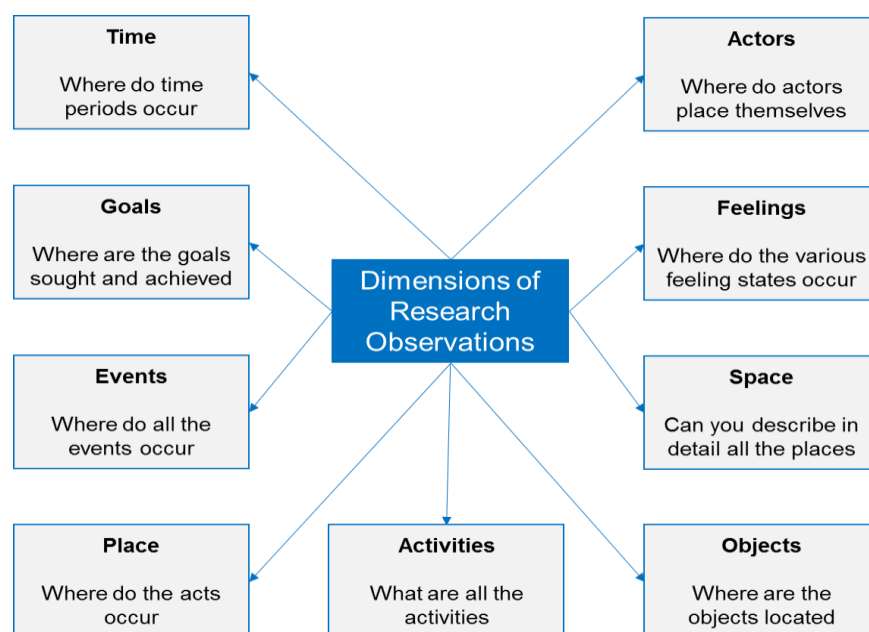
In this study, the initial plan was to adopt the ‘observer as participant’ role, as this increased the validity of the study and enabled the distinguishing between words people spoke during interviews and actions taking place during the observed social settings. However, in being both a mental health worker as well as a professional interpreter, the researcher’s opinion about certain issues that took place in the session were often sought by therapists involved in the observational scene, as discussed in Section 4.3.1. In addition, following the non-attendance of the interpreter in three sessions, the researcher was asked to act as an interpreter. This changed the researcher’s role to a ‘participant observer’. These particular encounters drew the researcher’s attention to the importance of considering positionality and its possible influences on the research process as explained in Section 4.3.1.

#### **4.6.2.2 Developing the Participant Observation Field Note Form**

Generally speaking, participant observation data consisted of the directly collected information recorded in the field notes while in the research field or shortly after the observed behaviours took place as recommended by Lewis-Beck et al. (2004). Spradley (1980) outlined three stages for the observation: descriptive, focused, and selective. The former relates to the researcher’s senses with everything in the setting, which can provide important information related to the research question and therefore should be recorded (Angrosino, 2005). Once the researcher progresses in the study, certain areas of the observed field become more interesting, and the researcher starts to become more focused on the relevant aspects of the subject matter. In the end, the researcher becomes highly selective and concentrates on certain issues only. The ethnographic approach of Spradley’s principles were

particularly influential in improving the researcher's observational practice and developing an understanding of the world from the participants' perspectives. It also helped gain further insight into the emotional expressions and manifestations of distress unique to the specific cultural backgrounds used when people of diverse cultural backgrounds interacted. Moreover, it was possible to gain a finer understanding of the consultation context from both patients' and therapists' perspectives. By entering into conversation with some of the participants in these situations, sharing their experiences and how they described and conveyed their emotions, their interpretations of the events, and how they defined their actions were understood.

According to Spradley (1980), the main dimensions of research observation are as shown in Fig 3.



**Figure 3 Spradley's (1980) Main Dimensions of Research Observation**

Mack et al. (2005) developed this further and gave additional guidance for observation, whereby they identified six main categories under participant observation. These are: appearance, verbal behaviour and interactions, physical behaviour and gesture, personal space, human traffic and finally, people who stand out. Taking all this into account, all the key and specific objectives of the observation were listed and a field notes form was then developed and divided into three sections (see Appendix 2). The first section

included demographic and background information of the patient using pseudonyms to protect the confidentiality of participants. The second section was used to record objective accounts of what was experienced and learned during the observed interaction. The last section was reserved for the researcher's thoughts, subjective accounts, and/or interpretations of the events taking place in the observed session. As suggested by Berge and Lune (2012), any post-observational perceptions were recorded in this last section of the form to ensure the researcher was not imposing her own judgement of what was observed. However, the presence of the researcher within the data was the most powerful source of validation, as pointed out by Adler and Adler (1994), because observational practices allow noting of all other non-verbal communications. These often added meaning to the words used and enriched the understanding of the phenomenon under investigation. If observational practices were not utilised, such information would have been missed with other methodological tools.

#### **4.6.2.3 Observation Recruitment process**

As explained in Section 4.3, contact was first made with the IAPT service manager and was followed with further discussions with the IAPT West and North sector teams as the majority of their clients were PSY patients, in order to outline the main aims and objectives of the research. Subsequently, numerous reminder emails were sent to IAPT therapists and follow-up phone calls and meetings were received with a number of them to explain the process further.

In total, eighteen observational sessions were carried out with two therapists who agreed to take part in the study. Most of the sessions observed were either at the assessment stage<sup>13</sup> or follow-up sessions<sup>14</sup>. Participants who took part in the observational sessions were different from those who took part in the questionnaire. Eight patients were from Pakistan, eight from Yemen and only two patients were of Somali origin. The two therapists who

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<sup>13</sup> The assessment stage occurs before a therapist starts the treatment with a patient, and in which the therapist assesses the patient's levels of depression and anxiety using a specific questionnaire.

<sup>14</sup> In a follow up session, therapists set agreed goals with patients to help maintain progress.

took part were psychological wellbeing practitioners (PWP). They have an important role in screening and assessing patients before signposting them to either cognitive behavioural therapy (CBT) or counselling. Unfortunately, it was not possible to recruit any CBT therapists or counsellors for the observed sessions although several attempts were carried out to contact them and encourage their participation as explained in Section 4.3.1.

#### **4.6.2.4 Data Analysis**

The interpretative phenomenological analysis and narrative inquiry analytical approach were initially considered as suitable approaches for this study considering that both approaches seek to interpret the human experience, each from a different perspective. The former is concerned with capturing individuals' accounts to infer their perspective on their world experience (Smith et al., 2009). It focuses on the meaning-making process by which the individual understands their experience within a specific context. The latter is more concerned with how people tell their own stories. By means of those stories, one can realise how these experiences impact on the people who are living them. It focuses on what these stories reveal about the complexity of the experience from a human perspective (Webster and Mertova, 2007). However, this research is not focusing on the individual's experience or how individuals understand the meaning of their experiences. It is more concerned with capturing and exploring the range of ways in which participants communicate their emotional experiences and searching for common themes among them. Also, the purpose of the study is to generate an understanding of the phenomena under investigation rather than being event-centred. For all these reasons, thematic analysis was selected. Particularly in the context of mental health, thematic analysis searches for patterns of any similarities and differences or generate unanticipated understandings in participants' perceptions of personal experiences (Crowe et al., 2015).

Thematic analysis is also more compatible with the social constructionist approach and it uses an inductive methodology, which enables the effective linking of the observational data sets together and dealing with the different kinds of information collected during the study. Additionally, observational

field notes were usually detailed and very descriptive. They included descriptions of the events taking place, as well as the researcher's personal impressions. Therefore, it was possible to sift through the field notes in order to look for recurring themes, identifying frequency in the data set, and to detect which themes were important to describe and interpret the phenomenon under study (Harper and Thomson, 2011). Hence, themes illustrated data in great detail and provided potential interpretations of participants' meanings, behaviours, actions, and thoughts, whilst reporting their realities. It also allowed the possibility to triangulate the different data collection resources which increased the credibility of the interpretation of the data (Lincoln and Guba, 1985). More importantly, it allowed demonstration of the relationship between the research concepts and the accounts collected from participants at the different stages of the study (Marks and Yardley, 2011).

Preliminary analysis of the data began alongside the observation process to allow room for further exploration in case gaps were identified in the data. Using Braun and Clarke's (2006) six-step guidelines as previously shown in Figure 2, the researcher started to familiarize herself with the data through reading and rereading of the notes before the initial analysis and interpretation began (Holloway and Wheeler, 1996). While in this process, initial codes were identified and began to uncover the relationships between the different categories of data collected through observations. The second phase involved highlighting specific texts from each participant's field notes, which could be used as an illustrative example to answer the research questions. Once the process of analysis started, work began with the raw data, processing it by coding and sorting it in themes (see Section 5.3, Table 13) (Fielding, 1993). Additionally, the researcher started to search for any missing information that could be linked to any of the categories, and to recognise, describe, and summarize them. The final stage involved interpreting the meaning of the data collected by displaying the related concepts and gaining insight into them before producing the final report.



### 4.6.3 In-depth Semi-structured Interviews

Informed by Litchman (2013) and Ritchie et al. (2014), the in-depth one-to-one interview method was used as it allowed the researcher to engage in a dialogue with participants and gain insight into deeper meanings about their feelings and points of view. Depending on participants' responses, questions were asked in order to expand on and explore areas which was not previously anticipated to be encountered, and certain issues could be clarified and understood. Hence, language played an essential part in conducting interviews, as the interviews depended both on the way language was used to clarify areas of interest as well as how people used language to express themselves and interpret meanings.

Merriam (2009) identified three types of interviews: the highly structured, semi-structured, and unstructured interviews. This study adopted the semi-structured interview style which consists of eliciting data from participants – with some flexibility – on their opinions about the research topic. The element of flexibility was one of the reasons behind the decision to use semi-structured interviews, because it allowed a developing of rapport with participants, enabled clarification of participants' perspectives, and the asking of probing and prompting questions to explore in-depth meanings.

Unlike highly structured interviews, semi-structured interviews are often dependent on how respondents direct the encounter, rather than being entirely constructed by the viewpoint of the researcher. In the particular case of this study, they allowed more focus on the interpretations of participants' articulations of their experiences and interactions between the participants to reveal the subjects' consciousness of the human world and to produce knowledge about specific events and situations (Kyale, 2009). Finally, in contrast to the other methods applied in the study, e.g. the questionnaire, participants who were unable to read or write were able to take part and voice their concerns and communicate experiences through the interview. The semi-structured interviews were used to address the research sub-questions as outlined in Table 5 below.

### 4.6.3.1 Design of Topic Guide

Before a semi-structured interview is conducted, a topic guide is prepared in advance, which guides the questions and conversation. In this study, the interview guide ensured that the researcher was able to collect similar types of data, ask relevant questions and maintain the focus of the interview (Patton, 1987), whilst at the same time allowing room for narratives<sup>15</sup> to develop, which can be useful in gaining patients' perspectives on cultural issues in therapy.

<b>Research Question(s)</b>	<b>What Specific Question(s) on the Interview Topic Guide will be used to Answer Each Question?</b>
How do PSY articulate their understanding of IAPT?	The “concept and content of therapy” section of the topic guide will be mainly used to answer this question. Also, some questions on the diary/therapy homework is expected to address the question.
How do PSY patients articulate their emotions?	Part of the content of therapy topic guide questions, such as ‘How do you express yourself in therapy?’ will be used to address the question.
Do PSY patients feel that language and cultural issues impact on their experiences of therapy, if so, how?	This will be addressed through “working through an interpreter”, “diary/therapy homework” and “the role of culture and religion” topic guide questions.
Do patients feel that emotions are being explored by therapists and if so, how?	The “working with a therapist” and ‘what made therapy work?’ topic guide questions are expected to yield information to address this research question.

**Table 5 Research Questions Addressed by Semi-Structured Interview**

As a good topic guide is crucial to effective data collection, a number of steps were taken to develop the guide used for this study. For instance, a number of PSY patients and the advisory group were consulted to discuss ideas and themes to be explored in the interviews. The patients and advisory group

<sup>15</sup> Although the term “narrative” has been widely used to engage audiences with past lived experiences, in this thesis the term refers to topically-centred and extended accounts of participants from a specific perspective.

mapped all the areas the researcher was looking to explore and listed a number of questions inquiring into these specific areas (see Appendix 4). The topic guide was also discussed thoroughly with the academic supervisors who helped refine the final version of the topic guide. While the topic guide was designed to facilitate effective conducting of the interview and answering of questions, it was used in a way that would give patients some flexibility and enable them to take the lead.

#### **4.6.3.2 Piloting the Interview**

Asking questions and interviewing people to collect the information necessary to answer research questions is a precise task and requires particular techniques and skills. Therefore, preparation for the interview was crucial as it enhanced the researcher's performance and added value to the research. Good preparation for the interviewing process as recommended by Gill et al. (2008), involves knowing your participants, preparation, checking the recording equipment, and preparing the questions carefully. Hence, a workshop<sup>16</sup> was attended to enhance performance and develop any further skills to ensure the data collected was representative of participants' accounts.

Piloting a test of the interview as highlighted by Turner (2010) assisted determining if there were any flaws, limitations or other weaknesses in the design, and to adjust and make any necessary changes prior to the implementation of the study. Furthermore, it helped in developing the interview questions and deciding on the strategies to elicit more information. For example, questioning strategies involved asking participants to expand more on the subject, probing to encourage them to elaborate, prompting them to elicit further meanings and ask for further clarification. Piloting the interview also helped to establish the effectiveness of the technique, determine the sample size, and estimate the time needed to conduct the interview (Teijlingen and Hundley, 2001).

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<sup>16</sup> 'In-depth interviewing skills' is a workshop organised by the Social Research Association in London.

For this study, two patients – one from Somalia and the other from Yemen – took part in the piloting test. The outcome of the pilot included the following positive comments:

- Participants praised the researcher's interpersonal skills and felt that she put them at ease.
- Participants felt they were able to ask for clarification and were able to elaborate on the topics as much as they wanted to.
- The flow of questions and transition was smooth and felt like natural conversation.

Additionally, they provided the following recommendations:

- To keep lexical choices neutral and not to use evaluative words as this might place people into categories.
- Not to make assumptions, instead to ask participants for their views.
- To use open questions in order to make people feel at ease.
- To avoid using jargon and use the same words as used by the participant.
- To avoid asking more than one question at a time.
- To give examples when people are unsure about the question.

The feedback was valuable in refining interview techniques and in ensuring the questions were fit for purpose.

#### **4.6.3.3 Recruitment Process**

##### **4.6.3.3.1 Sampling**

The inclusion criteria for the research was based on the participation of specified ethnic and cultural groups, i.e. Pakistani, Somali, and Yemeni people who suffered mild to moderate anxiety or depression and who have accessed the IAPT service. For this reason, purposeful sampling was used to capture the data required. Jupp (2006) defines purposeful sampling as a form of non-probability sampling in which the researcher decides which individuals are to be included in the sample. Thus, the goal was not to randomly select people but to select those who enabled the accessing of information central to the research question(s) and facilitated understanding

of the phenomenon under study (Patton, 1990; Ritchie et al., 2014). This technique involved selecting a sample that represented a wide range of variation within the groups of interest and was reflective of the important characteristics from which it was drawn. For example, the researcher was interested in how people articulated their experiences at the different stages of accessing the service and it was assumed that age, gender, level of education, and language proficiency were important background characteristics. Therefore, she decided to choose participants, taking into consideration all these characteristics to maximise the variation of sampling. Taking Bryman's (2012) and Patton's (1990) views into account, this variation of sampling served two purposes: first, it enhanced the ability to describe the range of cases that were related to the subject researched. Secondly, it allowed the investigation of the dependence of access to therapy on variables such as age, literacy and gender across the different cases and comparison between those who were most significant and those who were less important to the study.

While purposeful sampling enabled the identification of those who were most likely to yield information relevant to the subject matter, it can introduce the researcher's bias in identifying participants. Therefore, individuals were recruited through gatekeepers who controlled the access to potential participants and had responsibility for the action sites as explained previously in Section 4.3. The considerations behind adopting these recruitment methods were the thoughtful consideration of the vulnerability and stigma around mental health issues amongst the PSY groups and the difficulties anticipated in reaching them. In addition, should one recruitment source prove to be problematic, participants could be recruited from another source.

#### **4.6.3.3.2 Sample Size**

As qualitative research is not intended for generalisation but to develop an in-depth understanding of the subject of study, the sample size is usually small in number. A small sample size may be adequate to produce valuable and representative data for the research project (Adler and Adler, 2012). Also, the detailed nature of qualitative research can be considerably intensive

and simply unmanageable with a large data set (Ritchie et al., 2014). Hence, following the consultation with academic supervisors and the REC, it was agreed that 7 – 10 participants from each group would provide access to enough data, which would enable the reaching of an understanding of the subject researched and would generate an appropriate explanation of the topic under study. However, to reach this number of participants was not possible and the sample size was not the same across the three community groups. This was due to the difficulty of recruiting individuals who suffer from mental health issues and belong to cultural groups in which talking about mental health is considered a taboo subject. Despite this, the use of supporting observational notes supplemented the data and allowed for rich interpretation of patients' experiences from a range of perspectives, as well as broadened the understanding of the range of experiences amongst these groups.

#### **4.6.3.3.3 Recruitment**

In total, twenty-two participants from the three ethnic groups took part in the individual semi-structured interviews. In terms of gender distribution the sample consisted of eighteen female and four male participants. Ten participants were Pakistani, eight Yemeni, and four were of Somali origin. Table (6) provides an overview of the sample's characteristics, which is further detailed in Table (17) (see Chapter 5). In addition, a number of identity attributes was also included in Table (6) in order to understand whether or not these identity attributes had any impact on the articulation and access of therapy.

As discussed in Section 3.2.1.2, these identity attributes are correlated with expression of emotions in therapy. In this research the recording of identity representations revealed connections between them and the participants' expression of emotions and perspectives on therapy.

Originally, recruitment was to be through the researcher's attendance at observational sessions. Six participants were recruited through this strategy. However, three of these – a Pakistani male who did not want the interview to

Participant	Nationality/UK born or age of arrival to	Educational level	Age group	Recruitment source
Abyan – [F]	Somali born	undergraduate	25 - 30	Secondary mental health
Aliyah – [F]	Yemeni/UK born lived in Yemen/later moved to UK	Illiterate	40 – 50	IAPT observation
Atiqa – [F]	Pakistani born	College education	60 - 70	St Cuthbert Church
Azhar – [F]	Yemeni born	Illiterate	50 – 60	IAPT observation
Dalal – [F]	Yemeni born	Grade five, Primary School	40 - 50	Secondary mental healthcare
Jamil – [M]	Yemeni born	PhD	50 – 60	Secondary mental healthcare
Kausar– [F]	Pakistani born	Illiterate	50 – 60	St Cuthbert church
Khadra [F]	Somali born	Diploma in Accounting	40 - 50	ISRACC
Mahdi – [M]	Somali born	Currently doing MA	30 - 40	Community organisation
Maleeha [F]	Pakistani/came to UK as a child	Illiterate	60 – 70	St Cuthbert church
Momina [F]	Pakistani/UK born	Secondary school O level	40 - 50	St Cuthbert church
Mona – [F]	Yemeni born	Grade five, primary school	40 – 50	Darnell well being
Nadeem[M]	Pakistani/UK born	Undergraduate - business	20 - 30	IAPT observation
Nour – [F]	Yemeni born	Degree in Education	40 – 50	Secondary mental healthcare
Pakeeza [F]	Pakistani/UK born	GCSE	20 – 30	St Cuthbert Church
Rabab – [F]	Yemeni born	PhD	40 – 50	Sheffield University
Raeesa [F]	Pakistani/arrived UK when 4 Years old	Can read	50 – 60	St Cuthbert church
Rozena [F]	Pakistani born	MA in Business studies	40 - 50	ROSHNI
Sabiha– [F]	Pakistani/Came to UK as a new born	MA in Health care	40 - 50	PMWN
Salma – [F]	Pakistani/UK born	Social care degree	30 - 40	Secondary mental healthcare
Yabaal [M]	Somali born	Grade Six	40 - 50	MANN Somali mental health
Yusra – [F]	Yemeni/UK born	Undergraduate	20 – 30	Zest

**Table 6 Overview of Participants' Characteristics**

be recorded, a Yemeni female who was over-anxious about participation and a Somali participant who left Sheffield – withdrew from taking part. Accordingly, only three participants, a Pakistani male and two Yemeni females, agreed to take part in the individual interviews. Community mental

health teams were then considered as a recruitment ground and after meeting with managers and discussing the research objectives, emails were sent to Access team<sup>17</sup> members to identify potential participants who accessed the IAPT service prior to being referred to secondary mental health care. Four participants were identified: a Yemeni male and two females, and one Somali female.

Since difficulties in gaining access to potential participants persisted, meetings were arranged with community and voluntary organisation leaders to help identify and recruit participants for the study. Sheffield Asian Women's Resource Centre (ROSHNI) and Time Builders development workers were contacted for the recruitment of Pakistani participants, and between the two, nine female participants were recruited. Another two female Yemeni participants were identified from the community and a third through the University of Sheffield. One Somali male was also identified through University contacts. Due to the continuous difficulty in recruiting Somali participants, the following organisations were contacted with the hope of recruiting more Somali participants: MANN Somali Mental Health, Darnall Educational Centre, ISRACC Somali Community and Cultural Association, Darnell Wellbeing, Ship Shape, ZEST Community Centre and ESOL Teaching Centre in Darnall. Despite these numerous attempts, only two Somali participants were identified: one through ISRACC and the other through MANN Somali Mental Health. Consequently, the researcher tried the snowballing approach, in which recruited interviewees are asked if they know any people who fit the selection criteria (Patton, 1990; Ritchie et al., 2014). However, no further participants were identified.

#### **4.6.3.4 Interview Process**

In this study and upon recruiting participants, arrangements were made to contact participants and agree a suitable time and venue. Most interviews took place either at the participants' own homes to make participants feel comfortable or at health and community sector premises to ensure privacy

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<sup>17</sup> The Access team carry out triage, crisis assessment and duty function to determine the need and urgency of treatment and management of mental health problems.



and appropriate surroundings for the interview. The interviews were carried out during the day at a time convenient for participants and most interviews lasted between 45–60 minutes. Interviews were audio-recorded after obtaining permission from participants and were kept in a private space in accordance with the Data Protection Act and University regulations. Audio-recording was useful as it enabled the capturing of all the data, referring back to the interview whenever needed, confirming accuracy and recording direct quotes (Markle et al., 2011).

Prior to the start of the interview process, the researcher gave detailed information about the purpose of the research and the topics that will be discussed, confidentiality and anonymity measures, and how the information will be used and stored. Then, an informed consent form was obtained from all participants (see Appendix 5). Two copies were made; one for the participants and the other was kept by the researcher. Once the interview came to an end, before thanking them for their participation and handing them an incentive payment, participants were asked if they would like to add anything. The incentive payment, a voucher from a supermarket with the value of £10, was given as an appreciation for the participants' time.

#### 4.6.3.5 Transcription of Interviews

Once the interview process completed, the data was transcribed by the researcher using the verbatim transcription method (Poland, 1995).

1	Ensuring use of high-quality audio-recording equipment
2	Transcription of recorded material immediately after the interview
3	Listening and checking the recorded materials more than once
4	Paying attention to the non- verbal content details of the interview such as voice, tone, pitch, pauses, and their meanings.
5	Correlating the non-verbal communications of expression with the full meaning and context of words said (language use)

**Table 7 Transcription Rules to Ensure Consistency in Transcribing Interviews**

As the researcher was quite involved in the interview process, this gave her the advantage of noting the non-verbal signs accompanying the expression

of words. These were noted as a brief description of the emotional state of the interviewee, indicating pauses and silences in the transcription, which gave the data more meaning than if merely the spoken text was recorded. Moreover, the way the participants spoke, including voice, tone, pitch, and body language, were taken into consideration, particularly as the recognition of participants' non-verbal communication is central to issues such as reliability and validity of the data. In order to ensure consistency in transcribing the interviews, a tool was developed to include these into the transcription records, as shown in Table (7). Having the digital recording stored and backed-up, the recording was revisited multiple times allowing the verification of the transcription, and the familiarity gained with the recording facilitated jumping through interviews to retrieve specific excerpts (Tessier, 2012).

#### **4.6.3.6 Translation of Interviews**

This research involves the collection of data in more than one language of which one or more are different from the primary language used by the University of Sheffield. The use of different languages in this research was quite essential, as the main objective was to give participants the opportunity to voice their opinions in their own languages. Thus, this approach gave the opportunity to have a better understanding of the complexities involved when communicating in different languages and developed the awareness of the multilingual situation of the process (Holmes et al., 2013). While being a native Arabic speaker gave the advantages of fulfilling the role of interpreter and translator and communicating directly with Yemeni participants, interpreters and translators, were sought for some Somali and Pakistani participants.

Fifteen interviews were carried out in English as those participants preferred the language as a means of communication. Two interpreters were booked for a Somali and a Pakistani participant. An elderly Pakistani lady who was not proficient in English refused to have an interpreter and communicated through her learned English, in which she used non-verbal communication at times to convey her meanings. Finally, the remaining interviews with five

Yemeni participants were carried out in Arabic, the shared language, between participants and the researcher.

The ability to communicate with people who were not proficient in English in their own languages is of great importance since they were able to communicate their emotional experiences in a more relaxed and confident way. This enabled me to dig deeper into their meanings directly without the need for mediators (Shklarov, 2007). Yet, for the researcher, when translating the audio transcript from Arabic to English, numerous challenges were encountered. To capture what the participants were saying and put it in the right context, listening to the recording several times was required. Bearing in mind that the translation process involves decision-making about the choice of variables and the equivalence of translations (Chesterman, 1989), an effort was made to translate the whole phrases by paying more attention to the context rather than the form. Note of the connotation was taken, being as faithful as possible to the audio transcript as shown in Table 8 below:

Arabic	English
<p>شارد من الموت لا حضر موت mwt'</p>	<p>I came to England to escape death to find myself face to face with death</p>
<p>The person talked about how he escaped the death sentence in Yemen to face another when arriving to the UK, acknowledging the fact that what was predestined for him to happen will happen. He described his prolonged years of suffering to sort out his immigration status to the sentence of death in Yemen, because he was unable to do anything. The circumstances were different but he left one problem to find himself facing another.</p>	

**Table 8 Example of the Process Involved to Ensure Decision Making in Translation**

Another challenge faced was the fear that during translation nuances of meaning presented by participants might disappear. For example, quite often

people use poetic verses, proverbs or idiom of distress, which have cultural roots in the original language and if translated word for word, they might lose their meaning. Therefore, the whole interview was translated paying specific attention to those words and phrases that were directly related to the research questions. The translation of such scripts was approached through consulting different dictionaries to verify if the words and phrases used were the right ones without losing the meaning. Also certain terms and concepts were discussed with colleagues and professional translators from the same country of origin in order to ensure the right choice of lexical terms. Furthermore, it was aimed to give a brief explanation of the phrase if it appeared that certain words were not conveying the overall meaning, as shown in Table (9):

Arabic	English
الحبل لما يمتلي يا الله ما يتسع Alḥabel Ima yemteli ya Allah ma etesʕ	When the washing line is full you cannot add no more.
People in Yemeni villages are used to put their washing outside on a rope to dry. Yet, when the rope is full, they cannot add any more clothes. The interviewee used this proverb metaphorically to show that she has been bottling up her feelings, unable to carry greater burden and needing to get rid of some of the emotional weight she was carrying.	If the translation is left as it is, it might mean nothing for the reader.

**Table 9 Example of Using Idioms which have Roots in the Original Culture**

A third challenge was the fact that there is not one single translation for the text as it is all open to interpretation. The reasons for the production of multiple versions of a translation is not to reach “a perfect translation”; instead, it is because each version – as explained by Bassnett (1990: 100) – is “context bound and represents a reading accessible to the time in which it is produced”. Kamler and Threadgold’s (2003: 149) statement that “translation is never easy, never finished, [and] never clear-cut” was taken

into consideration and it was tried to place the transcript in a comprehensive context and interpret what was understood. It was quite a challenging process, particularly when some participants were struggling to find the right words even in their own language to describe their feelings. Returning to the audio transcripts continued in order to ensure that the participants' meanings and interpretations were well conveyed and a detailed representation of what was said was presented.

In addition to the above, using interpreters to facilitate the interview process was not without its implications and limitations and added an additional variable, as has been also reported by Kamler and Threadgold (2003). One of these complexities was the fact that the presence of the interpreter might have influenced the outcome of the interview, impacting on the data collection process (Ingvardotter et al., 2010). Therefore, notice was taken of the different voices and points of views that affected the dialogue with participants (Bradby, 2002). During the interview process, it was necessary to wait until the interpreter completed the interpretation process before asking any further questions. It was not possible to interrupt the flow of conversation and ask direct questions related to participants' responses and ask for clarification or the connotations of certain words. This sometimes led to the loss of vital information (Esposito, 2001). The complexities experienced during the interview process when using interpreters were partly related to the fact that those booked for the interview process and those used to verify the interpretation process, were from different linguistic backgrounds. For that reason, Kamler and Threadgold (2003: 146) warned that translations "are never easy, never transparent, never simple encodings and decodings from one language to another".

To reduce misunderstanding and loss of important information, interpreters were contacted to explain the research in detail and discuss the aims and objectives of the interview (Andrews, 2013). They were also briefed about the specific themes to be explored and the intention of using the topic guide to allow participants' responses to guide the structure of the interview. Despite these efforts, there were instances during the interview when it was

felt (as an interpreter) that there were some unapparent discussions going on or sometimes the answers did not match what the researcher asked as explained in Section 5.4.

Accordingly, a second opinion was sought to evaluate the qualitative data and enhance the methodological control. The transcripts were verified by the transcultural mental health workers, as they were quite knowledgeable both in cultural issues as well as lexical terms related to mental health. After briefing them about what exactly what was being researched, they listened carefully to the recording tapes and engaged in a process of negotiating sentence meaning. Paying attention to any metaphor or analogy used by participants, the transcultural mental health workers tried to convey either the exact meaning or explain the context for using such a metaphor. Finally, they verified the interpretation and highlighted any loss or addition of information or change of participant's meanings as shown in Section 5.4. New edited transcripts illustrating and clarifying the areas of concern were then developed to start the analysis process.

#### **4.6.3.7 Data analysis**

Following the completion of interviews, and the transcription and translation of data, thematic analysis was applied given its appropriateness for describing, analysing, and reporting themes and repeated patterns in data. The six steps guide to thematic analysis as outlined in Section 4.6.1.3 by Braun and Clarke (2006) was followed. The analysis strategy in this study first involved familiarizing myself with the data before generating themes from the interviews. This involved incorporating a deductive a priori template of codes, an approach contemplated from the research questions and an inductive approach to allow for any unexpected themes emerging from the data.

To enhance the credibility of the findings and to ensure the developing themes were grounded in the original data, a professional data analyst was consulted to check the overarching themes from the transcripts. This process strengthened the validity and trustworthiness of the results. A meeting with

the analyst was arranged to compare the similarities and differences of codes before agreeing upon the final themes. Each one of us later reread through the transcripts, reviewing and naming the themes to ensure they were reflective of the data. In addition, to facilitate the analysis of the interview transcripts, coding was conducted using the software Nvivo version 11. Using Nvivo in the analysis process has many advantages. One of these is the ability to store all the data and recorded transcripts and facilitate easy access to the data. In addition, it helps the researcher to index the data, mark certain concepts as important, and allow the organisation of data into a hierarchy of so-called "nodes". These nodes can be further categorised by attributing sub groups to each node (see Appendix 15). Moreover, the use of Nvivo allowed the arrangement of direct quotes and comments of participants on specific concepts or topics under these categorisations for illustration of each theme. Finally, the powerful search-query tool assisted in finding all the passages in which specific topics or subjects were mentioned and coded under a named theme. This helped build a rich description of the data and facilitated the interpretation of themes and additions of other annotations or reflections.

#### **4.7 Validity and Trustworthiness**

The concept of reliability, as argued by Krefting (1990), Noble and Smith (2015) and Rolfe (2006), is seldom relevant in qualitative research. This is because qualitative research is usually more concerned with understanding and gaining knowledge about the phenomenon under investigation rather than testing it. In addition, due to the pluralistic nature of qualitative research studies, it can be difficult to apply the same assessment criteria to all qualitative research. For these reasons, there was a need to identify criteria specific to qualitative research to ensure the true value of the qualitative research findings. Lincoln and Guba (1985) and Koch (2006) proposed four quality criteria to assess what they defined as the "trustworthiness" of qualitative research, which were followed in this study. These measures were: credibility, transferability, dependability, and confirmability. Credibility was achieved by rigorous interpretation of the data, the researcher clearly

pointing out that the research was an inductive one and that it was supported by participants' quotes and validated by members of the research team. Transferability entailed the description of reflexivity (Section 4.3.1) and outlining in detail the data collection methods (see Table 1). With dependability, in-depth methodological description was provided and conclusions about the findings were drawn depending on the process of analysis. Confirmability demonstrates the neutrality in the research study and that the findings emerged from the data and not from the researcher's prediction. In particular, raw data was passed to an independent analyst who was asked to categorise the data and report back the themes she derived to ensure transparency and quality of the research process.

Validity Threat	Approach used in this study to rule out the threat
<b>Reflexivity</b>	I have described the motives to undertake this research in detail and kept a reflexive diary containing subjective and objective notes where possible.
<b>Methods</b>	Detailed description of the method used and logic of inquiry.
<b>Sampling</b>	Purposeful sampling was used as it was more appropriate and provided variable views.
<b>Interviews</b>	Audio recording and verbatim transcription were used. Content of questions used covered the breadth and content of the field of study as indicated by the pilot as well as the discussion with professional colleagues.
<b>Observation</b>	To examine critically the discrepancy between what people say they do and what they actually do.
<b>Questionnaire</b>	Appropriate language used to enable participants to provide the information required and gain an optimum response. Also, it was self-administered to obtain feedback from a wider group of participants and to avoid the possible inference of the researcher bias.
<b>Analysis</b>	Detailed information about the procedures and any assistive tools used such as Nvivo clearly outlined.
<b>Saturation</b>	The inductive approach continued until no new data emerged.
<b>Triangulation</b>	Different methods were used to compare similarities and/or compare results.
<b>Fair dealing</b>	A range of views from prospective participants were sought to ensure the majority of views are taken into consideration.
<b>Use of participants' original words</b>	A number of participants' original quotes and words were presented to honour their voices and enhance validity.
<b>Positionality</b>	I have carefully considered my positionality as a researcher, interpreter, translator and a mental health worker and where possible made reference to these encounters.
<b>Inter-rater reliability</b>	Some of the interviews and observational records have been reviewed by supervisors and an independent professional analyst for consideration and agreement of findings.

**Table 10 Approach used in this Research to rule out Validity threat**



Throughout this work these measures were carefully observed and after consulting a number of authors (Cooper and Endacott, 2007; Mays and Pope, 1995; Mays and Pope, 2003; Morse et al., 2002), the key considerations to rule out any validity threats were set out as presented in Table (10).

#### **4.8 Summary**

The social constructionist theory adopted in this thesis required a range of methods to be utilised to allow the linguistically and culturally complex voices to come through. This includes a range of tools and data collection methods such as questionnaires, participant observation and semi-structured interviews as well as a detailed description of the researcher's positionality to provide readers with better insights into the interpretation and reporting of the research findings.

## **Chapter Five**

### **Overview Results from Research Tools and Data Collection Methods**

#### **5.0 Introduction**

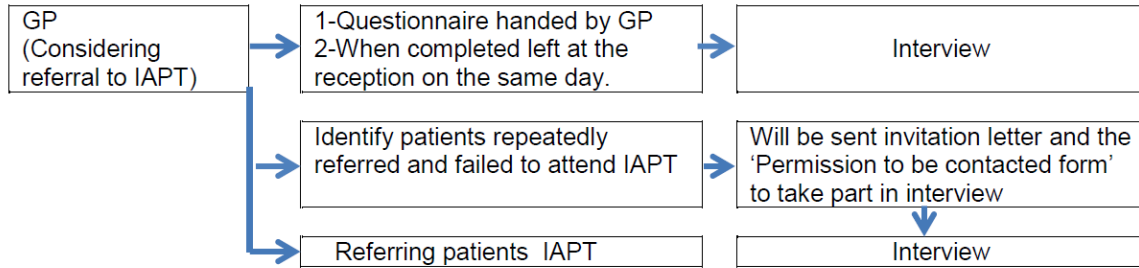
This chapter presents the data collection process outlining the research timeline, types of data yielded from the different methods used, and a summary of the findings. A summary of patients' backgrounds and their reasons for accessing therapy is included. Finally, an explanation and justification for the selection of the particular cases presented in the subsequent chapters is discussed.

#### **5.1 Data Collection Timeline**

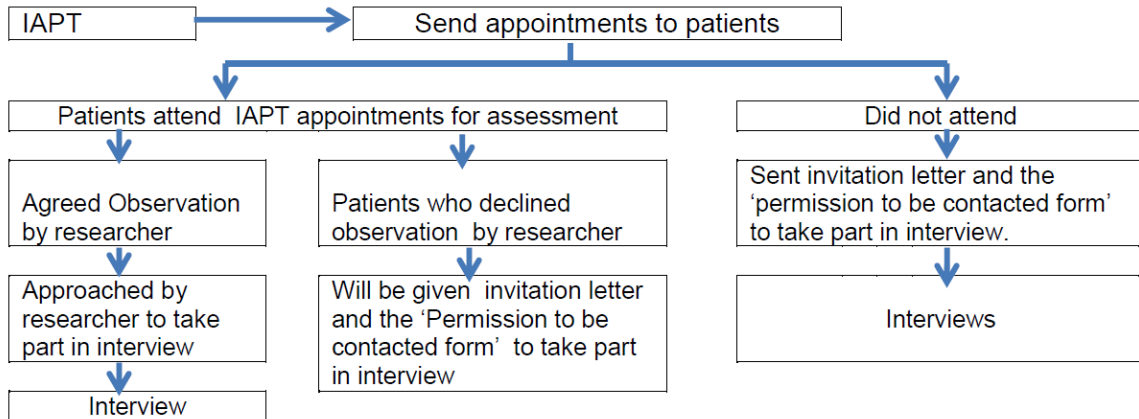
A systematic integration of the qualitative methods outlined in the previous chapter was used to decide at what stage each method will be used, and whether the collection methods will be used sequentially or concurrently. Taking into consideration that each data collection method has its strengths and limitations, careful planning was carried out to decide at which stage in the timeline of the research each data collection method was to be used to obtain the necessary information and a flow chart was prepared (see Figure 4 below).

Given that the questionnaire tool was intended to collect preliminary data for further discussion at the interviews, it was most appropriately used at the earlier stages of the study. Hence, a clear plan mapping the timeline for implementation was prepared as outlined in Table (11). However, certain practical issues may be difficult to overcome with a limited time and resources. For instance, refining the list of GP practices and identifying key persons to approach GP practices took longer than anticipated. Even after meeting with GP practice managers who indicated their interest to take part, many withdrew as explained in Section 4.3, which delayed the distribution of the questionnaire.

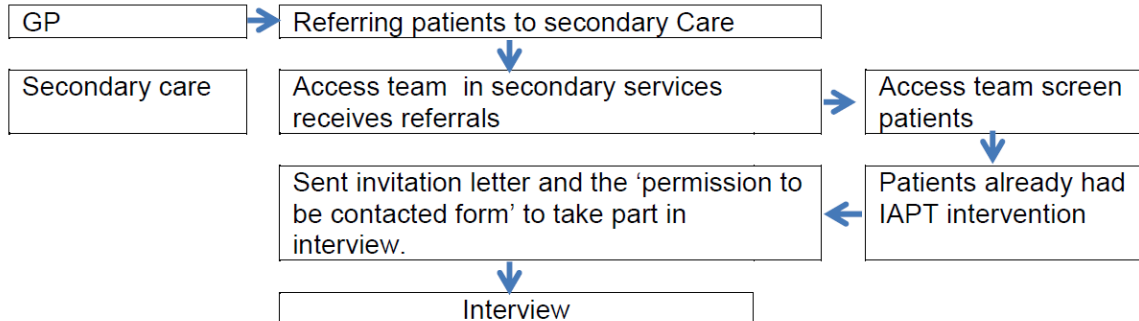
**(1) General Practice (GP)**



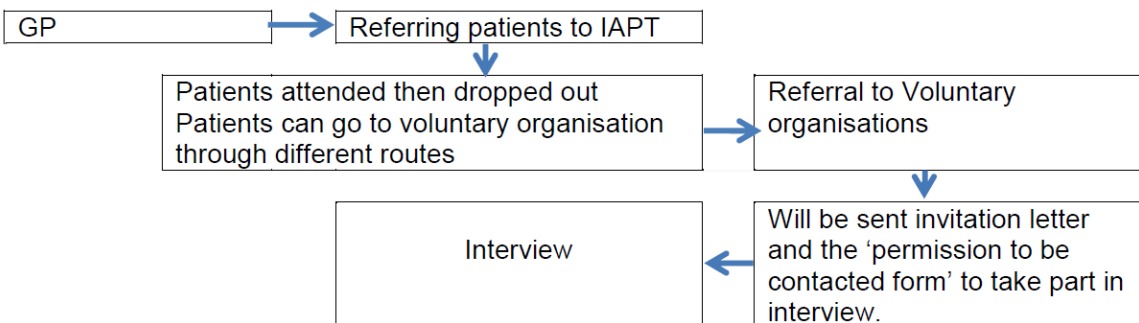
**(2) Improving Access To Psychological Therapy (IAPT)**



**(3) Secondary care**



**(4) Voluntary organisations**



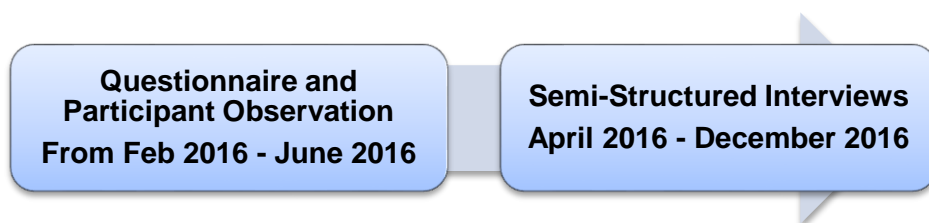
**Figure 4 Study Process: Recruitment and Data Collection Stages**

<b>Month</b>	<b>Activity</b>
<b>September 2015</b>	Refine GP list of practices with majority of PSY patients. Identify key persons to approach GP practices. Meet with GP practice managers, inform about the research and ask them to distribute the questionnaire. IAPT manager to contact IAPT workers at the GP practices identified and send an introductory email about the research
<b>November 2015</b>	GP practices start distributing Questionnaires Approaching IAPT workers and agreeing on mutual sessions for observations. Recruitment of patients at GP surgeries
<b>January 2016</b>	Contact with GP practices and collecting questionnaires. Initial analysis of questionnaire and generating themes.
<b>February 2016</b>	Contact with IAPT therapists continues Recruitment of patients continues Piloting the interview
<b>March 2016</b>	Conducting Interviews
<b>April 2016</b>	End of participant observation and Initial analysis begins.
<b>September 2016</b>	End of interviews
<b>December 2016</b>	Analysis of Interviews and producing the final report

**Table 11 Data Collection Timeline**

Under those circumstances, the timeline needed to be revisited and evaluated before a new plan was employed. The researcher decided to use the questionnaire and participant observation concurrently over a referenced period to complement one another and get a better feel of participants' perspectives as shown in Figure 5 below. But due to practical issues specifically related to the delay in the recruitment process (see Section

4.6.3.3.3), a number of interviews took place before finishing the final report of the in-depth analysis of the participant observation data. Although the unavailability of participants at the specific time of the research required flexibility in decision making and extension of the data collection timeline, this did not have an effect on the quality of data.



**Figure 5 New Timeline for Data Collection Methods**

Yet, to ensure that the interviews were informed by the outcomes of the participant observation, throughout the research process the researcher continuously and concurrently reviewed the themes identified from the participant observation and searched for any unanticipated topics or questions, which needed to be addressed or explored further in the interviews. A preview summary of the findings from the different data collection methods is now presented.

## **5.2 Questionnaire Distribution Context and Initial Findings**

The questionnaire was administered by proxy, through email, and face to face at different places (Section 4.6.1.2). The different locations and means of communication seemed to elicit four different types of quality and length of responses. Questionnaires that were distributed by proxy, in this instance, Sheffield Asian Women's Resource Centre (ROSHNI), contained very little detail as participants provided only just yes and no answers without elaboration. On the other hand, participants who completed the questionnaire during my visit to St Cuthbert Church and Fatma Mosque, provided intermediate responses of a few sentences. It seems the researcher's presence might have affected respondents by convincing them of the legitimacy of the study and clarifying any unclear questions. These questionnaires were the starting point for data collection. Questionnaires that

were emailed to participants, handed in by therapists and those received via the university, were more detailed in nature and contained some longer responses. Two participants and a therapist engaged in email correspondences with the researcher to ask for further clarification. The difference in the type of responses received from the different questionnaire contexts listed above may be related to the fact that people from the university are used to working in a research environment and they recognised that researchers are often seeking more detailed responses. It may also be that therapists who worked as gatekeepers have more of an understanding of the amount of information required. Moreover, people who were responding to the questionnaire with the therapist may have had more commitment to do it or may be that people who could choose when they completed the questionnaire were able to think more carefully about how to answer the questions.

The final set of questionnaires collected were those where the researcher spoke directly with participants and they responded to the questionnaire orally. They took the nature of a semi-structured interview because depending on the respondents, some of them did not decide that they would agree to be interviewed until after they answered the questionnaire. Those respondents agreed to answer the questionnaire in a face-to-face administered style where the researcher was able to ask for further details and explanation. Therefore, these questionnaires yielded richer data than the other questionnaires. Table (12) provides a summary of the number of times particular themes appeared in the questionnaire findings. These themes guided the discussion of the interviews.

What was interesting in the questionnaire administration, and worth noting here, was the fact that the majority of respondents were female except for two males from the University of Sheffield, despite efforts made to engage with males from all community groups.

<b>Category</b>	<b>Frequency of Occurrence</b>
<b>Language and Therapy Concerns</b>	
Communication difficulties	11
Terminology/Emotional expressions	3
Impact of using of interpreters	7
Body language/non-verbal communication of therapist	4
Physical expressions	2
<b>Cultural Concerns</b>	
Cultural beliefs and perceptions	10
Cultural/ethnic matching	7
Therapist's cultural understanding	3
<b>Role of religion in therapy</b>	
Advantages and Barriers	3
<b>IAPT service concerns</b>	
What is therapy	6
Perception of therapy	4
Expectation of therapy	2
<b>Service provision</b>	9
<b>Therapist skills</b>	2

**Table 12 Preview of Questionnaire Content Analysis' Findings**

### **5.3 Participant Observation**

The intended purpose of participant observation, as explained in Section 4.6.2, was to allow the researcher to trace through the process of therapy and report on the dynamics of the session as well as to have a better understanding of the consultation context from both the patient's and the therapist's perspectives. By adopting the 'Observer as Participant' role, in which the researcher chose to sit at the side of the room, she had the opportunity to concentrate on recording and observing how participants and therapists from diverse background interacted as well as to minimise any impacts of her presence on those observed (see Table 13). In addition, the researcher was able to note down some of the precise terms used by the

participants to describe their emotions and reflect on the events taking place as explained in Section 4.3.1.

<b>Process of Therapy</b>	<b>Consultation Context</b>
<b>Meeting the Patient</b>	On his own Interpreter booked With a relative
<b>The Session Process</b>	Explaining the procedure Discussing referral Understanding reasons for seeking help How patients articulate of the problem
<b>Questionnaire</b>	Therapist-led Filling the questionnaire with interpreter Patient-led Understanding the questions Explaining the purpose Explaining the scores
<b>Tasks/Activities</b>	Diary sheet Understanding the purpose Challenges Other therapy techniques
<b>Perception of Therapy</b>	Talk can help Therapist as doctors Learning techniques other
<b>Expectation of Therapy</b>	Medication Feeling better others
<b>Outcome of Therapy</b>	Group therapy CBT/Counselling Online support End treatment /unsuitability
<b>Communication and Emotional Expression in Therapy</b>	
<b>Language and Therapy</b>	English as a second language Non-verbal communication Role of interpreters
<b>Emotional Expressions</b>	Description of emotional feelings Description of physical symptoms Impact of illness
<b>Religious and Cultural Beliefs</b>	Role of religion Cultural understanding
<b>Therapist/patient Relationship</b>	Cultural/ethnic matching Body language Power relation

**Table 13 Summary of Participant Observation Process and Findings**

The initial aim in the participant observation was also to follow participants' journey through the different stages of therapy, which are the assessment, the follow up and possible referral to CBT or counselling sessions. However, it was quite difficult to gain permission to attend CBT or counselling sessions



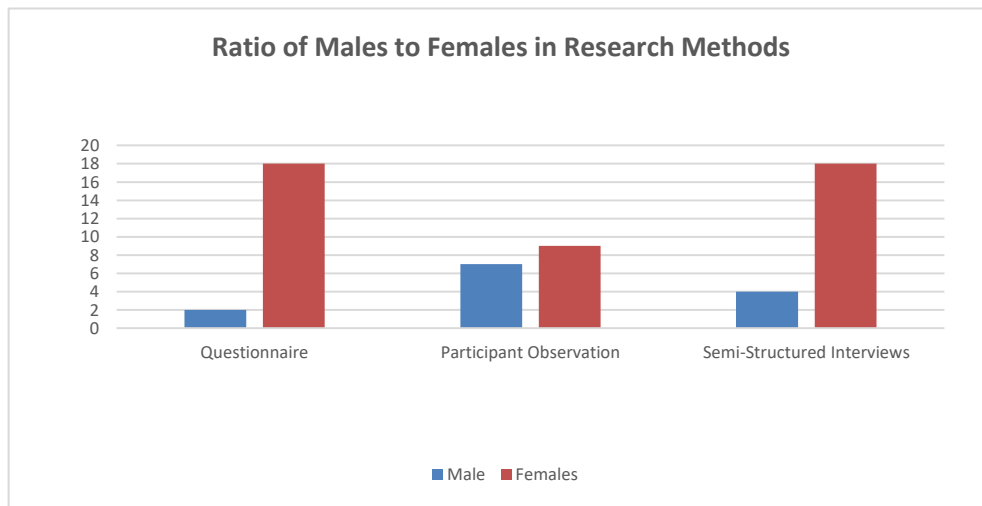
as almost all the therapists believed the researcher's attendance would inhibit participants from talking about their feelings (see Section 4.3.1). For example, at a counselling session, one patient was willing to have the researcher in the session, but the therapist refused on the basis that having a third party in the session [in this case the researcher] would impact on her relationship with the patient. Consequently, the patient agreed to fill in a questionnaire instead. At another CBT session, a therapist was happy to have the researcher observing, but the patient did not want the researcher in there. The patient, however, agreed to fill in a questionnaire. Another counsellor contacted the researcher to discuss the observation procedures before agreeing to take part, only to later change her mind for the same reasons mentioned above. Hence, the researcher contacted professional wellbeing practitioners who normally carry out the assessment sessions and they were more open to having an observer. Table (14) below outlines the participant observation dates and places, the ethnicity of both therapists and patients, as well as the type of sessions that took place.

During the participant observations, the opportunity arose to observe other ethnic groups. Although these patients were not from the same cultural groups as this study (which are Pakistani, Somali and Yemeni), they had similar cultural backgrounds and language concerns, which offered additional views and enriched my study. By drawing on the different points of views of patients on cultural sensitivity and language and communication issues of other groups, the researcher was able to expand on and examine the mutual issues shared with these wider groups. Moreover, in the course of observing the different and various sessions, patients gave a number of different reasons for attending therapy, some of which were quite complex in nature. In what follows, a detailed information about the patients is provided to enable the reader to have better understanding of the intensity and complexity of issues that were brought in by patients to the consultation room. See Table (15).

Date of the Observation	Place of the Observation	Ethnicity of the therapist	Ethnicity of the patient	How session was Conducted
29/02/2016	Park health centre	Yemeni	Bengali BM1- Male	Follow-up session with an interpreter present
29/02/2016	Park health centre	Yemeni	Pakistani PP1- Female	Assessment Patient has been living in the UK and able to communicate in English
02/03/2016	Darnall Medical Centre	Yemeni	Pakistani PN2 - Female	Follow up session with a UK-born patient
15/04/2016	Upperthorpe Medical Centre	British	Somali SN1 - Female	Assessment patient was able to communicate in English
22/04/2016	Upperthorpe Medical Centre	British	Yemeni YA1a - Female	Assessment patient present with her daughter who acted as an interpreter
22/04/2016	Upperthorpe Medical Centre	British	Yemeni YR2a – Female	Assessment patient is present with an interpreter
27/04/2016	Darnall Medical Centre	Yemeni	Pakistani PM3 - Male	Assessment patient is able to communicate in English
29/04/2016	Upperthorpe Medical Centre	British	Yemeni YA1b– Female	Follow-up session with an interpreter (on this occasion researcher acted as an interpreter as the centre didn't book on
06/05/2016	Upperthorpe Medical Centre	British	Iranian FM1 - Female	Assessment – Patient didn't want an interpreter and communicated in her non-proficient English
06/05/2016	Upperthorpe Medical Centre	British	Yemeni YR2b - Female	Follow-up assessment with an interpreter present
16/05/2016	Park Health Medical Centre	Yemeni	Yemeni YG3 - Female	Assessment – Patient communicated in her native language Arabic with the therapist who shared similar language and cultural background
25/05/2016	Darnall Health Centre	Yemeni	Pakistani PMY4 - Male	Assessment – Patient Is a UK born who is able to communicate in English
06/06/2016	Park Health Medical Centre	Yemeni	Somali SM2 – Male	Assessment – Patient is unable to communicate in English and a relative acted as an interpreter
12/06/2016	Park Health Centre	Yemeni	Yemeni YA6 - Male	Assessment – Patient is a UK born who communicated in English with therapist
15/06/2016	Darnall Medical Centre	Yemeni	Yemeni YL4 – Female	Assessment – Patient communicated in her native language Arabic with the therapist who shared similar language and cultural background
27/06/2016	Park Health Medical Centre	Yemeni	Bengali BH2- Female	Assessment – Patient is a UK born who is able to communicate in English
27/06/2016	Park Health Medical Centre	Yemeni	Pakistani PI5 - Male	Assessment – patient is able to communicate in English- He came later to the UK
15/07/2016	Upperthorpe Medical Centre	Yemeni	Yemeni YS5 - Female	Assessment – Patient is a UK born and communicated in English with the therapist
15/07/2016	Upperthorpe Medical centre	British	Sudanese SUM1– Male	Assessment – patient is present with an interpreter

**Table 14 List of Participant Observation Sessions Attended**

It was interesting to note that in the participant observation sessions, the researcher was able to observe seven males and nine females. This ratio was not reflected in the participants that were engaged with through the other methods. Figure 6 shows this in further detail.



**Figure 6 Ratio of Males to Females in Research Collection Methods**

The ratio of women to men in the study echoes the UK key statistics, which show that women are more likely to seek support and receive primary health care than men (Mind, 2016; NHS Choices, 2016). While some believe the reasons for this to be related to the belief that women express their feelings more openly and are thus more likely to report these symptoms, others believe they are a mixture of social, psychological and/or biological factors (Albert, 2015).

Patient	Background information
PO-BM1	A single male Bengali patient in his late twenties who does not speak English. He used an interpreter to facilitate the communication during the session. He was an asylum seeker who was waiting for a decision for his case. This has impacted on his life and on his social engagement. He describes his current situation with "I lose my existence, I lose myself" (line 194-195)
PO-PP2	A single female Pakistani patient who has been living in the UK for a long time and was able to communicate in English. She suffered panic and anxiety attacks. She described her experience with stress control group as 'they gave lectures, some information was useful but we were not able to do anything practical. When you are stressed you can't get things in' (line 33-34)
PO-PN3	A married female Pakistani patient, UK born, who came to therapy with a phobia from cats. Yet, when speaking with therapist, she brought in personal problems to the session such as problems with her husband and sister. She did not focus on the main issue. She described her problem as 'stuck in my mind' (line 140).
PO-SA4	A single female Somali patient in her mid-sixties, who could speak but not write English. She found difficulty in understanding information over the phone. She had several physical health issues, lived on her own and was referred to therapy by her GP. Yet, she did not know what the appointment was for. She was unable to sleep due to her physical health problems. She described her religion as the drive for hope in life 'I must be with God, nobody can help but God, I do my prayers... it gives me hope in the future' (line 159-163).
PO-YA5a Azhar	A married female Yemeni patient in her mid-sixties who did not speak English and was accompanied by her daughter who acted as her interpreter. She moved to the UK to live with her daughter after the war in Yemen and was distressed being away from her other children not knowing what was happening to them. She described her situation as 'the war in Yemen made me feel quite desperate and I am losing my mind, it has put an end to my strength and eagerness' (line 72-73).
PO-YR6a	A female Yemeni patient in her thirties who did not speak English and requested an interpreter from outside her ethnicity because she believed interpreters cannot be trusted. She suffered anxiety and fears of getting sick and dying. She lived on her own with two children after divorcing from her husband. She described her reasons to attend therapy as 'I am fearful of sickness, I am worried waiting, always looking at the negative side rather than the positive' (line 67-68)
PO-PM7	A married male Pakistani patient in his mid-sixties who had been in the UK for a long time and spoke English, though struggled to respond to the questionnaire due to the difficulty of the terms used and needed further clarification. He suffered from phobia, particularly closed places after being stuck in the crowd during Hajj. He was referred by GP and expected to be medicated.
PO-YA8b Azhar	This was a follow up-assessment session with PO-YA5a – Still no interpreter booked for this session. I agreed to interpret for this session. Patient used a lot of prayer and colloquial analogy to present her feelings 'I felt so scared, no one can feel your pain but those who are near to you. I felt quite depressed; having too much depressing news, increases your pain' (line 92-94).
PO-FM9	An Iranian Christian lady in her thirties, who has a deaf child, disabled husband and a young daughter. She spoke English but could not express herself fully. She has no family or relatives in the UK and was quite anxious about the future. She did not want an interpreter, fearing confidentiality and described this as a 'big problem... I am dependent on someone wherever I go and it is a bad feeling' (line 183-184).
PO-YR10b	A follow-up session with PO-YR6a – this time the patient brought up cultural issues and beliefs about mental health 'people say I have mental health issues and I feel having mental illness is not good, and I think the interpreter has told the community about it' (line 78-79).

Patient	Background Information
PO-YG11	A married female Yemeni patient in her late forties who had very long history of depression and trauma in her life. She also had serious physical health problems impacting on her mood. She was quite suicidal 'I was neglected, no one loves you or care about you' (line 58-59). She did not speak English and benefited from having a therapist who shared her language and cultural background.
PO-PY12	A married male Pakistani patient in his fifties, who has been in the UK all his life and speaks English. He used to work since the age of 15 but due to physical health problems, he had to stop working which impacted on his emotions. He was depressed and suicidal ' <i>my body won't help me to do what I want. When I can't do things, I become trapped</i> ' (line 105-106). Religion was his main protector ' <i>I find relief in religion and in reading Quran and praying and that will be the first place where I will seek help from not therapy</i> ' (line 212-213)
PO-SM13	A single male Somali patient who had been in the UK for more than 12 years and has been working. He was referred to therapy after recently coming from Somalia where he witnessed the murder of his sister and her children. He suffered severe depression that affected his ability to speak in English. He was accompanied by his cousin who acted as an interpreter and volunteered at times to speak on his behalf. Religion for him was a protective factor to stop him from acting on his suicidal thoughts (line 93).
PO-YL14 Aliyah	A married female Yemeni patient in her late forties, who moved to UK aged 24 but does not speak English. Therapist spoke Arabic and shared similar cultural background, which put patient at ease. Patient suffered depression after her father recently passed away. Yet when asked about her expectation from therapy, she said she wanted help with benefits claim.
PO-BH15	A single female Bengali patient in her twenties, UK born and spoke English. She was worried about the future. She did not want to take medication, therefore, GP referred her to therapy. She did not inform her parents about her depression because she believed they would not understand what depression is.
PO-PI16	A married male Pakistani patient in his late thirties, working in UK as a taxi driver. He was accused of not taking care of his daughter who reported to school the bad behaviour of the Imam who was teaching her Islamic education. He was asked to leave the house for 3 months. He described his problem as ' <i>A Muslim whose culture is different from this country and if anything happened, he is exposed in the media</i> ' (line 64-65). He was asked to attend therapy to help with his anger issues. He felt relief sharing these issues with a Muslim therapist.
PO-YS17	A female Yemeni patient, born in the UK and speaks English. She has a learning disability where she was unable to read or write. She explains her situation as ' <i>I kept things from the past in a box and didn't talk about it. I can't talk about it. It is ruining my life</i> ' (line 48-50). Therapist was unable to deal with the situation due to the restrictive model of IAPT service where it is difficult to cater for all patients' needs.
PO-SM18	A married male Sudanese patient in his late forties, did not speak English and had an interpreter booked for the session. Patient had been referred to therapy for low mood and past traumatic experience. Patient was an asylum seeker who had been granted leave to remain. He suffered an awful experience of neglect through his journey to UK and had some serious physical health problems. He had been under secondary care for some time. Patient got really upset during the session and therapist was unable to carry out the assessment as she felt patient will not benefit from therapy.
PO-YA19	A divorced male Yemeni patient in his mid-twenties, born in the UK and speaks English. He was referred to therapy by the GP after being stabbed by his ex-partner who took his daughter away from him. He described the situation as ' <i>I am the victim and the police is not treating me right, I don't know which channel I should take... I have explained everything but if I did the same, I will be put in prison</i> ' (line 48-51). During the session he kept threatening to retaliate back. Therapist again felt the case was too complex to be dealt within the IAPT service.

**Table 15 Participant Observation Background Information**

## 5.4 Semi-Structured Interviews

The in-depth semi-structured interviews were used at the last stage of the research process to bring about and explore in detail participants' articulations about their experiences of therapy. It also allowed the researcher to question the deeper meanings of participants' perceptions as well as gain insight into their feelings, beliefs and views. Table (16) lists an overview of the timeline and setting of the interviews.

Name of Participant	Ethnicity	Date of Interview	Place of Interview	Language
Nour	Yemeni	15.04.2016	Sheffield secondary care	English
Rabab	Yemeni	27.04.2016	Sheffield secondary care	English
Noman	Yemeni	06.05.2016	Participant's House	Arabic
Yusra	Yemeni	11.05.2016	Sheffield University	English
Momina	Pakistani	18.05.2016	Cuthbert Church Sheffield	English
Raeesa	Pakistani	18.05.2016	Cuthbert Church Sheffield	English
Dalal	Yemeni	27.05.2016	Sheffield Secondary care	Arabic
Salma	Pakistani	27.05.2016	Participant's house	English
Kauthar	Pakistani	01.06.2016	Participant's house	Using an Urdu interpreter
Nadeem	Pakistani	03.06.2016	Hallam University – Sheffield	English
Rozena	Pakistani	06.06.2016	Participant's house	English
Pakeeza	Pakistani	07.06.2016	Participant's house	English
Maleeha	Pakistani	08.06.2016	Participant's house	Using Her basic English
Sabia	Pakistani	09.06.2018	Participant's house	English
Laila	Yemeni	17.06.2016	Participant's House	Arabic
Amina	Somali	08.08.2016	Sheffield Secondary care	English
Atika	Pakistani	17.08.2016	Participant's house	English
Mahdi	Somali	09.09.2016	Sheffield secondary care	English
Mona	Yemeni	30.09.2016	Participant's house	Arabic
Azhar	Yemeni	30.09.2016	Participant's house	Arabic
Yabal	Somali	02.11.2016	Participant's house	Using a Somali Interpreter
Khadra	Somali	23.01.2017	Participant's house	English

**Table 16 Interview Timeline and Setting**

The interviews were conducted using participants' own choice of language as this gave participants from the target groups the opportunity to voice their concerns as well as for hidden voices to be heard. There were four different languages used in the interview process: Arabic, English and interviews that were conducted in Urdu and in Somali languages through the use of an interpreter to facilitate the communication (see Table 16). This approach allowed the researcher the opportunity to understand the complexities involved when communicating in different languages and developed the understanding of therapists and patients' positions during therapeutic encounters.

The nature of the data derived from the interviews, and the range of responses gleaned, were governed by the language used as well as the varieties in participants' characteristics, such as age, gender, level of education and ability to communicate in the English language. One of the advantages of the researcher's ability to communicate directly with participants who used the Arabic language was allowing them to fully express themselves as well as being able to dig deeper into their emotional expressions and thus their meanings. In relation to the interviews conducted in English, the researcher had a more limited opportunity to learn about the particular terms used in other languages. However, she was still able to record two noteworthy linguistic features. The first was related to the use of language to draw on specific world views and religious beliefs as the case with Raessa-P<sup>18</sup> in the quote below:

*"I used to recite (Kalima)<sup>19</sup> and Darood Sharif<sup>20</sup> and I am a true believer in God because when we clean our heart, (Allah)<sup>21</sup> clean your past so I am a true believer in that... Darood Sharif... gave me strength and power to be able to cross every barrier safely and soundly". (P-27- 36)*

The second, which was really interesting and worth noting here, was the fact that two participants, though proficient in the English language, kept code

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<sup>18</sup> Since the research is looking at the range of emotional expressions and cultural references amongst the research participants, and in order to highlight the use of specific and relevant Arabic religious terms, the letter P (Pakistani), S (Somali) or Y (Yemeni) will follow the name of each participant in the interviews.

<sup>19</sup> All Arabic words uttered by Urdu or Somali speaking participants will be written between single brackets Kalima refers to the six significant parts of one's religious belief, see glossary for further information.

<sup>20</sup> Darood Sharif is an Urdu word meaning the blessings, prayers and praise sent to the Prophet Mohammed, peace and prayers be upon him.

<sup>21</sup> Allah is an Arabic word meaning God used by an Urdu speaker

switching between the Arabic and English languages to express their emotions. When asked about the reason, Abyan explained:

*“Your language means a lot to you and sometimes I could say things to you like water but it won’t have the same effect on you... When you say it in your own language and your own culture, it has more effect on you and it brings all the احساس – Ihsas (feelings) in you, it brings all the upsets and all the emotions, yeah it does” (S-543-548).*

As for the two interviews that were conducted using interpreters, various elements seemed to have caused certain results to come about. Primarily, the language barriers limited the researcher’s ability to have such direct access to participants’ expressions or to be able to prompt for further clarification. The possible explanation for the quality and depth of understanding gained in the presence of the interpreters was partly related to their work experience. It may also be related to their understanding of the context of the encounter or due to the complexities related to participants’ underlying conditions. While a briefing session with interpreters was carried out to increase awareness of the research objectives and explain how questions should be phrased, different sets of results were obtained. For example, in the interview that was carried out in Urdu, some of the questions asked by the researcher were understood differently by the interpreter which then changed the essence of what the question actually was referring to as shown below from Kauser’s interview (line 195-197):

*“Researcher: you told me that the GP referred you to therapy, why was that? Tell me more about it.*

*Interpreter: تم کیا سوچتے تھراپی ہے؟ اور کیا آپ سوچتے ہیں تھراپی آپ کی مدد کر سکتے ہیں؟ (what do you think therapy is? And do you think therapy could help you?)”<sup>22</sup>*

Also, regarding the issue of access to therapy, the participant stated that she:

*میں انگریزی زبان نہیں جانتا۔ میں ہوشیار یا چالاک سے نہیں تھا۔ میں شریف تھا اور پھر میں نے اس وقت تک پریشان نہیں کیا جب میں تھراپسٹ کو دیکھتا ہوں (I didn’t know the*

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<sup>22</sup> This is a translation of the words used by the interpreter booked for the interview. The transcultural mental health worker verified how the interpreter translated the information.



English language, I wasn't smart or clever, I was Sharif and then I didn't bother when I was referred to see the therapist)" (199 – 200).

However, the interpreter did not highlight these words and instead interpreted the sentence as: "I didn't know the English language and then I didn't bother when I was referred to see the therapist". This was a challenge during the interview as there was no way to check the accuracy of the interpretation and it was only after the recording was reviewed by a transcultural mental health worker colleague that the researcher became aware of these issues. If the words stated by the patient were focused upon a little more, it could have possibly led to more in-depth understanding of her perspective.

Conversely, when the researcher had the Somali interpreter, she had a different experience. The interpreter addressed the questions appropriately and the researcher was able to gain a fuller understanding of the terms used by the participant and improve her familiarity with his cultural norms as shown in the quotation below from Yabaal's interview (line 610-620):

*"Researcher: did your culture give any meaning to you about what was happening to you?"*

*Interpreter: when you look at the Somali culture, did it give you any meaning or understanding of what was happening to you, what you were experiencing?*

*Yabaal: Waxa ihayey 'stress'...Imka see waan ladanahay (What I had was stress, and I am well now)<sup>23</sup>*

*Interpreter: yes but when you look at it from our culture, how you would describe 'stress' as this is an English term?*

*Yabaal: Imika nin bisaraad hayso waa nin waalan, haddii lacag la siiyo waa skaa faraxayaa (if you have a very poor man today and tomorrow you give him a lot of money, he will be happy with his life)*

As noted from the quote above, depending on the answers given and the key words used by the participant, the interpreter was able to prompt the participant on the researcher's behalf and ask for further clarification. This prompting encouraged the participant to use an analogy from his cultural background to

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<sup>23</sup> This was a translation made by the interpreter and it shows that the Somali language has no equivalent words for stress, therefore, both interpreter and participant used the same word, stress.

better explain his thoughts and beliefs. Thus the researcher gained a deeper understanding of patient's idiom of distress and their meanings. As can be noted from the two examples above, the experience of working with the two interpreters highlighted some of the challenges to the research objectives.

The interviewing style was greatly dependent on the participants and how they responded and interacted with the researcher. To be able to collect similar types of data around the key issues, the researcher prepared a topic guide as explained in the methodology chapter, Section 4.6.3.1. The style of interaction used with participants was very much responsive to the conversational skills of participants involved. While some participants engaged in a back and forth type of discussion, others offered their story at once in an extended narrative kind of style. The latter style of interacting – while still reliant on using the topic guide to maintain control of the interview – enriched the conversation and brought about unprompted responses to the research questions. The reasons that some participants chose to interact in this style maybe related to their being more confident and comfortable than others. Another reason may be their being aware of the researcher's background as a mental health worker and because of that, they sought some therapeutic benefits from the interview. Further, it could be simply related to the different backgrounds of participants involved. Table (17) below provides a reflective summary of participants' background and their reasons for attending therapy in order to enable better understanding of the issues that were discussed in the interviews.

Patient Pseudonym	Background Information
Atiqa	A Pakistani female, Urdu speaking, aged 65, moved to England when she first got married. She used to be a teacher in Pakistan and lecture about political problems and her father was very proud of this. When moving to England, she attended English classes to build up her confidence in speaking English. She suffered a stroke and had to have an operation. She was quite depressed and anxious. Therefore, her GP referred her to counselling which helped her. But the main thing that kept her going was her religion <i>"I will say whatever I want to say to Allah... when I get up from the prayer mat, I feel so relaxed that I have told everything to my Allah, he will help me"</i> (line 482-484).
Kausar	A Pakistani female, Urdu speaking, in her late fifties moved to England when she first got married. She never received any education and when she first moved to England, she was fine but then she encountered some difficulties in her life and became quite depressed. She was offered therapy but didn't attend because she didn't know English <i>"I was reluctant and thought will I be able to go? What will it be? What will it involve? How I will speak... things like this stopped me from seeing the therapist"</i> (line 205-207).
Maleeha	A Pakistani female, Punjabi speaking, aged 65, who came long ago with her family. She got married, had a son and a daughter but her husband left her for another woman. She did not go to school and speaks a bit of English. She refused to have an interpreter and communication was quite difficult on the day. She had stress related issues about her family and was referred to therapy. She thought about ending her life but religion for her was a protective factor. Talking helped her to feel better particularly, as she saw a therapist who was able to speak in her own native language. She believed her problems were related to black magic. <i>"... his mother every time keep asking and asking and putting black magic and he was listening to her"</i> (line 145).
Momina	A Pakistani female, Urdu speaking, in her mid- forties came to England in the sixties and grew up and received education in the UK up to O level. She is married and has four children. Her mother and sister were sick for some time and three years ago they passed away which was traumatic for her. She was diagnosed with post bereavement depression so the GP referred her to counselling. She considered being close to God a major help <i>"My prayers were the major thing as well because I felt prayers in my head will go up... and I felt I could talk to God about it and I could send messages, my love and emotions, and God was listening to me so that was the major thing for me that helped me"</i> (line 279 – 297).
Nadeem	A UK born Pakistani single male, Urdu speaking, aged 24. He was an undergraduate in business management. He had a behavioural problem as a child and was diagnosed with ADHD, and has a problem with concentrating. He was not able to formulate his expectation of therapy but felt attending therapy would help him understand things better. When asked to expand on what he meant he said <i>"to be honest I don't really know what actually I am trying to get out of it as yet, my mum is the one who told me to go for it"</i> (line 64-65).
Pakeeza	A UK born Pakistani female, Urdu speaking in her thirties. She has completed GCSE's and did a computing course for two years. She suffered panic attacks after someone young she knew died suddenly. She was referred to counselling and got a lot of help. She felt sharing the same language with the therapist (English) was quite good <i>"language was really good because she was English and I could speak English so we could explain everything together"</i> (line 295-296).
Raeesa	A Pakistani female, Urdu speaking, in her fifties. Arrived in the UK when she was 4 years old. She got married when she was 16. She had a lump in her chest and started to feel quite worried even after she had the tests and nothing was diagnosed. She was referred to the therapist as she did not want to take medication. She also read Darood Sharif which gave her (skoon) peacefulness and described the feeling as <i>"it gives me a lot of (skoon), it is like I am sitting in Heaven"</i> (line 42).

Patient Pseudonym	Background Information
Rozena	A Pakistani female, Urdu speaking in her forties moved to the UK after being forced into marriage because as she said: <i>"I was taught the wrong concepts of religion" and I was taught that obedience to parents meant just giving the control of life to them ... otherwise I will burn in hell"</i> (648-649). For that reason, she agreed to the marriage. She had an MA in business studies from Pakistan. She developed chronic fatigue because she was over doing things. She also had many shocks in life which led to her depression. Her ex-husband has given her a difficult time and she was faced with deportation at one stage because she had no legal paper to stay in the UK. She was quite happy to have a Muslim therapist as she <i>"could say (salam) to her... and I feel closer to the person when I greet him/her in my own language and in my own cultural terms"</i> (line 547-551).
Sabiha	A UK born, Pakistani married female, Urdu speaking, aged forty-one. She has an MA in health care. She was referred to therapy because she was suffering from anxiety and depression. She had a forced marriage but after three years, she got a divorce. She had gone through major events in life where her uncle was murdered and her father died. But the most major event was experiencing a stalking case from someone who wasn't in the country. The stalking campaign was very intense. She had tried to contact all possible help including the police but it was beyond her capacity. Her experience with therapy wasn't a successful one because <i>"I felt like I had to explain why I was stressed at this particular event... I also think it was around some cultural issues as well"</i> (line 254-255).
Salma	A UK born Pakistani female, Urdu speaking, aged thirty who has a social care degree, married and with two children. She was diagnosed with post-natal depression and was referred to therapy but she did not go: <i>"I was put off going because I knew they will ask me about family life and culture, etc., and I thought I am going to explain it but they won't be able to understand it, why waste time telling them, they will tell me what they want not what I actually need because they do not understand my culture"</i> (line 177-181).
Aliyah	A Yemeni female, Arabic speaking in her late forties, UK born but moved to Yemen when she was 2 years old. Returned later to the UK after being married and having children. Her mother, whom she was told was dead, applied for her to come back. She did not receive any education and did not feel happy in the UK <i>"I don't know why I came, I felt like, on one hand I wasn't able to speak the language and am not able to communicate with others"</i> (line 107-109). <i>"Living in the foreign countries away from our own country is quite difficult so I became quite distressed and was referred to therapy"</i> (line 153-156).
Azhar	A married Yemeni female, Arabic speaking in her mid-sixties and illiterate. She came to the UK five years ago to get treatment. Her daughter applied for asylum because she was unable to return to Yemen due to the war. Azhar became quite anxious and depressed as she did not know of the whereabouts of her children in Yemen. She explained the reasons for attending therapy <i>"because of the pressure and stress of life...life is full of problems and everyone is keeping things to themselves and how much can one keep things inside... when the rope of washing gets full, you can't add any more"</i> (line 81-86).
Dalal	A Yemeni female, Arabic speaking aged forty-three with two sons. She came to England sixteen years ago when she got married, but then her husband called the police to get her out of the house. She finished preparatory school in Yemen and was married at a younger age as she was living under specific traditions and social customs and a lot was going on within the family. However, she swapped horrific circumstances in her family for bigger problems. She explained her situation in the UK as <i>"difficult in everything, how to perceive people, how to accept their traditions, their life style, I didn't know the language at</i>

Patient Pseudonym	Background Information
	all and this has made things even more difficult” (line 93-96). She was referred by her GP to see a therapist and she “used to fear and feel ashamed to admit she has an emotional wellbeing problem” (line 182-183).
Jamil	A married Yemeni male, Arabic speaking, in his fifties moved to the UK as an asylum after being seized from his work in Yemen and threatened with death. He has a PhD in Political Science and international relations. However, when he came to the UK, he was unable to fulfil his dreams. He needed to have complete mastery in English language in order to be able to work in his field. He explained the situation as “maybe I had difficulty learning English because of my physical health, the continuous headaches changed the physical illness to mental illness, and this has shifted to a state of losing hope and being desperate” (line 74-78).
Mona	A Yemeni female Muslim, Arabic speaking in her forties who did not go to school, moved to the UK when she got married. She suffered panic attacks and depression and was referred to therapy. At the start she didn’t understand anything “I used to go there and question the reason for my attendance” (line 78-79). When she went to therapy she felt quite worried to talk about herself “because your own personal life, you wouldn’t like to share with others” (line 105-106)
Noor	A Yemeni female, Arabic speaking, in her late forties moved to the UK after getting married. She has four children and currently separating from her husband. The youngest of her children had a disability. She also had responsibility for her elderly parents, who came to the UK after the war in Yemen. She had a degree in Education from the UK. She was overwhelmed with stress and anxiety and was referred by her GP to CBT therapy. While she was able to communicate in English she felt “ <i>English is not our first language, sometimes we only use the words that we have learnt... I try to pick up any word I find in the dictionary or whatever to see how can I express myself...[but] in our language we have more choices of words to express ourselves not like English, it is like limited</i> ” (line 460-466)
Rabab	A single Yemeni female, Arabic speaking in her late thirties who came to the UK and claimed asylum. She has a BA degree in political science and has just finished doing her PhD in the UK. Before moving to the UK, she had a good career position in Yemen. However, she developed depression because when moving to the UK, she faced many difficulties, one of which was the inability to speak English. She felt quite isolated, which affected her health. She had a gallbladder problem but health services kept saying it is in her head and referred her to therapy. She described the experience as “ <i>it is not language, it is not culture, it is beyond all that, and it is about understanding or willing to understand minority women who come to seek for help</i> ” (line 180-183).
Yusra	A UK born Yemeni female, Arabic speaking in her late twenties. She has a child aged 10 years old. She was divorced six months after being married and she was dealing with post-natal depression. She started a foundation degree at university but didn’t finish. She was referred to therapy and explained the experience as “ <i>the community you have, you don’t really express your feelings. You kind of stay at home and deal with whatever you are going through... Islamically you deal with things spiritually and that’s helped me</i> ” (line 77-79).
Abyan	A married Somali female, Arabic and Somali speaking, aged thirty years old, moved to the UK aged fourteen to get treated as she used to have strokes regularly. She was eighteen when she had a mental health problem and was taken to a Sheikh to read Quran and to bring out the Jinn (Muslims believe that Jinn can harm humans) and accordingly, protection is attained by

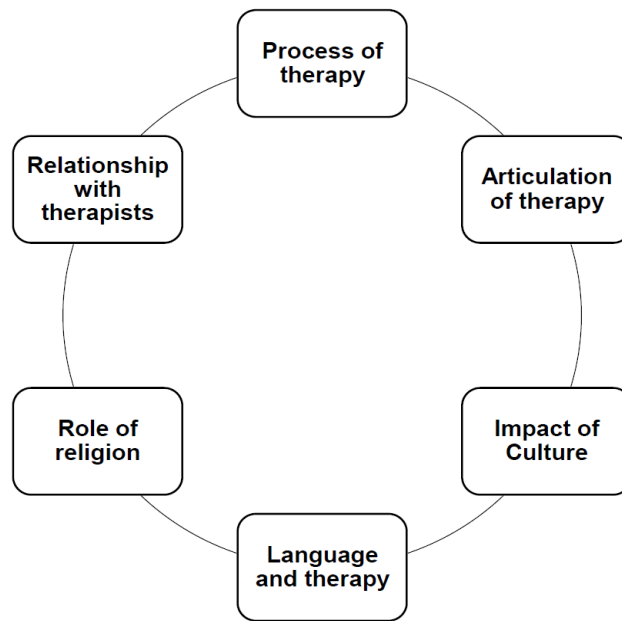
Patient Pseudonym	Background Information
	reciting Quran as prescribed in Islamic law). She felt quite relieved when they read the Quran. She had been raped by her cousin. She was referred to therapy but she had a bad experience and requested a Muslim therapist. She felt a Muslim counsellor <i>“would understand the religious issues and will be able to offer advice based on her religious understanding and I will be able to feel comfortable talking to her”</i> (lin3 381-385). She also spoke Arabic and kept switching during the interview between English and Arabic because she felt <i>“when you say it in your language and your own culture, it has more effect on you and it bring all the feelings, it brings all the upsets and all the emotions”</i> (line 545-547).
Khadra	A Somali female, Somali speaking, in her forties. She moved to the UK after getting married. She did a diploma in accounting in Kenya where she used to live. It was quite hard for her when she moved to the UK and she became depressed because she wasn't doing anything. Then she started volunteering as a support teacher and she felt better. However, she had post-natal depression twice and became depressed when she found out her daughter has special needs. As she did not want medication, her GP referred her to therapy. She went for the assessment but then did not return. When asked about the reason, she said <i>“because I cry a lot and I don't like it”</i> (line 223). She also informed me of the religious beliefs amongst Somali's <i>“to treat something like depression, people read Quran, and do (ruqyah)<sup>24</sup>”</i> (line 343).
Mahdi	A Somali male, Somali speaking, married, in his mid-thirties and currently doing MA in education. Moved to the UK after the war in Somalia to join his father who was already working in the UK. When his father died, he was only fifteen and had to pick up a lot of things and take care of nearly ten siblings. He was at the university doing a quantity surveyor course when things became quite difficult and he was falling behind his assignments so his lecturer advised him to see a counsellor. He described the experience as <i>“I found it alien and I couldn't relate to it...my initial reaction was this is strange, it stretched me out of my comfort zone or it is not in my culture”</i> (line 149-156). He added, in his culture, <i>“you can't show weaknesses, you can't show emotions, you can't cry... when you come from a culture that is kind of very matter driven, it is not easy to come or find someone to talk to”</i> (line 116-119)
Yabaal	A Somali male, Somali speaking, married in his late forties came to the UK in 1990 as a refugee from the war. He does not speak English very well and an interpreter was booked. He has finished only his grade six schooling. He had some family problem and depression and was referred by his GP to therapy. He was also told by the job centre to attend therapy and to go to school to better himself. He explained his problem as <i>“I said I couldn't hear because of Jinn and things were talking to me”</i> (262). When asked about his experience of therapy he said <i>“it's not something I have seen before but it was beneficial”</i> (291). <i>“I have never seen therapy back home”</i> (666). <i>“There are no doctors, people would be locked up and Quran would be read to them”</i> (671-672).

**Table 17 Interviewee Background Information and Reason for attending Therapy**

<sup>24</sup> See Glossary for meaning

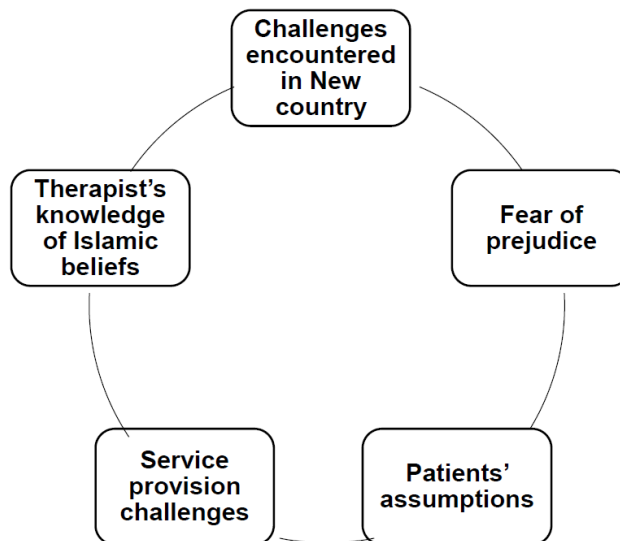
## 5.5 Pre-theme verses Post-theme Findings from Research Methods

The research question(s) were the starting point to explore participants' articulations of their experience of IAPT and to understand how they exhibit and communicate their emotional distress. Additionally, the topic guide interview was designed to cover language and cultural issues in lines with the research questions and themes that have been identified as important, as outlined in sections 1.2, 3.7, and Figure 7 below.



**Figure 7 Research Methods Pre-Themes**

This process allowed for other themes to emerge, which were either identified as less important or had not been identified in previous research (see Figure 8).



**Figure 8 Research Methods Post Themes**

The interview process gave space for such unexpected results to be further explored. These issues were central to the research questions for many reasons. First and foremost, language is a means of communication and the inability to speak the language in a foreign country can compromise peoples' rights such as in an inability to access available services. Moreover, it impacts on peoples' abilities to communicate their emotions, can increase misunderstanding and may put life in danger. Similarly, the culturally related elements raised questions around the complexity of ethnic and cultural matching in therapy and queried the benefits of developing cultural competency amongst therapists.

## **5.6 Explanation and Justification for the Selection of the Cases Presented in the Subsequent Chapters**

As explained above, the participant observation and interview process gave space for unexpected results to emerge. Some of these results were identified as a worthwhile addition of knowledge relevant to the research questions. For that reason, the researcher decided to describe the data as they took place in therapeutic settings in order to be faithful to patients' voices and give the reader a better understanding and feel of their true essence. Moreover, by including the cases in the findings, the researcher was more able to reflect on the interpretation of the data and provide evidence from different sources. Due to the limitation in achieving a better insight by some of the research approaches, using the examples of cases allowed the researcher to examine certain complex areas in detail. In brief, the cases were intended for the purpose of education and to bring some of the complex concerns to light in order to note the significance of language and cultural influences on the life of PSY patients as summarised in Table (18).



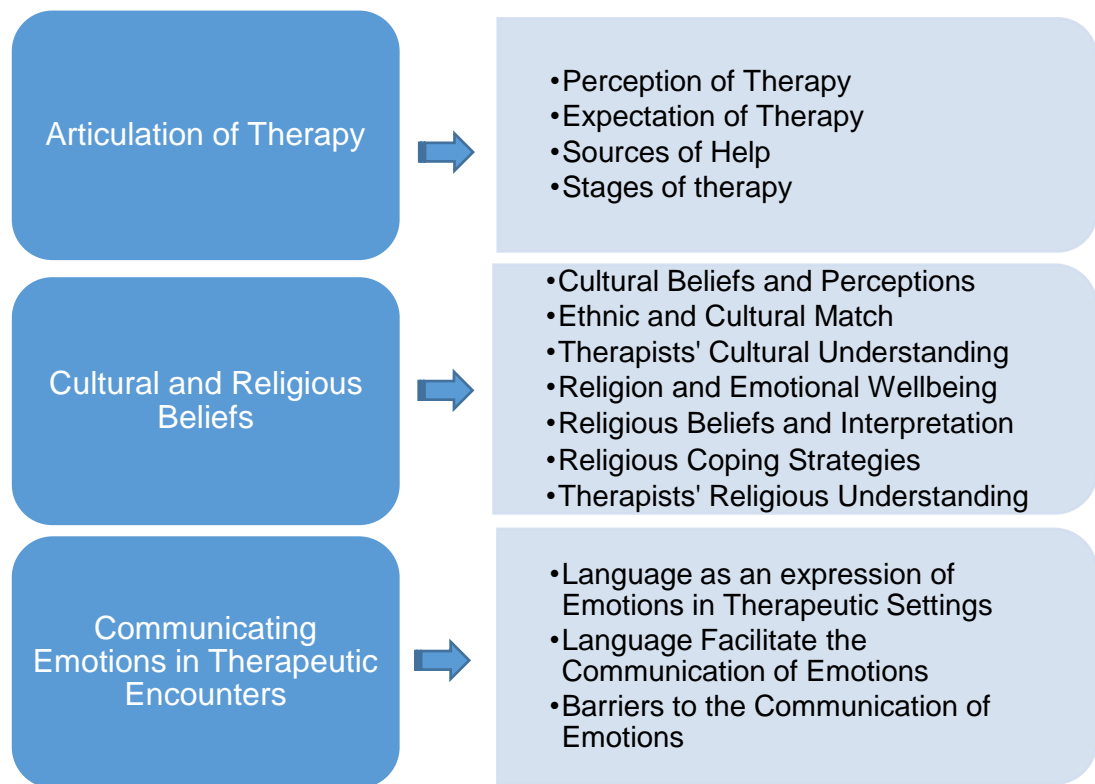
Case Example	Reasons for Selection
Case 1	To demonstrate some of the service provision challenges (e.g. online computerised programme) and to highlight the limits of the programme as a treatment option in certain situations.
Case 2	To highlight the importance of understanding cultural issues related to the different groups and the challenges that some new comers may encounter in a new country, which is beyond their capacity to deal with. (in this case the stalking)
Case 3	To draw attention to how Muslims believe they are negatively perceived in the media, their fear of prejudice and how this may impact in terms of lack of understanding amongst some therapists.
Case 4	To highlight the importance of integrating the religious beliefs and practices into therapy to help patients manage their emotional well-being problems.
Case 5	To demonstrate the complexity involved in using interpreters in therapeutic sessions and how they may impact on the process of therapy. Particularly, missing data and/or relaying information inaccurately.
Case 6	To point out how patients' basic grasp of the English language and limited knowledge of vocabulary constrain their abilities to express themselves and provide further explanation of their feelings

**Table 18 Explanation and Justification for the Use of Particular Cases**

## 5.7 Summary

This chapter outlined the different types of results yielded from the different research methods and provided a reflective summary of participants' backgrounds and their reasons for attending therapy in order to enhance the reader's ability to relate and understand the data in context.

In the following chapters the researcher will provide an in-depth report of the findings that were derived from the different research methods. Three central themes and sub-themes emerged from the data as shown in Figure 9 below.



**Figure 9 Summary of Research Finding themes**

These main themes were: participant's articulation of therapy, cultural and religious beliefs, and communicating emotions in therapeutic encounters.

During the process of outlining the findings in the three subsequent chapters, the six cases are discussed to enable a deeper exploration of these issues as it was evident from participants' narratives that they have experienced notable challenges in the course of accessing therapy.

# Chapter Six

## Perceptions and Beliefs about Therapy

### 6.0 Introduction

Having mapped out the data collection timeline, which enabled an overview of the findings from the different research tools and data collection methods, this chapter and the subsequent chapters will present the findings that emerged from questionnaires, participant observations and semi-structured interviews that were guided by the aims of the study and analysed using a thematic framework.

This chapter focuses on the perception and beliefs of therapy and begins with a detailed description of participants' articulations of therapy including their expectation and perception of therapy as well as their main sources of help. The stages of therapy are discussed next, drawing on the administration of and participants' beliefs about the patient health questionnaire (PHQ). This is followed with a reflection on therapeutic tasks and their challenges in providing mechanisms to cope with emotional distress. The different therapeutic approaches will be outlined while focusing on how these impact on participants' experiences of therapy. Finally, a case from the participant observation to explore the online programme as a new initiative by the government to improve IAPT as perceived by a participant who has a learning disability will be discussed, highlighting during the process the implications the new programme may have in relation to the research question(s).

### 6.1 Articulation of Therapy

#### 6.1.1 What is Therapy

Participants identified therapy as a two-way process whereby you can “talk to someone, and be listened to”<sup>25</sup> QY1 (42). Many of the participants believed that an individual does not have to attend a formal type of counselling to talk about their distress because “... *talking to other people... is a form of counselling... [and] if there is a listening ear, you can get things out, which*

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<sup>25</sup> All translated quotes from the questionnaire, participant observations and interviews extracts will be written in standard font rather than italics

*will be helpful*" (Momina-P, 459 -463). Mehdi further clarified that "[*therapy*] is not about finding answers, it is just sometimes listening to somebody" (S, 620-621). Thus, 'listening' was perceived by participants as essential, whether in a conversation with family and friends, or within a one-to-one formal counselling, because patients felt highly valued and were able to talk about their problems. In fact, the study found that 'listening' was a key strategy developed by patients to understand how they were perceived by therapists in order to evaluate their interactions with therapists and determine the latter's ability to connect with their problems (see Section 8.1.2).

### **6.1.2 Confidentiality**

Participants also identified a key aspect of therapy to be confidentiality, where patients, as mentioned by Nadeem, "*can literally tell somebody all their problems on a confidential level*" (Nadeem-P, 465-466). This would enable patients to express their feelings "*without the fear of being judged*" (Momina-P, 150), or their trust being betrayed.

In order to work effectively with a therapist and open up about her problem, it seemed important for Noor to work with "*someone who doesn't know me and... someone who is not going to tell anyone else*" (Noor-Y, 392-393). Speaking to a complete stranger who was external from her community appears to alleviate any possible fears to disclose confidential information. However, as one questionnaire respondent pointed out, therapy is not completely confidential as "*it requires registration and sharing of data with law governing institutions*" (QY5, 28-29). Under those circumstances, another questionnaire respondent raised his concerns "*if his access to the service would be recorded on any official documents*" (QY17 – 27). Because some IAPT therapists may have on occasions discussed patients with other workers or shared their notes with GPs or professionals (as observed during some therapy sessions), some participants may voice concern over their notes becoming official.

The nature of therapy as a confidential activity has significance on participants' help-seeking behaviour regardless of any cultural backgrounds. Because therapists in health and social care may have occasion to share

patient's notes, absolute confidentiality is not always possible. If confidentiality is broken, this can be a barrier for PSY groups to engagement in therapy (see Section 7.1). Given that a number of participants in this study may have had to complete official documents, which could affect their status in the UK, it may be that official recording is a particularly threatening issue for them.

### 6.1.3 Perception of Talking Therapy

Participants had different sets of opinions about how they perceived talking therapy. Common themes repeated in respondents' answers included getting things out, understanding themselves, getting advice and bringing up painful memories.

Typically, many PSY patients relied on talking to family members or friends about their emotional difficulties to alleviate their distress (see Section 3.5.3). Therefore, the use of therapy as a process to offload was raised by one participant as "the most important thing" (QY1 – 42), and for others "*it meant to get rid of it from your heart*" (Atiqa-P, 266-267), because as stated by Azhar:

"I wasn't able to talk to my daughter or my husband and upset them... [But] I was able to talk about everything that was in my heart, which I have bottled-up, and I felt better when I said everything I wished to say to the therapist" (Y, 16-19).

Although talking with a professional enabled a number of participants to open up, share their feelings and get the help needed to deal with their pain, some participants struggled with the concept of therapy. Elaborating further on this, Mehdi said:

*"I started to realise why this is medical and is part of the medicine community. I suppose... because it is heavy and the other person can kind of, I don't know, sever it through and get the core of the issue, give you different angles to kind of deal with it and I think that's what I found in the end which is good about it"* (Mehdi-S, 236-242).

By telling the professional about his problem, finding the meaning and understanding the causes behind his distress, Mehdi seemed to feel comfortable enough with the therapist and able to engage positively with therapy. Following an understanding of the link between mind and body, Mehdi was able to realise that therapy was the key to understand his mental distress.

The perception of therapy as a way to equip people with techniques that improve their attitudes to stay in good mental health was also emphasised during participant observations as pointed out by a Yemeni participant who informed the therapist that she was “aware that there are talking therapy techniques and she would like to try these in order to control her panic attacks and manage her anxiety” (PO-YR6a, 97-99). Here, the participant recognised the value of talking therapy and the mechanisms involved that will enable her to better deal with her problem.

While almost all participants perceived talking about their feelings with someone as being helpful in dealing with the issues that troubled them and as being an opportunity to express their worries, there were different views held by a handful of respondents. Those participants believed talking therapy often reawakened painful memories and opened their wounds. Jamil clarified:

“The therapist repeats the same questions which I have already answered. Sometimes he takes me back to the stressful situation that I am trying to forget. He opens the wounds by digging deeper and reawakens painful memories that I have buried, and which I have sometimes difficulty repressing them... When I remember the past, I remember my suffering, I remember my torture, I remember a lot of things and I start asking myself... why I should face all this suffering” (Jamil-Y, 302-312).

By having the same questions repeated to him, Jamil was possibly feeling he was not being listened to or the therapist was unable to understand him. Further, Jamil appeared to lack the understanding of some of the common practices that are central to CBT, such as the cognitive techniques whereby

patients are asked to rationalise and challenge negative thoughts related to past trauma. Therefore, he could not understand how talking about the pain, suffering and torture, which he had experienced could be helpful for him. This is possibly related to CBT being based on western models, or the power relation between therapists and patients, where patients sometimes are either not given enough information about the harms and benefits of therapy, or informed decisions about treatment are often made without consulting patients. This was further demonstrated by Sabiha-P:

*“I think I could have had a lot more verbal communication from the therapist... I was doing all the talking and then coming out feeling quite low and being reminded of everything I just talked about. But I wasn’t given any kind of proper guidance as to what I needed to do ... What was the point of talking about it?” (570-574).*

It may be that Sabiha found that therapy dismissed and neglected her individual needs because she had little explanation or less guidance from her therapist. It seems she believed that therapy was doing her more harm than good, and for that reason, she questioned the benefits. But the inability to talk about the stressful feelings was more painful for those participants who were taught they should not discuss their private or personal life with a stranger – the therapist – as pointed out by Yusra-Y:

*“I came from a family background where speaking to my father has always been a difficult thing... My mum died whilst I was young... I have never been able to express my feelings to my dad... So seeing a counsellor and speaking to her about the way I felt was quite difficult. Sometimes you feel ashamed of yourself... because you should always try to be patient” (257-266).*

There might be a common perception held by people across every cultural background that family issues are an important part of the counselling process (see Section 3.5.3). Some of the issues raised by Yusra may not be specific to PSY groups. However, the issues raised here, that is the expectation among PSY groups to resolve their problems within the family circle, and the inability for some PSY patients to discuss mental health related

problems with their families, are quite relevant here. For some participants it may be particularly difficult to talk about family issues because of the tradition of dealing with it within the family. There may be also fears that information will leak out and patients are often concerned with what others will think and what the consequences might be not to them individually but to their families. Therefore, some patients, as Mona commented, believed that: “you have to keep your own personal and private things to yourself” (Y, 106). This illustrates not only that the discussion of mental health issues is perceived as a socially unacceptable topic among these groups, but also that patients from these groups need to consider the consequences on one’s family, which makes therapy a problematic activity. Cultural backgrounds may also influence participants’ understanding of what therapy is and how participants conceptualised what constituted help or who they turn to in order to access the right treatment at the right time (see Section 7.1).

#### **6.1.4 Sources of Help**

Across the different research methods, participants identified that the concept of help is a two-way process involving a speaker (the patient) and a listener. The latter could be a professional, a member of the family, a friend or in some cases the ultimate help was from the Almighty God.

Participants who preferred to work with a professional considered the latter to be “*someone to talk to about your feelings, and they understand and tell me what to do and what not to do*” (Pakeeza-P, 79-81). Thus, effective communication and understanding were perceived amongst those participants as essential to develop an effective relationship, and helped them communicate and express their emotions, and/or enact positive change.

In addition, the concept of help from a professional as described by Rozena involved “*understanding the patient’s position... the causes behind the illness... then finding a way to cure that illness... and prescribing treatment*” (P, 567-570). ‘Upholding confidentiality’ as discussed in (Section 6.1.2) was another reason for choosing to speak to professionals instead of family members or friends as pointed out by a participant in the observation:



*“I don’t want to talk to friends as this is my secret life... and I need to be careful” (PO-PI16, 88-90).*

The consequences of cultural stigma and attitudes attached to mental health within PSY community groups appear to be the main reason for the participant’s reluctance to share his problems with friends.

However, several participants in this research did not find it easy to talk openly to professionals about private issues. Instead they reported *“you can have therapy with a friend or with a family member” (Salma-P, 480)*, whereby they were able to get ‘support and counselling all the time’:

*“Friends made a big difference, they were quite involved in my life... we have that bond and they have been through my experiences, it was easy for them to understand” (Yusra-Y, 124-137).*

Additionally, a network of family and friends within the community was perceived a more culturally appropriate source of help as it provided patients with a sense of security and helped them to share their problems as pointed out by Salma:

*“From the culture and family background where I come from... I have support... I have joint family and extended families and that kind of service is for someone who doesn’t have anybody... and who needs to speak to somebody and to expose things” (Salma, P-482-487).*

The participant appears to have a specific view of whom the service might be relevant, but seemingly, her preference of family and friends as a source of help can be in part due to lack of trust towards the service, or as Yusra pointed out: *“I didn’t think a counsellor that isn’t a Muslim will be able to relate to me” (Y, 125)*. Cultural beliefs and religious differences can determine the ease with which an individual can seek help, or they can be barriers to accessing and engagement with IAPT service.

Since family networks played an important role and was perceived as the primary source of help for PSY individuals, the different community groups provided an additional source of support for those participants who did not have family members around as pointed out by Khadra:

*“The good thing about our community is you get a lot of support from the community and we help each other a lot... because if you have nobody here, it gets difficult” (Khadra-S, 427-431).*

Through these community groups, patients as explained by Nadeem *“met with a lot of other people that have gone through [similar] problems in their lives... [and] it solved like counselling in itself” (Nadeem-P, 301-304).*

Considering the mental health stigma amongst these community groups, such informal support could be perceived as an alternative to accessing IAPT possibly because it may address cultural and religious needs and improve social isolation as reported by Kausar:

*“When I go there, I see other people around me, that gives me pleasure, I feel happy, we say prayers for each other and that gives me encouragement... then we have a chance to talk to each other... which helps me and make me feel happy” (Kausar-P, 263-266).*

Separate to the concept of help as support from a professional or talking with surrounding friends, family or community groups, a new concept emerged through the interview process and was brought to the forefront of the discussion whereby participants reported praying and talking to God and asking him for ‘guidance and assistance’:

*“When I don’t want to tell anyone, I make (wudu)<sup>26</sup> and bring the prayer mat... I will sit over there and will pray and tell everything to God. I will cry and I will laugh and will say whatever I want to say to (Allah)... I feel so relaxed that I have told everything to (Allah) and he will help me. I do believe in that” (Atiqa-P, 476-482).*

According to Atiqa, there are particular moments in the individuals’ lives where they are unable to handle their emotions and for that reason, they turn to the practices of their religion, relying on God’s help.

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<sup>26</sup> The ritual of cleansing the face and body organs that are always in contact with things before daily prayers. It is expected to give Muslims peace in heart and spiritual power in preparation for worshipping. Also, Muslims expect their sins to be washed away as they make wudu in preparation for worshipping.

As explained in Section 3.5.1, cultural and religious beliefs provided some individuals with meaning for their suffering. Yet, the field of counselling in the West has been slow in recognising the need to address spirituality and religious needs. While recently there has been further interest in the role of spirituality and religion in counselling (Isgandarova, 2012, Pathan, 2016), there is still lack of understanding about the meaning of relief that Muslim patients may feel upon entrusting their emotions to God, and the belief that striving to achieve closeness to God and asking for his help and guidance would lead to the enjoyment of numerous benefits. One of these benefits is to have strong belief that he (God) would protect them from the challenges of life and hereafter and would never let them down as pointed out by Atiqah. By calling upon Allah, addressing Him directly and entrusting Him in all matters, some participants were able to reach a level of spiritual fulfilment, and were able to use references and interpretation from the Quran, where they were enlightened about the benefits of other sources of help and were prompted to seek further support by turning to counselling for example in dealing with their pain (see Section 7.2.2).

#### **6.1.5 Expectation of Therapy – What Therapy can do**

Participants' attending therapy anticipated therapeutic sessions to be centred on "*understanding more about the problem*" (Nadeem-P, 61), receiving further "*advice and how to deal with the situation*" (Yusra-Y, 50), learning "*some form of behavioural change*" (Sabiha-P, 547) and "*strategies about how to cope*" (POYR6a-98) with traumatic events of their life in a more comprehensive and positive way that would lead to an improvement in their well-being.

The expectations about the level of wellbeing that participants were aspiring to achieve, were related at times either to previous experiences or understandings of what therapy is, and were different from one person to another.

For instance, Dalal said:

"I had a lot of hope that I will find a therapist that will give me the magic words to change me to become totally another person, but how and

how long it will take, and whether it will be successful or not, I didn't have any idea about that" (Dalal-Y, 215-218).

On the other hand, Abyan said:

*"كان عندي أمل) - I had hope)... that she could heal me. Well I think she could heal me is a big word, because I know only (Allah) can heal people. But what I meant is (الجرح اللي كان عندي هي لمستته) - she was able to touch my pain) and to sort it out" (Abyan-S, 459-462).*

Clearly, the participants have different expectations from therapy which may have been determined by their beliefs and/or understandings of what therapy can provide or how it may help. Some participants like Dalal, were looking for solutions, and others like Abyan noted that their solutions could only come from Allah.

A small number of participants described how therapy could work for them if they took part in nature-based activities. One patient explained how access to nature can be particularly important to access her feelings and said: "... seeing the nature... can challenge the feelings... I choose nature because... this would make me relax and I would be able to express myself more" (Noor-Y, 409-418). Jamil added that if he was taken away on a relaxing journey where he would enjoy "the company of a specialist therapist who would be able to understand the situation... take me to parks... and plan a programme that would help improve my depression" (Jamil-Y, 261-280), he would have been more able to cope with his problems. But instead as the participant commented: "they brought me to the same GP practice" (Jamil-Y, 281).

Here, the participant seems disappointed with the fact that the IAPT service was housed within the GP premises and that new activities such as nature-based activities were not on offer, which he believed, could have helped him to address his problems and ease his depression.

On the other hand, some participants were unable to expect anything because as explained by Atiq:

*"I had no experience, I didn't know what counselling is... I didn't know anything about it. I just went there because of my doctor... I said don't*

*give me any medicine, I just wanted to chat, make me comfortable”*  
(Atiqa- P, 290-297).

Although Atiqa did not experience being in therapy before, she seemed to understand that therapy is not about taking medicine and that it may involve the opportunity to talk about her problem. This was a common theme noted during participant observation where many patients were “referred by the GP to attend therapy” (PO-SM13, 107; PO-SM13, 107; PO-PM7, 135-136; PO-PMY12, 232-233; PO-YA19, 106-108) and therefore, they were unable to identify any goals from attending therapy as reported by a participant: “I didn’t know what I hope to achieve” (PO-PMY12, 232).

In addition, when participants were referred to therapy, some assumed “the therapist was a doctor” (QY2, 37; QY4, 58) and often expected to be treated medically. From a cultural point of view as explained by Mehdi, this could be because people in his community were used to being medicated physically:

*“Your medicine is physical, it is a tablet so a lot of people from my community, they will go to the GP and unless they see a tablet, they haven’t been medicated”* (Mehdi, 221-222).

For other participants, they were unable to understand what therapy can do for them and for that reason, they were reluctant to attend therapy as pointed out by Kausar: “I was reluctant and thought... What it will be. What it will involve.” (Kausar-P, 205-206). These participants were unable to relate to the concept of therapy, because as Mehdi clarified:

*“It is not in my culture or my understanding of my culture or my religion”*  
(Mehdi-S, 156-157).

The different PSY patients hold different beliefs about the different levels of wellbeing expectations. However, patients’ cultural beliefs in this research have played an important role in determining some of these expectations and arriving at them.

## 6.2 Stages of Therapy

### 6.2.1 Assessment Stage

Therapeutic sessions always started with an introduction about the therapist's role, including providing patients with information about the process of the session and assurance about confidentiality procedures. This was often followed up with an open question from the therapist used to elicit more information from patients about their current situation, and the reasons behind seeking therapy as well as the kind of help they were expecting. Throughout the sessions observed, some patients, when asked about the reasons for attending therapy, often took this opportunity to describe the bodily experiences that caused them discomfort in various ways, with the tone of their voices revealing familiarity in discussing their physical complaints:

*“Three months ago I suffered a heart attack which caused me to quit my job and left me low in mood... I don't like small rooms particularly if they are locked and I don't like to stay in crowded places as I start to panic... I lose concentration all the time... I can't remember appointments or names... I had an operation in my back and three discs have been removed ten years ago and as such I can't get up easily. Further discs have been damaged recently... I can't walk fast and I am struggling in everything” (PO-PMY12, 55-71).*

Other patients described how they felt physically when asked or prompted by therapists to identify any physical symptoms experienced as a result of their mental distress:

*Therapist asks patient about any physical symptoms... Patient describes his physical symptoms and says:” My heart is pounding but I don't sweat, my mouth gets a bit dry” Therapist explains that these are some common symptoms of anxiety and fear (PO-PM7, 49-54).*

Somatic complaints can be a direct consequence of common mental health problems as shown in the above quotes. Yet, some patients may be unable

to recognise symptoms of mental illness because they never heard of mental health in their native countries:

*“I had a still-birth before I came here and I used to cry but I didn’t know anything... but when I came to this country... I heard about depression after birth and then I realised this happened to me”* (Khadra-S, 296-301).

Others may be unwilling to accept a diagnosis of mental illness for fears of being stigmatised as explained by Khadra:

*“A lot of the women are depressed... but they don’t like saying they have depression... they don’t want other people to know... it may be pride... or they hide their problem... they may feel it is shameful”* (S, 398-422).

As part of their role, it is a standard practice with all patients for therapists to ask patients to fill in a patient health questionnaire (PHQ) that incorporates diagnostic depression and anxiety criteria to enable patients to understand the impact of emotional distress on physical health.

### **6.2.2 Administration of the Patient Health Questionnaire**

The PHQ is a screening tool very much focused on the physical symptoms associated with depression and anxiety levels that enable patients to elaborate more on their physical symptoms. The PHQ (Appendix 11) was either therapist-led (PO-SN4, 52-101) or patients were asked to fill in the assessment on their own (PO-BH15, 69-84). For those who requested an interpreter for the session, they completed the questionnaire with the help of the interpreter (PO-BM1, 43-61; PO-SM13, 48-99; PO-YA5a, 96-151). Patients who were not proficient in the English language were also given a choice to either fill in the PHQ in their native language (PO-YL14, 101-131; PO-YG11, 132-225; PO-PI16, 106-113) or were asked the questions in an easy to understand manner (PO-PN3, 53-59; PO-PMY12, 127-178).

### 6.2.2.1 Participants' Beliefs about PHQ

Participants reported their views on how they engaged and understood the PHQ assessment. Common themes reported were mainly related to meeting patients' needs, such as the inability to express themselves in detail, inadequacy of the PHQ, adverse effects resulting from repeating the questions and lack of understanding about the intended purpose of the questionnaire.

Carrying out the task of the PHQ assessment, as reported by several participants, did not allow them the opportunity to express themselves in detail. One participant commented that *"it was just like fill this paper and I will read this paper and get the information"* (Abyan-S, 664-665). Another participant elaborated further on the process and described it as follows:

*"The questionnaire depended on yes/no questions, for example, I have this sleeping problem for some time now and it becomes [questions about sleeping]... Roughly how many hours you manage to sleep... It is not anything to do with sleeping. It is about the experience of sleeping... You are not given the chance to talk. You are not given the chance to say it exactly as it is, it is like you are saying something and someone knows what they are expecting... the finishing of the sentence"* (Rabab-Y, 349-360).

Others, found the questions to be pointless as explained by Salma:

*"When I started they did like one to ten score about how you feel, and because I knew what was wrong with me and I knew how I was feeling and what I needed to do to make myself better, I felt like I didn't need that... I thought no I don't need this, I was put off"* (Salma-P, 182-189).

The above quotes show that the formal structure and content of the questionnaire ultimately prevented participants from utilising the full expertise of the therapist and sharing their problems in more depth. Given that effective communication is central to therapy, this suggests that participants were indirectly referring to the constraint of the IAPT programme in meeting their different needs.



Although participants on the whole reported understanding the apparent purpose of the PHQ assessment in relation to measuring their condition and monitoring any improvements, some participants were still not convinced about the use of the questionnaire: “I did not understand why we were carrying out the questions every session” (Dalal-Y, 413). Another participant questioned the reasons and said: “why she is asking all these questions, what for?” (Azhar-Y, 225).

Others, found the process upsetting because they were reminded of events that upset them as the case with Raessa: *“I felt like I am going back to my fears of having a breast cancer again”* (P, 136-137). Nevertheless, a number of participants valued seeing the scores as this reflected the change in their experiences of depression, and enabled them to understand their treatment response (PO-BM1, 169-175; PO-PN3, 53-56). For instance, when the therapist showed the patient in (PO-BM1, 183-186) his scores as presented in the diagram and explained their meanings, the patient felt better and commented that “in the last weeks, I was seeing friends and received positive encouragement”. This suggests that when patients are well informed about the use of PHQ, they are likely to recognise the benefits of psychological support.

On the other hand, several participants thought the PHQ assessment was a diagnostic tool and they would be prescribed medication after the assessment as asked by a participant in the observation after being informed of the assessment outcomes: *“so will you be giving me medication to deal with my problem?”* (PO-PM7, 106-108).

Such responses suggest that PSY patients may not necessarily be familiar with therapeutic assessment and they may need further explanation.

### **6.2.3 Therapeutic Tasks and Challenges**

Following the PHQ, patients were asked to perform some tasks or activities. These therapeutic tasks involved filling in a diary sheet, carrying out certain activities, for instance, walking and socialising with people, psycho-education such as breathing techniques to help patients with their panic attacks, and/or listening to a relaxation CD to help with their anxiety problems. Participants

expressed their opinions about the different tasks and techniques involved in therapy sessions, and their feelings towards the performance of these tasks.

Participants reported that they were asked to identify some pleasurable activities such as walking and socialising with others that could help and stop them from becoming depressed. They reported positive feelings when they carried out these social activities. For instance Khadra said *“I used to feel down... after I had the baby... and this is maybe why I used to go to the gym to help myself”* (S, 254-257). Two other participants reported going to the women’s group, which allowed them to *“see different people which made me feel a bit better”* (Mamina-P, 245-246) and *“talk with them and my time pass and I feel happy”* (Maleeha-P, 90). Possibly, participants who carried out these activities were aware that exercising and socialising can offer them the opportunity to be active and meeting with other people, which helped them relieve symptoms of depression and gave them a sense of connection with others. Accordingly, engaging in such activities can improve social isolation and address patients’ particular needs.

However, some participants drew attention to a number of challenges that may stop them from participating in these activities. Physical health, depression, non-understanding of the tasks or the ability to comprehend the reason behind it, in addition to language barriers were common themes shared amongst participants.

The impact of physical abilities and/or severity of health problems can stop participants from taking part in these activities as explained by a participant:

*“I had an operation in my back, 3 discs have been removed ten years ago and as such, I can’t get up easily. Lately further discs have been damaged but I have been told they can’t operate on them... I can’t walk fast and I am struggling in everything... I am vehicle bound and can’t walk... things have changed now... I don’t do any activities now... I used to do lots of gardening... but... I don’t want to do anything now”* (PO-PMY12, 66-149).

When patients are affected by their physical illnesses, their state of mind can be quite challenging as participants no longer value their life as meaningful. A Somali participant explained this further (PO-SM13, 69-74):

“I used to work for almost 12 years in the UK but since coming back from Somalia [where he witnessed the killing of his sister and her children], I have been staying at home and I’m unable to return back to work... I used to be very active but now I am scared to go out” (68-75).

In this quote, the participant demonstrates his emotional wellbeing and physical abilities are connected. Yet, some participants sometimes were unable to understand the link between carrying out therapeutic tasks and the potential benefit this could have on their emotional distress as explained below:

*Patient is advised to use breathing techniques. Therapist demonstrates this to the patient and they try the techniques together for some time, but then the patient says “this doesn’t work, how stomach exercise can calm the stress?” (PO-PP2, 43-46).*

As such, when participants were unable to grasp the value of such tasks, these activities were repeatedly ignored. For instance, (PO-PN3, 72-94) a Pakistani participant who had a phobia of cats, was explained ‘exposure to the situation’<sup>27</sup> techniques, but she was unable to perform the task or understand the reasons behind it. Also, when she was taught to use other techniques such as the relaxation CD to calm herself, she said: “*I couldn’t understand the CD*” (PO-PN3, 144). Similar thoughts were echoed amongst a number of participants such as Noor:

*“She gave me a CD and she told me to listen to it and follow it up... but the CD was a bit boring and make you sleepy” (Noor-Y, 592-599).*

Using the CD for relaxation techniques in the style demonstrated in the lecture course was another problem perceived by some participants as

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<sup>27</sup> “Self-exposure therapy (de-sensitisation) involves gradually increasing the length of time that you are exposed to the object of your phobia” (NHS inform).

unhelpful. In particular, participants who were not proficient in the English language were unable to understand the content. One participant commented:

“I was given a CD and a book to read from... It was about a person who has depression... The CD was in English... but I wasn't able to understand” (Aliyah-Y, 302-310).

Due to therapists' adherence to using a standard set of techniques throughout the sessions offered to patients, the participants were possibly pointing out how the IAPT programme was not addressing their linguistic needs in managing anxiety and depression.

Similarly, participants who were asked to keep a log were unable to fulfil the task. Participants were expected to record and grade all the activities that they were planning to do in order to monitor their progress. Yet, participants responded with different and mixed views about the activity. Participants who were non-proficient in the English language were unable to fill in the diary sheet on their own as was the case with (PO-BM1), who needed either a person to help him, “I filled the diary with a relative, I did it with her” (PO-BM1, 90), or “I write the diary in my own language and if interpreter is present on the day, he can translate this” (PO-BM1-215-21). This case presents a challenge for therapists as it can impact on the session. The therapist needs to have an interpreter booked to translate the content, which is time consuming in itself and means less time is available during the session to focus on other aspects of therapy. Furthermore, depression sufferers found it difficult to fill in the diary sheet: “I didn't feel like I want to write anything ... I didn't feel like I was able to do that” (Mona-Y, 241-244). Dalal pointed out how the instability and difficulties encountered in her life stopped her from being able to keep a diary and said:

“Considering the nature of my situation because I wasn't settled in one place... and sometimes I used to move from one place to another, it was difficult to keep a diary” (Dalal-Y, 624-632).

Depression as an illness can drain patients' energy so that they may lose interest and pleasure in almost all daily activities. Especially, the experience

of being a refugee or an asylum seeker in a new country, including the loss of family, may additionally impact on the management of mental health (see Section 1.2). Dalal's comments emphasise the importance for therapists to understand the social experience of refugee and asylum seekers, and possibly develop different resources that can help them to maintain a healthier wellbeing.

A handful of other participants described the activity as being useless: *"I didn't find any help in making a list of the things that I've been doing... or how I was feeling... I felt that therapists could have been more proactive"* (Sabiha-P, 451-456). Those participants believed the activity prevented them from utilising their time efficiently with therapists as reported by Abyan:

*"I used to say to myself she never had the time to get to explore things more, she wanted everything written so she can read it...I felt she should bring it up with me rather than me writing it up for her... If she want to know, then just try to explore it... for God's sake speak to me"* (Abyan-S, 814-820).

Abyan's view demonstrated that therapy should not only involve homework that tracks your mood or a log diary where you write about your thoughts. Instead, therapy is an opportunity to engage in an effective communication and build a trusting relationship between therapist and patient in order to address the problem. Therefore, several participants drew attention to the importance of being given some tasks that involved challenging their thoughts as it made them change their attitudes and behaviours in order to tackle their problems as indicated by Rozena:

*"Once she said we are going to play a game, a stone's game, so that sounded exciting... it was learning. It was recognising myself more, it was recognising my emotions more... She spread the stones and said just pick up a stone... hold it in your hand ... feel the emotions and then I would express myself. I found it interesting... as it made me think that whatever you do is related to your mind"* (Rozena-P, 423-437).

The engagement in games that stimulated the mind, as pointed out by the participant, not only improved her ability to recognise her emotions, but also allowed her to better express those emotions. This suggests that patients who are not proficient in the English language may benefit from these techniques in expressing themselves more comfortably through transferring their feelings to objects.

#### **6.2.3.1 Alternative Coping Techniques and their Benefits**

Participants realised that despite the help they might gain by performing the different therapeutic tasks recommended by therapists, other coping techniques, such as their religious practices, provided them with equally valuable therapeutic techniques and coping strategies to overcome the distressing events and enabled them to live in harmony. In particular, participants reported using specific verses of Quran, ḍikr, regular recitation of Allah's specific names, and ruqyah as they stated these tasks had a positive effect on their emotional wellbeing. For instance, the recitation of Allah's name is an equivalent to relaxation techniques but the aim is to contemplate on the meanings of the words and phrases. By performing these techniques, participants acknowledge the other therapeutic strategies and work in parallel with Western psychology. These issues will be discussed in detail under Section 7.2.3 on the role of religion.

#### **6.2.4 Therapeutic Approaches**

##### **6.2.4.1 Participants' Views on CBT and Counselling**

One of the outcomes of therapy involved referral to a cognitive behavioural therapist (CBT) or a counsellor. Those who were referred to counselling reported that while they had the opportunity to talk to a specialist on a one to one basis, they believed counselling sessions lacked structure. To illustrate this, Rozena described the session with the counsellor:

*“The IAPT worker would just listen to my story, that's it... She kept listening to me and she just said talk about whatever you feel like talking... All the session we were just talking, once in a while she will*

*say something... There was one or two things she will say, for example you said this and it means this" (P, 296-325).*

Sabiha who also reflected on her experience, believed initiating discussion without being given proper guidance was difficult:

*"She said where do you want to start... and I found that part difficult because I didn't know where exactly to start at that time... I wasn't getting any pointers as to how I should start things or you know I have the right to feel that way" (Sabiha-P, 412-441).*

As a result of the communication being a one-way interaction, the participants didn't receive any active feedback or engage in meaningful conversation to try to help them cope with the situation. Though this was not an experience that participants described as having often, these encounters highlight how standard counselling techniques can be off-putting and affect the communication. Emphasising this point further, Yusra, who was dissatisfied with her therapy session, revealed how the body language of the therapist affected her engagement with therapy:

*"It was very hard for me to talk, even her body language wasn't great because she was constantly nodding the head... I was just talking and she was agreeing like she has done so many times before" (Yusra-Y, 151-154).*

The therapist's ability to non-verbally communicate with patients is crucial for their engagement in therapy because non-verbal communication can help patients build feelings of trust and determine the emotions that are perceived by therapists (see Section 8.2.1.2).

Other participants continued to experience difficulty in communicating their feelings due to a lack of proficiency in the English language, preventing them from being able to fully articulate their emotions, as Noor highlighted:

*"She told me to express it more... I tried to express it but I just didn't know how to express it more, what to say and I just thought, I sit quietly and she said if you don't want to talk about it don't talk and I said it is*

*not about talking about it, it is about how to get it out, what to say”  
(Noor-Y, 760-764).*

Noor’s quote clearly demonstrates the difficulty she experienced when talking about her emotions in another language. Articulating emotions within therapeutic sessions can be difficult for some people even in their native language, and with the presence of language issues, the task is even harder. These issues will be further discussed in detail in Section 8.3.

#### **6.2.4.2 Participants’ views on Group Therapy**

Another outcome of therapy was a referral to group therapy. Although group therapy offered participants the possibility of meeting with other people and sharing similar feelings (see Section 6.1.4), participants were faced with further challenges and consequently had different opinions. Because group therapy usually involves PowerPoint presentations, information on screens, and a lecture based on how to manage anxiety and depression, which were all presented in English, participants who were not proficient in English were unable to fully benefit from attending the sessions. One participant who was not proficient in the English language struggled to attend the group and stated:

“My therapist sent me to a stress management group for seven weeks. My language was very limited then... I didn’t understand much... I only went once ... I wasn’t able to speak English and I wasn’t able to engage with the session... It wasn’t of any benefit to me” (Yabaal-S, 306- 323).

Although the limited understanding of English was one of the reasons which stopped Yabaal from attending the group therapy, he could also be pointing out how the IAPT programme was not addressing patients’ different linguistic needs. In one of the observation sessions, a participant who was able to communicate in English, took the argument further and described her experience with the stress management group as follows:



*“They gave lectures, some information were useful but we weren’t able to do anything practical. When you are stressed you can’t get things in” (PO-PP2, 32-33).*

Having discussed the possible impact of depression on patients’ ability to fully concentrate on or comprehend the information, the participant focused on the ways in which the IAPT programme is delivered, which she believed, may narrow the options available for people who seek help.

On the other hand, there are many practical barriers to group therapy such as the absence of a crèche or facilities for the disabled, and the non-provision of interpreters. For instance, when the therapist informed the patient (PO-FM9) about the benefits of attending group therapy, the patient was unable to benefit from the service because she had a young child who needed a crèche and it was difficult to find a group who could provide this service (138-142). Likewise, an elderly patient (PO-SN4) who was keen to attend group therapy was faced with two challenges: the first was finding a therapy group that had disability access and the second was around the provision of an interpreter. The therapist informed the participant that the sessions were provided in English and that the patient would be given a booklet explaining what the session was about. As the patient had difficulty in understanding the written format, the therapist suggested the patient takes the booklet to a friend who might be able to explain the information (PO-SN4, 126-136). These two examples demonstrate some of the service provision challenges in relation to language and its impact on the access of therapy as well as meeting patients’ different needs.

#### **6.2.4.3 Online Computerised Sessions**

The online computerised CBT programme is a relatively new service provided by IAPT to enable patients to access therapy from the comfort of their own homes. Participants are expected to help themselves using online resources in their own time while getting telephone support in between the sessions. Only a handful of participants were offered the service during the research process and were able to comment on the programme. Overall,

three participants expressed reluctance and unwillingness to use the service. Rabab, a Yemeni participant explained her reasons and said:

*“The therapist... asked if I have access to the internet. When I said yes, she said I will give you some websites to access. I am good at that, I am good with reading and I am doing my PhD. I told her I’ve got long term depression, I’ve got very serious things and I need really serious help, but this is the kind of service available now” (649-653).*

Although Rabab was a highly educated person, had access to the internet and was able to speak English, she preferred not to take this option because it lacked face-to-face communication with a therapist. Face-to-face contact is often regarded as essential in therapy as it can provide non-verbal cues and sets the foundation of trust essential to create a better working therapeutic relationship (Mallen et.al, 2003). Similarly, a UK-born patient, encountered during the participant observation, when offered a choice about the different types of help available, she preferred the group sessions as it offered more interaction with a therapist (PO-BH15, 100-102). Although the intention of using the online programme was to help patients who have physical health problems or those who are experiencing certain difficulties in leaving their homes, Rabab’s comments raised questions about the appropriateness of the online programme to those patients who may not be proficient in English or may have insufficient computer literacy. The following case will explore how this programme was perceived by a patient who was computer illiterate and had a learning disability.

#### **6.2.5 Case 1: Implementation of the Online Computerised Programme:**

YS17 is a UK Yemeni-born participant with a physical and learning disability. She described the cause of her disability and said:

*“I was four years old when I had an operation and things went wrong and affected my ability to read or write” (PO-YS17, 64-65).*

Due to her disability, the patient attended therapy in a wheel chair and explained her reasons for attending therapy as being: *“stuck in the past... stuck in that circle and can’t seem to move forward” (31-33).*

During the therapy session, the therapist looked at the options available and enquired if the patient would be able to attend group therapy as this would give her the chance to meet with other people. However, the patient explained to the therapist that she would not be able to take this option for two reasons. Firstly, she had a problem with her eyesight, which would restrict her ability to see the PowerPoint presentation. Second, because of her learning disability, she would not be able to read. Regardless of the patient's reasoning, the therapist attempted to further explain the structure of group therapy by handing the patient a booklet on this option where she pointed at the speech bubbles, asking the patient if she was able to read them. This was clearly uncomfortable for the patient as she explained again her inability to read. The effect of this continuous non-intentional reminder of her learning disability was clear in the patient's non-verbal reaction where she exhibited crossed hands and frequent sighing as she tried to concentrate.

Taking these cues, the therapist, considering the other options on offer, asked the patient if she has access to a computer. Although the patient had a laptop, she only uses it to find out information with the help of her partner or support worker. The therapist enquired if the patient would be able to access support using the online computerised programme, but the patient stated that the option would be quite difficult for her due to her learning disability issues. She added *"I am usually by myself until my partner comes back"* (PO-YS17, 87). The patient was trying to point out that her disabilities restrict her from being involved in tasks that involve reading or writing but the therapist continued to discuss this option with her. The therapist suggested the patient request help from her support worker instead, however, the patient clarified:

*"The support worker is only there for short periods of time and only supports me with my essential needs such as giving me my medication, ... bathing and preparing meals" (111-113).*

By explaining the limited support the patient has access to, she was expecting the therapist to take her current situation into account. However, the therapist continued to discuss the online programme with the patient, explaining it would be easy to use once set up. The patient clearly exhibited

behaviours that indicated her frustration with the process (e.g. pulling her hair back, sighing and gazing at the booklet (PO-YS17, 116) and she reinforced this by saying that:

*“It is potentially tiring to do that as I would struggle to concentrate too much and my eye sight will flicker” (117-118).*

By pointing out her physical and learning disabilities, the patient was hoping the therapist would understand how these disabilities impact on her life and why she would not be able to access the programme in a meaningful way. Nevertheless, the therapist disregarded the latest comment and suggested breaking the materials into small slots. The patient then gave up and inquired what would happen if the programme did not help her. The therapist explained that a worker would telephone her regularly to ask about her progress, but the patient informed the therapist that she struggles with accepting telephone calls. In response, the therapist suggested the worker could contact her via email but the patient reminded the therapist that she does not have email because she is unable to use the computer alone.

As the therapist was unable to offer any further help, she emphasised the help options available (online computerised programme and well-being session). The patient finally stated:

*“I need to go away as I have got too much information and I need to think about it and decide what I want” (211-212).*

This case demonstrates the accessibility issues created by the online computerised programme and how the programme was perceived by a participant who is both computer illiterate and has a learning disability. The participant considered the programme as a difficult-to-access option. The reasons given included physical difficulty in reading or writing and because the participant was technology illiterate, and she needed someone to help her access the programme. Although the participant speaks the English language, she struggled to understand some of the terms and questions used during the session. The therapist did make an effort to explain these terms and accommodate the patient’s level of understanding. With this in mind – and following the researcher’s discussion with the therapist about the online

programme – the therapist explained that the gaps in treatment options available were mainly related to the restriction of the IAPT service model, which prevent it from accommodating people’s different needs. Throughout the observation session, it was noted how the outcomes of this session could have impacted on a patient who is not proficient in the English language and who might have needed the help of an interpreter. The therapist described the process then to be more difficult and even problematic or impossible. This case has demonstrated the different considerations that apply to the online computerised programme with emphasis on the need to assess the outcomes and to highlight the limits of the programme as a treatment option in certain situations. Related to this is accessing patients’ perspectives on the experiences of therapy in order to better understand the outcomes patients are seeking and present treatment options suited to this.

### **6.3 Summary**

Participants pointed out their perceptions and expectations from therapists and therapy, noting any particular cultural beliefs influences. Overall, they regarded their therapists and GPs as authoritative figures who took responsibility for the referral process and in consultation sessions. Participants expected therapists to ask questions to find out the causes for depression, direct patients towards the appropriate sources of help and find solutions for them.

Participants also drew attention to many aspects related to the articulation and access of therapy in which culture, religion and language played an important role. For instance, participants understood therapy as an opportunity to open up about their problems, believing therapists would be able to cure their illnesses. Other participants pointed out the importance of their religious beliefs in achieving better emotional wellbeing outcomes and demonstrated how it helped them to cope with their distress. In addition, while the different therapeutic approaches allowed participants the possibility to engage with different sources of help, issues of language differences and/or literacy problems were an added challenge that affected the access to these services. Accordingly, the next two chapters will shed light on the role of

culture and religion on accessing therapy for research participants and their use of language to communicate their emotions in therapeutic encounters.

# **Chapter Seven**

## **Cultural and Religious Beliefs**

### **7.0 Introduction**

Understanding cultural beliefs and being aware of the traditional views that may affect PSY patients' access to therapy was a recurring message voiced by participants throughout the research process. Due to the nature of these issues, the first part of this chapter discusses these cultural beliefs and perceptions in detail before considering how participants feel about cultural and ethnic mapping. Then, therapists' cultural understanding, the assumptions made by participants and the implications these have for therapeutic encounters are discussed. In the first section of this chapter, two cases are presented – one from participant observation and the other one from interviews – in order to fully understand the influence of culture and the consequences that understanding such issues have on the attendance at, and access to, therapy.

### **7.1 Cultural Beliefs and Perceptions Surrounding Seeking Help**

Accessing mental health support can be difficult for anyone, particularly as many people find difficulty having to admit something is 'wrong' with their mental health and they may feel there is no need to seek treatment for their concerns. Accordingly, seeking psychological help is still not a reality for many people, particularly PSY people who have different beliefs, values and feelings around mental health. These views were additional barriers to delay or prevent seeking appropriate care as reported by the participants.

Typically, participants identified that it was challenging to confront and discuss mental health and its related concepts due to the negative stigma or shame of talking about it openly. Beliefs that prevented people from seeking help from therapy included fear and shame of being labelled as 'crazy', stigma and disgrace surrounding seeking help, and beliefs about privacy and how to address mental health problems.

Many participants believed that their community groups perceived individuals who were seeking help from a psychologist as being 'crazy':

“The concept of seeking help from a psychologist in our Arabic countries is different. If you have mental health, then you are crazy” (Q4, 58-59).

The respondent is possibly pointing out the differences between conceptions of mental health in her own country and the West and is clarifying the concept of ‘mental health stigma’ as it applies within the Arab countries. As a result of such negative perception of mental health, a participant reported being reluctant to admit her mental health problems, giving the following explanation:

“I didn’t tell anyone about my mental health problem because I was afraid and felt ashamed to talk about my mental health problem” (Dalal-Y, 181-182).

Stigma and the fear of becoming subject of scrutiny by the community were continuously highlighted by participants. One Yemeni patient in the participant observation described her experience, drawing attention more to the issue through the example she gave:

“People say I have a mental illness and I believe having a mental illness is not good... People keep asking about my emotional wellbeing and are looking out for information... I believe having a mental health problem is a stigma... I was attending a gathering with the Yemeni women at the park and I realised that a grandmother was attending the community gathering with her grandchild. When I asked the women about the whereabouts of the child’s mother, I was told that she is suffering from a mental illness” (PO-YR10b-68-75).

The word ‘mental illness’ is considered by the patient to imply a negative meaning because it is used in her community to indicate a negative evaluation of the person concerned. As a consequence, the patient seems unwilling to admit the need for help for fears of becoming the centre of attention and gossip.

Participants’ willingness to access therapy was also influenced by cultural beliefs regarding privacy and solving problems within the family. It is unlikely



that family would approve of a family member attending therapy and seeking extraneous assistance as clarified by Yusra:

*“It’s the culture, you don’t talk about things, and you can’t talk about things. Everything is kept in a closet with the family and whatever you deal with, you deal with it at home with the family... um, and you don’t really talk about it much” (Y, 80-83).*

As explained in Section 6.1.3, it appears that the main reason that stopped a number of participants from seeking help was respect for the autonomy of the family and for the confidentiality of family related matters, which caused some individuals, like Yusra, to go so far as to keep their problems hidden. Such situations may impose challenging decisions for PSY patients who may feel unwilling to risk the loss of family connections and traditional values.

The involvement of family in encouraging/discouraging an individual from seeking help varied among PSY individuals, and participants exhibited different opinions on the effect of family support to accessing therapy. This was closely related, as highlighted by many participants, either to the wider sense of shame on their family, or the understanding of mental illnesses and acknowledging the need for help. For instance, a questionnaire respondent pointed out that *“In some ethnic cultural beliefs, families may class working with a professional as a shame, which prevents people from seeking or accepting the help they need” (Q3, 35-37)*. In comparison, when family members showed support and understanding towards an individual for seeking help from a counsellor, participants reported appreciating this:

*“My husband said to me that I should go [to therapy] to help me to go back to the person who I was before... Family members were saying I must go to get help. Family backed me” (Mamina-P, 388-391).*

*“My daughters always advised me to go and see a therapist... and not to be afraid of other people’s opinions” (Aliyah-Y, 548-554).*

As outlined by the participants, the caring role of the family often improves engagement with IAPT services. Yet, what is of interest in Aliyah’s quote is her pointing out a difference of opinions between the different generations.

Younger generations, while still acknowledging the need for privacy, seems to be better able to understand mental illnesses and recognise its symptoms, whereas older or first generation immigrants may find difficulty seeking help from therapy. According to Atiqa, this could be related to cultural up-bringing:

*“At my age, the women were scared but our children are not scared. We were brought up in a different way in Pakistan. Children who are born here... they are different” (P, 384-387).*

Although Atiqa believed that the younger generations, who were brought up in the UK, might have a better understanding of mental health issues, research in this area has shown that younger adolescents from BME communities are still under-represented in mental health services (Beck, 2016). Six participants from the different PSY groups who were brought up in the UK belonged to this category. While they offered a range of reasons for accessing therapy, it is interesting to note that three of these younger participants were encouraged to attend therapy by family members, which appears contradictory to what Yusra believed (Section 6.1.3). As an illustration Nadeem said:

*“My mum put me forward for it and made the calls for me and this is how I got the appointment” (P, 27-28).*

Unlike Nadeem, PO-BH15 did not tell her parents about her thoughts or depression because she believed *“they wouldn’t understand and can’t understand what depression is.” (PO-BH15, 76-78)*. Seemingly, those of an older generation would not understand terms such as *‘therapy’*, *‘depression’* or *‘anxiety’* as they do not exist in their heritage language. This was evident in responses obtained from older participants or those who were born outside the UK. For example, a Pakistani women from the older generation reported unfamiliarity with the concept of therapy when she was offered a referral and said: *“I didn’t know what is meant by therapy and how it could help with recovery” (Kausar –P, 22)*.

Willingness to access therapy is related to the cultural beliefs and the misconceptions PSY groups attach to mental health and its treatment.

Therefore, understanding and recognising the culture from which an individual comes is needed to improve engagement of therapy.

### 7.1.1 PSY Groups Perception of the Term '*Depression*'

In the data, certain terms related to the access of therapy were recurring, and these terms reflected the reasons some PSY patients were unwilling to engage with therapy or acknowledge the need for help. Because the IAPT service provides treatment for people with anxiety and depression, in this section, the researcher is focusing on the range of opinions on the misconceptions associated with the word '*depression*' and what it relates to.

Since discourse regarding '*depression*' is more prevalent in the West, many PSY participants reported finding the label '*depression*' morally unacceptable, shameful and stigmatizing.

Conscious of the common negative misunderstanding of depression, Rozena reported how her sisters used the word to make derogatory references about her mental health problems:

*"My own sisters say look at her, she is becoming a patient of depression"* (Rozena-P, 669-670).

Rozena points out the emotionally-charged prejudice by the community against people who suffer depression, which exacerbates the negative self-image the patient may have as someone with depression.

The word '*depression*' was also reported by many participants to carry its own mark of disgrace, "*people feel ashamed to say I have depression... It affects them*" (Khadra-S, 442-444), and to contribute to social stigma, "*If you say I am depressed... you will be starting to feel like you don't want to share it because of the way the community are going to look at this issue*" (Rabab-Y, 597-600).

Gilbert (2000) and Zalav (1998) explained that it was relatively common for some patients who suffered from depression to experience a feeling of shame. They clarified that those patients may perceive themselves as being wrong or behaving differently.

The different research groups varied in their perception of '*depression*' and exhibited different opinions on the misconceptions associated with the word. While some participants believed they were able to recover from depression and feel better, others believed once the person is mentally unwell, their mental stability can never be regained. For instance, although the term '*depression*' does not exist in Urdu, many Pakistani participants seemed to have an awareness of the term '*depression*' as an illness that could be related to physical, emotional or stress related issues. However, several participants described themselves as '*crazy*' when they were unable to cope with life stressors "*... I am going crazy. The thoughts in my head, I don't know where they are coming from*" (PO-PMY12, 75-76).

Depression as an illness was also perceived differently amongst Yemeni participants. Some of these participants believed depression to be related to various life events and by talking them through with therapists, they were able to overcome their problems as stated by Aliyah:

"I talked about my depression... about the past problems... it is quite painful and distressing... but Alḥamdullah I felt relief after talking to the therapist and getting things out of my chest" (Y, 384-395).

On the other hand, several other participants believed they would never be able to get better as a result of being judged by their community. Elaborating further on this, Dalad said:

"I used to think a person who suffers from depression can never be someone who can enjoy everything... But I learned that a person who suffers depression can be a mother. I wasn't aware of that. In Yemen, if a mother suffers from a mental illness such as depression, her children will be taken away from her. It will be impossible for her to see her children again. This is what encouraged my ex-husband to take a stand against me. I feared being labelled '*crazy*' and not being a good mother for long years" (Y, 533-541).

This quote reveals the stigma associated with depression and the cultural norms that reject people with depression, preventing them from seeking appropriate help. The participant seems to realise that challenging

stigmatising attitudes towards mental health can be a key to improve better understanding of mental health care. With this in mind, Jamil emphasised the need for the community to be better informed about the consequences of the negative labelling of others and said:

“Often, lots of people need to seek help for their depression to be able to cope with life events. Not everyone who seeks help from a therapist is crazy. We need to improve the attitudes towards mental health because they can impact on people’s life” (Jamil-Y, 517-520).

Clearly, the community group has a fixed opinion and stigmatising beliefs about people who might seek help from therapy. Such beliefs, as the participant believed, are products of socially dominant groups, who through the use of language not only exclude patients from engaging with the community, but can also reinforce certain labelling, which could threaten patients’ emotional wellbeing and the stability of their family life, preventing them from seeking help.

On the other hand, Somali participants reported a different perception of the word ‘*depression*’ which stems from the non-existence of an equivalent word in the Somali language and/or the difficulty translating the term (Section 8.3.3):

*“There are no words for stress, anxiety or depression, there are no words... so it is hard... to pick up those kind of things. You are in a culture that does not recognise them... and in many ways that is the first hurdle to cross” (Mehdi-S, 185-190).*

Mehdi draws on the fact that each cultural group has their own words and terms of reference through which they express the lived experience in its cultural context. Yet, in the absence of a shared conceptual framework of mental illnesses and patients’ experiences of pain, one may raise the question of how non-Muslim therapist would be able to understand or appreciate patients’ articulations of their experiences.

Somali participants also pointed out that within the Somali culture “*if you are not normal, you are crazy, there is nothing in between*” (Mehdi-S, 184, 185),

and reported that patients who were diagnosed with depression were labelled as 'crazy' and were locked away and treated differently:

“Somali will say the person is mental... he wouldn't see a doctor... he wouldn't have a chance over there” (Yabaal-S, 656-666).

For that reason, patients may try to conceal the problem and avoid interaction with community group members for fears of being recognised through visible or different signs and behaviours as described by a participant in the observation:

“I am avoiding social contacts as I feel ashamed and worried that I could make a fool of myself in front of people... I am afraid they might notice my physical symptoms as most of the time I am feeling dizzy” (PO-SM13, 62-66).

The participant appears to construct his view of depression drawing on his visible observed behaviour of instability, which he sees to be different, and could result in judgement from the community. It could be that Somali people identify individuals with depression through their visible signs, which would explain why they consider people to be either 'sane' or 'insane' with no continuum in between.

Somali participants also reported the traditions of the Somali culture to discourage them from discussing mental health issues such as depression and/or complaining about their worries, as clarified by Mehdi:

*“From a cultural point of view, this is kind of my personal upbringing especially with the war... You can't show weaknesses. You can't show emotions, you can't cry. So you know when you come from a culture that is kind of maturely driven, it is not easy to come or find someone to talk to” (Mehdi-S, 107-119).*

Mehdi acknowledged that culture and his personality traits, stability and life-style were all factors that played a role in his upbringing and consequently, he was unable to show his emotions or to consider seeking help from professionals. In his narrative, Mehdi also appears to draw on male dominated cultures where men need to be seen as strong and dependent on

themselves to solve their problems. The endurance of pain is portrayed as being a cultural norm, which may result either in hiding the problem or being unable to admit the need for help. Khadra explained:

*“Our community needs a lot of help... [But] it depends on the individuals, do they want help... They don’t like saying they have depression... it may be pride or they hide their problem”*(S, 394-404).

Cultural differences between PSY patients and Western therapists may cause the former to reject explanations of their symptoms that are acceptable within the perspective of Western psychology. For that reason, being aware of the cultural differences in help-seeking behaviour among individuals as well as within the different groups can allow therapists to respond better to the different perspectives and use culturally-sensitive language to describe depression and related suffering.

### **7.1.2 The Misunderstanding between Cultural Beliefs and Religious Values and their Influences on the Access to Therapy**

Participants who are not used to talking about their emotions or those who are unable to recognise the reasons for their depression may be unable to understand how attending therapy and talking about the problem could help them. For such participants, religion can provide an explanation for the causes of their illnesses, believing their problems are related to black magic, the evil eye or Jinn:

*“Me as a person and with my own understanding, I believe this is not an illness, this is magic that someone blew over me or an evil eye. We do believe in the evil eye, the prophet (peace and prayer be upon him) says: (ثَلَاثُ قُبُورٍ أُمَّتِي مِنَ الْحَسَدِ) – one third of those who are in the graves are there because of the evil eye)... I have been to the doctors, got medicated but I haven’t got any better... I have definitely been cursed with a black magic or an evil eye”* (Azhar-Y, 353-362).

As part of their daily existence, people try to explain the causes of the psychological difficulties they may face in life. Because mental illnesses are usually in the mind and have no tangible or seen causes, some participants,

like Azhar, believed their illnesses to be related to the influences of supernatural causes or the unknown, such as 'black magic', 'evil eye' and 'Jinn', which are believed to exist because of their mention in the Quran. For that reason, several participants reported seeking advice from faith healers or religious leaders who are supposed to provide advice in accordance with the Quranic principles to deal with their psychological problems rather than seeking help from therapy. This model often explains mental illnesses as a possession by Jinn and is pointed out by several participants as being the oldest cures for mental disorders to dispel or contain the evil that has entered in the form of Jinn. Despite the value of spiritual healing, participants expressed different opinions on the subject. A few participants did not believe in this form of healing and mentioned that because families may not accept mental health diagnosis, they may seek supernatural explanation. Others believed consultation with an Imam who will work in accordance with Islamic principles can be helpful. Dalal and Abyan reflected on their experiences with spiritual healers and the perceived effects on their emotional wellbeing and said:

"I used to suffer panic attacks when I was about 15 or 16 years old. My mother and my grandmother believed that I was possessed with Jinn... [ans] they took me to a Walī<sup>28</sup>... The Walī believed that I had older people spirits in my head and ordered my mother to fill a bucket with cold water and pour it on my head to clean away the Jinn spirits, then he brought a razor and made a cut in my head until the blood came out and once the blood came out, it meant all the evil spirits had gone out. That day I had a fever but the fever was treated, I am not quite sure how. It could be because of the fear or it might be because they used cold water from the well... my mother paid him money" (Dalal-Y, 440-480).

Dalal described her experience of her family consulting a traditional healer, pointing out references to cultural influences in believing her illness to be related to jinn possession. However, Dalal appears to be unsure if the improvement in her condition was a result of the traditional healer who

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<sup>28</sup> Walī is derived from the Arabic word walī Allāh meaning Friend of Allah. The lexical meaning of the word is supporter, guardian or protector.



allegedly had contact with the spirits. This could be because the way the traditional healer dispelled the bad spirit is deplored by Muslim scholars, particularly as the treatment pathway is far from the Islamic instructions recommended in the Quran to expel the Jinn (Khalifa et al. 2011). In contrast, Abyan said:

*“My aunt took me to a Šayx (Sheikh)<sup>29</sup> who read Quran on me and he said that the problem is related to Jinn. He sent me to another Šayx who said that he didn’t think I am possessed with Jinn because when they normally read Quran on the person, he/she acts differently. The Šayx said this girl is very calm... when he was reading Quran... Then he said this girl is fine, leave her alone... every family if something was wrong, they think it is Jinn, but I don’t think this is the case in every scenario” (Abyan-S, 211, 220).*

Abyan, while agreeing and drawing on the cultural beliefs that perceived mental disorders to be caused by Jinn possession, displayed some rational thinking. By providing an example of being able to experience calmness and relaxation during the recitation of Quran, Abyan demonstrates the potential efficacy of spiritualism in the form of Quran recitation as a means of healing.

Participants who reported similar experiences believed that *“people with knowledge should be listened to” (Nadeem –P, 378)*, mostly those who offer free alternative treatments based on the use of Quranic verses and the power of God’s name:

*“My sister calls people like scholars and the (Šufi<sup>30</sup>) who diagnose magic and all these things... They tell me to read [verses of Quran] and I read everything regularly” (Rozena-P, 894-901).*

Seeking advice from scholars and people with knowledge was fully supported by several participants, who believed specific verses of the Quran, which are considered to be Allah’s direct words, could be used to treat their ailments. However, a number of participants pointed out how people sometimes confuse the cultural practices of their country of origin with practices

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<sup>29</sup>A man respected for his religious learning

<sup>30</sup>The Šufi is a lover of God and he/she proves their love to God by constant remembering of Allah.

grounded in the Islamic religion. This can often result in a misunderstanding and confusion between culture and Islam and may prevent people from accessing appropriate help. For instance, Rozena described how the incorrect belief that certain cultural practices were grounded in Islamic law ruined her life and caused her distress:

*“I was taught obedience to parents means just giving the control of your life to them, so whoever they tell you to marry, you marry; otherwise you will be burn in hell... the other thing is that marriages are made in heaven. So I thought if marriages are already made in heaven, no matter even if I have taken a stand against this proposal, if I am destined to marry the person, I will marry him. So I didn't take much of a stand against it... then I came here to the UK and I talked to scholars about it and they said... you have to respect the parents, serve them but then, you have to take the decisions of your life yourself. This was something new which I came to learn and hear from the scholars. Over there in Pakistan, religion is overpowered by culture and the scholars put culture into religion and they say this is religion. It is a misinterpretation” (648-663).*

Rozena differentiates between two important perspectives that impacted on her life: the Islamic values that are rooted in the Quran and Sunnah<sup>31</sup>, and the cultural norms that are grounded in Islamic beliefs but are not Islamic practices. Muslims believe that all the Islamic values have been listed in the Quran and only those should be followed. In addition, nearly all Muslims perceive Sunnah, which refers to the Prophet's way of life and are usually found in Hadith<sup>32</sup>, as an interpretation of the meanings of the teachings in the Quran. However, Sunnah, as part of the foundation of Islam, and the Prophet's Hadith, can, as perceived by some Muslims, be subject to misinterpretations or fabrications induced by the language whereby some Muslims may have different readings, understandings or even innovate

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<sup>31</sup> Sunnah is the way of life which the Prophet - peace and prayers be upon him- taught the people in theory and practice and for which, in his capacity as a teacher of Islamic law, he laid down ideal standards of leading a life which one should meet to earn Allah's approval through complete submission to His Commandments. Available at: [www.al.mawrid.org](http://www.al.mawrid.org).

<sup>32</sup> Hadith is the memorised teaching of the Prophet (peace and Prayers be upon him) which were written down and scrutinised by his companions. Hadith explains and illustrates the teaching in the Quran.

incorrect practices in the religion. As such, and after moving to the UK and meeting with religious scholars, Rozena came to realise that the religious beliefs and values that she had been taught in Pakistan, were influenced and overpowered by cultural norms. Rozena's ability to draw a line between what is Islamic and what is cultural is possibly related to moving to the UK and meeting with other religious scholars. By understanding obedience to parents as a matter of obligation rather than a legally binding duty, she realised that there were alternative readings to the deeper meanings of Islamic values and that particular readings may be preferred on the basis of other cultural norms.

Similarly, the issue of divorce, which affects the divorcee women emotionally, was perceived differently by Yemeni and Pakistani women. Ali et al. (2011), and Khan's (2017) research revealed different perceptions of divorced women such as bringing 'shame' to their families and considering them 'crazy' if they decided to file a divorce. Elaborating further on this issue, Yusra, a Yemeni UK-born participant, showed her resentment against the confusion of cultural norms and religious beliefs that impact in particular on women's lives and pointed out the differences between family culture and Islamic teaching on the issues of divorce and said:

*"We Muslims don't tend to talk about a lot of things because everything is just kept under the carpet, like divorce, a big thing in the Muslim community. It is not religion because it is fine in religion. You are able to get a divorce... It is allowed to get a divorce in Islam if you are not getting on... and as a last resort. But in culture, women would listen to husbands regardless and they will try and try to make it work... because the community have an opinion on women who are divorced"* (Yusra-Y, 221-235).

Yusra pointed out how simple it is for the lines between religion, and cultural practices of Muslims to be blurred. However, because of the possible and different interpretations of Quranic verses, people in such patriarchal cultures often confuse their Islamic religion with the bonds of culture and traditions. They draw on language to reframe such cultural beliefs from an Islamic perspective, which is produced from within the diverse Muslim communities who have different ways to interpret, understand and live out Islam. These

differences can reflect the practices of certain groups but are not necessarily in accordance with Islam as believed in, or practiced by, other Muslims in the world. What is apparent from Yusra's quote is that living in the UK may have empowered her to understand her rights and freed her mind from the imprisonment of the confusion of cultural norms and religious beliefs that impact on women's lives in her country of origin, and this eventually allowed her to seek help from therapy.

Culture, including beliefs about the spirits and the unknown (Section 3.5.1), plays a big role in people's lives, enabling them to make meaning of their suffering, providing an explanation for the causes of their distress, and promoting social rules that facilitate communal living (see Section 7.2.1). People who still maintain many of these cultural practices and traditions believe cultural beliefs are grounded in Islamic teaching. Individuals in different cultures may have different views on what the causes of distress are within their cultural beliefs and how they may interpret the Islamic views on such issues. For that reason, understanding the cultural beliefs regarding the causes of mental distress, and how patients may interpret their views when referring to culture and religion is central to therapist/patient relationship in therapy. With this in mind, exploring participants' views on working with therapists who may differ or share similar cultural backgrounds is essential to understand how this may influence the access to therapy.

### **7.1.3 Cultural/Ethnic Match: Advantages and Disadvantages**

Ethnic matching as pointed out by Springer et al. (2011) refers to the historical cultural patterns and collective identities shared by groups from specific geographical regions of the world. Winlow (2009) defined ethnic mapping to be related to aspects of ethnicity including religion, language, nationality and culture. In this research, participants defined ethnicity as the meaning of belonging to the same community group and sharing similar nationality, language, religion and/or social norms.

In this research, the issue of ethnic and cultural matching between patients and therapists and the effects this can have on the outcomes of therapy have been explored with participants where they exhibited different opinions on the

topic. Some participants believed sharing a similar ethnic background with therapists an advantage that enabled them to feel a direct connection with therapists, improve access to therapy and outcomes, and opening up about topics concerning culture and family issues. For instance Aliyah said:

“I felt relieved that I was able to talk on my own without talking to someone and they repeat what I said... I felt relieved that I was able to speak by myself because the therapist was from the same ethnic background and we spoke the same language” (Aliyah-Y, 324-335).

The ability to communicate directly with therapists without the need for an interpreter is important for Aliya as this seems to empower her to depend on herself and discuss particular events in her life. Overcoming language barriers enabled other participants to engage better with therapists and improve access and continuity of contact with the services. Jamil and PO-YG11 explained:

“I had an experience with a British CBT therapist before and I didn’t continue attending because I wasn’t able to understand her... I preferred a counsellor who speaks my language and shares a similar ethnic and cultural background to enable a better therapist-patient relationship, continuity in the treatment, and engagement in therapy” (PO-YG11, 278-282).

Research has shown that the ability to communicate in the mother tongue prolonged patients’ engagement in therapy as therapists of similar ethnic background make better use of time without an interpreter who may slow things down, and address patients’ needs in a more sensitive way (Section 3.5.4).

Similarly, Salma whose second encounter with a therapist was with a Muslim Asian professional, commented:

*“I thought he might be Muslim but he definitely was Asian so I thought he probably understand this so I was a bit open” (Salma-P, 240-242).*

Possibly, Salma reported satisfaction with the therapist and the ability to open up about the issues concerning her, related to the fact that sharing similar

ethnic backgrounds can help to lessen the feeling of difference, and progress the goal of achieving understanding with the therapist.

In contrast, when a number of participants were asked about ethnic matching in therapy, one respondent replied:

“I didn’t want to work with someone from the same ethnic background and same country of origin, Yemen. I was afraid about confidentiality. She might be able to talk to me in the same language and understand me, but... I feared that everyone might know about my problem” (Q4, 40-44).

Despite the advantages that ethnic matching may provide, clearly the respondent viewed ethnically similar therapists to be less confidential sources for help. Fears about confidentiality appear to be one of the main reasons for the respondent’s assumption as clarified by Mehdi: *“If I do speak to someone within my social norms as in people within the culture, there is only so much to open up... to safeguard yourself”* (Mehdi-S, 195-197). An additional reason, as another questionnaire respondent replied, was: *“If you work with someone of the same ethnicity and belief, you may feel judged”* (Q15, 25).

It is notable from the above quotes that patients should regard their therapists as trustworthy in order to fully open up about their distress. Therefore, to ensure privacy and to divulge their deepest emotions, a handful of participants believed that working with a therapist from a different ethnic and cultural background would make it *“easy to open up... and also not having fear of community backlash”* (Q15, 27). Moreover, as Pakeeza commented *“it was more helpful with an English person... because she was more understanding”* (P, 190-192). Making an effort to understand the feelings and perspectives as reported by those participants can possibly break down cultural boundaries and achieve better outcomes for patients.

Other participants showed a preference for working with a therapist with a different ethnic background but who shared a similar linguistic or cultural understanding:

*“It would help to have someone from the same cultural background as they will be alignment with myself. If their culture is from an ethnic background, Muslims and they are from Pakistan, Yemen or Middle East... their cultural values would probably be a lot more similar than someone who is not ethnic or Muslim” (Nadeem-P, 258-262).*

According to the participant, sharing similar cultural and/or religious views can lend a common language between patients and therapists. Therapists’ familiarities with patients’ beliefs were highlighted by many participants as a keystone to unite patients with therapists as it allowed therapists to be more able to acknowledge the stigma of seeking professional help (Section 7.1.2). To make this point clearer, a participant in the questionnaire explained:

*“I used to work with a British counsellor before but I used to feel like there was a wall between us. I felt she was unable to understand me. However, when I worked with a counsellor who shared similar cultural and religious backgrounds, she was more able to understand... For example, I came alone from Yemen and lived on my own, which was very difficult. The British counsellor wasn’t able to understand how difficult this was for me... But with the counsellor who shared similar cultural and religious beliefs, I felt more comfortable” (Q4, 25-34).*

The respondent used the metaphorical term ‘wall between us’ to indicate the barrier formed by the therapist’s unfamiliarity with her cultural and religious beliefs. In contrast, sharing similar cultural and religious backgrounds with the therapist influenced the counselling atmosphere so that the respondent felt more comfortable discussing her cultural up-bringing. This was also noted in a number of the observed sessions, particularly when the issues reported were very much related to cultural or religious matters as the case in PO-PI16, PO-PMY12, PO-PM7, PO-YG11, and PO-BH15. In these observations, it was noted through the signs of relief exhibited by patients that they were comfortable seeing a therapist who either shared their cultural or religious backgrounds. This will be discussed in Case 4, Section 7.1.6. Moreover, participants in the interviews highlighted some reasons for their stance. A number of participants they believed that *“a Muslim therapist would be able to understand... a lot of family morals and values and obviously the need to*

*have a strong family bonds” (Nadeem-P, 99-103). In addition, as pointed out by Salma, a Muslim therapist “will give you a different type of advice” (P, 174). Other participants stated that having a Muslim counsellor will enable them to work within the confines of their religion and accept advice that fits better with their spiritual beliefs:*

*“...if the therapist used Quranic verses and the prophet’s - peace and prayer be upon him - narratives. It is better” (Q1- 33-34).*

Participants in the research have shown different preferences when working with therapists. Some participants preferred to work with a particular ethnicity or particular cultural background as they found difficulty engaging in therapy with someone ‘who is not like them’. Several research studies in counselling have documented this preference as has been discussed in Section 3.5.4. For example, Lopez et al. (2013) showed how Latino patients benefited from working with Latino and Spanish speaking therapists, and Czyzelska (2002) pointed out that gay people would prefer to seek therapy with therapists who are either gay or at least straight and gay-friendly. This allows therapists to be more able to respond comprehensively to their patients’ needs. When patients work with therapists with similar beliefs in key areas, the relationship becomes more valuable and powerful.

Other preferences may relate to the gender of the therapist as reported by Burman et al. (2003) and Landes et al. (2013). Their research carried out in the counselling setting shows women to prefer working with female counsellors due to comfort in self-disclosing to female therapists. In this study, the issue of gender-matching was only pointed out by four participants. Those participants exhibited different opinions on the subject. For instance, Mehdi, a Somali participant, preferred a male counsellor:

*“The counsellor was male which was quite important particularly for the first two sessions. I am coming from a masculine culture. Being a male... I am not weak and I don’t want to be perceived as weak” (Mehdi-S, 235-237).*



As indicated by Mehdi, the preference for the gender-typed therapist reflects his cultural definitions of gender-appropriate behaviour or the standard against which, he believes his behaviour will be evaluated.

Conversely, Yabaal and Nadeem preferred a female therapist. They explained:

*“A woman could understand my mother’s point of view more, whereas a man would understand it more from a scientific perspective like the things that affected me and how to handle these. But he will lack a woman’s sort of emotions behind it... a woman might show empathy that can help the person open up” (Nadeem-P, 235-241).*

The preference for a female therapist could be related to feeling more comfortable talking to women, believing female therapists to be more empathetic or wanting to work on problems with women. Preference for a female therapist was also observed during observational sessions where participants exhibited relief and an openness towards discussing their personal issues. However, a Pakistani female born in the UK drew on her second encounter with a male therapist and said:

*“He was a man, but I think I liked that because sometimes men can think differently. When two women are together, I think it is too much of the same thing but when somebody is a bit of an outsider, who converses differently without getting too emotional... I think they can see things more clearly” (Salma-P, 232-237).*

Although this case was the only of its sort in this research, other research studies have also found that female patients revealed more to male counsellors than female ones (Brooks, 1974). Here, Salma believed the male therapist allowed her to look at the problem differently in order to best solve it.

It is important to acknowledge that different groups of people have different perspectives on their experiences. If anything, these differences point to the importance of increasing awareness of the emotional expressions and cultural beliefs of PSY groups. Being aware of the differences enables

therapists to understand patients' points of view on issues related to Muslim family morals and values as well as about cultural identity in a foreign society. Although this section highlighted individual preferences, many participants emphasised the importance of having therapists who were able to understand different cultural beliefs as the lack of this affected the encounter and, on some occasions, stopped participants from accessing therapy.

#### **7.1.4 Therapists' Cultural Understanding**

Therapists' cultural understanding plays an important role in therapy. While therapists' cultural understanding is not directly related to participants' perception of therapy, the likelihood of the outcomes of therapeutic encounters being affected by cultural considerations is quite significant as demonstrated in the previous section. Because of the differences between PSY patients and non-Muslim therapists in culturally-defined practices, participants exhibited different opinions on the subject. While a handful of participants felt comfortable in addressing and explaining their cultural values with their non-Muslim therapists, numerous participants were unable to have productive discussions.

Participants who felt comfortable discussing their cultural beliefs pointed out that when they attempted to explain the cultural norms within their communities or their religious education, non-Muslim therapists were quite open to understanding these issues and asking for clarification as explained by Noor and Atiqa:

*"The therapist... was English and... she didn't know where I am from, which community is mine... I told her everything... I told her sometimes the community talk about me... In our community people talk too much and that's put you down. I explained this to her... and [she was able] to give me advice" (Atiqa-P, 250-272).*

*"She asked me why you have to do everything to the family by yourself. You can hire... someone to care for them. It is my religion that I have to care and respect my parents no matter what happened. So I have to tell her this... My therapist learnt a lot... and she was more understanding after a couple of sessions" (Noor-Y, 835-865).*

Both participants acknowledged the cultural differences with therapists and willingly addressed the cultural and religious issues that were related to their presenting problems. By engaging in conversations about their beliefs and values, the participants seemed empowered and more actively involved in therapy.

In addition, having a therapist who can be both knowledgeable and who demonstrates awareness of the influences of cultural factors on health and emotional wellbeing helped a few participants to trust the therapists and improve their situation as explained by Rabab:

*“She understood where I came from and the clashes I used to have by moving from a different country and different culture and different experience... It was good for me to find a person who understands this culture move because... understanding that gap is not easy... understanding the shift between you who came from a different country, a different background and having a difficulty with your new life” (Rabab-Y, 510-518).*

The struggle of being in two different cultures and finding a balance between the old culture and the new one can affect emotional wellbeing, as pointed out by Rabab. Yet, having a therapist who understands the impact of the immigration experience and its impact on health and emotional wellbeing, helped the participant to overcome her problem and manage her situation better. What mattered most to Rabab was the ability to feel understood and to be able to exchange and share thoughts and views on a personal level. This includes issues around cultural variations, loss of identity and social support system.

However, not all participants were able to have a productive discussion with a therapist. Several participants explained that it was quite difficult to address their cultural beliefs with therapists:

*“I tried to explain to the therapist about divorce and being a divorcee in the Pakistani community and how this affected me... But the facial expression I got back put me off. So I held back more information, then I stopped talking about the more cultural issues” (Sabiha-P, 277-279).*

As demonstrated by Sabiha, addressing cultural beliefs with therapists can be a challenge in therapeutic encounters, particularly when therapists prejudge patients' beliefs or act in a dismissive way. The therapist's non-verbal behaviour during Sabiha's discussion of cultural beliefs communicated a feeling of distance, which negatively impacted on Sabiha and influenced her interaction with the therapist.

Other participants did not enter into a dialogue about their cultural values because they believed therapists would not understand their perspective:

*“There were cultural barriers and I thought if I want to say certain things, they are going to look at me and think I am weird... they were unable to register things” (Salma-P, 495-497).*

This could be related to the tendency of some therapists to draw on stereotypical images, or make statements that reflect differences instead of exploring these openly with patients.

Familiarity with patients' cultural beliefs is an essential requirement that was continuously voiced by PSY participants in order for therapists to work effectively with PSY patients. The following two cases illustrate the challenges two participants faced when discussing cultural beliefs and religious values and how these challenges influenced the outcome of therapy. While the first case demonstrates how lack of awareness of cultural beliefs has influenced the access to therapy for a Muslim Pakistani female, the second case shows how effectively the Muslim therapist incorporated her awareness of cultural and religious values and worked effectively with a Pakistani male participant.

#### **7.1.5 Case 2: Implications of Therapists' Cultural Understanding**

Sabiha is a Pakistani female Muslim in her forties. She came to the UK with her family when she was quite young. She was brought up and educated in the UK and has an MA degree in healthcare. She accessed the IAPT service because she was suffering from anxiety and depression that later turned into post-traumatic stress disorder. This was due to a few major events in her life. One of these was an arranged forced marriage, which ended with a divorce

three years later. Her uncle, who was a father figure to her, was then murdered following the death of her own father who suffered from lung cancer. At this stage, she was unable to handle these life-changing events and they started to affect her work and her life. In addition to this, she was then stalked by an acquaintance:

*“It was somebody who wasn’t in the country, somebody who I never met before but his stalking campaign was... severe... This was somebody who I just befriended through professional level online... and I just became an obsession for him... he got hold of my family’s phone number... and my best friend’s phone number who was a lawyer. He rang over fifty solicitor’s offices in Sheffield to find out which office she is in. He tried to find which surgery I am registered with... It was really, really bad and it came to a point where he threatened to harm me physically and he would come to the country if I didn’t marry him. So I completely broke apart” (96-109).*

With the description Sabiha provided, she drew attention to the characteristics of the stalker and how intense and extreme his actions were. She informed the police but they were unable to do anything because the stalker was not in the country. Sabiha started to exhibit anxiety symptoms where she was unable to sleep, she started to smoke, and became a “shadow of her former self”. She was too scared to go out because the harassment was still going on. Initially, she did not want to involve her brothers and was trying to hide all these issues from them because, as she explained: *“In Asian communities it can become very tense if something like this happens with someone’s daughter or sister” (124-125)*. She was faced with this cultural dilemma in addition to her other difficulties, but as the issues became inseparable, she started to think of alternative means for seeking help.

When she contacted the police for the second time, they issued the stalker with a warning. However, this did not have the intended effect. In response, the stalker flew to the UK and was in the country. She found herself face to face with the person who had been persistently harassing her, asking for her mother’s address in order to marry her. She escaped to her brother’s house, and contacted the police who arrested the stalker and she was asked if she

wanted to press charges against him. However, Sabiha decided not to press any charges explaining:

*“I was sitting there in the police station in the middle of the night having to give a statement. It was a lot to take in for me and I didn’t press charges. One of the reasons because he tracked down my family in Pakistan so it was too much for me” (177-181).*

Sabiha was quite worried about her reputation and decided to seek help. Accordingly, she went to her GP a number of times before she was referred to IAPT for CBT. Because Sabiha did a basic counselling course a few years ago, she was able to understand a lot about the process. She described her experience with the first sessions:

*“After three sessions, I didn’t feel any benefit at all... I didn’t find my therapist helpful at all unfortunately. By the end of the second session I had a bit of an inclination to say hang on I am not really sure this is going to benefit me. By the end of the third session I thought we are half way through this, I don’t feel I gained anything so I stopped the actual session” (198-202).*

Sabiha found the communication with her therapist very difficult because as she explained: *“there were certain facial expression that the therapist was using that put me off. For example, if I was trying to describe a particular event to her... and how it had affected me, um, I could tell on her face whether she understood it or she didn’t” (238-242).*

Because the therapist displayed some non-verbal reactions such as looking to the side, and she did not give Sabiha any prompts like asking for further explanation or elaboration, Sabiha used these non-verbal communications to draw the conclusions that the therapist was not interested. It is important to note that no single behaviour or non-verbal cue means the same thing in every culture or context. Certain cultures may have different rules as to how to respond to a particular emotion and it could be that the therapist refrained from making any eye contact, believing it may be interpreted differently in Sabiha’s culture.

Yet, when Sabiha tried to explain some of the cultural issues to her therapist, she was troubled with the fact that she felt the need to explain herself:

*“I felt like I had to explain myself for the emotions I was feeling... I felt like I had to explain why I was stressed at this particular event... and I also think it was around some cultural issues that... deeply impacted the women in my culture” (251-261).*

Although, as explained in Section 7.1.3, cultural-matching does not always guarantee better therapist-patient relationships, as pointed out by Sabiha, competence in learning about cultural differences and being mindful of verbal and non-verbal cues can be critical. One of the issues that distressed Sabiha was the discussion around forced marriages, which is a big issue, particularly in the Pakistani community. Sabiha was feeling pressure as a subject of gossip in the community but she was finding it hard to explain this to someone who does not understand her culture:

*“Explaining things like that to someone who doesn’t understand your culture is very hard, you almost feel like eh, embarrassed or you feel a bit ashamed of having to end up explaining what is going on in your culture... because this is dependent on the way, I think a therapist talk to you and interact with you” (3243-350).*

In this quote Sabiha raised two important issues: therapist cultural understanding, and communication difficulties with the therapist. Although the communication between Sabiha and the therapist was in English, Sabiha reported her inability to explain some of her problems to the therapist. According to Sabiha, this was related, on the one hand, to the therapists’ non-understanding of cultural issues, and on the other, to the therapist’s counselling skills. Also, the body language exhibited by the therapist *“for example, like frowning and looking up... and putting the head to the side and looking everywhere to think” (353-355)* was another issue that was continuously pointed out by Sabiha as a barrier to engaging in meaningful conversation with the therapist. But what is of immense interest is the repeated pointing out of the missing ‘understanding’ from these interactions: *“I could tell she was trying to process the information but I could tell there*

*wasn't the understanding" (356-357).* What Sabiha exactly meant by 'understanding' is questionable. Here, Sabiha could be referring to her preference for working with someone who shared an identity that mirrored hers such as cultural or religious backgrounds or her wishes for the therapist to behave in a certain way as explained below:

*"Probably I would like therapy to be with somebody with similar background or one who had really good knowledge of my culture and religion" (258-260).*

In the end, Sabiha managed to seek advice from a private counselling helpline who provided more proactive advice. The helpline counsellor was not of the same ethnic background as Sabiha. Yet, Sabiha reported her to be more understanding and assertive in her style of counselling than the IAPT therapist: *"It was a bit more proactive conversation with this therapist even though this was over the phone... She said to me you have the right to feel this way, I can understand. I can see why you feel this or act in this way... I didn't get this from my IAPT therapist" (396-400).* Acknowledging Sabiha's worries and showing empathy towards her feelings is undoubtedly considered crucial to the success of this form of therapy. However, in the absence of visible body language, one may question whether the receptive and considerate tone of the helpline therapist was the reason that allowed Sabiha to feel understood and engage in therapy. While understanding the cultural issues was important to Sabiha in the first therapeutic encounter, it seems that understanding feeling and the style of counselling were more important in the second encounter. This seemed to help Sabiha to open up and benefit from therapy.

Apparently, the approach that worked for Sabiha on the second occasion was the provision of specific guidance for her issues and acknowledgement of her feelings. This means that a therapist's ability to make their patients feel understood and being considerate towards their problems can possibly challenge the issue of cultural matching. It is possible that the helpline counsellor's personal characteristics are partially responsible for these effects, since Sabiha repeatedly highlighted the non-verbal communication of the helpline counsellor as conveying an important message. She said:



*“I really felt that someone was there listening to me, on my side... I think when you are a therapist, you need to be showing that you are that person on my side” (652-654).*

The helpline counsellor, by being an attentive listener and considerate of Sabiha’s situation, was able to send a message of empathy and understanding. Through her positive tone of voice, the helpline counsellor was able to assure and reinforce Sabiha’s message. By agreeing with Sabiha’s rights to be upset, the helpline counsellor was able to gain her trust and give valuable feedback and guidance (see Section 8.1.2). This was a key aspect that enabled Sabiha to define her relationship with the therapist and establish a connection with her.

Later in the discussion, Sabiha reflected and pointed out how actually finding refuge in her religious beliefs and spiritual practices helped her take the first steps towards dealing with her problems. It is not uncommon for people from Sabiha’s community group to turn to their religion in times of despair and Sabiha was not an exception. Sabiha was on edge almost all the time. Therefore, she turned to religion to feel protected. Once she got this back, she was able to overcome her distress. Yet, one must acknowledge here that people have different attitudes towards these rituals and what could be more significant to one person may not be to another.

This case highlights several pertinent issues for service provision as well as for patients who have linguistic needs and who are less able to access the IAPT service. The case reveals the importance of understanding the deeply seated cultural issues that may impact patients’ wellbeing and the different cultures patients may belong to, in order to be able to incorporate a framework more focused on the individuals’ empowerment in therapeutic practice. Furthermore, it shows that effective communication not only includes listening to what the patient has to say, but, equally important to the patient, feeling that his/her meanings are being understood. Paying attention to the symbolic meaning of body language and how to relate to the communication style is another essential component of therapist-patient interactions as it often involves breaking the distance and encourages building trust (see Section 8.1.2). Finally, although extreme, the case outlines

some of the complex challenges that people who have linguistic needs may encounter in a new country, and the cultural aspects of the events that they may experience as a consequence. After all, a good experience of therapy is all about receiving help to feel better and as this case shows, for those who do not feel comfortable with one therapist, it does not mean that therapy will be of no use to them.

### **7.1.6 Case 3: Implications of Therapists' Cultural Understanding**

PO-PI16 is a Pakistani Muslim male in his late thirties attending therapy. He has been in the UK for some time and is able to communicate in English. He is married to his cousin, who brought him to the country. He works as a taxi driver. He was required to attend therapy because it was recommended by his social worker in order to manage his anger, following an incident that took place with his daughter. As the therapist was wearing a hijab, the patient was able to identify her as a Muslim and as such displayed signs of relief on his face when meeting her (see Section 8.1.4.1). The therapist was a Muslim but from a different ethnicity. The patient addressed the therapist as 'sister' and said:

*"You are a Muslim and you know how we care about our daughters... My issue is very much related to how we as Muslim people care about raising our daughters in a foreign country" (27-30).*

By pointing out the therapist to be a Muslim, the patient demonstrates the comfort he feels in talking with her and the connectedness he is experiencing. Based on his statement, the patient did not provide any further information and instead, assumed through the use of the pronoun 'we', which indicates inclusivity, that he and the therapist belong and comply with the same group's values. Therefore, he continued to draw on his Islamic beliefs and said:

*"I am a Muslim and I care for my daughters as a Muslim. The Prophet, peace be upon him said that whoever has three daughters and is patient with them and treats them kindly, he will be rewarded with Paradise for that" (43-46).*

Here, the patient gives more insight into his Islamic values and shares his religious beliefs with the therapist. He shows his comfort in the situation by opening up. When the therapist asked about the problem he explained:

*“I asked an (Imām)<sup>33</sup> who is a religious and well-respected person in the community, aged 65, to come and teach Quran to my daughter who is twelve years old. But my daughter went to school and claimed the Imam was touching her inappropriately. I was called to school and was accused of not taking care of my daughter. I was quite angry at the beginning as I couldn’t believe the allegation and explained that I was only trying to raise my daughter in accordance with Islamic teaching, but the social worker who was involved in the case requested that I should be removed from the house, claiming I am not a good father” (48-57).*

Muslims, while ethnically diverse, share some common faith and cultural values, which appears to be the reason for the patient to open up and engage effectively with the Muslim therapist. In contrast, the patient tends to believe that non-Muslim professionals, such as the social worker, lack the understanding of Islamic beliefs and their possible influences in relation to family dynamics, which, if not addressed properly, may negatively affect the care of Muslim patients. Under those circumstances, the patient believed he was treated unfairly as he stated: *“I was kicked out of my own house because they believed I am not a good father and I should be away for 45 days excluding weekend” (61).* He added *“I was told by the social worker that I have anger management issues and I needed to attend counselling sessions before I would be allowed to return to my house” (62-63).* Using his own lived experience, the patient appears to draw attention to the need to address religious non-understanding not only by mental health services, but also by other services including welfare services. The patient clarified that as a Muslim, his cultural values are different from those people in the UK, but the negative portrayal of Muslims in the media can play a role in religious discrimination and said:

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<sup>33</sup> Imām means the person who leads prayers in a mosque and usually offers support to his fellow Muslims. He is also supposed to have undertaken certain training in Islamic thought.

*“If anything happened to or by a Muslim individual in the society, he is exposed in the media and action will be taken against the person” (65-66).*

By highlighting this issue, the patient brought attention to the negative associations made in the media between Muslims and violence, which he believed, is the reason for being asked to manage his anger. As the therapist continued to display an understanding and a considerate approach to the patient’s problem, the patient continued to open up and express his views:

*“If you break the law, they use their power against you. I can’t return to my house... They claim I have anger issues. I am a father for five kids, a Muslim father who is trying to give guidance to his children. It is our culture and religion. They think I am going to take them to Pakistan and force them to marry. I don’t do that” (75-79).*

Here, the patient drew attention to some of the assumptions, he believed, are made by Western society about Muslim people, where they tend to be negatively presented and stereotyped. Comparing Muslim and non-Muslim therapists, the patient stated *“I am happy to talk to you because you are a Muslim and able to understand” (83-84)*. The patient went on to demonstrate a connection with the therapist, discussing further with her some of the cultural issues that he was experiencing with his daughters in a foreign country and said:

*“One day I returned home at almost 2 am in the morning and my younger daughter who is 5 years old was watching cartoon in the TV when she was supposed to be sleeping. When I asked if I can have the remote control to change the channel as it is daddy’s time, she told me that she won’t change the channel and if I shout at her, she will call 999. I was shocked to hear this from her as this won’t happen in our culture. A young child won’t talk to her father in that way, it is not accepted, even in our religion, children should always respect their parents” (124-131).*

Living between two cultures and the difficulty one may experience appears to impact on the patient, possibly because he recognises that his daughter

starts adapting the new host culture lifestyle and rejects her own cultural values. Because the patient believed the therapist was able to understand his viewpoint, which is rooted in his culture, he expressed his dissatisfaction with the host country values and was able to assert his identity and have a positive engagement with the therapist. Consequently, when the patient was asked about his goals and expectations he stated:

*“I want my family and daughters back. I want my whole peaceful life back again... I want to have a good relationship with my family” (116-118).*

Facing new cultural challenges possibly broadens the patient understanding of the differences between himself and the host culture due to instability and loss of family. Thus, when he was provided with the information about the anger management course, he was quite happy to attend as demonstrated by his commitment to dealing with his issues in the above quote.

Due to the complexity of the issues discussed in the session, the researcher was hoping to follow up the observational session with an interview to discuss things further and to better understand the events. However, the patient declined because he did not want the interview to be audio-recorded.

The different cultural beliefs that are based on Islamic values can influence therapeutic interactions between Muslim patients and therapists. On one hand, the case demonstrates how the therapist's familiarity with cultural and religious aspects led the patient to open up and discuss the issues affecting him. On the other, it brings to the forefront of the discussion the question of how a person with such challenges would be able to discuss issues that are deeply seated in culture and religion with a therapist who might lack an awareness of Islamic teachings.

In this section, if we look at some of the points raised in the two cases, we can conclude that therapists' awareness of the implications of cultural beliefs that are based on religious values can improve the outcomes of therapy and ensure efforts are undertaken to achieve a more culturally sensitive care. The need to feel understood is also equally important regardless of the ethnicity or cultural sensitivity of the therapist (Reis et al, 2017). Also, as noted from

this section, it is quite difficult to separate the role of culture from that of the religion because culture may influence the interpretation of religion. Therefore, the next section focuses on understanding the religious beliefs and their relation to emotional wellbeing and discusses the influences of religious practices on patients' access to therapy.

## **7.2 The Role of Religion in Therapy**

Taking the significance of religion for participants into consideration, this section starts with a focus on religion and its relation to emotional wellbeing followed by a discussion on the influences of religious beliefs on access to therapy. The section also presents the religious coping practices adopted by participants to overcome their distress, therapists' religious understanding, the assumptions made by participants, and their implications to accessing therapy. Finally, a case from the interviews is presented in order to draw on the religious beliefs and practices and raise awareness of alternative approaches that may meet the needs of those patients with a religious background.

### **7.2.1 Religion and Emotional Well-being**

Religion, as reported by participants, played an integral part in their recovery journey and served as an additional or alternative therapy in many situations. The reasons given by participants who reported a positive relationship between religion and emotional wellbeing included: religion provided them with explanation for their distress, rules and regulations for right and wrong behaviour, and insight into how to find answers to their problems.

Some participants reported adhering to religious practices shaped their psychological perception of pain, enabling them to have wide-ranging insights and explanations, which helped them to face the difficulties of life and cope with their emotional distress as explained by Nadeem:

*"[My religion] says anybody who doesn't pray the five prayers, will be lonely and depressed... If we don't pray, we are not going to be happy and we will be always depressed" (Nadeem-P, 413-417).*

As stated by Nadeem, non-adherence to the practices of religion appears to cause distress and is often considered an indication of poor mental health. As a result, some participants interpreted their misery and sadness to be a negative consequence of weak faith. This was simplified by an analogy used by Yabaal:

*“If you are a crazy man, the angels will run from you and if you read Quran, they will return” (Yabaal-S, 801-802).*

By using this analogy, Yabaal believed detachment from God causes mental unrest and unstable emotions (symbolised by the angels running away) whereas adhering to religious practices (reading the Quran) would enable the person to function better and overcome his difficulties.

A number of participants also viewed their religion as a comprehensive guide to living that teaches them right and wrong behaviours and said:

*“Religion gives you outline of how to live your life. It gives you control of yourself as well, like it restricts you of what you can do. So when people goes out of these boundaries, it causes unhappiness” (Nadeem-P, 295-297).*

Moreover, some participants believed religion can prevent a person from doing something that may incur God’s displeasure and provide support to enhance endurance as stated by Jamil:

*“If you think about committing suicide, you start thinking about standing in front of God on judgement day and having to explain things. This makes you quite attentive and fearful to act on your thoughts” (Jamil-Y, 478-481).*

Several other participants explained that religion provided them with detailed instructions and guidance, such as the actions of the Prophet Mohammed, to respond to life events and achieve satisfaction in all aspects of life: *“I looked at our Prophet’s way of life and I could make the connection, and I could understand the things that are in our religion” (Sabiha-P, 734-736).* This was reiterated by Yusra saying:

*“You try to look at the positive outcomes of the situation, so you look at the good things rather than the bad things and you reflect on your experiences and just be patient and hopeful that something better will come along... that’s what I took from my religion” (Yusra-Y, 285-290).*

As noted above, religion has the potential to teach individuals to think and reason, and draw on their faith and the example of the Prophet who turned to the Almighty God in his own circumstances of hardship. This, as pointed out by many participants, can provide individuals with a form of guidance to build their emotional resilience and implement a successful therapy.

### **7.2.2 The Influences of Religious Beliefs on Patients’ Access to Therapy**

When people practice their religion and believe in God, and have complete surrender and devotion in His healing power, some may become hesitant to seek or accept the help of a therapist in providing an explanation for their mental distress. This suggests that religious beliefs can offer an interpretation or understanding of the causes and treatment of mental distress that may differ from therapy and/or may influence patients’ help-seeking. As a consequence, participants differed in their opinions of how the religious beliefs can affect the decision to seeking help.

Many participants as shown in Section 7.2.1 above, agreed that using therapy is not contradictory to their religious beliefs. In fact, they believed therapists can incorporate religious practices in therapy. Others believed one should rely on God only for healing and they listed the beliefs that were reported to protect them from ill health and helped them manage their distress in a better way such as: worshipping God in a meaningful way, believing in fate and destiny, leaving problems in God’s hands and accepting life events as a test from God. A few other participants found it difficult to integrate mental health with their religion and were unable to seek help from professionals.

Participants who used therapy as a complementary treatment to their religious beliefs stated that in addition to acknowledging God’s ability to solve their problems, one should seek help from the different venues, one of which could be a therapist: *“You know for depression, our religion give us certain*



ways to get out of it. The main thing religion teach you... when you feel low to start reciting Quran... then you go and share with someone like the counsellor” (Atiqa-P, 567-571). This was reiterated by Mehdi saying:

*“God is in control and what is written is written. I am a firm believer of that and... I don't worry about it... But God send his servants [to guide you through your difficulties] this is my interpretation of God. So when my lecturer said I should go to a counsellor, that's to me God's intervention... to kind of save me” (Mehdi-S, 591-831).*

Here, the participants appear to understand that their difficulties require appropriate preventative measures and acceptance of realities to manage their problems. Clearly, accessing therapy was not believed to conflict with the religious beliefs and in fact, it was an additional source of help to be utilised when distressed:

*“My family used to say pray and you will get better... read the Quran ... and that will help you a lot... I used to read to make myself feel better. I think all of it was connected as counselling helped as well” (Pakeeza-P, 227-232).*

Conversely, participants who endorsed the view that they should only seek help and direction from God believed *“if anyone is going to help me out of the situation, it is God. He is going to help me out of it” (Sabiha-P, 727-728).* Furthermore, they were less likely to endorse willingness to attend professional help and more likely to support total dependence on God during hardship: *“God knows the way you feel, so you don't even have to explain... God would understand... whereas others won't” (Yusra-Y, 453-459).* For that reason worshipping God in a meaningful way was understood amongst those participants to protect them from ill health: *“When I get tense, I pray until I feel calmer... Praying to God control my anger” (PO-PMY12, 144-145),* and to enable them to bear their distress in a better way: *“Sometimes I think about ending my life but then quickly regret that and I return back to God... being closer to God is much better” (PO-YL14, 119-121).* By doing acts of worship, the participants believed that they were more able to be motivated

and gain control over their souls, and for that reason, they did not consider access to therapy as their main priority.

Believing in fate helped those participants to make sense of the undesirable or unexpected events in their lives as reported by Abyan:

*“Allah knows why it happened and why it happened to me... Whatever happened to you has already happened and (Allah) made the best plan” (Abyan-S, 949-952)*

While the participant acknowledged that major incidents that took place in her life were predestined by God, she appears to understand that accepting God’s plans is part of the healing process, which will lead her to a more satisfying and productive life. In fact, Abyan went further to clarify that what happened to her contributed to the knowledge that was above or beyond her understanding and said:

*“[What happened to me] may have happened to make me a stronger person, maybe it happened to make me more experienced in life, maybe to help others... (Allah) knows what is the (حكمة - the wisdom) from it” (Abyan-S, 948-953).*

As a result, those participants accepted that everything that occurred in their lives was a test from God to make them think about all the good things they had. By going through these tests, they believed their sins will be wiped off and they *“will be raised to a higher rank in heaven ... [and] will be rewarded with so many things” (Abyan-S, 977-979)*. The blessing behind enduring the hardship of life is considered by those participants a sign of God’s love and therefore, many of those participants believed people should not resent these challenges and consider them as a punishment from God. Instead, as recommended by Momina they should: *“have patience and you will be in a better place that will give us comfort” (P, 345)*. In this context, the participant points out that religion attaches great importance to having patience in order to face the challenges and distress caused by the difficult events of life, which comes out of the submission to the will of God and affects the decision to seek help from therapy.

However, Mehdi and Khadra approached the topic of religion differently. While both believed religion played a fundamental part in addressing their mental distress, they differentiated between reliance on Allah and implementing the means that have been permitted to cure their distress:

*“I am a very faith-based person... I have a balanced relationship with faith in the sense that I will pray and respect religion... but I am not extreme... Religion doesn't stop advancement... Religion makes you better as a person, better in how you deal with others and how you deal with yourself” (Mehdi-S, 570-815).*

The participants differentiate between *tawakūl* and *tawākul*. The first is a Muslim's trust in Allah and the importance of accepting His will. The latter indicates laziness and expecting Allah to take care of their affairs while they do nothing. Participants believed that while one should apply religion in one's daily life, it is still their own responsibility to strive to achieve the best outcomes in their life. In addition, they believed every matter has a cause and that religion encourages people to seek the knowledge to get the cure.

Despite the fact that almost many participants reported religious beliefs as having a positive influence on their perception of distress and emotional well-being, and worked as a form of therapy, three participants believed religious beliefs to have a negative impact on their abilities to deal with or manage their depressive mood.

On being put to the test through the hardships of life and suffering, Rabab believed her faith was shaken and questioned the reason for being tested and/or the purpose. She said:

*“Sometimes I used to reach a level where I didn't even trust God. When you lose that faith because of the pressure put on you, you know this question why me and what if it becomes too much around me. It made my relationship a bit weak... When I talk to God, you know He will not argue with you and actually you don't get anything back... you don't get a response back from God. When you are in a high level of stress, you need someone to say something back to you and you feel*

*like you are talking (sorry for this) you are talking to a wall, you just bang your head” (Rabab-Y, 608-627).*

Rabab reported feeling despair during a period of hardship and her relationship with God was questioned. She seems to feel abandoned because her prayers were delayed. Recognising her vulnerability, Rabab also appears to struggle to live in total submission to God. In such context, how individuals conceptualise God’s role in dealing with their distress may influence their access to therapy.

Similarly, some individuals were unable to understand the hidden or true purpose of their suffering and for that reason, as pointed out by Sabiha, they *“blamed themselves and said I sinned in the past and... this is my punishment” (Sabiha-P, 742-743).* Therefore, they may believe that they must take responsibility for their actions, and deserve to suffer as a result of their sins. As a consequence, they may feel less able to resist such negative thoughts and to seek help from therapy.

Jamil, another participant, pointed out that obligatory practices and the overly rigid interpretations of their meanings by people can cause the person to feel guilty because they are unable to fulfil their duties towards God and this could impact negatively on the person:

*“I am a believer, I pray and do certain things but sometimes I find myself unable to leave bed. Sometimes, I feel paralysed, unable to pray and in this state, I feel religion becomes a burden and I feel guilty because I didn’t pray... The problem is, some people’s understanding of religion is wrong. If you don’t pray, people will say God will punish you... people changed religion from something that is good to something that cause fear and panic” (Jamil-Y, 497-507).*

As demonstrated by Jamil, feelings of depression may stop a person from fulfilling their obligatory duties to the Almighty God. This can have an important bearing on the person and widen the gap in their relationship with God, particularly if they did not receive the right advice. Jamil is possibly cautioning against rigid interpretations of religious practices where some Muslims can make aspects of the religion difficult for others. Such

interpretation of faith can impact on access to therapy as the individual may view the use of therapy as denial of God's power to solve the problem.

Dalal further argued that there are issues with the perceived assumption that religious beliefs are sufficient to enable people to cope with mental health problems. She explained:

*“Those who claim that they feel reassured when they hear prayers or make supplications, believe me... this doesn't have any relation to mental illness. Mental illness and physical illness are different. You can heal the physical illness with treatment of ruqyah<sup>34</sup> or duṣa'<sup>35</sup>... but the emotional side is completely different... the sickness of the soul is different from the sickness of the body” (Dalal-Y, 496-505).*

Here, the participant separates the mind from the body and sees them as totally separate entities. Therefore, she is unable to perceive how religion can play a role in understanding her suffering or provide value in healing her distress. Although this may be true, the participant appears to interpret her suffering as endless, which can also have an impact on her decision to seek appropriate help.

Participants discussed how their religious beliefs influenced their help-seeking decisions from IAPT service. Although seeking help from therapy was not perceived by many participants to be in conflict with their religious beliefs, the different interpretations of religious beliefs can influence the decisions to seek help from therapy. These views were related to the religious coping practices, they believed, to be essential for their recovery, and which can affect the willingness to access therapy.

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<sup>34</sup> Ruqyah is an Arabic word consisting of specific portion of Quran or contains a praise of Allah's words as an invocation of his help, protection or cure against the evil eye, black magic, touch of Satan and other ailments.

<sup>35</sup> Duṣa is the act of supplication, calling out to God, communicating and conversing with the Creator, the knowing and the Powerful. It is one of the most powerful and effective act of worship a human being can engage in. it is the submission to God and a manifestation of a person's need to God. Available at: <https://www.islamreligion.com/articles/4005/dua-supplication-part-1/>

### **7.2.3 Participants' Religious Beliefs and Practices and Their Influences on Access to Therapy**

Religious beliefs and religious coping practices were perceived by many participants as providing them with an alternative therapy or additional source of help (Section 7.2.1 and Table 19). Some of these practices were also reported to be in line with therapeutic principles used in CBT, such as, identifying unhelpful thoughts, using positive reasoning, evaluating the situation and challenging the negative thoughts, which as mentioned by participants can encourage alternative thinking. To illustrate, Nadeem provided an example and said:

*“My religion takes my problems away. When I pray, it takes the worldly problems away and puts things into perspective for me. It teaches me that I have a house and a roof and that other people are a lot worse than me and I feel better straight away” (Nadeem-P, 422-424).*

The idea that thoughts, beliefs and behaviours play an important role in influencing the emotions appears to be also grounded in Islamic teaching. Therefore, by identifying the unhelpful thoughts and that other people were worse than him, Nadeem was able to get to crux of the problem, realising that his problem could have been worse and as a result, he was grateful for what he has. The application of religious practices, as mentioned in Table 19, can help Muslim patients discover meaning for their distress and reach a positive interpretation of life events. In fact, there is evidence that using these religious practices in therapy can improve Muslim patients' access and outcomes of therapy as demonstrated by Meer and Mir (2014) and highlighted by many participants in the study. Despite the positive correlation between these religious practices and maintaining good health and emotional wellbeing, some participants pointed out that some non-Muslim therapists were not taking these practices seriously enough. This can affect the willingness of some Muslim patients to engage in therapy.

Participants exhibited different opinions on the subject and responded differently to non-faith adapted therapy. Those who identify themselves as

Religious Practices	What Participants Reported
Reciting and Listening to the Quran acts as a spiritual cure to heal the souls and all types of ailments.	<p>"Quran is medicine and when I read it I feel energised" (Yabaal-S, 800)</p> <p><i>"When I read Quran... It stops me from acting on my thoughts to end my life" (PO-SM13, 75-84)</i></p> <p>"Quran gives you the answers to everything. Whatever phase you are going into in your life... it is holistic and a whole approach that is going to suit you in every way" (Salma-P, 555-563)</p>
Reciting Darood Sharif mainly by Urdu-speaking helps overcome distress. It lifts up the hearts and drive away the darkness of depression, bringing blessing to patients.	<p><i>"When I give daily blessing to the Prophet Mohammed - peace and prayers be upon him - ... the Prophet will bring blessing to my life and I will never be misguided. This gave me strength and power to be able to cross every barrier safely and soundly" (P, 32-36).</i></p> <p><i>"It contains definite affective words... which brings you some kind of strength" (Sabiah-P, 722-724).</i></p>
Dikr is believed to purify the souls, achieve tranquility and peace of mind and heart	<p><i>"When I leave my house I always read ('Bismillahi tawakkaltu 'lallahi la hawla wala quwwata illa billah'- in the name of God, I entrust God in everything and there is no might or power except from God), and I strongly believe when I say this that God will help me... I strongly believe that (Allah) is with me on every single step of my life" (Atiqa-P, 95-99).</i></p>
Praying is a form of mediation. Praying is a state of submission to reap the true benefits of prayer. Praying is an experience of calmness as a result of getting rid of the extra electromagnetic energy with the forehead to the ground, where participants were able to embrace a personal connectedness with God.	<p><i>"Praying... keeps you grounded and keeps you in perspective. It allows you to ask for what that you want" (Nadeem-P, 283-284).</i></p> <p><i>"Whatever you have in your heart you can just release and you know, God knows the way you feel, so you don't even have to explain ... after that you feel fine ...and hopeful because you know that God is hearing and is listening to you" (Y, 452-456).</i></p> <p><i>"I only found peace in (sajdah<sup>1</sup>)... I was on edge... but I only found peace when I was praying... I used to stay in prostration for as long as I could because it was the only time I could feel safe... I actually felt strong... like nothing can touch me... because I felt God was watching over me" (Sabih-P, 674-685).</i></p>
Ruqyah affects the mood as a remedy and a protection from sickness or other problems.	<p><i>"I do ruqyah daily, never miss... The blessing words of God and by repeating them, me and my family will be protected" (Noor-Y, 985-988).</i></p>
Sadaqah helps patients to rise above the difficulties of life.	<p><i>"Two weeks ago I called my brother and he was in hospital and I was really upset... He wasn't able to talk... I gave (sadaqah)... and I said (Allah) help my brother, he is in your protection... and now (mashallah) he is better" (Atiqa-P, 598-611).</i></p>
Fasting during the month of Ramadan satisfies the soul and gives it peace and contentment.	<p><i>"Ramadan is meant to bring blessing in your life and you are blessed by (Allah)." (PO-BH15-39-40).</i></p>

1. An Arabic word means kneeling in prayers but it demonstrates the act of humbleness in front of the creator of the world of worlds and shows gratitude to Allah in the form of prostration.

**Table 19 Religious Practices and Their Influence on Access to Therapy**

highly religious preferred seeking religious consultation and were less likely to access therapy. Other participants avoided discussing their Islamic practices with non-Muslim therapists and continued to use their religion and spiritual coping as an additional source of help. A number of participants reported working successfully with non-Muslim therapists possibly because the latter discussed incorporating the religious coping practices in their therapy or because utilising the Islamic coping strategies was not a main concern.

Participants who required an appreciation of spirituality as a component of therapy believed non-Muslim therapists might find difficulties understanding faith or incorporating Islamic practices in therapy, as pointed out by Yusra:

*“I didn’t feel that she was really able to relate to me. Religiously, obviously she wasn’t a Muslim. She wouldn’t be able to relate to me in that sense and she wasn’t on the same background as me, she wouldn’t understand where I am coming from” (Y, 92-95).*

The concept of believing in the divine and other spiritual elements, as explained in Section 7.2.1, can be quite challenging for some non-Muslim therapists, especially those who are trained to think that such beliefs, for instance in Jinn, are part of a mental illness and must be cured. As a result, Salma believed that non-Muslim therapists may find difficulty addressing religious and spiritual issues explaining that:

*“Sometimes, if they do not believe in religion, they will think what she is on about, why she is bothering, and deep down inside they might not have that understanding and connection towards it because they don’t believe in God” (P, 497-500).*

For that reason, those participants appreciated working with therapists who had an understanding of their religious beliefs and respected the spiritual and religious practices of patients, using these as a tool for treatment. This was evident in several of the observed sessions, in which patients talked openly about their religious beliefs and practices with the Muslim therapist. This is demonstrated in the extract below:

*The participant discusses his religious practices with the Muslim therapist and talks about reading the Quran and specific verses to help*



*him cope with his distress and says: "I am a Muslim... when I am praying I am unable to do kneeling and instead I do it while I am sitting. Praying tend to control my anger... and I look forward to every Morning Prayer. My religion stops me from using the knife, it is (haram<sup>36</sup>)" (PO-PMY12, 153-159).*

As shown above, the patient revealed a number of religious practices that he believed helped him to cope with his distress where in turn the therapist was able to relate to the patient and provide him with appropriate religious advice. The patient went on to acknowledge that having a Muslim therapist made him feel: *"quite relaxed ... because she shared similar ... religious beliefs. This has encouraged me to talk about my religion"* He further admits that: *"I wouldn't have talked about my religion if the therapist wasn't a Muslim"* (PO-PMY12, 206-210).

Having a Muslim counsellor enabled some participants to work within the framework of their religion: *"She was a Muslim and she was wearing (hijab<sup>37</sup>)... When I said it was because of my (hijab), that is my mother was angry at my wearing the (hijab), she could understand obviously how important it is for a Muslim woman to wear (hijab) and how passionate she feels about it"* (Rozena-P, 448-451), and accept advice that would enhance their spiritual inclinations: *"She used to tell me everything is from (Allah) and (Allah) loves those who love Him, she will give me reassurance... and I would feel more comfortable this person could treat me"* (Abyan-S, 431-434)

Two participants admitted that they were looking for an IAPT therapist from the same religious background because as they explained:

*"I wanted them to say this is how you need to use your religion because I kind of lost that focus a little bit and I needed someone to push me again"* (Salma-P, 528-530).

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<sup>36</sup>Haram is anything that is prohibited by the faith.

<sup>37</sup>Hijab means barrier or partition but in Islam it has a broader meaning. It is the principle of modesty and includes behaviour as well as dress for both male and females. Here it means the visible head covering that many Muslim women wear.

*“I went to my GP and I said I want a Muslim counsellor. So my GP said at the moment we don’t have one, but... we could look into it... and I said to him that’s the only way I could get better” (Abyan-S, 375-377)*

In the examples above, participants preferred to work with therapists with a religious background in the hope that they will offer advice that aligns with their Islamic perspectives and offer a service in which they can feel a greater sense of connection and comfort in addressing their issues.

Participants who avoided discussing their Islamic practices with non-Muslim therapists believed the latter might be unable to interpret their religious practices appropriately. Elaborating further on this issue, Sabiha said:

*“There has been a situation where you sometimes went and held back talking about strong beliefs... because you think you will be ridiculed or you might end up offending someone” (P, 799-802)*

In this example, the participant raised two important issues: firstly, she didn’t want to discuss her religious practices because she believed the therapist would not understand her perspectives. Secondly, she assumed the therapist did not believe in God and, therefore, she did not feel comfortable opening up about her views on religious practices fearing she might be ridiculed, or to avoid being in a conflict. Yabaal stressed this last point and said:

*“When I was with the therapist I didn’t go near religion and I didn’t talk about it because I feared getting into an argument about religion” (S, 842)*

The participant in this quote did not want to initiate discussion about his religious beliefs or practices, fearing the likelihood of dispute over such beliefs. Therefore, he took the decision to respect these perceived differences and not to discuss his beliefs. While Momina and Raessa reached the same conclusion, they had a different perspective on the matter. Momina clarified:

*“Us Muslims, when a mother or nearest female relative passes away, we have to have the final wash... I didn’t talk about that, had I talked about that to the therapist, she probably wouldn’t have understood” (Momina-P, 128-133).*

The participant appears to withhold information about her beliefs believing that the non-Muslim therapist might not be able to accommodate her sensitive needs. Similarly, Raessa withheld information about her religious practices but for another reason, as explained below:

*“I just told her that I was doing a bit of reading (patient was pointing to her ḍikr and reciting of Darood Sharif)... but I didn’t tell her what I was reading... because she might think I am stupid in my mind but I wasn’t because everyone does reading” (Raessa-P, 166-171).*

A major factor that influences an individual’s behaviour is their cultural and/or religious practices. Although Raessa recognised the importance of adhering to her religious belief system, she didn’t feel comfortable discussing this with the non-Muslim therapists because she mistakenly feared the therapist would prejudge her faith or consider her mentally unstable. The latter assumption could be related to the fact that many therapists during their practising experience have encountered patients for whom irrational beliefs have genuinely been part of their mental illnesses (Laird et al., 2007; Loewenthal and Lewis, 2011). Those patients use their religion to confuse spiritual experiences with their mental illnesses, which then presents a challenge for the diagnosis. It could also be related to the fact that understanding the role of religion requires therapists to understand the unique meaning it holds for the individual.

On the other hand, several participants reported working successfully with counsellors who were non-Muslims and with whom they did not share faith or world-views. In these encounters, the participants reported having a positive relationship with their therapists, as demonstrated by Pakeeza:

*“It was very helpful because she talked to me about how I feel and explained everything about the panic attack, how it comes on, draw me diagrams and things like that, which helped me so much... She was very understanding” (P, 306-310.).*

Dalal further described her experience and pointed out some objective signs, which helped her to achieve better therapeutic outcomes and said:

“This therapist helped me to put my foot on the right path. I was able to admit that I wasn’t feeling well and that I needed help... She was really good and I really liked her as I was able to feel her honesty and sincerity in doing her job. She didn’t just assess my current mental health and then discharge me. For that reason, I attended many sessions with this therapist and I was able to stay longer in therapy” (Dalal-Y, 184-190).

What is apparent from the participant’s quote is her preference to work with a therapist that demonstrated good communication skills, both verbally and non-verbally, provided practical feedback and made her feel cared for and understood. The good communication skills seemed to be more important than sharing similar religious beliefs, which enabled the participant to connect better with the therapist, and open up about her depression. Yet, as is evident in the examples above, the participants did not refer to any discussions related to religious beliefs in these instances. Reasons for this could be due to their belief that religion was not necessarily related to their reasons for seeking help or they might not have been asked about their religious background.

However, what was noted during the observational sessions was the ability of patients to confide better about their religious beliefs and practices with a Muslim therapist than with a non-Muslim therapist. They often offered information about their religious beliefs and practices without being asked. In their encounters with non-Muslim therapist, this rarely took place. When participants were asked about the reasons, they repeatedly referred to their perceived assumptions that non-Muslim therapists will not understand. Though, in one observation, an older Somali participant was asked about what kept her going in life. She replied:

*“My religion is the main factor... Going to the mosque is quite important for me. I must be with God, nobody can help but God. I do my prayers and manage my pain. It gives me hope that sometime I will be ok” (PO-SM4, 157-162).*

Although the participant believed religion to play a central role in managing her distress, the non-Muslim therapist did not probe further to possibly include these beliefs in the patient’s treatment plan. Upon querying the therapist about

the reasons for not doing this, the therapist said that she was not a faith-based person. She accepted the importance of religion to the patient, but she was only interested with the way the patient used her religious practices as means of protection. However, accepting one's religion is one thing, but showing interest and discussing how it would be applied to offer help and support for the person is another. According to NICE guidelines (2011), enquiring about the individual's religious or spiritual beliefs and incorporating these into the treatment plan can facilitate the understanding of the patient and improve engagement with therapy. Participants emphasised the need for therapists to have an awareness and understanding of their Islamic faith and use spiritual approaches that are congruent with Islamic practices to improve the outcome of therapy.

To understand the complexities involved within these encounters, the following case will illustrate how the different practices – a non-Muslim therapist compared to a Muslim therapist – affected the interaction and outcome of therapy for a Somali female participant.

#### **7.2.4 Case 4: Implications of Therapist's Religious Understanding on Access to Therapy**

Abyan is a married Arabic-speaking Somali female, aged thirty years old, who is able to communicate in English. She came to the UK when she was fourteen years old to be treated after she had a stroke. She lived with her grandmother and completed her education in the UK. As a young girl, she was raped by a relative but never had the opportunity to tell of the incident with anyone. She was diagnosed with depression and other mental health issues but later decided to study psychology in order to be able to counsel herself.

Her problem began when she started questioning the purpose of life. She had a dream that the Prophet – peace and blessing be upon him – told her that she had a mission in life and then disappeared. She woke up screaming, was admitted to hospital where the doctors believed she had a shock. She was discharged from the hospital but her situation became worse. Her family, attributing the problem to a religious cause and suspecting she was possessed by Jinn, decided to take her to London to see an Imam. During the religious

ritual, the reading of Quran brought her a great deal of comfort and calmness, such that she believed she was able to smell the scents of Paradise. The Imam confirmed that she was not possessed by Jinn and there was nothing wrong with her. However, as she continued to experience panic, she was admitted to hospital again and given medication before she was discharged.

As she became older, Abyan continued to experience panic and feel depressed but, at the same time, she wanted to treat herself through talking therapy. She wanted to work with someone who was able to provide a religious perspective based on Islamic teachings. Therefore, she asked her GP to refer her to a therapist. The GP sent her to a non-Muslim therapist but according to Abyan: *“she was not what I wanted, that wasn’t healing me... and I wanted something different” (348-350).*

Abyan believed that the therapist lacked experience. She also believed the therapist was not passionate about her work. Therefore, she went back to her GP and insisted on being referred to a Muslim therapist. Due to the nature of her problem, Abyan also preferred to work with a female Muslim counsellor. She specified the reasons for her decision:

*“The reason why I needed a Muslim counsellor, first...the role of religion where she could use her expertise and knowledge of religion and advise me of what I could do and how I could treat myself. Plus, she is a Muslim so I can trust her... She could tell you so many other things and you would feel comfortable. Also, she has the expertise so I think she could treat me” (380-385).*

Abyan believed understanding of religious beliefs, use of faith-sensitive coping strategies, and sharing of religious backgrounds were all qualities that allowed her to benefit and work better with the Muslim therapist. For instance, when she met with the Muslim therapist for the first time, she described her reactions when the therapist greeted her using Islamic greetings and said:

*“When I heard the therapist saying Salam Alaikum, I thought oh my God! Then she asked me why I think a Muslim counsellor will work better with me... and I liked that because the first therapist didn’t ask me how important it was for me to get help” (409-413).*

The exchange of a simple Islamic greeting with the Muslim therapist had an immediate effect on Abyan because, as a Muslim, she acknowledges that the return of the greeting is a religious duty. Additionally, the therapist enquiring about what help Abyan was expecting enabled her to connect better with the Muslim therapist and made a good first impression, unlike her earlier experience with the non-Muslim therapist:

*“When I was with the non-Muslim therapist... I didn’t have that connection with her... and she wasn’t for me” (571-577).*

Abyan went on to compare her two experiences of therapy and said that one of the problems she encountered with the non-Muslim therapist was the inability of the latter to understand her religious beliefs and practices such as her feelings of comfort when reading Quran or praying. Abyan recalled a session where she told the non-Muslim therapist about Qiyam-ul-layl<sup>38</sup>:

*“I told her what usually help me is doing my night prayer... (Qiyam-ul-layl), but she couldn’t understand, she said I know that you normally pray five times a day so is this prayer the last prayer and I said no. I said this prayer you could spend most of the night in praying and worshipping God. But, it was really difficult to explain to her [that] as Muslims, we know one of the healing things is to do (Qiyam-ul-layl)” (988-993).*

Abyan demonstrates how the non-Muslim therapist’s unfamiliarity with her religious belief system prevented her from opening up or giving further details about her problem. In comparison, Abyan reported that working with the Muslim therapist who shared similar religious beliefs, offered her consolation, meaning and understanding and said:

*“It was quite easy to explain to the Muslim therapist as she was able not only to understand but also to tell me to read specific prayers. Also, when I used to tell my Muslim therapist that I forgot to read my (ḍikr), she was able to calm me down and tell me not to worry and that (Allah) is taking care of me. There is a lot of difference when you tell the person*

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<sup>38</sup> Qiyam-ul-layal is spending part or whole of the night performing worship such as reading Quran and praying, and its rewards and spiritual merits are emphasised in Muslim scripture.

*that you forget to do your morning ḍikr and the therapist says and what is that?” (1001-1006).*

Moreover, Abyan was unable initially to deal with the subject of rape due to the nature and stigma of the subject in her culture. However, when she discussed it with her Muslim therapist, the latter using and emphasising the teaching and principles of Islam, enabled Abyan to relate more to her religion and understand her grief through the belief system of Islam:

*“She used to tell me that everything is predestined by God and (Allah) loves those who love him... She will give me assurance... She will tell me that Allah tests those whom he loves and whatever happened, there is a reason behind it” (432-436).*

Furthermore, Abyan pointed out that the Muslim therapist used the religious and spiritual strategies of her faith, which enabled her to cope with her depression and to have better outcomes for healing her wounds:

*“I used to have tummy upset and it used to hurt me... When I got raped, it was sort of related to that area... The Muslim therapist told me we need to heal that and the way to heal that is to read Quran and use (zamzam) water to clean it. So would you expect that to happen with the other counsellor? Not in a million years! ...But I used to do that and it healed me like I had no pain” (584-592).*

Abyan stated that her mental health issues were entangled with her religious beliefs and that without the ability to take these into consideration, she would not be able to get the help needed to overcome her problems. She added that the Muslim therapist was able to talk her through her pain by telling her that *“All of us have a message and a purpose, and each person should understand what his purpose is. Unless you understand that, there is no point thinking about why this happened to me. Otherwise, you are stopping God’s destiny, because Allah knows why it happened” (943-947).* Through this explanation, Abyan was able to understand that whatever happened to her has been predestined by God and He made the best plan for her. Abyan summarised the importance of religion, saying: *“Sometimes we look for answers and*



*sometimes we can't get the answers, but when we look back to our religion – what makes us – it is our religion which makes us” (1038-1040).*

The integration of religious beliefs and practices into therapy to manage the emotional well-being problems of the patient was essential in this case. Through the help of the Muslim therapist, the participant reported that she was able to explore alternative coping strategies that were more effective and appropriate in dealing with her issues, which were entangled with her religion and culture.

Religion allowed participants to have a sense of peace, purpose and meaning of life, and taught them how to overcome the difficulties of life through the reading of Quranic verses and learning from the Prophet's stories. Additionally, religion provided participants with a source of identity, which enabled them to regulate their behaviour. In times of hardship, religion gave self-discipline and empowerment to participants to better deal with the trials of life. Moreover, religion provided participants with answers to all questions related to their existence. In particular, answers within the supernatural offered causes for their experiences, which lie beyond their control. Participants believed the religious practices offered them a channel through which to focus and think positively about life events, stopped them from drowning in their sorrows and provided a better way to deal with their fears and to feel safe. Therefore, many participants believed working with Muslim therapists provided more person-centred care for them where they were able to use Islamic teachings in conjunction with Western medical care, improving access to therapy.

### **7.3 Summary**

The relationship between culture and religion is complex. In many cases, it is difficult to separate them as the understanding of both is highly important in therapeutic encounters. Participants demonstrated how spiritual and religious beliefs are entangled with cultural views, and cannot be understood in isolation from culture. This is because the interpretations of the belief systems are often shaped by the local culture, and practices are often expressed by language. The way participants used language to connect to their emotions and talk about their feelings varied, with contribution from both their cultural frame as

well as their individual perception of the lived experience (Sections 7.1, 7.2.1, 7.2.2). For example, some participants believed that major incidents that took place in their life were predestined by God and that, with the help of God, they were able to manage their difficulties. Others related their distress to cultural impacts such as being a divorcee or as a result of living in a joint family. The ways in which participants used language to emphasise these feelings were likely beyond comprehension to some non-Muslim therapists, because they were unable to see through the same cultural frame of the community groups, or understand what being part of it means. For that reason, many participants struggled to negotiate the meaning of their cultural or religious beliefs to non-Muslim therapists – whether interpretable or not – and highlighted the need for non-Muslim therapists to develop an awareness of the differences between cultural beliefs and religious views when working with them. In addition to these challenges, the Arabic language, being the language of Quran, is used by followers during prayer and supplication, and is the language in which the Quran is written and recited, sometimes without a full understanding of the meaning by non-Arabic speakers (Section 7.2.3, Table 19). This raises questions, such as, how were these religious practices understood during the absence of a common language. In the next chapter, these questions and the role of language in therapeutic encounters are taken into consideration to explore what it means in such contexts.

## Chapter Eight

### Communicating Emotions in Therapeutic Encounters

#### 8.0 Introduction

As reported by participants, language involving verbal and non-verbal communication played an important role in communicating their emotions in therapeutic settings. Emotional expressions are often shaped by cultural practices and are revealed through cultural norms and behaviours, which in turn regulate the way individuals express their emotions in a particular situation. As a result, it is difficult to separate language from culture, and the understanding of both is equally important for therapists to achieve better understandings in therapeutic encounters.

Since language and culture are intertwined, this may cause misunderstanding over meanings between therapists and PSY patients and the ability for therapists to understand the emotions as articulated by patients becomes a difficult task. This is because language often fails to express the complexity of one's emotion or can build more complex meanings of the emotions through the use of words. In addition, because language is dynamic, words can change their meanings over time and new words can be either borrowed or created which can cause further difficulties in understanding during therapeutic encounters.

Taking all this into consideration, this chapter focuses on participants' use of language in therapeutic encounters. The relationship between language and the articulation of emotions is explored. Firstly, the main role of language in therapeutic sessions is outlined. Then, linguistic compatibility and incompatibility and the impact of words on the expression of emotions in therapeutic encounters is examined. Finally, the barriers to the communication of emotions, mainly English as a second language (ESL), code switching, borrowed and loan words, untranslatability and non-equivalence of cultural and religious terms, and the role of interpreters in understanding and conveying the expression of emotions are explored. Taking into account the latter, two cases are presented from the researcher's observations that draw on her personal insight, which she shared with some participants, to enable a

deeper exploration of the challenges surrounding the expression of emotions through a third person in a triadic relationship.

## **8.1 Language as a Tool of Communication in Therapeutic Settings**

Participants reported using both verbal and non-verbal communication to communicate their emotions and distress. This mainly happened in three ways: by describing their physical symptoms, displaying appropriate emotions and articulating emotional expressions.

### **8.1.1 Language and the Description of Physical Symptoms**

People use language to describe their physical symptoms or interpret their symptoms of distress as physical illness to therapists. For example, when patients were asked about their problems or feelings, patients were more likely to describe physical or bodily sensation:

“I feel overwhelmed with strong tightness in the chest... when I am upset, the tightness in my chest feels like something is raging inside me” (POYL14, 48-51)

*“I have lots of shoulder pain. My blood pressure has been high and I am unable to do anything” (POPI16, 74-75)*

“I feel very sad. I feel something has happened in my heart. I start crying and then I will not feel like ...doing anything ...and I don't sleep” (Kausar-P, 188-190)

“I felt my head is going to blow off” (PO-YA8b, 77)

The experience of psychological distress in the form of physical symptoms is not uncommon and in fact, it has been recognised as a commonly encountered problem in primary health care. Yet, patients may find difficulty describing their physical symptoms using the PHQ. This is because either it leaves no room for details on the severity of their symptoms, or the description of their physical symptoms might be hard to translate into other languages as they often relate to specific concepts within a culture, which the PHQ does not take into account. Mehadi elaborated further on this saying:

*“If I use the Somali language... the sort of words is not even fitting... to the description... if I say it in English. If we have three levels like high, middle and low, the middle word in English will be quite low in Somali” (S, 428-436).*

Therefore, as explained in Section 6.2.2.1, several participants considered the PHQ as an obstacle to expressing their emotions in more depth.

Unlike the PHQ, participants reported that describing their physical symptoms using metaphors and/or somatic and bodily references, facilitated the expression of their emotions. This could be related to the fact that the understanding of illness is often shaped by cultural beliefs, which can affect the expression of somatic and psychological illness. To illustrate, the initial analysis of participants’ contributions indicated that many participants commonly referred to their distress using specific bodily complaints. In particular, they repeatedly referred to their hearts, heads, and chests when talking about their feelings. These physical references appears to reflect Islamic teachings, where participants, as stated in Chapter 7, believe illness and health to have a spiritual and physical dimension. Hence, many participants believed that for their hearts to find rest and assurance, they needed to purify their souls, as highlighted by Raessa:

*“I need to get this feeling out of my body... when we clean our hearts, (Allah) clean our souls” (Raessa-P, 20-29).*

However, the description of somatic symptoms might be difficult for therapists to understand for many reasons. Firstly, many terms related to the expression of physical distress, such as worry or poor sleep, may be indicative of mental distress but may also be used to describe other behaviours. Secondly, the concepts and terminology of physical symptoms and descriptions may have a different meaning in Western terminology where therapists might be unlikely to recognise the more specific cultural significance related to the description of physical symptoms or to understand patients’ meanings. Lastly, although many research participants identified certain physical complaints as indicators of early symptoms of depression, therapists should not prejudge the meaning of claimed physical symptoms or judge patients from all community groups

according to some generalisation. While it is important to understand the relationship that may exist between physical complaints and mental health, some bodily complaints can be a sign of a real physical illness that needs immediate medical attention as illustrated by Rabab:

*“Sometimes they don’t know about... health problems, what is going in your body... You know that you’ve got a physical problem, they don’t believe in you... They kept saying it is in your head, which is not... it is in my body... It was a bad experience with my gallbladder where I used to be sent to the hospital... I used to say there is something you can’t touch, and they used to say no, it is in your head... You are stressed or because you are alone... Everything I used to say, they used to refer without even looking or investigating to a mental health problem, which affected me mentally” (Rabab-Y, 121-134).*

Here, Rabab refers to her physical problems, which eventually impacted on her emotional wellbeing because, as pointed out by Rabab, they were not addressed properly by the GP or therapist. It could be that Rabab had difficulty explaining the symptoms, which led the physical complaints to be disregarded and treated with tranquilisers. As for the therapist, possibly attributed Rabab’s physical complaints to stress due to ineffective communication.

While Rabab’s story relates mostly to the insufficient attention payed to symptoms from the GP and therapist, the story also drew attention to the communication barriers due to language differences in how different ethnic groups may describe their symptoms. The inability of health professionals to effectively communicate with different ethnic groups can prevent the latter from accurately explaining their problems or receiving the appropriate treatment.

### **8.1.2 The Expression of Emotions through Paralanguage and Non-verbal Communication**

Participants used different modes of non-verbal communication in combination with the verbal message in order to interact with therapists and share information. The paralanguage and non-verbal communication adds depth to the interaction with therapists and in some cases, influences the therapeutic relationship between therapists and patients. Non-verbal communications

include facial expressions, smiling, eye contact, head nodding, hand gestures and body postural positions. Paralanguage communications include speech characteristics such as speech rates, loudness, pitch, pauses and interruptions.

Non-verbal communications convey affective and emotional information and were used by participants to reflect their illness state by giving cues relating to the physical pain or psychological distress, take over the communication, for example, when patients were tearful, and accompany the linguistic expression and give context to words.

Participants displayed certain gestures and bodily movements during their interactions with therapists, which were noted during participants' observations. For example, it was noted during PO-BH15 that the participant pointed towards his head when referring to his inability to concentrate, stating "My life problem" (190). Also, he put his hand on his heart to indicate he has palpitations and that his heart was beating fast. Similarly, in PO-SM18, it was noted that the participant exhibited certain bodily movements and posture, indicating his distress. The participant's hands were shaking continuously, and he was sitting uncomfortably and with tears in his eyes as he recalled his trauma:

"My friends died in the war, the government opened fire against us... Only two of us survived and we surrender to the government. I travelled to many countries on foot and I had nothing but a dry piece of bread... being and living with these problems, I am unable to say anything. I am just tired" (PO-SM18, 137-145).

After some time, the participant started to breathe heavily and began to cry loudly, repeating he was unable to continue talking. He clutched his clothes and looked faint, which were all expressive signs of his distress.

Sitting and standing up were other postures used by a few participants to communicate their feelings. For example, PO-SN4 who, is elderly and suffers from back pain, had to stand up on many occasions during the session as a result of her pain. These behaviours were exacerbated by her distress as she

was quite upset about the impact of physical problems on her day-to-day life and stated:

*“I used to be strong... but I can only do what I can now... When I look back at what I used to do, it hurts me” (PO-SN4, 183-188).*

On the other hand, the therapist in PO-YS17 tried to talk the patient through the online computerised programme despite the latter’s inability to use it due to her learning disability as discussed in Case 1, Section 6.2.5. As a result, the patient leaned back in her chair and crossed her hands sighing every now and then to show frustration, which could be attributed either to the therapist’s non-understanding or to the participant’s own disability (100-104).

Paralanguage, such as the pitch, volume and rate of speech was used by participants to convey their emotional reactions during the observational sessions and interviews, which helped them to convey their meanings. For instance, PO-YA6 attended therapy for anger management reasons after he had been stabbed by his ex-partner and her friends. Because he was depressed, the GP referred him for therapy to give him the opportunity to open up. The patient took the opportunity to relay his anger through his tone of voice that was intensified with his choice of lexis and was indicative of his feelings of anger about the incident:

*“The police are not doing the right thing, they came to the hospital once, took my statement but they didn’t do anything as if they don’t care... What has happened affected me mentally... I will take revenge. I don’t have fears... I couldn’t take this out of my head” (PO-YA19, 61-67).*

The paralanguage and non-verbal communication, helped the patient to express his emotions, support his verbal messages, and communicate his interpersonal relations during the session.

Participants in the interviews also reported how they perceived the way therapists themselves used the different modes of non-verbal communication to interact with them and stated that they use this form of observation to evaluate their interactions with therapists. They pointed out that non-verbal communication that involved empathy, understanding and respect such as



keeping eye contact, listening, and smiling allowed them to open up and exchange information with therapists, as demonstrated by a questionnaire respondent:

“I wasn’t able to express my emotional feelings but what was really important to me was the non-verbal communication exhibited by the therapist which showed her interest. She paid attention to what I was saying and kept eye contact and interest in my story, which was quite important to me” (Q1, 21-25).

The respondent believes eye contact is highly expressive, possibly as an indication of respect and a sign that her speech is important.

Many participants pointed out that listening by focusing on and paying attention to what patients are saying, conveyed a message of openness. For example, Momina said: *“the therapist was caring... because she let me talk... It is very important... to be quiet and to listen to that person and show that you are interested”* (P, 156-158).

On the positive side, smiling was also reported to affect patients’ mood positively and to help them feel better:

*“When a therapist smiles that could give the person relief because it makes the person feels welcome”* (Noor-Y, 892-893).

Similarly, during observed sessions when therapists displayed certain non-verbal communication that was empathetic towards participants, they were more likely to open up and engage in a meaningful conversation. For instance, when PO-SN4 was quite upset because she was no longer able to perform normal activities as she used to, the therapist didn’t say much but approached the participant and touched her hand to calm her down (185). Touching hands in this context fostered a feeling of closeness and empathy between therapist and participant.

On the other hand, several participants reported that when non-verbal communications were ambiguous, this created a distance between them and their therapists and made them feel less trusting and less willing to talk. Such

non-verbal communication includes facial expression, nodding, rushing and silence.

Facial expression and nodding the head are indicators of feeling connected with other people and can increase the feeling of closeness. However, as explained in Section 6.2.4.1, Sabiha was unable to experience such connection with her therapist as the latter did not show any facial expression, which made Sabiha feels uncomfortable. Also, while Sabiha interpreted nodding as agreement, giving feedback, and showing support, Yusra believed that the therapist's head-nodding was a mechanical tool to signal her to continue the conversation rather than a sign of understanding, which led her eventually to disengage from therapy (Section 6.2.41).

Similarly, rushing patients to talk about their problems, affected the ability of some participants, like Dalal, to engage effectively in therapy:

“I felt she was taking things hastily. She was always in a hurry. She didn't give me time and ask me questions like the previous therapist... such as how I was feeling, how my day was... then gradually move to the next topic... I wasn't able to talk like that, I didn't know what to say” (Dalal-Y, 255-260).

The participant believed the therapist's behaviour in putting pressure on the patient to talk about their problems and focusing on getting through the session, to be ill-considered and a hindrance to the therapist-patient relationship.

Silence in therapeutic encounters is also an important indicator that can communicate the dynamics between therapists and patients and affect therapeutic settings. During PO-YS17, silence was observed to dominate the session at the start. Initially, it seemed that the therapist was using the silence to give herself the space to understand, reflect on the patient's responses and think about the process of therapy (52-54). However, as the moments of silence became prolonged during the interaction, the patient was noted to feel uncomfortable and distant from the therapist. At one point, the patient broke the silence and said:

*“I had a problem with my partner because I keep talking about the past... Sometimes I need to hide my tears and act as if nothing happened and act as normal” (56-60).*

Yet, the therapist did not take the opportunity to ask for further clarification. Instead, she continued to talk about the different therapeutic approaches on offer. Because therapeutic approaches on offer were unsuitable for the patient as explained in Section 6.2.5, the patient was observed to be disinterested through her non-verbal behaviour ‘*crossing her hands*’ (100), ‘*patient looks thoughtful, taking her hair back, sighs and looks at the booklet*’ (116-117). The participant completely shut down and disengaged from therapy requesting to leave.

Non-verbal communication clearly plays an important and dual role in patients’ encounters with therapists. On one hand, it helped participants to express their emotions and make sense of their experiences throughout their interactions with therapists. On the other, it provided them with another way of understanding their relationships with therapists and establishing rapport with them. Non-verbal communication cues were also used to evaluate therapists’ understanding or misunderstanding of patients’ emotions, and to judge their responses to patients’ emotions.

### **8.1.3 Emotional Expressions and their Meanings**

Participants expressed their emotions during therapeutic encounters through the use of idioms of distress native to their own languages. Although all groups of participants generally used similar emotional words to describe their feelings and distress, they varied in the way they expressed their meanings. For instance, several Pakistani expressed themselves by quoting words and verses from the Quran and Hadith. Two Somali participants used analogies to explain meanings. Finally, some Yemeni participants used proverbs, similes and metaphors to convey their meanings.

Therefore, this section aims to shed light on the rhetorical strategies that PSY participants used to express their emotions

Participants used a number of emotional expressions when talking about their distress. One of the key themes is poor mental health as craziness. Some participants as demonstrated in Table (20), described themselves as being ‘mad’, ‘crazy’ and ‘mental’ possibly because of the negative thoughts they had, which made them feel out of control or embarrassed about their actions. In fact, one participant developed a negative sense of the self as ‘crazy’, using the metaphor ‘his emotions run away’ (Yabaal-S, 802). This expression is usually associated with materials and indicates the participant’s understanding of the relationship between poor mental health and instability of emotions.

<b>Theme</b>
Poor Mental Health as Craziness
<b>Emotional Expression</b>
<i>“I don’t know if I am going crazy, the thoughts in my head, I don’t know where they are coming from” (PO-PMY12, 74-75).</i>
<i>“I feel I am mental now if I live in home here, I think about things with my kids and the problems” (Maleeha-P, 174-175).</i>
“Most of the time I am preoccupied with thoughts about going to be mad” (PO-YR8a, 48).
“If the man is crazy, his emotions will run away from him” (Yabaal-S, 802).
“I normally talk to myself but then I feel embarrassed and try to find out if anyone around saw me but my children say there is no one. But I try to say I am not crazy” (PO-YG11, 86-88).
<i>“Sometimes I end up talking to myself in the head” (PO-YS17, 152).</i>

**Table 20 Mental Health as Crazy**

Similar to Yabaal, Dalal believed physical illnesses can be medicated and treated but it is quite difficult to heal the soul from prolonged years of traumatic events because as she clarified: “A person might reach a certain point of recovery but he will still have some cracks” (Dalal-Y, 630). While cracks might be fixed, they will always be a point of weakness. Similarly, the person might recover and seem healthy from the outside, but from the inside, he could break into pieces quite easily. Several participants used metaphors to describe their depression, as shown in Table (21). Here, several participants used metaphors to show the intensity of their depression and their understanding of its effect on them.

<b>Theme</b> Articulations of Depression
<b>Emotional Expressions</b> “ ما أعرفش زي كأنه عتشش داخلي – It is like depression has a nest inside me... and I feel like something is holding me from inside” (Aliyah-Y, 487- 616).
<i>“This massive web that I had in my head, I wanted to try to get out of it” (Sabiha-P, 219).</i>
<i>“I thought I am dying... I got scared of death” (Pakeeza-P, 236 - 255).</i>
<i>“I used to do lots of gardening and I used to love roses... but now my roses are dying... and my world is just me and my thoughts” (PO-PMY12, 147-150).</i>
<i>“I lost interest in life and I can’t enjoy anything... When my daughter opens the curtain to bring light in, I shut them again as I want to stay in the darkness... غلقت نفسي من كل شئ - My soul no longer able to take things in” (PO-YA5a, 83-88).</i>

**Table 21 Articulations of Depression**

For instance, Aliyah and Sabiha drew on metaphors that evoked images of birds and insects that had settled inside them or have trapped negative thoughts in their heads to express their emotions and this helped them to build meaning out of their depression. Another example used by a participant was that of a dying roses that receive no care. In cases of depression, participants reported feelings of despair as outlined in Table (22).

<b>Theme</b> Feeling of Despair
<b>Emotional Expressions</b> <i>“I am stuck in the past and I can’t move from that past. I am stuck in that circle and I can’t seem to move forward” (PO-YS17, 31-33).</i>
<i>“I felt strangled and someone is holding a blade and keeps poking me” (Azhar-Y, 263).</i>
<i>“I escaped hell to go to a bigger hell” (Dalal-Y, 71).</i>
<i>“I came to England to escape death but I found myself face to face with death” (Jamil-Y, 47).</i>
<i>“It was like being given a black canvas and being asked where would you like to start” (Sabiha-P, 217).</i>
<i>“I knew I was thrown into fire... I drowned my own self because of my wrong religious thinking” (Rozena-P, 677- 691).</i>

**Table 22 Feelings of Despair**

As shown in Table (22), some participants used different lexical items to show their despair and inability to do anything. Words like ‘stuck’, ‘strangled’, ‘hell’, ‘black’ and ‘fire’ all convey the meaning of helplessness and endless suffering. One reason for the tendency to use such negative terms might be participants’ inability to see light through their apprehensive thoughts. Other participants used proverbs and metaphors to describe their emotions possibly because they communicate feelings in a lucid and concise fashion.

Participants who were experiencing discomfort with situations that may not be observable to others acknowledged the need to talk about their problems and open up to release the pain in their hearts, as shown in Table (23). Those participants used proverbs from their cultures and metaphorical language to give depth to their description of their feelings, which brought together explicit as well as implicit meanings of idiom of distress, as demonstrated by Azhar’s quote.

<b>Theme</b>
Acknowledging Experiences of Discomfort
<b>Emotional Feelings</b>
“Because of life’s stressors ...everyone keep things in his heart as much as he can but how much one can take in?... الحبل لما يمتلي بالله ما يتسع - When the washing line is full, you can’t add no more” (Azhar-Y, 81-90).
“A good analogy will be you kind of bottled it up and towards the end, the bottle just pops, the lid comes off and you kind of wow! What’s going on?” (Mehdi-S, 103-105).
“A drowning man will clutch a straw” (Dalal-Y, 654).
“I needed someone to put me back on track to where I have fallen off” (Sabiha-P, 553).
“I needed to get this feeling out of my body... When we clean our hearts, Allah will clean our souls” (Raessa-P, 29-30).

**Table 23 Acknowledging Experiences of Discomfort**

The Somali participants tended to favour the use of analogies in their expression of emotions to convey an accurate idea of their circumstances. For example, by pointing out the massive fizzy mess created by a bottle of soda when unscrewing its cap, Mehdi drew attention to the uncomfortable feelings of holding things in. Other participants used lexical items to denote their emotions, such as the choice of the words ‘clean’, which suggests a need to sort out the clutter and muddle in a person’s life, and ‘put back on track’, which

suggests that there is a track that the person was previously on (Beaver, 2001). Although many participants acknowledged the need to tell professionals or people around them about how they felt, a number of participants had difficulty talking about their experiences and when they did, their pain was palpable, as outlined in Table (24). The examples in Table (24) show how the combination of certain words together, in this instance, ‘*dug*’, ‘*deep*’ and ‘*wound*’ can add more details and make the effect more vivid. Thus, participants, in using the word ‘*wounds*’ metaphorically, are referring to unpleasant experiences. The similarity between the phrases ‘*can of worms*’ and ‘*kept the past in the box*’ is that both refer to the hidden, but once they are open, it is difficult to re-contain them. For that reason, participants did not want to talk about their grief.

<b>Theme</b>
Difficulty Opening Up and Dealing with Psychological Wounds
<b>Emotional Expressions</b>
“He dug so deeply in my wounds ...and brought out all the hidden things that I have been hiding for so long” (Jamil-Y, 304-306).
<i>“The session I had, it really dug up everything that I had already buried” (Sabiha-P, 368).</i>
<i>“It opens the wounds and it just makes you remember things” (Raessa-P, 115).</i>
<i>“Sometimes when you talk about things then it opens a can of worms with loads more.” (Salma-P, 389-390)</i>
<i>“I kept things from the past in a box and I didn’t talk about it... It is ruining my life and I need to sort myself first” (PO-YS17, 48-50).</i>

**Table 24 Difficulty Opening Up and Dealing with Psychological Wounds**

Instead many participants sought refuge in spirituality and religion and expressed their emotions through this channel, as shown in Table (25). Citation of religious beliefs and references to faith practices which helped participants to overcome distress can be seen in those participants’ language use. For example, Yusra used the words ‘*lift up*’ metaphorically when describing spirituality as a life saver for desperate people like herself. Having confronted a troubling experience in life, Abyan used the word ‘*new chapter*’ to indicate turning the page over and directing her attentions to fill new pages in her life. Moreover, Yabaal linked his emotions to the engine of the vehicle,

which if it stops working, the car will stop. Similarly, he believed when individuals have problems in their hearts, they need to recite the Quran as this will boost their energy and they will be able to confront the difficulties of life. He drew on the word 'faulty', which is normally associated with machines to construct his meaning. The choices of words and phrases narrated by participants to express their emotions about the spiritual coping strategies were quite rich in meanings, as shown in Table (25) and outlined in Section 7.2.2 and 7.2.3.

<b>Theme</b>
Taking Refuge in Spirituality
<b>Emotional Expressions</b>
<i>"When I was going down I needed to lift myself up spiritually" (Yusra-Y, 118).</i>
<i>"It was a new chapter in my life, a clean chapter that has not been discussed with my soul or felt ashamed of" (Abyan-S, 468-469).</i>
<i>"(Quran) is medicine, when you are a little faulty, you begin to run and you feel you are healthy" (Yabaal-S, 795-796).</i>
<i>"Darood Sharif give me lots of (skoon), it is like I am sitting in Heaven" (Raessa-P, 41).</i>

**Table 25 Spirituality and Emotions**

Several participants also believed using other therapeutic techniques such as games, word meanings, and storytelling to be enriching. Through the use of specific descriptive words, some participants felt more able to label and express their emotions. According to Corn (2000), these creative therapeutic methods stimulate patients to express their feelings succinctly where simply talking is not expressive enough, either due to limited language or other communication difficulties. As illustrated in Section 6.2.3, Rozena (P, 382-398) believed the stone game enabled her to have better self-awareness and interact more effectively with the therapist. Likewise, because Abyan was raped by a relative but never had the opportunity to open up, her therapist encouraged her to write about her emotional experience and the ups and downs she faced during her life. This made Abyan feel empowered and liberated and enabled her move on and start a new chapter of her life, as she explained:



*“I wrote a poem about my feelings and I wrote a lot about that guy, the person... It helps you a lot to express everything and to put it into words” (Abyan-S, 856-860).*

It appears that when Abyan wrote about her feelings, she was not only able to explore her thoughts and emotions, but also she set up processes of semiotic connection, which promoted change and knowledge, and linked together the emotional memories.

In like manner, other participants, like Momina, who lost her mother and sister to severe illnesses, believed defining the emotional terms she held for her mother and sister helped her to talk about her emotions and allowed her to understand her painful memories. For example, she explained what words such as ‘comfort’ meant for her and said:

*“Comfort for me is that the loved ones that I lost are in a better place and that I will see them” (Momina-P, 307-308).*

A close analysis of the way in which PSY participants expressed their emotions in this section reveals the metaphorical and rhetorical traditions unique to each of the participants’ personal and cultural backgrounds. PSY communities make plentiful use of idioms of distress and folk sayings when making mental complaints, as opposed to Westerners, who are more direct. For these communities, such symbolic expressions, often unique to a subculture and not understood by all speakers of the language, offer a satisfying method of self-expression. Therefore, understanding the use and meaning of these idioms of distress from the perspective of the sufferer is one step towards a more satisfying therapist-patient interaction in therapy.

Since the manifestation of distress is unique to a particular person or cultural background, in the following section, the researcher explores how certain linguistic features can create a sense of identity.

#### **8.1.4 Communication of Emotion and the Development of Identity**

The influence of the collectivist ethos that PSY groups largely belonged to, contributed to the construction of participants’ identity and how they communicated with therapists, who are mostly individualistic (Sections 3.2.1.2

and 3.5). During the expression of emotional suffering using words, physical complaints, gestures and images, participants, consciously or unconsciously, reflected about themselves and their identity. This involved the effect on the patient's openness to emotional expression due to the therapist's way of dressing, cultural, religious, ethnic and racial backgrounds, as well as use of proverbs and analogies, and also references to imposed identities and othering. As a result, participants were able to create a unique impression of their self as members of a whole group; their subjective reports containing self-representations revealed different layers of identity (Sections 7.1, 7.1.3, and 7.2.2).

#### **8.1.4.1 Emotional response to Items of Clothing**

The choice of a therapist's clothes, such as the hijab for Muslim women, affected the emotional state of several participants, particularly those who had an encounter with a Muslim therapist as demonstrated in Case 3, Section 7.1.6. Those participants believed the visual display of Muslim clothes created a sense of belonging, a personal identity and a powerful cultural/religious expression of the self as explained by Rozena:

*"She was an Arab Muslim woman and she was wearing a (hijab), so she could understand me better when I told her about the (hijab), like why I want to wear it" (Rozena-P, 407-412).*

Revealing the therapist's Muslim identity through the visually displaying of the hijab reflects positively in Rozena who identify easily with the therapist and open up more comfortably about her emotions.

#### **8.1.4.2 Reference to Ethnic, Cultural, Religious and Social Class Identities**

In therapy settings, participants drew on their culture, religion and ethnicity while talking about their emotions, as discussed earlier in Sections 7.1, 7.1.3, 7.2.2 and 8.1.2. For those participants, these factors provided them with a sense of identity, enabling them to understand their emotions in specific contexts. For example, the sense of belonging from recognising the therapist to belong to a similar racial or ethnic group can allow a person to cope with

his/her emotions and feel connected with a therapist. Mehdi, who identified himself as a black person elaborated further on this said:

*“If I walked into a room where somebody is black, I will have a sense of belonging, even if I come to the centre today and there was one black therapist and ten others who are white, I will still have a sense of belonging... because this will put me at ease” (Mehdi-S, 398-403).*

According to Mehdi, sameness would have put him at ease to express his emotions comfortably even before therapy had begun.

#### **8.1.4.3 Proverbs and Analogies**

The use of idioms of distress in the form of proverbs and analogies, as explained in Section 8.1.2, Table (22) was another way that helped participants construct their identities and express their emotions. Proverbs often contain emotional references and relate to a certain culture, which can give insight into the social and moral values, and geographical origins of the individual and the group they belong to. The following is an example by Yabaal:

*“If you have a crazy man today and you gave him a lot of money, he will be happy with his life” (Yabaal-S, 613-614).*

In this example, Yabaal is trying to develop a sense of the self and understand the causes of mental illnesses through this analogy from Somalia, drawing attention to two points: the harsh judgement on those with mental distress, and the poverty in Somalia caused by war and its impact on people. Yabaal draws a parallel between the crazy man and the conflict in Somalia, and implies that in his country, money is the foremost way to improve the situation politically, and in the case of the ‘*crazy man*’, improve his mental health.

#### **8.1.4.4 Imposed Identities and Othering**

Participants were comfortable choosing their own words and phrases to describe themselves and express their identities. However, they pointed out how the negative words or labels imposed by others, like community groups and therapists, can affect them, which in turn can create a sense of

apprehension amongst participants and affect their emotional wellbeing. For example, many participants pointed out how being labelled as ‘*crazy*’ or ‘*mentally unwell*’ and ‘*depressed*’ carried certain negative markers of disgrace and significantly impacted on their access to therapy (Section 7.1):

*“One of the cultural difficulties to approach therapy is people’s understanding of therapy and describing people who attend therapy as crazy and mental. It is a fact... But if we... change the word for example to relief or relax... I think we can have some other terms better than this” (Noor-Y, 790-801).*

Noor acknowledged that negative labelling of people with mental health has an impact on the self-concept. Despite these negative effects, she believed that positive effects also exist. Consequently, she argued that fostering positive labelling can make it more likely that an individual seeks treatment. The interesting point made by Noor here is the fact that people should not assume that because someone is from another background, he/she cannot understand the role or power of language, as Noor appears to understand these issues quite well. Although her first language is not English, she was able to propose in the English language what could make a difference for people with mental distress.

Several other participants also explained that some of the language terms used to describe people with mental health problems are used in a negative way during everyday interactions. Terms such as ‘*mentally ill*’, ‘*mad*’ and ‘*crazy*’ describe and position those with mental illness as inferiors who pose a threat to society (Granello and Gibbs, 2016). As explained by Jamil (Section 7.1), the media can play a role in reinforcing such connotations by referring to people who do bad things, for example, as having mental health issues, without having solid evidence of their mental status. As a result, people may adapt their meaning of these terms for casual use and throw them around in habitual conversations to refer to behaviours that are out of the ordinary, which can harm and stop those who are in need of help from acknowledging their need for help.

Participants' self-consciousness of, and therapists' abilities to attend to, participants' identities are contingent upon how language is used in particular contexts. How language is used is dependent, in turn, upon how therapists respond to patients in any given context, which can bring patients together with therapists to share information and work cooperatively to solve their problems.

## **8.2 Language Facilitating or Suppressing the Communication of Emotions**

Linguistic compatibility focuses on the shared knowledge and similarities found in language-use between two speakers (therapists and patients). In contrast, differences in language-use and lack of understanding can create distance between therapists and patients.

### **8.2.1 Language Brings People Together**

Speaking a common language, saying specific words or phrases in patients' native languages, and the use of specific pronouns were reported by some participants to bring them closer to therapists. For instance, Rozena and Abyan pointed out how the Islamic greeting from the therapist had such an effect:

*“One thing I really liked is that I could say Salam to her... You feel closer to the person when you greet them in your own language and in your own cultural terms. You feel direct closeness and association with that person” (Rozena-P, 548-554).*

Also, as demonstrated in Section 7.1.3, participants who have limited proficiency in English believed that the ease introduced by linguistic compatibility enabled them to open up without the need for a mediator and facilitated a social bond with therapists. In addition, the use of pronouns such as *'I, we, us and our'* by participants to describe themselves and therapists, whether intentionally or unintentionally, expressed and affected how they felt towards their therapists, as shown in the examples below:

*“Language wasn't a problem because she speaks English and I speak English, so we were both ok” (Pakeeza-P, 286-287).*

*“The therapist told me that we are going to work together to get through it” (Mehdi-S, 261-262).*

When those participants adopted these pronouns, they expressed inclusivity in a positive way. Also, when participants used words in a positive way, this indicated their ability to work in harmony with therapists and build a stronger relationship with them. For this reason, several participants pointed out that there is more to commonality in language than just sharing a language, as illustrated by Rabab:

*“It wasn’t about the language as letters; it was more about understanding... She was the person when you say something, she realise and understand what you are saying” (Rabab-Y, 451-453).*

Rabab’s impression of the therapist as being understanding could be due to the therapist being able to attend to Rabab’s specific needs and being attuned to her state of being, which communicated this impression of empathy to Rabab and enabled her to connect with the therapist and open up about her emotions. Yet, when language caused misunderstandings, discrimination, or separation, participants believed language to be a barrier to effective communication.

### **8.2.2 Language Pulls People Apart**

Several participants had different ideas about why communication in therapy may fail. These are: therapist communication techniques, misunderstanding of the message (what is said), the use of medical terminology, and therapist’s attitudinal barriers.

Several participants reported their inability to convey their messages to the therapists about their problems, as explained by Noor:

*“Sometimes some of the questions were so tricky you can’t even express yourself... You want to say you feel something and you can’t express it enough. You feel like she is unable to reach you” (Y, 420-425).*

It could be that Noor is referring to the therapist's style of communication, which may have influenced Noor's ability to express her feelings. Patients differ in their reactions to therapeutic communication, and Noor possibly believed the therapist was unable to understand the communication in the way she intended.

Therapeutic communication techniques are one of the main ways therapists establish trusting relationships with patients. However, these techniques may have a contrary effect and may inhibit the communication with patients, causing resentment. For example, Abyan talked about her experience and described how she was unable to engage in meaningful dialogue with the therapist and said:

*"It was just words... but I didn't have that connection... she couldn't understand how I felt. I felt she didn't. It was like a brick wall"* (Abyan-S, 602-603).

The words used by Abyan to describe her communicative experience with her therapist indicate that speaking in the same language does not always guarantee the understanding of the message. The use of the word 'brick wall' shows the difficulty Abyan was experiencing in communicating her problem successfully to the therapist. The intention a person has when encoding his/her message can be different from how the other person receives, understands and interprets the message (Grice, 1957; Searle, 1979).

Moreover, a number of participants reported that the way the questions were phrased made them difficult to be comprehended: "Sometimes when the therapist asks me a question or tells me to do something that I am unable to understand, I used to cancel the next appointment and say I won't go again" (Mona-Y, 262-264). Aliyah explained: "this is because I didn't go to school. The person who didn't go to school finds the way educated people talk difficult to comprehend" (Y, 421-422). Aliyah is possibly referring to the use health-related terminology by the therapist with which she is not well acquainted, which can impact on the access to therapy. Poor knowledge of health-related issues is not limited to ethnic minority groups, as studies on the general population have documented a gap between patients' health literacy and

actual participation in healthcare prevention; patients may attend healthcare intervention without understanding why or what is expected of them (Adams, 2010; Kyle and Shaw, 2014). Patients' health literacy is defined as the capacity to seek, understand and act on health information (Nutbeam, 2008). Thus, health literacy is not limited to being able to read leaflets and making appointments. Rather, it involves patients' ability to access and seek information, ask questions and fully engage with healthcare provision and decision making. However, BME groups face additional barriers, related either to the use of English as a second language, or to the use of interpreters, which will be discussed in section 8.3.

In addition, therapists' prejudices due to cultural differences, which lead to false assumption can cause a real barrier to therapist-patient interactions. For instance, when the therapist lost sight of Rabab's real physical health problems and mistakenly understood these as cultural presentations of mental distress, as illustrated in Section 8.1.2, Rabab believed the therapist demonstrated a level of rigidity and remoteness. The failure to accept Rabab's analysis of the problem impacted on the encounter and eventually stopped her from attending therapy.

Moreover, some participants pointed out that language that includes unsupportive messages or perceptions can create distance from therapists and prevent them from communicating effectively with patients, as detailed by Dalal:

"The therapist started the session by asking me how I thought about trying to kill myself while being a Muslim. She judged me directly without giving me a chance to talk about why I was thinking about this. This is wrong. Therapists should give patients the opportunity to discuss their mental distress... They should treat patients equally regardless of their religion or nationality or background. Therapists should first assess the mental distress then they may discuss the patient's background, nationality or religion" (Dalal-Y, 346-352).

Dalal appears to be dissatisfied with her therapeutic experience, which she believes, is related on one hand to the therapist's perception towards cultural



differences, and on the other, on the pre-judgmental behaviour when the therapist did not show tact and consideration towards her feelings.

### 8.2.3 Language as an Expression of Power

Words are powerful tools of communication by which both patients and therapists in therapeutic encounters exercise their powers differently. Power differential was expressed using pronouns, the knowledge of therapists, English as a second language and institutional and discriminatory discourse in therapy settings.

Participants use of the pronouns *'I'* and *'we'* drew attention to their agency and gave an insight about what they thought of themselves as well as how they interpreted the other. For example, when Kausar was asked about the reasons for not attending therapy, she replied:

“I wasn't smart, I was (Sharif), and I didn't bother about seeing the therapist” (Kausar-P, 211-213).

Using a cultural reference to help her feel more comfortable, Kausar described herself as a decent person in her use of the word *'Sharif'* and valuation of the self using the pronoun (*I*). Possibly, this gave Kausar a better image of herself and indirectly implied her perception about the kind of people who might access therapy.

In addition, the pronouns *'they'* and *'them'*, were used by participants to distance themselves from therapists (Brokensha, 2011; Fairclough, 1989):

*“I felt I couldn't open up and I thought they are not going to understand what I am going through... There was a lot of things that if I have said, they wouldn't understand” (Salma-P, 140-146).*

In this example and as explained in Table (23), Salma was unable to open up to her therapist about the cultural issues that affected her life. But, she did not attempt to explain these either, assuming the therapist would not understand. The word *'wouldn't'* points towards the certainty of Salma's assumption. Therefore, Salma tried to protect herself by not offering any information to the therapist.

Knowledge and education were also perceived by a number of participants to establish therapists' dominance, which could affect patients' engagement and expression of emotions in such encounters. Mehdi elaborated further on this topic and said:

*"I always have this kind of distorted viewpoint where if I am meeting this person you know, the power is with them... They are White; they are more educated than I am... They are English, so there was power imbalance in my view" (Mehdi-S, 355-358).*

What Mehdi may be implying in pointing out the perceived power imbalance in therapy room is that perhaps by being knowledgeable and educated about the emotional experience and how to manage distressed emotions, the patient can balance the relationship between therapists and patients and help the latter to engage effectively with therapy and express their emotions rather than avoiding them. Also, he points out how some individuals can feel regarding their inability to speak the language of power, which may leave them reluctant to talk about their emotions for fears of being misunderstood. Several participants shared similar viewpoints to Mehdi, particularly those who were illiterate as demonstrated by Azhar:

*"I was under their treatment and they were the one who were able to decide what to do. I couldn't speak the language and I couldn't understand them either. I was like a sheep in submission for slaughter" (Azhar-Y, 159-162).*

The metaphor used by Azhar shows her powerlessness in having a say in her treatment through the image of herself as the sheep and the therapists as the butcher. Although it is quite a strong expression, it points towards the authoritative position therapists have.

Moreover, a handful of participants pointed out the dispassionate use of imperatives by therapists, as explained by Dalal:

*"I only attended once and I couldn't continue with her... I didn't feel she was credible... She wasn't able to take in the information and I was quite fearful and I didn't trust her... I felt she was taking things in haste.*

She was always in a hurry and she didn't give me time and ask me like the previous therapist... she used to have a paper and a pen in her hand and look at me then say 'tell me'. I wasn't able to talk like that. I didn't know what to say" (Dalal-Y, 290-302).

Dalal believed the therapist was unable to relate to her and made her feel uncomfortable talking about her emotions using the role power in their relationship. The choice of words used by Dalal to describe the dictatorial style of counselling through the use of the imperative '*tell me*' and the end result of her being '*quite fearful*', demonstrates the power of language in such encounters.

Although the method of accessing therapy is usually a referral by the GP, two participants were instructed by the social services or police to do so. One participant in the observation told the therapist:

*"I was asked to solve my anger issues in order to be able to get to my family... They used their power against me and I can't return to my house... They claimed I have anger problem. I am ... a Muslim father who is trying to give guidance to his children" (PO-PI6, 67-78).*

In the above quote, the participant, through the use of certain phrases such as '*was asked*' and '*used their power*', pointed out the institutional power exercised by the social services against him. Then, by using '*I am*' as a categorical assertion, and '*they*' followed by '*claim*', as an example of epistemic modality (Macfarlane, 2011), he placed himself in a better position than the social worker. As explained by Jeffries (2010), the participant's use of the discourse *us* vs. *them* is an indicator of his attitude towards the social workers (Van Dijk, 1993). In addition, by pointing out the cultural differences between himself and the social workers, he was creating an opposition that is implicitly presented (Blackledge, 2005).

A small number of participants believed that some therapists responded in a discriminatory manner to their health complaints and mental distress. Jamil clarified:

“Some therapists when you explain your problem, they think your main purpose of attending therapy is to get out of going back to work and seeking employability benefits, or to be able to get help with your asylum application... This is what I felt sometimes when they treated me” (Jamil-Y, 451-455).

Jamil assumes that therapists as influential figures believe patients sometimes approach them to help with their asylum claims or benefits. As a result, his therapist, he believes, treated him with distrust, which impacted on his self-image.

Related to language issues in therapy is the use of words, which have the power either to facilitate the communication, or to hinder it by creating a closed climate. This in turn can impact on the patient-therapist interactions and act as a barrier to access services.

### **8.3 Barriers in the Communication of Emotions**

Participants reported an inability to express their emotions about the traumatic events in their lives due to English literacy, the untranslatability and non-equivalence of cultural and religious terms and the use of interpreters.

#### **8.3.1 English as a Second Language (ESL) and the Limited Knowledge of Vocabulary**

English as a second language (ESL) is the main medium of communication between PSY patients and therapists. Thus, participants believed the ability to speak the language is a key to overcoming communication barriers in these settings, as stated by Momina:

*“I speak English well and I understood what she said and I could express myself with the words I wanted to use so I had no problems” (Momina-P, 183-184).*

Participants who were born and grew up in the UK were more able to speak and express their feelings as noted during the participant observation (PO-BH15, PO-PI16, PO-PM7, PO-PMY12 and PO-PP2) and pointed out by a questionnaire respondent: *“On a personal note I am a British Pakistani so I*

*have full language and communication ability” (Q15, 17-18). They also reported that “Language wasn’t a problem because the therapist spoke English and I could speak English, so we could explain everything together” (Pakeeza-P, 295-296).*

On the other hand, participants without a native grasp of English believed that the inability to speak English is a key barrier to effective communication and expression of emotions between therapists and patients, as explained by Noor:

*“English is not our first language, sometimes we only use the words that we have learnt. We are not perfect at the language even if we are able to speak English” (Noor-Y, 460-462).*

The ability to communicate in ESL varied, and those who lacked the proficiency in ESL exhibited different opinions on the subject. Elderly participants, and those who moved to the UK later in their lives, were more likely to experience difficulty as pointed out by a questionnaire respondent:

*“If a member of my old family were to accept having help, they may struggle if the therapist was only English speaking and don’t speak the same language” (Q15, 20-21).*

Participants who did not speak the language reported finding difficulty expressing their emotions: “I wasn’t able to speak English and even talking about common things was difficult for me to explain... It was quite a difficult task. I wasn’t able to express my emotions” (Q2, 18-20; Q4, 17-21). They also reported difficulty absorbing information delivered in English as illustrated by Mona:

*“I wasn’t able to understand what they - the therapist and the interpreter - were saying. I used to pity myself ... I wasn’t able to understand what they were saying and I wasn’t able to respond back” (Mona-Y, 267-271).*

The inability to speak and understand English, as commented by the participant, brought about a sense of helplessness, which elevates the

patient's stress level and hinders her ability to ask questions or seek further clarification.

The encounters with research participants who were not proficient in ESL revealed examples of the different levels of difficulties experienced by participants when using ESL to express their emotions. The grammatical structure of participants' sentences, which showed the different levels of participants' English skills, the phonological differences between languages, and the understanding of word meaning, were some of the difficulties that caused potential problems for both patients and therapists during therapeutic interactions.

#### **8.3.1.1 Syntax**

Participants who have basic knowledge of ESL created their own linguistic norms that were influenced by their L1 and are different from Standard English. The end product could sometimes be peculiar in comparison to the language of someone who has grown up speaking English as illustrated in the example below:

*“They using her England, he is illegal immigrant. They was coming different names, same person two names, you know and they were using my daughter” (Maleeha-P, 113-115).*

In this example, by incorporating aspects of her native language into English, Maleeha inappropriately structured her sentence, which affected the content and complicated the comprehension. This was probably because the grammatical structure of the participant's native language is quite different from the word order of the English language. In addition, the key differences in verb tenses amongst the participant's language and the omission of some verbs such as the verb 'to do' and 'to be' were quite common. Due to the combination of these problems and other differences related to each language, the participant faced numerous challenges when attempting to express herself using ESL and failed to communicate what she intended to say. This has also caused native English speakers – the therapists – in therapeutic encounters to have difficulties understanding participants.

### 8.3.1.2 Phonology

When participants used ESL for communication, some traces of their mother tongues in their spoken languages remained, which were quite easily detected by therapists and reflected patients' identities as non-native speakers. These phonological differences have a number of potential causes. Firstly, they may be related to differences in the consonant and/or vowel inventories of the patient's first language and British English. For instance, the consonant (p) is not found in either Arabic or the Somali languages, so that a patient may mispronounce the word (pain) for example as (bain). Secondly, intonation systems across languages can vary across languages, leading to different defaults for how stress patterns are applied in the pronunciation of words. The results of these issues caused some therapists to have difficulties in understanding participants:

*“People don't try to understand what I am saying because of my accent, they quickly say I don't understand” (Q17, 18-19).*

### 8.3.1.3 Semantics

During the interviews with participants and observations of therapy sessions, the researcher and therapists had to deal with some situations where participants were unable to understand the meaning of certain words or questions because they either lack the knowledge of these words, or concepts did not exist in their languages. For example, when Maleeha was asked about the reason for accessing therapy she said:

*“Because you know my arm tissue broken, that's why... it was very bad... pain. I can't do anything before. They gave me pain killer” (Maleeha-P, 67-69).*

The word '*therapy*' is confusing for Maleeha since she relates the word to physiotherapy treatment. Hence, when she was asked about the reason for accessing therapy, she explained the physical reasons. The term '*counselling*' seems a more acceptable term because the participant heard this term in her meeting with her GP and health professionals. Also, the term is more known

to be related to advice in her mother tongue (*mashwarah* - مشورة) because it does not refer to physical health.

Similarly, when participants were confronted with a difficult question, they used to resort to avoidance:

“When I attended therapy and the therapist asked me questions about things that I didn’t understand, I didn’t answer these questions and I didn’t say anything about these issues either” (Mona-Y, 310-314).

It is possible that the participant genuinely did not understand the meaning of the questions or she did not want to talk about herself for some reason. In therapeutic sessions, the situation of being asked a difficult question can influence the expression of emotions between therapists and patients.

However, some participants who were proficient in ESL stated that sometimes they found it difficult to express their emotions because of the way questions were phrased during therapy as illustrated by Noor:

*“Sometimes some of the questions were so tricky, you can’t even express yourself. You want to say, like you feel something but you can’t express it enough. You feel like... she is not reaching you right... For example... she said why do you have this anxiety? I said because things are not in place. She said you could put them in place. I couldn’t express what I wanted to say to her, what is inside me... It was difficult to express how I actually feel about it” (Noor-Y, 420-437).*

Expressing something intangible like emotions can be difficult even for native speakers, but for Noor, a non-native speaker, the task, she believed, was even harder. Possibly, Noor was unable to describe her emotional state because as she explained, she has not reached a level of proficiency in ESL to allow her to find the right vocabulary. Likewise, Aliyah who is illiterate, drew on her experience and stated:

“I understand a little bit but I can’t express things like an educated person does... I wished ...that I was able to write down the words I hear so that I can remember them... My mother’s native language is English and mine is Arabic. When I sit with my mother, it is so difficult for me



sometimes to understand her when she talks to me... I feel quite upset that I am sitting in front of my mother and I am unable to express my feelings to her in her or my own language... this is quite upsetting” (Aliyah-Y, 429-476).

By drawing on her experience with her mother, Aliyah drew attention to the difficulty one may have when speaking in another language that they are not proficient in. Her limited vocabulary meant she was unable to communicate properly or get her point across.

During observed therapy sessions, several patients and a number of questionnaire respondents shared the same views, pointing out how “*the inability in understanding therapeutic terminology or what new words mean can be problematic*” (Q3, 19). In particular, terms used in patient health questionnaires and the diary sheet were problematic:

*“Patient was handed a copy of the PHQ in Arabic; yet, she was unable to understand some of the expressions and what is meant by the questions... For example, the question about feeling bad about oneself or that she is a failure or has let herself or the family down. Patient couldn’t understand the question so therapist explained further and referred to patient’s current situation to allow the patient to understand” (PO-YL14, 101-114).*

The example demonstrates how when some patients were handed a copy of the PHQ assessment in English, or even in their native language, they were unable to fully comprehend the intended meaning of the questions and needed the questions to be rephrased to provide accurate responses. This was especially the case with patients who were elderly (PO-SN4, 35-101) or had a learning disability (PO-YS17, 126-158). Literacy was an additional problem reported by patients who had never been to school, impacting on their abilities to comprehend the PHQ content and causing difficulty in engagement with and access to therapy (PO-YL14, 111-114).

Receiving leaflets, signposting to online materials, or being referred to group therapy which involved oral presentations and use of technical terms, were also reported by many participants to affect their engagement with therapy

(Sections 6.2.4.2, 6.2.4.3 and 6.2.5 Case 1). It was evident from participants' quotes that they had difficulty understanding the technical terms and the resultant concentration required to absorb the information.

Participants who were not proficient in ESL reported the challenges posed by their limited English-speaking in therapy. In particular, they reported the difficulty understanding word meanings, the inconsistency of terminology, and the struggle to express their emotions. Therefore, ESL was perceived by many participants to obstruct effective communication with therapists and hence access to therapy.

### 8.3.2 The Use of Code- Switching

Many participants, primarily those who were non-proficient English speakers, believed using words in their first or native language(s) would convey more accurate picture of their emotional state. Some participants believed their emotional experience may be tied to their earliest experiences of language-use.

Many participants reported that using ESL can act as a barrier to expressing their feelings because as explained by Abyan: *"I can express myself in English but it just won't be the same... [Because] it all relates to what is in the heart"* (S, 643-656). Abyan went further to emphasise the value of expressing the emotions in the native language as she believed the choice of words is more likely to evoke greater emotional resonances. To illustrate, Abyan talked about her preference to use the Arabic word 'اغتصاب' – 'Iḡtiṣāb' which means 'rape', to talk about her experience and said:

*"I don't want to say 'rape' in English because the word in English doesn't have the right meaning to me... Although it is the same meaning but it doesn't mean anything to me."* (Abyan-S, 543-550).

Apparently, the word 'rape' did not evoke the same emotional reaction the participant felt with the Arabic word, which she believes, is of high importance for the purpose of communicating her feelings. For some people it may be that first languages connect more directly to their emotions as clarified by Noor:

*“In our language we have more choices of words to express ourselves unlike English, which is kind of limited... When I did the accident for example, I wanted to tell [the therapist] I felt like I am nothing... I wanted to express it more in a way where I wanted to say to her like this is impacted on my thinking, impacted on my feeling... I was stressed... I hated it... but... I didn’t know how” (Noor-Y, 494-503).*

Noor believed using ESL limited her ability to express her feelings and did not signify the full range of her emotions as her native Arabic language did.

Conversely, a number of participants believed that using different languages can each provide them with different emotional resonances. The reason for this was that each language was linked to the emotional experience they learned and stored from the two different cultures. Mehdi explained:

*“When I used English, I used to explain the events and my understanding of what they were... but if I used the Somali language, you will be seen as very weak, you are a broken man... You have let yourself and your family down. That kind of how I will probably end up because the kind of language will be fitting to these emotions” (Mehdi-S, 421-431).*

Mehdi revealed the varieties of meaning attached to the words he used to describe his distress in both English and Somali languages. Possibly, the linguistic differences between the two languages influenced how Mehdi views the events that impacted on his life and therefore, he was more able to open up about the hardships that affected his life using the English language and gain a better understanding of them. This points to the idea that the way words are said<sup>39</sup> is of immense value in order to be able to understand the variable meanings of words and what they stand for, which was particularly true when participants used loan words to convey different meanings.

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<sup>39</sup> This study is not looking at describing the way the words are said or how one can change the habitual vocabulary to convey something. While this is important, it is outside the remit of this study.

### 8.3.3 Borrowed Words

Participants borrowed some words from the English, Arabic and Persian languages. The main English words used by Somali and Urdu participants were related to mental health illnesses such as ‘*depression*’, ‘*anxiety*’, ‘*stress*’ and ‘*therapy*’. Because these words do not exist in Urdu or Somali languages, participants who adopted the words from the English language reported being more able to describe their emotions as shown in Mehdi’s quotation above. In addition, many of them tried to fit their understanding of the terms into their knowledge and understanding of their problems as pointed out by Yabaal:

“Depression iyo waxba I haystay” (Yabaal, 113) “Depression and something had me”

“Waxa ihayey ‘stress’... imka see waan ladanahay” “What I had was stress and I am well now” (Yabaal-S, 610).

By borrowing the English words, it appears that Yabaal was more able to describe his mental health, understand the meaning of the words and show readiness for adjustment and progression. However, when he was probed further about what he meant by stress and low mood and his understanding of the word therapy, he voiced the unfamiliarity of Somali language or culture with these concepts, as he explained:

“Somali language doesn’t have an equivalent of these words... Somalis don’t have these illnesses” (Yabaal-S, 726-745).

Yabaal clarified that Somalis have a variety of words to describe people with mental illness, but none of them fit the concepts mentioned above. Some of the words used by Yabaal were ‘*waalanyaha*’ meaning crazy or mad, ‘*arbushanyahay*’ meaning out of control and ‘*mashguul*’ meaning his mind is busy in another world:

“Wuu xanunsanayaa, wuu waalanyaha, wuu arbushanyahay” “The person is sick and needs care, he is mad and out of control” (Yabaal-S, 750-751)

“Haa... gofkeni waa mashguul” “his mind is in another world busy and occupied with something else” (Yabaal-S, 775)

As explained in Section 7.1.1, Somalis’ perception of mental health concepts mirror their cultural beliefs and the notion that mental health status is either ‘sane’ or ‘insane’ with no grey area in between. Hence, by using the English terms, perhaps Somalis can escape the stigma associated with mental health and cultural evaluations and distance the illness from themselves.

### 8.3.3.1 Religious Loan Words

Words borrowed from the Arabic and Persian languages tended to reveal participants’ Islamic identity. The main Persian words were ‘Darood Sharif’, ‘Namāz’ and ‘Turjuman’. All other words in Table (26) were the Arabic words used by participants when they made a reference to religion (see Glossary (1) for the meaning of all the words listed below).

<b>List of the Arabic Words used by Pakistani and Somali Participants</b>				
Ɠmrah	Allah	Quranic	Ɠikr	Maqam
Wudu	Ɠajj	SaƓaqah	Ɠaber	Jana
Tasbeeh	Ɠalat	Kalima	Skūn	Ɠaq Maher
Ɠalal	Ɠijab	Salam	Ɠerk	Xutbā
DuƓa	Tafseer	Ruqyah	Tajweed	Sajdah
Hiba	Qadar	Ɠeix	Zamzam	ƓirƓ
Qiyam Al Lail	Arbaš	Mašgūl	DaƓwa	IƓtmad
RamaƓan	Ɠaram	Madrasa	Dwra Quran	Imam
Mašallah	Wali	Ɠūfi	Sunnah	Tawakul
Tawākul				

**Table 26 List of Arabic Words Used by Somali and Pakistani Participants**

According to Hussein (2010), the Somali language appears to originate from the Arabic language with a phonetic and semantic shift<sup>40</sup>. In addition, Islam as a religion is part of, and is embedded in, both Somali and Pakistani cultures, which is vitally important for their national identity. For that reason, religious and Islamic education influenced both the Somali and Urdu languages and a

<sup>40</sup> Somalia was the first migration area for Prophet Mohammed’s first Muslim followers who sought refuge from the persecution of the ruling Quraysh tribe of Mecca. As a result, The Somali people seem to have a cultural and ethnic ties with the Arab world.

lot of the vocabulary was derived from the Quran. As the Quran was revealed in Arabic, many Arabic terms used by the participants were Islamic. Such Islamic terms enabled individuals to interpret their emotional experiences and as a result, some participants believed some sayings such as calling Allah's name were to be said in Arabic in order to feel the spiritual feelings as clarified below by a questionnaire participant:

“When I used to call God's name or say what is from God is accepted (Alḥamdullah), I didn't feel it gave me the same meaning or feeling as when I said it in Arabic” (Q4-28-29).

One reason for this could be that some participants believe the concept of saying 'Allah' functions differently to the use of 'God' because the name 'Allah' has no gender or plural term; therefore, it is quite unique when compared to the use of 'God'. Moreover, the meaning of the impact of recitation of Allah's name on the soul is untranslatable. Finally, it is not so much about performing the practices as much as it is about believing in their effect and impact on the person that becomes difficult to translate. However, when some participants attempted to semantically translate these lexical terms as explained by the questionnaire respondent above, they were faced with difficulties caused by the non-availability of cross-culturally equivalent terms for these religious concepts in English.

#### **8.3.3.2 The Untranslatability and Non-equivalence of Cultural and Religious Terms**

Participants believed that the untranslatability or the non-equivalence of religious terms and concepts and references to cultural beliefs was not so much about the linguistic compatibility as much as it was specifically related to the expressiveness of these rituals and beliefs when participants reflected on their emotions.

Emotional terms can be difficult to translate because of the lack of equivalence between languages (Sections 3.3.1.2, 3.3.2 and 7.2.3). This is because when people become connected to a language, they employ this language for their symbolic purposes and understandings. For instance, participants used Arabic wording rather than the translation when expressing the emotional responses evoked by the performance of ḍikr:

*“When I leave my house I always read Bismillah, Tawakaltu ʕla Allah wa lā ḥawla wa lā quwwata ilā billāh<sup>41</sup>, and I strongly believe when I say this that (Allah) will help and guide me” (Atiqa-P, 95-97)*

The participant’s use of the Arabic language is possibly relevant to her beliefs that *ḍikr* can only possibly be appreciated in Arabic. This could be either because the Arabic language may have a specific meaning that nourishes a kind of consciousness in her soul, or she believed using English cannot accurately express the true meaning of her emotional state.

Cultural beliefs and proverbs that often have specific religious meanings can also be difficult to translate when used to reflect an individual’s emotions. For instance, Azhar used a proverb to describe her feelings and deal with her emotions when she decided to stop accessing help from therapy, explaining:

*“الشكوى لغير الله مذلة - Al a škwa liġyer Allah maḍalah”*(Complaint to any but God is humiliation (Y, 183).

The proverb centred on perspective of emotions. The proverb addressed how Azhar should deal with her emotions and suggests to only seek help from the Almighty God as He is the one who can remove the grievance or hardship. Proverbs have specific cultural and religious meanings and rendering the surface meaning might only add to the ambiguity of the phrases. Therefore, these phrases needed to be thoroughly explained in order to grasp the intended religious and culturally specific meanings.

Several other participants reported difficulty in finding equivalent words to convey their emotions. One of the reasons for this was the meanings of certain words in English do not have corresponding lexical items in participants’ first languages, as pointed out by Mehdi (Section 7.1). The absence of equivalent words in Mehdi’s language was one side of the problem. But what was more challenging is finding a way to relate these emotional terms to his cultural beliefs. Therefore, he needed to address these new concepts in order for the therapist to understand and for the process of therapy to be beneficial to him.

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<sup>41</sup> In the name of Allah, I have put my trust in Allah as there is no strength, no power except by Allah

Similar cases were observed during participant observations where, due to the unfamiliarity of patients' languages with clinical terms in the therapists' language, both therapists and interpreters had to explain the terms (PO-BM1, PO-FM9, PO-PN3, PO-SN4, and PO-YA10a). For example, during the session with (PO-BMI) the therapist introduced the term '*routine activity*' to the patient. As the term has no equivalent in Urdu, a different type of explanation was needed. The interpreter, after further inquiry with the therapist, explained the term using equivalent cultural terms such as '*the five daily prayers*' to ensure the participant understood the meaning (PO-BMI, 128-129).

In addition, as explained earlier in 8.3.3.1, many of the words borrowed were mostly from Quranic verses, which were often expressed in the Arabic language as was evident in participants' discussions during the interviews. As reported by participants, this has caused certain difficulties, such as the non-existence of equivalent words for these Quranic terms in Urdu, Somali or English, which meant that participants were offering an explanation of the terms rather than an equivalent meaning. Explaining the Quranic terms can be a difficult task for Muslims in general, and non-Arabic speakers in particular, due to the complexity that people may encounter in understanding the essential meaning of the language of the Quran. Further difficulty in explanation occur due to cultural distance between the groups and therapists; the Quranic verse can contain many layers of meaning whereas the translation can only provide one connotation of the possible meanings of the word. As a result, those participants find it difficult to provide an equivalent meaning in English. For instance, when Maleeha attempted to explain the word '*Tasbeeh*'<sup>42</sup>, she resorted to the act of saying the words instead:

*"I do (Tasbeeh), I say (Subhan Allah, Alhamdulillah, Allahu Akbar, La ilah illa Allah) and Mohamed is (rasoul Allah)" (Maleeha-P, 318-319).*

When she was asked what it means, she said: "I can't explain" (Maleeha, 324). Also, because some of the Islamic concepts do not exist in the English culture, several participants provided an extended description to explain the meaning.

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<sup>42</sup> the act of glorifying, praising, magnifying and extolling Allah by tongue or by heart



For example, Abyan tried to explain the term qiyam al layl to her therapist and said:

*“I told her what usually helps me is (qiyam al layl) my night prayer... She couldn’t understand... I said this prayer you could pray from this time until this time. But it was really difficult to explain to her. We know one of the healing things is (qiyam al layl), it is the time when you can talk to (Allah) and pray for his help” (Abyan-S, 988-995).*

As demonstrated by participants, religious concepts and references to cultural beliefs that have been learnt and acquired earlier in participants’ lives have affective meanings, which were difficult to conceptualise to non-Muslim therapists. This can result in losing the core meaning of the words and impact the communication of emotions in therapy settings. In such cases, interpreters may try to explain the meaning of these phrases by providing full explanations of the social tradition or Islamic values in order to reveal the in-depth meaning of the terms. In the next section, how participants perceived the role of interpreters in therapeutic settings and their role in the process of conveying the messages of participants is discussed.

### **8.3.4 The Role of Interpreters in Therapeutic Encounters**

Using interpreters in therapeutic sessions can be valuable for both therapists and patients. However, some participants believed communicating their emotions through an interpreter was disempowering. Hence, this section starts with an insight into participants’ perceptions of the use of interpreters in therapeutic settings to communicate their distress, and how the use of interpreters may/may not affect the interactions in these settings. The section concludes with a discussion of what participants think about the effectiveness of interpreters with regard to understanding and conveying their expressions of emotions.

#### **8.3.4.1 Participants’ Perceptions of Communicating the Emotions through interpreters**

Participants reported different views on the use of interpreters to communicate their emotions. While a few participants valued the role of interpreters in

enabling communication with therapists, several others believed it restricted them from opening up and expressing their feelings to therapists.

Participants who believed interpreters empowered them to express their emotions described interpreters as enabling them to voice their problems, convey their feelings and avoid misunderstanding. Responses in support of this idea include, “I felt the interpreter was able to help me talk about myself” (Aliyah, 374), and “She interpreted what I said and what the therapist said... I felt the therapist was able to understand what I meant” (Azhar-Y, 324-327).

Conversely, some participants viewed some interpreters as unable to relay information accurately, as pointed out by Aliyah, who said: “Sometimes I feel interpreters don’t interpret things as said by the person” (Y, 336), or unable to uphold confidentiality: “The interpreter broke the confidentiality and said he interpreted for me when I sought help from the therapist and I found that some people start labelling me as crazy... The interpreter betrayed his profession... He disclosed information about me” (Jamil-Y, 522-537). The latter issue was a major concern, which was also voiced during two participant observations (PO-YR10b and PO-FM9) by patients who were anxious about what to say in front of the interpreters, in case the information is being leaked in the community or they are misunderstood by therapists. For that reason, participants often avoided the use of interpreters from their own communities, as shown in the extract below:

*Patient explains that she has recently seen a doctor where a Yemeni interpreter was present and said: “After the session, people started talking about me and I believe the interpreter said something around in the community and that’s how the people became aware of my mental illness. This is why I don’t want a Yemeni interpreter to be present” (PO-YR10b, 61-65).*

In some cases interpreters are essential in understanding the verbal and non-verbal communication between patients and therapists. However, in other situations, interpreters’ presence is an added challenge. They may influence what patients may want to say about their emotions, and can negatively affect the engagement with therapy.

#### **8.3.4.2 The Impact of Communicating the Emotions through Interpreters in Therapeutic Sessions from Participants' Perspectives**

Participants who were non-proficient in English and used relatives or professional interpreters in therapeutic sessions reported the presence of interpreters to affect the interactions and communication of emotions in various ways.

One of the strongly evoked feelings in participants was the discomfort in disclosing their intimate emotions in the presence of their relatives, as illustrated by Azhar:

“I wasn’t able to talk in front of my daughter and let her know that I had problems or know about my private concerns. Each one of us has his/her own secrets that he/she wouldn’t like to share with his/her families whether daughter, son or husband” (Azhar-Y, 136-139).

Also, some participants reported dependency on their relatives to talk about their emotions for not knowing enough English, which was perceived as disempowering, as explained by one participant:

“I started to get quite annoyed when I needed to attend therapy and I needed to ask someone to interpret for me... I got fed up. I don’t know I felt quite stressed. I want to depend on myself but I don’t know how” (Aliyah-Y, 199-206).

Furthermore, it was noted that some relatives can add their own thoughts and speak on participants’ behalf as observed during two participant observations (PO-SM13 and PO-YA5a). The following is an extract from PO-SM13 session:

*Using the PHQ form, the therapist starts asking the participant questions about his depression. Relative acting as interpreter volunteers to give answers on behalf of the patient. Therapist asks the relative to only interpret what the patient says and not to attempt to answer on his behalf as she wants to understand the patient’s feelings (PO-SM13, 49-53).*

It is evident from the participants' views that the involvement of relatives in therapy disrupted the therapy session and affected the communication and interactions with therapists.

In terms of the use of professional interpreters, participants reported similar experiences and reported that interpreters' knowledge, specialism, and understanding of mental health issues can affect their ability to talk about their emotions and disclose or share feelings about their distress. For instance, in reporting his experience with the interpreter, Jamil said:

“Sometimes you bump into an interpreter whose ability is shocking... This is because not everyone who speaks the English language can become an interpreter... Sometimes you encounter a lot of psychology terms that even the interpreter is unable to comprehend... the interpreter may be unable to convey the meanings that you intended to communicate to the therapist... if the interpreter is unable to understand these terms... This may... give a wrong impression of me in his interpretation to the therapist” (Jamil-Y, 153-171).

Given the lack of in-depth knowledge in psychological terms, Jamil appears to be particularly concerned that the interpreter is unable to provide accurate accounts of his emotional distress or convey his emotions in a meaningful way. Other participants believed that differences in dialect introduced difficulty, as stated by Aliyah: “the interpreter is Arabic speaking but her dialect is different... She doesn't understand me sometimes” (Y, 212-219). Another participant believed that the inclusion of an interpreter can influence the content of her narratives and her ability to express the nuances of her emotions into another language. She explained:

“It is not the same when you get the information through someone and having the information directly. Sometimes you aren't sure if the interpreter conveys these accurately. But when you talk directly and understand English well, you will be able to understand and absorb everything” (Mona-Y, 445-449).

Participants also explained that the inclusion of an interpreter slows down the communication, leaving less time available for an in-depth exploration of their

feelings, as stated by Pakeeza: *“If I used an interpreter, it would take longer... by the time the interpreter told the therapist what I said and translated back... there will be less time to talk”* (Pakeeza-P, 298-301).

As can be noted, using interpreters can be an added challenge in therapeutic encounters creating difficulties for patients in talking openly about their emotions and accurately revealing their feelings. For that reason, participants’ perceptions of the ability of interpreters to receive and convey their emotions are explored next.

#### **8.3.4.3 How well Interpreters are Able to Receive and Convey Patients’ Expression of Emotions**

Participants exhibited different opinions on interpreters’ abilities to convey their emotions. Generally, those who had positive experiences with interpreters cited the latter’s expertise in accurately conveying their messages. In comparison, those who had negative experiences saw interpreters as an impediment to effectively communicating their emotions in therapeutic settings.

Participants had strategies in response to issues with interpreters’ skills. These were: the ability to understand some English words, interpreters repeating information back to patients, and asking interpreters about their qualifications.

Some participants reported that by understanding certain English words, they were able to follow discussions and ensure interpreters were conveying the right message:

“I understand a little but I can’t respond back... I was following the interpreter and he couldn’t trick me” (Yabaal-S, 479-488).

Through the use of the lexical term ‘trick’, Yabaal suggests a lack of trust in the interpreter possibly because he thinks the interpreter may not necessarily work in his best interest.

A number of participants reported that interpreters were repeating things back to patients to ensure they fully understood the communication taking place, as explained by Dalal and Azhar:

“She used to repeat and interpret what the therapist said... and I was monitoring her accuracy through the therapist’s response... So when the therapist was asking a follow-up question, I believed the interpreter was delivering the right message” (Dalal-Y, 280-287).

Another approach, as highlighted by Jamil, was asking interpreters questions about their qualifications to ensure they were able to express patients’ emotions properly:

“I used to ask interpreters about their qualification... and about their specialism... I used to ask the interpreter questions and discover that he/she found difficulty in understanding some of the medical terms... This can be problematic... because your fate and life is in their hands” (Jamil-Y, 208-222).

The issue of competency was demonstrated during an observed session PO-SM18, where the researcher noted how the interpreter erroneously used ‘generalised anxiety’ to paraphrase a more complex sentence spoken by the patient, as shown below:

*Therapist asks patient about his thoughts and whether they are real or intrusive. The patient says: “the thoughts disturb me as I have to deal with the constant talk to myself inside my head that is playing like a tape during the day, and to see the vivid images in my mind at night”... However, what the interpreter said was the patient is having generalised anxiety which affects his sleep and affects his physical ability (PO-SM18, 58-62).*

By the interpreter formulating an opinion about the patient’s feelings and not conveying exactly what the patient said, the therapist lost important information that could have helped her to assess the patient’s problem further.

Relevant to the access to IAPT and language issues in therapy is the active role of interpreters in facilitating the communication between therapists and patients. However, as demonstrated in this section, the addition of an interpreter in these therapeutic settings can influence the narration of patients’ emotions during these interactions.

To illustrate how the use and non-use of interpreters as an intermediary between patients and therapists can affect the expression of emotions during therapeutic encounters, the researcher chose two examples from the interviews. In this context, the use of interpreters to conduct the research is addressed to discuss the different issues that may confront therapists who are required to engage with interpreters in similar encounters. The first case demonstrates how the use of an interpreter influenced the interaction and communication of emotions and the second case shows how the inability to speak English as a second language may influence the ability to express the emotions.

#### **8.3.4.4 Case 5: Impact of Using Interpreters**

Kausar is a Pakistani female, Urdu speaking participant in her late fifties. She does not speak any English and has never received any education. She moved to England when she was first married and after a while she became quite depressed. She was offered therapy but she did not attend. Kausar gave her consent to take part as a participant in the interview and an Urdu speaking interpreter was booked and briefed prior to the interview with the participant. The audio recording was verified by a transcultural mental health worker, as explained in Section, 4.6.3.6 to minimise the loss of any important information.

Kausar became depressed but she wasn't able to understand the reasons for her depression. In expressing her feelings, she said: "I was very well, but slowly slowed down" (58). However, this was interpreted as: "first I was ok, but then gradually, I started feeling awkward" (60). When the participant was asked what she meant by awkward, the interpreter phrased the question as: "how did this change come to you?" (62).

Although the question was put in a different way, the response by the participant did not suggest any variation in the questioning and in fact, it allowed the participant to express her emotions and give further insight into her problem as she explained:

"I just used to feel like crying suddenly. I used to say to my younger brother-in-law 'I'm scared, don't go to school' (63-64).

Provided that the content is not changed, it is not uncommon in the interpretation process to rephrase questions to be more applicable to patients' level of understanding. As can be noted from Kausar's response, she was more able to relate to the question and to give an insight into her feelings.

Kausar did not speak any English and for that reason, she was dependent on her husband and children to act as interpreters, mainly with medical care. At first, Kausar was prescribed medication for her depression and explained "I just took medication. I was up and down with it" (107). What she meant, as was verified by the transcultural mental health worker, was she only took her medication when she was not feeling well. However, the interpreter missed this vital information in the interpretation and said:

"When I started medication, I felt I am getting better. Then it started again (meaning depression), and sometimes I will feel normal and other times I won't feel well" (108-110).

While the interpreter was able to describe the actual state of feeling better when taking medication, she misinterpreted what the participant actually said. In an actual therapeutic setting, this meant the therapist could have lost vital information about the patient's non-compliance with medication and could have put the patient's life at risk.

As the focus of the research was to explore participants' emotions, Kausar was encouraged to talk more about her fears in order to have a better insight into her emotions. Nevertheless, she was unable to understand what was intended by the question. Accordingly, the interpreter suggested providing an example about how she felt when she was burgled. While the example was useful for the participant as it provided further explanation, the narration took a long time. In actual therapy session, this need for extra explanation may restrict the patient from utilizing the time efficiently to talk about her worries.

Kausar was also asked if culture provided any explanation for her depression. The question was intended to search for any cultural meanings that provided Kausar with any further understanding of her distress. Kausar's daughter arrived at this point and she immediately became involved in the session, acting as an additional interpreter at some points. This complicated the



process further because she would inject her own opinion into her translation. For instance, Kausar's daughter provided the following explanation for her mother's depression:

*"I think my uncle's wife was here. She and my mum were quite close and they used to go out together. But then my auntie's sister got married... and she came from Pakistan. My auntie and her sister started doing things together. So my mother kind of was left alone. Because she didn't have a sister, this has affected her life" (157-162).*

As Kausar was noted to become quite frustrated, the researcher enquired if the information provided by her daughter was correct. Regrettably, the interpreter focused on the participant's cause of illness and emphasised the need to explain 'why' she felt the way she did. The interpreter said:

"I have asked her if she agreed to the reasons given by her daughter about not having a sister. Kausar said that she doesn't agree to the reasons because she herself doesn't know. I told Kausar that if you know the reasons behind it then it gets very easy to solve the problem" (179-183).

The interpreters' (including the daughter) comments appear to have influenced the interview and made Kausar less responsive and guarded. This is an example of how the addition of relatives' views and the inability of interpreters to convey the patient's emotions in a meaningful way can lead to incomplete disclosure of patients' psychological distress, which can affect the process of therapy. Therefore, a decision was made to rephrase the question and instead to ask Kausar to describe her emotions in her own words. This enabled her to become engaged again and provide a detailed account of her feelings as she replied:

"I felt very sad. I felt something has happened in my heart, then I started crying. Then I wouldn't feel like eating or drinking or doing anything. I lost my interest in everything. I didn't sleep, I didn't like doing anything" (188-190).

During the discussion, Kausar said she was offered therapy but she didn't attend for two reasons: first because she didn't know English, and second because she was *Sharif* (a decent person). But yet again, the interpreter omitted this valuable information and only said "I didn't know the English language and then I didn't bother when I was referred to see the therapist" (199-200). Clearly, the participant had particular beliefs about the kind of people who needed to access therapy. If the words stated by Kausar were focused upon a little more, it could have possibly led to more in-depth knowledge of her perceptions and the researcher would have the chance to explore her emotions further.

Kausar pointed out that she did not understand what therapy meant and, for that reason, she did not attend the session. When asked if religion provided her with any help, the interpreter said:

"Do you use any religious means, for example, attending gatherings, such as (ḍikr), where (duḥa) are made or reading of some sort? You know what is meant by reading? Reading yourself, etc." (247-249).

This was quite confusing for Kausar. What may have been more appropriate and helpful was to ask if being a Muslim and having religious beliefs helped or hindered her mental health issues in any way. This may have given her the opportunity to explore the emotional component in religion and how it may help her address emotions such as fear. In the interview, the question about religion as phrased by the interpreter led the participant to believe it referred to a specific kind of prayer or social gatherings since Kausar replied "I don't go towards reading... but occasionally go to some gatherings if invited" (250-251). Similarly, when Kausar was asked what help meant for her, the interpreter translated the question literally, which was commendable as interpreters are trained to translate in such a way in mental health interpretation. However, in this case, the participant understood the question as referring to social gatherings that she attended, rather than her mental health and therapy process because she replied:

“Just to know that other people are well and happy gives me happiness ... When we meet each other and ask about each other, how families are doing, it feels good to catch up” (273-275).

Since religious beliefs may serve as a source for regulating emotions and may influence emotional wellbeing, further clarification was needed about the kind of help Kausar meant. For that reason, the question was phrased again by Kausar’s daughter. Although Kausar identified talking to her GP, relatives and friends as helpful, her daughter volunteered again and provided more detailed information in this respect. While the information enabled the researcher to have valuable background information about the participant, it was believed to disempower the participant and affect her ability to communicate her own perspective.

As demonstrated by this case, the use of interpreters was quite useful in the sense that it provided a voice for participants who were not proficient in the English language. However, the use of an interpreter impacted the process of the interview on many occasions. In particular, relaying information inaccurately influenced the responses of the participant and affected her ability to open up or talk about her emotions. Additionally, the use of relatives as interpreters was not without its limitations as Kausar’s daughter continuously intervened and injected her opinion, which seemed to upset the participant and prevented her from communicating her emotions effectively.

#### **8.3.4.5 Case 6: English as a Second Language and the Inability to Express the Emotions**

Maleeha is a Pakistani, Punjabi speaking female, aged 65, who came with her family to England a long time ago. She did not attend any classes but speaks a little English. She refused to have an interpreter for the interview and communicated through her basic English. Communication with Maleeha was difficult and, on many occasions, there was misunderstanding and confusion on both sides. She attended therapy with a Punjabi speaking therapist and believed it was helpful.

When interacting with people who have only a basic knowledge of the English language, it is not uncommon to face difficulties understanding certain

vocabulary items and their intended meanings, as was the case with Maleeha. On a number of occasions, when Maleeha was asked a question using words that she did not know the meaning of, she struggled to respond to the questions. The inability to understand the meaning of medical terminology can affect the ability to communicate the emotions and engage effectively with therapists. For instance, when Maleeha was asked about her background and was given some examples to assist her in understanding the word 'background', she was quite confused. Therefore, the researcher had to rephrase the question as outlined from the interview extract below:

*"R. Tell me about your background... For example, where did you come from, and when? Things like that.*

*M. I don't know that*

*R. When did you come here to England?*

*M. Long time ago...*

*R. Are you living here on your own or with family?*

*M. Yes, I live with family.*

*R. You live with family, who is the family you are living with?*

*M. My son and daughter before (14-23).*

As shown above, collecting basic background information was quite time consuming, which may mean less time is available for Maleeha to talk about her emotions in actual therapeutic sessions. Maleeha was only able to respond to the questions when they were formed simply and easily. Also, words that did not exist in her first language confused her and she needed further explanation in order to respond to questions correctly. For instance, when she was asked about the reasons for attending therapy, as explained in Section 8.3.1.3, she misunderstood the word 'therapy' with physiotherapy and explained her physical problems instead. Familiarity with medical terminology, in this case the word '*counselling*', enabled Maleeha to open up and express her emotions, and explain the reasons for attending the women's group:

*"I am so stressed, depression and I go there (meaning women group). All women there. There talk with them and my time pass and feel happy*

*when I see each other people because when I stay home and see nobody there is more stress... My son's and my daughter's marriage not much very nice and the stress" (90-94).*

Maleeha disclosed the reasons for her distress to be closely related to her son and daughter's failed marriages and she was able to open up about her feelings. However, the non-standard sentence structure and the resulting made it difficult to make meaning out of Maleeha's speech. For example, when Maleeha tried to explain the non-provision of interpreters during her appointments with her GP, she said: "*You know, sometimes need, but this time hard now*" (59). She continued: "*Sometimes interpreters to pay the doctor surgery, they understand*". As can be noted, both sentences lacked a typical English grammatical structure and were difficult to comprehend. Following further clarification, it became apparent that what Maleeha intended to say was: "booking interpreters became quite hard because the surgery had to pay them in order for patients to understand".

Also, Maleeha's answers were not always direct and they were quite confusing. For instance, when she was asked about her husband, she replied: "*Husband no*" (29). This was understood as either her husband passed away or she never got married. Further clarification was sought where Maleeha used hand gestures to indicate he left her. The use of non-verbal communications as explained in Section 8.1.2 is of immense help when conveying emotional information and in Maleeha's case, it helped making sense of her verbal messages.

Moreover, Maleeha talked about how her mother-in-law used black magic to break up her marriage. Again, in communicating her problem, Maleeha failed to follow expected grammatical patterns. This meant her sentences became difficult to comprehend at points:

*"R. What is the black magic?"*

*M. They broke married.*

*R. So you are saying that your aunt was doing... (Interrupted by M)*

*M. That's right, you know, when they say the other people, I say not talking any like that because God no like it.*

*R. God not like black magic or talking about other people?*

*M. Yes because (Saber) is best*

*R. So you don't like to talk in front of people about what happened?*

*M. Yes because (Saber) is best." (146-154)*

As demonstrated by the transcript above, the researcher was finding difficulty following Maleeha's syntactic structures and needed further clarification to understand the problem she was referring to. In an actual therapy session, the participant's basic English language can be a source of miscommunication between her and the therapist, as it may not be the language corresponding to the emotions being described.

Expressing something intangible like emotions was a challenge in this encounter because Maleeha lacked the vocabulary to explain her emotions or explore their meanings. During the interview, she explained that the GP prescribed medication for her, but she was not taking them regularly because of the side effects. When asked to explain the side effects she said: "*You know when you take, I feel like oh! No energy. I can't explain*" (187). The word 'can't explain' was repeatedly used during the interview, particularly when the participant struggled to convey her feelings or find the right words to describe her emotions. For instance, when Maleeha was asked about the nature of her encounter with the therapist, she was unable to provide detail:

*"R. What were you talking about?*

*M. Can't explain.*

*R. When you say can't explain, did you talk about your problem with her?*

*M. Eh not much but not tell still.*

*R. What do you mean by not much?*

*M. You know she is a confident person, she won't tell anybody (223-228)*

Even when the researcher suggested that Maleeha speak in her own language to convey her emotions, she found the task quite difficult to perform:

*R. Just say the words you used to talk about your emotions*

*M. Can't understand that*

*R. Is there any specific words in Punjabi to talk about your feelings?*

*M. Can't understand*

*R. Describing your feeling to the counsellor, what words did you use?*

*M. I say I've got, eh I am not feeling happy, I got eh, I am not happy, can't explain" (243-250)*

Apparently because Maleeha never went to school, responding to complex questions or questions that required articulating emotions was a struggle for her. To ensure effective communication with her, several techniques such as slowing down the speech, using body language and appropriate vocabulary as well as rephrasing and simplifying the questions were employed during the interaction. This was important to understand the participant's perception of therapy and how she articulated her emotions and the meaning of help.

Although communicating about religious and cultural beliefs created a common language between the researcher and Maleeha, with Maleeha showing willingness to express her feelings through religion, her limited proficiency in English continued to impede further elaboration:

*M. I use my religion... read the Quran, read the good things... I sit at home and I take (Tasbeeh, like Subhan Allah, Alhamdulillah)... You know Darood Sharif, when I read, I feel better.*

*R. So when you do Tasbeeh and read Darood Sharif you feel better?*

*M. [Eagerly] Yeah, yeah*

*R. Why is that?*

*M. because it is, I can't explain, my, you know, eh, when a problem, not much feel very bad, my out feeling better, happiness when I read." (315-325)*

Because Maleeha borrowed words from the Arabic language to reveal and communicate her religious identity, she struggled to convey the meanings of her emotions through these words. The difficulty in finding equivalent words or

difficulty translating them, particularly for a non-proficient English-speaker can be an added challenge in an encounter with a non-Muslim therapist who may have limited knowledge of religious practices.

This case shows that the ability to communicate in English enabled the participant to express her emotions without the need to have a mediator in between. However, the participant's basic grasp of the English language and her limited knowledge of vocabulary constrained her ability to express herself. In particular, sentence formation caused a lot of misunderstanding and confusion. Although sharing a common cultural or religious identity could create a common language that would enable understanding between the therapist and the patient, a low level of competence in English can limit the ability to express the self. The case further points to how the untranslatability or non-equivalence of religious concepts can cause difficulty for communicating the religious affective meanings of these terms between a non-proficient English-speaking patient and a therapist with whom they do not have a cultural/religious connection.

#### **8.4 Summary**

Verbal and non-verbal communication are often used to express emotions related to participants' experiences of distress. The emotional expressions consisted of verbal messages that used specific lexical items and other rhetorical strategies such as metaphors, Quranic verses, and analogies that were shaped by cultural and religious practices and norms. In addition, participants used paralinguistic and non-verbal communication, which accompanied the verbal expressions and gave further meaning in context. The paralinguistic and non-verbal communication regulated how the emotional expressions were communicated in specific settings and offered valuable insights into patients' messages. On the other hand, somatic understandings of mental health issues allowed participants to shape their beliefs and construct meaning out of their experiences. As a result, participants were able to develop an emotional awareness of the self and the other, and reflect on their personal identities.



The analysis of both verbal and non-verbal communications drew attention to the complexity of communicating the emotions in therapeutic encounters, in which the communication can be quite a difficult task to achieve between therapists and patients. On the one hand, language often builds more complex emotions through the variability of word meanings in the forms of proverbs, analogies and the use of idioms of distress. On the other hand, borrowed words – while giving further insight into participants' social, moral, and cultural values – can cause further difficulties in understanding participants' articulations of their emotional experiences. Communicating emotions in moments of stress in a therapeutic setting can be difficult enough without the added issue of using ESL. Therefore, communicating in ESL can be more difficult to achieve and may result in possible conflict over meanings between participants and therapists.

Communication of emotions can be influenced by (a) verbal expressions, (b) cultural differences, and (c) non-verbal and social conventions. In some instances, verbal expressions cannot always relay information adequately because certain words that may refer to concepts in the English language may not exist in other languages. In other instances, cultural differences can influence the expression of emotions in which one message encoded in one culture can be encoded differently in another culture. Hence, they may lose their intended meanings when translated into the English language. For example, equivalent words are not always able to connote concepts such as '*depression*' or '*anxiety*' adequately in the culture of participant' groups. In further instances, social conventions can shape the way people feel in certain situations and the way individuals should talk about their emotions. Yet, some aspects of emotions can be culturally different and therefore, there might be an emotional gap between a word that is uttered and the feeling with which it is associated, particularly when said in a second language. In this process, limited English proficiency can be an added barrier to expressing the emotions effectively. While the use of interpreters can be useful as it allows patients to disclose their emotions in their first languages, the use of interpreters is not without its problems as the translation could result in the loss of intended meanings and influence the disclosure of emotions.

# Chapter Nine

## Discussion

### 9.0 Introduction

The objectives of the current study were drafted with a view to gain a better understanding of PSY groups' articulations of IAPT services and how language and culture, including religious beliefs, influenced their ability to express their emotional distress and fully benefit from these therapies. Three main themes emerged from the analysis of the data as discussed in Chapters 6, 7, and 8. These themes are: (1) perception of and beliefs about, therapy, (2) cultural and religious beliefs, and (3) communicating emotions in therapeutic encounters. Each main theme has additional subthemes providing a comprehensive view of the data and explaining patterns of participants' experiences (see Fig 9).

Drawing from these themes and in order to address the main research question (How do PSY patients articulate their experiences of IAPT with particular reference to culture and emotions?), this chapter begins by focusing the discussion on addressing the main four research sub-questions (Section 1.3). During this process, the implications of the findings on academic as well as clinical practices will be pointed out. Finally, the chapter concludes with a concise summary of the importance of this research and the contribution it has made in understanding the research problem.

### 9.1 Research Question 1

#### ***How do PSY Patients Articulate their Understanding of IAPT?***

To enable the understanding of participants' articulations of therapy, three main themes were explored: participants' definitions of therapy, sources of help, and their perceptions and attitudes towards seeking help.

#### **9.1.1 Participants' Definition of Therapy**

Therapy as a Western concept stems from Western health models is perceived amongst many participants in this study to be unfamiliar (Bhui and Morgen, 2007; Rathod and Kingdon, 2009; Tribe, 2014). This means, as argued by

Tribe (2014), that general implementation of Western models can undermine other people's concepts of mental health and may not take into consideration their cultural backgrounds. The study demonstrates that participants from the different research groups show different attitudes towards the concept of therapy. While the Somali and Yemeni groups appear to be less familiar with the concept of therapy, the Pakistani group – of which five are second generation – seems to be readily able to understand the term and work with therapists.

It is possible that these results are due to psychological practices and mental health services being less developed in Somalia and Yemen, where people with mental health disorders are treated differently (Saleh and Makki, 2011; Wood, 2004). It seems also possible that by adopting the term "counselling" instead of therapy, Pakistani participants appear to be more willing to attend therapy. The term can be more culturally acceptable, as it is connected to the Urdu word "mashwarah", which means "advice". This may explain why Pakistani participants are able to see counselling as an opportunity to relieve stress and equip themselves with coping strategies. However, with a small sample size, the data must be interpreted with caution, because an understanding of the concept of therapy is not the norm amongst all Pakistani participants, and the results draw attention to the importance of studying such cases in order to enable sound recommendations to be provided and to understand the factors that influence effective care delivery across different cultural groups.

Also, this finding, while preliminary, suggests that a direct link may exist between the language used by participants and the language used by therapists in relation to mental health. The latter, particularly in relation to the use of specific diagnoses, may not only denote a negative labelling but can also be seen as an exercise of power. Therefore, as highlighted by a Yemeni participant, there is a need to develop lexical items to be used in mental health that denote positive effect in order for the words to make sense to patients and their families. Investigating the use of positive words in addressing issues of access to mental health could be an interesting avenue of research in the field of mental health discourse analysis. Such research may raise awareness of positive labelling amongst patients and their families and enable medical

professionals to become more aware of the effect of culture and language in mental health care. The present study supports previous research by Ashcraft and Anthony, 2006, Lynn, 2010, and Schiffrin et al., 2001 (discussed in Section 3.3.6 above) and promotes the use of positive words as a source of hope. In addition, this thesis reinforces the recommendation by Hobbs (2014) which introduced a new approach to tackling mental health issues through the development of resources on depression and anxiety disorders that take into account the different perspectives of medical professionals, faith and cultural communities, and patients. This thesis is building on current practices and is providing research evidence for the need to consult PSY patients to develop resources for therapists on how PSY patients communicate their emotions.

### **9.1.2 Sources of Help**

From the results it is clear that family, friends, community groups, and religion helped PSY groups to overcome their depression and anxiety. Consistent with the previous research of Dwairy (2006), Kai and Clive (1999) and Keynejad (2008), PSY groups often prefer non-directive support from family members, as they believe that family welfare should not be discussed with professionals. The results highlight support from family members as essential because they can either encourage engagement with professional help or, in the case of poor or negative family support, act as barriers to seeking help. This is quite evident in the present study, in which participants who had encouragement from family members were more likely to report better outcomes and engage with the treatment process. The reason for these results may be related to the positive attitudes of family members towards accessing therapy. This can allow patients to overcome the potential stigma surrounding mental health and be less reluctant to open up to different treatment possibilities. While Park et al. (2011) and Weich et al.'s studies (2012) reached similar conclusions to the current study, they cautioned against the over-involvement of family members in therapy because they might hinder recovery and independence of individuals in making decisions.

The current study also found talking to God, in particular, was perceived as an important source of help, which PSY participants adopted to protect their privacy while at the same time strengthening their religious ties by asking God

for guidance and assistance. This point will be further discussed under Section 9.3.2 (see below), but what is worth mentioning here is that this finding can help us understand how some people cope with their distress in order to reinforce their sense of meaning and approach their healing from their own perspectives. However, the results show that some participants struggled to explain such beliefs and their emotional impact. It may be that these participants feared their values would be undermined, dismissed, or they would be perceived as irrelevant and irrational. Another possible explanation for this is that these participants feared disagreement and confrontation with non-Muslim therapists. These perceptions are in line with the “spiral of silence” theory (Noelle-Neumann, 1974) in which minorities are found to be less likely to express their views on a subject if they are in opposition with the majority, in fear of negative consequences (see Sections 3.3.4, 3.5.1, and 3.5.3 above). The attitude of some therapists towards minorities’ beliefs and values in this subject matter is worthy of further research to establish better insight and promote attitudes that are more sympathetic to PSY’s needs. The results also point to the potential of improving therapists’ knowledge to act constructively and develop better “social worlds” or communication levels between therapists and patients (Cronen, 2001).

### **9.1.3 Perceptions and Attitudes towards Seeking Help**

Differences in cultural beliefs and interpretations of religious practices for seeking help are seen as potential barriers for accessing therapy. For example, previous research by Rose et al. (2007) and recently published research by Hwang and Hollingshead (2016), focusing on studying words and labels used to stigmatise people with a mental health experience, revealed that some words have the potential to influence the perceptions and actions of mental health sufferers. Additionally, these studies showed that negative attitudes towards mental health and therapeutic treatments prevented people from expressing their distress or accessing services. Memon et al. (2016) further added that the shame and stigma associated with seeking help from professionals often restricts the individual from engaging with therapy as the shame can also affect family members in the eyes of the community. This is supported by the findings of the current study in which many participants stated

that poor understanding of mental illnesses and negative perceptions surrounding seeking help discouraged them from seeking it.

The outcomes of this study reinforce current practices, which have begun to consider consultations with PSY groups on the negative implications of stigmatising words and labels in participants' native languages.

This thesis provides research evidence on what it means to be stigmatised for seeking help from professionals and offers an insight into why, for instance, the word "depression" was found to carry negative perceptions. The current study explains that because 'depression' is a Western construct that has no equivalent meaning in certain languages, some participants in the research are unable to relate to the term. As a result, they feel reluctant to admit their illnesses or talk about their problems. The results indicate that therapists should avoid the use of terms that would be perceived to be stigmatising and which may affect engagement with these groups. However, because some languages have no equivalent terms to psychological English terms, the current study found several participants used similar words as therapists to describe their wellbeing. This can either facilitate or hinder the process of understanding or appreciating participants' emotions, particularly in the absence of a shared conceptual meaning behind the words used by therapists and patients. This implies the need for therapists to seek clarification and understanding of the meaning behind the words used by patients to enable better understanding of patients' emotions.

This thesis builds on previous research and offers an insight into some of the variations and differences that exist amongst the research groups in recognising depression and in what way culturally specific structures determined and impacted on the way in which they sought help. For example, unlike the Pakistani group, the results demonstrate that Yemenis with poor educational levels and Somalis have different views on depression, which are filtered through their culturally specific assumptions. Because Somali people have no grey area between sanity and insanity, discussing mental health issues or complaining about their worries are usually brushed off and people try to deal with their emotions quickly (Whittaker et al., 2005). "Mental health" and "depression" are often associated with being labelled as crazy and being

locked away in special institutions with no hope of recovery. Similarly, a number of Yemenis believed they would never get better as a result of being judged harshly by their community group. This may explain why these participants delay their treatments or fail to seek help. It is surprising that despite the extensive research on the barriers to accessing mental health services for Pakistani and Somali groups, this study found only limited existing research on Yemeni's perceptions of mental health (Saleh and Makki, 2011). It is difficult to explain this fact, but with the current civil war in Yemen and the subsequent increased Yemeni refugee population in the UK, this work has important implications for developing an understanding of Yemeni's perceptions of mental health. Future studies on the current topic are therefore recommended. The findings also provide some guidance for therapists in order to bridge the gap with these patients and respond sensitively to their needs.

With regards to attitudes towards seeking help, the study also shows some differences between genders. The results of the current study found men less likely to access therapy than females. This is quite evident in the study through the limited number of men who agreed to take part in the current study (4 of 22) and those who were observed to access therapy (7 of 16). The imbalance in representation mirrors the findings of Oliver et al. (2005) and Winerman (2005) where men in general were found to be reluctant to seek help, mainly if it was as a result of stress-related issues and distress in their lives. Within the total number of males who do access therapy, the percentage that is BME is even smaller (Memon et al., 2016). This may be due to the traditions of their cultures, which discourage them from seeking help in relation to their worries. The current study found PSY men to keep things to themselves and believe in solving their problems on their own for fear of being judged as weak.

Women, on the other hand, and particularly Pakistani females, were more likely to attend therapy. This is contrary to previous research by Keynejad (2008) and Shefer et al. (2012), which found Pakistani women to be less likely to access therapy for fear of harming the family reputation or affecting marriage prospects. It seems possible that these results are due to the increased awareness of mental health carried out by the local branch of the

MIND<sup>43</sup> organisation in Sheffield, where informal psycho-educational group sessions are held in community centres and delivered in Urdu. This has the implications for clinical practices of helping to engage with the different groups within therapy. By promoting the seeking of help in community centres or places of worship and delivering awareness courses in the groups' native languages, this may allow those groups to escape the stigma surrounding mental health. DH (2009) and Local Government Association's report (2017) and Hobbs (2014) and Keynejad's (2008) research provide case studies of how working with the different faith groups and community groups across the UK can help in promoting health and wellbeing. This could also encourage other individuals to consider therapy and change their attitudes towards seeking help. More importantly, by addressing potential barriers such as language and exchanging knowledge and awareness of the different cultural and religious beliefs, the target PSY groups may be able to see the value in seeking help from professionals.

## **9.2 Research Question 2**

### ***How do PSY Patients Articulate their Emotions?***

Taking into consideration that the overt display of emotions is viewed as a sign of weakness and/or reflects the stigma associated with mental distress, the use of physical complaints is not uncommon practice amongst the different groups to express their psychological distress. Although these findings are consistent with previous research by Bhugra and Bhui (1988), Dwairy (2006), and Loewenthal et al. (2012), this research shows that the PHQ used by therapists as a screening tool for depression and anxiety disorders does not take into account participants' physical complaints. The findings draw attention to two important points.

First, rating participants' emotions in accordance with an outcome measure tool may not take all physical complaints into account or may not measure to the specific description of depression and anxiety within a culture . The findings may be explained by the fact that participants repeatedly related their somatic

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<sup>43</sup> MIND is a voluntary organisation in Sheffield working in partnership with communities such as Pakistani advice and community association to end the discrimination and stigma surrounding mental health. Further information available at <http://www.sheffieldmind.co.uk/component/content/category/51-ourservices>



symptoms to three areas of the body: heart, head and chest. Religious beliefs may have played an important role in choosing these bodily organs and providing an explanation for their choice. Consistent with the Islamic theory of psycho-spiritual healing and pathology offered by Al Ghazali, a well-known Muslim Scholar, explained in Sections 3.1.1, 3.5.6 and 8.1.1, the heart, in particular, is recognised and emphasised in Islam to be a central organ for the physical and spiritual wellbeing of a person that impacts both on body and mind (Haque and Keshavarzi, 2014). This may explain why a number of participants in the study are found to seek the spiritual intervention of their hearts to heal their bodies. A growing interest in the heart and its relationship with the mind has been developed by many researchers, which supports the perspective of this study (McCraty and Royall, 2015). The PHQ does not account for psychosomatic complaints, such as complaints of an aching heart, which are common amongst mental health patients from Muslim populations. This information can constitute culturally specific markers of mental health problems which are important to therapists. There is currently a growing interest in the importance of such issues, which merits further investigation to yield further understanding of the heart/mind relationship in PSY groups and their perceived effect on the individual's mental health. A recent published study by Nyboe et al. (2016) proposes to look into the bodily complaints made by patients, the potential barriers in the assessment questionnaires, and possible ways to evaluate them to be consistent with patients' descriptions of symptoms, which is supported by the current study.

Second, the generalisability of PSY groups' bodily complaints as being solely due to somatisation with relatively little knowledge of how people describe their physical symptoms can result in putting patients' physical health at real risk. This may be related to therapists' having a prior judgement or no awareness of patients' subjective experiences and complaints due to language differences and ineffective communication with patients (Loewenthal et al., 2012; Momen et al., 2016). It is important, therefore, for therapists not only to concentrate on identifying specific cultural symptoms, but also to work with patients in a positive way that will ensure the provision of culturally appropriate health care.

The participants in the study were also found to use sayings and idioms of distress, which were often layered with culturally different meanings, to communicate their emotions. In addition, because religious beliefs were found to provide patients with meaning for their pain and to offer an understanding for their suffering (Ali, 2013; Bhui and Morgen, 2007; Keynejad, 2008), many participants made direct references to spiritual beliefs when talking about their distress. For instance, eight Pakistani participants made direct references to religious manifestation compared to Somalis and Yemenis who employed such references to a lesser degree. This can be related to the fact that Pakistan as a nation is established on the basis of the Islamic identity in which the implementation of the state is in accordance with the teaching of Islam (Pande, 2011). On the other hand, two Somalis and six Yemenis used analogies and metaphorical expressions to a greater degree than Pakistanis when talking about their emotions. As outlined by Thagard and Shelley (2001), analogies can richly convey the emotional experience. This can be related to the fact that the use of analogies is usually linked to previous memories and cultural background beliefs. The use of analogies, as such, can facilitate an understanding of participants' current distress and offer therapists a different perspective on patients' emotions (Blenkiron, 2005). This then allows therapists to gain an insight into the cultural origin of patients' beliefs. The results demonstrate that participants, through the use of analogies and their search for ways to make it easier for themselves to understand their feelings, draw on similarities that may exist between their previous memories and their current experiences (Feiereisen et al. 2008). However, analogies were found to generate two meanings: the intended meaning by the speaker and the meaning interpreted or understood by the receiver. Therefore, therapists need to explore the meaning of these analogies to ensure a shared understanding of participants' intended meaning is reached.

Proverbs, on the other hand, are the outcomes of traditional practices and social constructs which belong to a specific group (Tair and Edward, 2006). The findings of the present study demonstrated that through the use of proverbs, participants were able to shape their opinions and beliefs and reveal the individuals' knowledge of belonging to certain social groups to establish their identity (Dwived, 2015) and yet the results found that while proverbs may

have equivalent universal meanings, some proverbs are intended to express specific meanings that are unique to specific regions. The inability to recognise the specific meaning of proverbs can cause difficulties for therapists. Accordingly, therapists need to be knowledgeable of the social constructs of participants' regions of origin in order to appreciate the intended meanings.

The analysis of these expressions shows expression of emotions to be generally regulated by the traditional norms and cultural rules of each group, which highlights the relationship between language and culture. A similar pattern of results was obtained in Al-Kernawi and Graham's (2000) and Bentley and Owens' (2008) studies, in which the use of idioms of distress helped individuals to engage in effective emotional communication that is meaningful and appropriate in a given cultural context. This implies that the language of emotions is an important issue for future cross-cultural research and assessment. For instance, the results suggest the need to distinguish between the explicit meaning of the said words, and their implicit meaning, which is in line with Grice's (1967) theory of conversational implicatures (Grundy, 2008). This means that understanding the words is not simply a matter of translating the lexical meaning from one language to another. Rather, translating involves interpreters conveying the overall meaning of these idioms of distress to allow therapists to develop an understanding of the culturally specific meaning layered within the words.

One unanticipated finding that appeared to address this challenge – at least in part – was the use of word games. In this study, several participants pointed out that by identifying and labelling their emotions with appropriate descriptive words, they were able to express their emotions more accurately and have a better understanding of their feelings. Word games were also enlightening for therapists, as they were better able to understand participants' meanings. The findings support Schafer and Reid's notion (2001) that playing games in therapy not only allows people to enhance their understanding of their problems, but also enables the expression of thoughts and develops better understanding of the context. This is better explained by Rozena who believed that word games allowed her an insight into the self:

*“It was learning; it was recognizing myself more. I was recognising my emotions more... and it made me think that whatever you do is related to your mind” (Rozena, 382-396).*

From the perspective of this research, the overall impression is that the way participants used language appeared to be dependent on certain cultural ties that form one’s view of the world. The finding, therefore, has important implications for clinical practice. It implies that by developing such techniques as word games further and encouraging therapists to employ them, therapists can have better communication with patients and gain better insight into their perceptions and emotions.

### **9.3 Research Question 3**

#### ***Do PSY Participants Feel that Language and Cultural Issues Impact on their Experiences of Therapy, and if so, How?***

Participants perceived language and culture, including religious beliefs and practices to have an influence on therapeutic encounters. The following is a discussion of how they believed language, culture and religion influenced their experiences of therapy and communication of emotions.

#### **9.3.1 Language as Influencing the Communication of Emotions**

Language plays an essential part in therapeutic settings. Participants with limited ability to use ESL found language to act as a barrier to communicating their emotions effectively. It caused misunderstandings and affected their ability to absorb information, alleviating their distress and increasing reluctance to access therapy in a timely manner. This has also been found to be the case in previous studies by Bhui (2013), DH (2009), Loewenthal et al. (2012) and Suresh and Bhui (2006), which reported limited English proficiency to be the main barrier preventing ethnic groups from accessing the service or communicating the emotions effectively. For instance, language impacted on obtaining accurate assessments through the administration of PHQ in two ways. First, the translation of the PHQ in the different languages did not guarantee an understanding of the meaning. Secondly, participants who were illiterate or affected by their depression needed further explanation.

The results run parallel to previous research centred on identifying the difficulties related to the use of translated interventional tools (Bhugra et al., 2011; Haque and Keshavarzi, 2014; Lopez et al., 2014; Lu et al., 1995). The study found that the current translation of the PHQ seeks to reproduce an equivalent word meaning of the PHQ in the patients' languages, which is in line with the domestication values of Nida's (1994) equivalence theory. That is, the current translation of the PHQ is tailored to only accommodate and introduce the terms through the frame of already-known concepts that do not help PSY communities gain the new perspectives that they need. However, what the findings from this study highlight is the need to introduce a revised version of the PHQ, if we are to improve the communication of emotions and engagement with therapy. The revised version needs to introduce communities to the key concepts that underline therapy in order to facilitate their understanding of the process and engage with it productively. This is relevant to the foreignization concept of translation (Venuti, 1995), which is more concerned with retaining the culturally-specific meanings conveyed by the source text.

Similarly, the findings suggest that illiteracy and limited English proficiency are major factors affecting patients' ability to communicate their emotions and impacting on patients' non-compliance with therapeutic activities, such as writing a diary. The results pointed out the need to both adapt therapeutic tasks to the needs of participants and ensure that these new tasks are equally effective. A recent study by Sidhu and Begum (2017) which supports the perspective of the current study, showed that when CBT therapy for the South Asian community was adapted using culturally-specific examples and encompassing religious practices and activities, women reported a more positive experience and likelihood to express their emotions and engage in therapy. These findings are important in challenging the notion that these groups are intrinsically less likely to engage in therapy and to emphasise the need to raise awareness and facilitate access amongst them. Equally importantly, the results indicate that therapists should be aware of the differences that exist amongst the different groups and that they should not restrict themselves to one generic form of treatment.

Access to group and online computerised therapy was also impacted by the limited ability to use ESL. From the results it is clear that the provision of such services in the English language only, with the non-provision of interpreting services in these settings, disregards some patients' needs as they were unable to sign up for these programmes. This might indicate a kind of hidden power exercised against participants who had different linguistic abilities or different cultural backgrounds through the non-provision of equitable services (Fairclough, 1989). As discussed in Case 1, (Section 6.2.5), the results of the current study identified the shortcoming in the online computerised programme that does not accommodate for different needs, particularly those with a learning disability and those who are either illiterate or have only basic English skills. The results point out the need to assess the outcomes of such programmes and their limitations in order to provide recommendations and improve treatment approaches.

The results also highlighted non-standard sentence structure as a factor that affects meaning and may cause difficulties for both therapists and patients in therapeutic encounters. As explained by Baker (1992: 110) sentence structure can "impose a restriction on the way the message is organised in that language", and imposing that restriction in another language results in difficulty to understand speech. The result indicates that for therapists to be able to understand the communication taking place and interpret the intended messages, they need to consistently check with participants about their intended meanings. As demonstrated in Case 6, Section 8.3.4.5, English proficiency impacted on both the researcher obtaining information and the ability of the participant to express her emotions effectively.

Illiteracy issues and non-proficiency in ESL were also found to affect participants' abilities to communicate their emotions effectively as they do in their native languages. The results concur with the findings of other studies (Bhui and Morgen, 2007; DH, 2009; Eleftheriadou, 2010; Keynejad, 2008; Loewenthal et al., 2012), which found the use of patients' first languages to reveal their true feelings and carry emotional resonances. The use of language allows people not only to communicate their emotions, but also to recognise and associate words and phrases with sensation to make meaning out of their emotions (Lindquist et al., 2015). Therefore, certain words might be tied with

specific emotional experiences learned and stored from past experiences. This finding suggests that language will not only help in describing the emotions but will also help in forming and shaping the perception of the emotional experience, the reason being that the participants' knowledge and experience of their emotions are tied up with their first languages in which the previous knowledge about the emotions was experienced. This finding provides further support for Lindquist et al.'s (2015) research, which revealed language to be a main construct of both emotional experiences and perceptions.

These results may help us to understand why some patients may experience difficulties when trying to articulate their emotions in ESL. An explanation for such results can be that an equivalent word of emotion in English may have no meaning in patients' first languages or vice versa. Another explanation is the fact that speaking two languages or knowing two languages does not necessarily mean patients have the same understanding as their therapists. In such cases, therapists might encourage patients to talk in their native languages and later discuss what the experience was like in order to develop an understanding of the equivalent emotional word. Likewise, these results can suggest that the reason some participants were able to feel empowered in ESL, was linked to the emotional learning experience of new words from the new culture.

On the question of using interpreters to communicate the emotions and address language barriers, the finding of this study is in agreement with Bhugra and Gupta (2010), Burman et al. (2003), Costa and Briggs (2014), and Keynejad (2008), which showed linguistic proficiency, knowledge, and expertise to be core competencies that allowed patients to talk about their emotions in therapeutic settings. Despite numerous research studies that have called for high-core standard interpreting services as well as developing guidelines for training interpreters, the results of this research showed that patients continued to report dissatisfaction with the interpreting service provision in communicating their emotions (Costa and Briggs, 2014; Lee, 1997; Putsch, 1985; Tribe and Morrissey, 2004; Tribe and Ravel, 2003; Westermeyer and Janca, 1997). An implication of this could mean that patients may be unable to express their emotions or may face incidences of misdiagnosis.

One particular concern amongst participants from the different research groups who used interpreters was the issue of confidentiality and discomfort in disclosing their emotions in the presence of interpreters. The issue of distrust was noted to impact on the expression of emotions and engagement with the services, which was also observed in earlier studies by Bhui and Morgen (2007), Keynejad (2008), Loewenthal et al. (2012) and Rathod and Naeem (2013). Issues of trust and confidentiality require further consideration and implementation of regulations and rules. These results are noteworthy as they draw attention to the need to understand the qualities and expectations that form the basis of trust between people, particularly as some concerns were also highlighted amongst several participants when working with therapists with similar ethnic backgrounds as discussed in Eleftheriadou (2010) and Kai and Hedges' (1999) research.

What is surprising, is that participants who have limited understanding of the English language developed certain strategies to assess interpreters' skills and expertise. Participants pointed out four main strategies, which include understanding some English words, interpreters' repetition of the exchanged translation, assessing therapists' responses, and asking interpreters about their qualifications. This finding has important implications in understanding the broader issue with interpreters and could be useful for considering guidance for interpreters as well as help to develop an overview about particular approaches to interpreting and what makes one better than others. For instance, since participants with limited English proficiency used their limited understanding to assess interpreters, therapists should ensure using uncomplicated language to build trusting relationships between interpreters and patients and facilitate the communication.

On the other hand, having a therapist who speaks the same language was found to impact positively on therapeutic relationships between therapists and participants. D'Ardenne and Mahtani (1999), Lago (2011), and Lopez et al. (2014) highlighted that speaking and sharing a common language enables participants to open up and engage effectively with therapists, and facilitates a bond between them. This means that language compatibility can create a sense of connectedness and sameness with therapists. This is particularly important in a broader society where they are categorised as 'other'. These



language-related issues are critical to therapeutic encounters because it is through language that therapists can either exercise power and create a closed climate or relate to patients and develop service provision that is both more linguistically and culturally care-appropriate.

However, the findings cannot be extrapolated to all participants as the results indicate that the ability to speak in a common language is not always a guarantee of understanding. Speaking the same language does not necessarily mean sharing a common culture, and the language-use to express the emotions may vary within the different regions of the country, where the vernacular differs from the standard language (Drolet et al., 2014; Loewenthal et al., 2012).

In the context of considering an appropriate therapeutic alliance, the evidence of this study shows that many participants manifested a preference for working with therapists who were familiar with their cultural and religious milieu as pointed out by Gallardo (2012) and discussed in Cases 2, 3, and 4, (Sections 7.1.5, 7.1.6, and 7.2.4). One way to interpret these results is to consider that culturally-informed therapists and those who are able to attend to a Muslim patients' belief system are more able to work in conjunction with their distress and improve treatment strategies. In the current study, some participants acknowledged a sense of wariness that their cultural and religious beliefs would not be taken seriously or would be dismissed, which stopped them from opening up or discussing these beliefs. This result is consistent with the view that understanding religious beliefs would require non-Muslim therapists to understand the unique meaning that religion holds for the individual (Haque and Keshavarzi, 2014). This finding suggests that non-Muslim therapists who work with Muslim patients should develop their understanding of Islamic religious belief systems. This can be carried out by reading more about Islam, attending workshops that focus on Muslim beliefs and gaining an understanding of the vocabulary that is unique to Muslim patients. More importantly, since NICE guidelines (2011) necessitate the need for therapists to consider how individuals' religious and spiritual belief systems may be relevant and to incorporate these into their treatment plan, future research avenues may explore the reasons as to why non-Muslim therapists struggle to initiate discussions with patients about religious beliefs.

### 9.3.2 Cultural and Religious Beliefs

As outlined above, the study finds that in order for therapists to familiarise themselves with participants' concepts of mental illnesses, they need to attend to participants' cultural beliefs and religious values. For instance, on the question of causes of depression, the study found that some participants referred to supernatural causes such as Jinn, evil eye, and black magic to determine their destiny. These results are consistent with studies by Gater et al. (2010), Khalifa et al. (2011) and Rathod et al. (2010), who found the reason that for people to refer to such causes to be related to the many verses in the Quran that refer to the existence of Jinn and black magic, which can cause people distress in life. It appears that such beliefs are often a ground of conflict between Muslim patients and non-Muslim therapists, but this conflict may not necessarily be considered as unhelpful. As explained by Ting-Toomey (2007), when two different cultures meet, people often bring their own values and beliefs to the encounter and in order for both parties to overcome the disparity they need to adopt flexible communication skills that are based on being knowledgeable and mindful of the other as well as being skilful in managing cultural and individual differences. This means that by exploring the religious dimension of patients' background, therapists would have a clearer picture about patients' beliefs, understand their narratives and be able to offer the help needed (Abu Raiya and Pargament, 2010). By understanding a patient's religious beliefs, therapists can build a better relationship and communicate more effectively. This means that therapists can enter patients' worlds and engage with their stories, and patients would be able to reconnect with their faith and explore sources of struggle. For instance, some patients may lose trust or feel unable to fulfil their duties towards God when they are faced with the hardships of life, which may leave them feeling guilty.

Participants in this study expressed particular emphasis on their religious beliefs and the importance of addressing these in therapy. The findings confirmed that using Islamic teaching and religious coping techniques allowed many participants to manage their distress and find answers to their problems. Exploring Islamic religious practices has gained an increase in interest recently and has been demonstrated that using effective spiritual teaching can ensure a more culturally and spiritually appropriate treatment is available for Muslim

patients (Dwairy, 2006; Hamdan, 2008; Isgandarova, 2012; Pathan, 2016; Weber and Pargament, 2014). However, the present study found that there is little evidence that such religious teachings are currently adapted or used in therapy with Muslim patients. Meer and Mir (2014), who explored the possibility of incorporating religious healing methods to existing therapeutic approaches, found non-Muslim therapists to be reluctant to use such techniques. They speculated the reasons to be due to some therapists knowing little about Islam and believing they needed further training to use such a new framework for treating depression. Also, they believed other therapists were unwilling to impose religion on Muslim patients. The results of the present study are significant in at least two aspects. They give a clear message that when therapists communicate well with their patients and encourage them to talk about their beliefs, an effective engagement is more likely to take place. Secondly, it points out that when therapists increase their knowledge about Muslim religious beliefs and take an approach that encompass these beliefs, patients feel more comfortable in discussing their spiritual practices.

In this study expressing the meaning of religious rituals and cultural concepts that do not exist in the English language or culture were found to be a challenge for both participants and therapists. There are a number of explanations for this finding. First, translating the meaning of cultural beliefs and/or proverbs that may have specific religious meanings can be difficult because language influences the way the meaning is perceived by a specific community group. Secondly, rendering the surface meaning of these religious and cultural practices might only add to the ambiguity of the phrases. Finally, finding equivalent words to convey emotional terms that are related to cultural or religious concepts can be difficult, as they might not exist in the target language, or if they do exist, they might have different connotations. This finding supports earlier studies by Catford (1965), Newmark (1988), and Qian Hu (1994), who all believed in the difficulty of reaching the concept of “sameness” or total compatibility between two languages. This is particularly problematic when even the concept itself does not exist with the culture. As pointed out by Nida (1994: 161), the “...real problem is not the incommensurate nature of languages but the need for an insightful

understanding of the linguistic and cultural bases for translating”. It can thus be suggested that for therapists to achieve a better understanding of these culturally-bound expressions, they need to grasp the intended meaning with its cultural association. This can be achieved by spending more time with patients, asking for further explanation, and exploring the possible meanings.

Another issue that emerges from these findings is the difficulty of translating religious loan words used by Urdu and Somali speaking participants, for many reasons. First, religious loan words are connected with Islamic religious practices and are learnt for the purpose of reciting the Quran, but without fully comprehending their meaning outside the religious context. For that reason, these words were found to be hard to translate or to render their meanings. Secondly, the Islamic terms have no equivalent words in Urdu or Somali languages since both those groups adopted the Arabic terms in their languages. Finally, explaining the Quranic concepts can become a difficult task as one needs to understand the rich layers of meaning to provide an explanation of the intended meaning. Larson explains:

“Terms which deal with the religious aspects of a culture is usually the most difficult, both in analysis of the source vocabulary and in finding the best receptor language equivalence. The reason is that these words are intangible and many of the practices are so automatic that the speakers of the language are not as conscious of the various aspects of meaning involved.” (1984: 198).

These findings may help us to understand the complexity of the intercultural communication encounters taking place in therapeutic settings. It seems that for patients to communicate the in-depth meanings of the religious terms they are not only translating words and phrases but also transmitting their cultural belief system through linguistic means. Yet this does not imply the impossibility of interpreting the meaning as pointed out by Nida and Taber (1982), but rather points to the challenges. The results reveal the need for therapists to engage in a meaningful discussion with patients about their specific meanings, develop a better understanding of patients’ cultural and/or religious backgrounds as well as learn how to address these issues. On the other hand, patients need to learn how to communicate the meanings of their cultural and religious beliefs

and find ways to explain the meaning of these terms to ensure therapists come to a clearer understanding of these terms.

#### **9.4 Research Question 4**

##### ***Do PSY Patients Feel their Emotions are Being Explored by Therapists, and if so, How?***

In this study, the display of appropriate non-verbal communication that involved empathy, understanding, and respect demonstrates the correlation between the ability of therapists to attend to patients' emotions and understand their feelings, and the ability of patients to express their emotions. Positive non-verbal communication displayed by therapists was found to create a sense of connection between patients and therapists (Foley and Gentile, 2010). In comparison, and consistent with Patterson (1996), non-verbal communications that were perceived as showing indifference were found by several participants to create a distance and bestow power onto their therapists. This means that non-verbal communication can provoke certain reactions in patients without the therapist saying a word. Ting-Toomey (1999: 115) pointed out the need to be mindful of non-verbal communication in intercultural settings because they "carry powerful emotional wellbeing and provide context for how the verbal message should be interpreted and understood". Since non-verbal communication can transmit emotional messages in therapeutic settings, future research to study how such non-verbal communication can be taught and learned may be of benefit for PSY patients.

The current study identified nodding, facial expressions, smiling, and eye contact as having an impact on patients in therapeutic encounters, which supports findings reported by Finest and Del Piccolo (2011) and Hall et al. (1995). Importantly, "silence", a key form of paralanguage (Mariska and Harrawood, 2013), was used in one therapeutic encounter and was found to cause discomfort to a patient. Although the finding is limited to one case, silence has received some interest recently and a number of research studies have been conducted to evaluate its use in therapy (Hill et al., 2003). Previous research studies by Black et al. (2009) and Lehman (2014) have pointed out

that silence may either improve or impede the type of communication that fosters healing between therapists and patients. However, there is relatively little known about patients' perceptions or reactions to silence in therapy. The findings of this study suggest that further research is needed to understand the effect of silence on patients in therapeutic encounters as this may also contribute to an understanding of power dynamics in them

The communication of emotions in therapeutic encounters is dependent on building a bond with therapists. Yet, language as an expression of power can affect therapeutic relationships between patients and therapists, suppressing the expression of emotions (Barden and Williams, 2007). The present study illustrates how specific language constructs can create a sense of control and hide power, which can impact on the dynamics of the relationship between therapists and patients. In this study, the way therapists asked questions and responded to patients' emotions using unsupportive messages that demonstrated insensitivity or rigidity was found to disengage patients from therapy and create the perception that therapists are unable to attend to patients' emotions. Moreover, the inability of therapists to understand patients' cultural and/or religious beliefs as well as the imbalanced nature of the power relationship between therapists and patients due to background differences and variations in education levels are found to disempower those patients and create a distance between them and therapists. As explained by a participant:

“The person who didn't go to school finds the way educated people talk, quite difficult to comprehend” (Aliya, 421-422).

This means that therapists' psychoanalytic dialogue and the use of language that requires greater linguistic knowledge or the use of diagnostic labelling in particular contexts can elicit negative patient reaction and affect their self-disclosure and their relationship with the therapist. This is consistent with Thornborrow (2002: 9), who recognised that in order to “analyse how discourse can be powerful, we need to take into account not just how speakers get to say what they do, but what it is that they say”. From the results of this study, it is clear that patients believed that therapists need to address each individual according to their level of language competency in order to communicate effectively with them. Perhaps even more importantly, patients believed that

therapists must educate themselves about the values and cultures of others, be mindful of language-use, and ensure language is used in a way that is beneficial and relatable to the other (Thomas and McDonagh, 2013). The present study highlights the importance of understanding therapist-patient similarities and/or differences such as personal background, personality characteristics, personal variables, and the possible implication these may have for therapy outcomes. To address issues that may stem from these similarities and/or differences, further research that takes these variables into account will need to be undertaken.

The analysis of the present study also demonstrates two further points. First, several participants indicated that they attended therapy without any prior knowledge of its content and that they were referred to the services based on consultation with their GPs as authoritative figures. Other participants were referred to therapy as a preference over medication. Taking into consideration the role of language as a potential barrier, this may raise questions about the nature of communication that took place between GPs and some patients and whether these patients were able to access key information about how they can access therapeutic services and appropriate advice about the benefits at this point in their mental health care journey.

Secondly, the findings point out that therapists often prejudge PSY groups as not willing to attend therapy. Existing research by Ahir (2014), DH (2009), Keynejad (2008), Rathod et al. (2013) and Suresh and Bhui (2006) documented BME groups as having poor access to mental health services, high dropout rates and poorer outcomes. Because some PSY patients are unable to label or understand their distress, it appeared that they were not always offered the option of therapy. This research provided evidence that there was willingness to attend therapy amongst PSY groups. In addition, PSY participants who attended therapy – even for only one session – were able to gain some benefits. The reasons for not offering the option of therapy to PSY patients appear to be based on a generalised view in which individual differences are ignored. This could have damaging consequences and/or pose risks to patients' emotional wellbeing and health. GPs as authoritative figures and therapists need to be more transparent and understand the differences that may exist between the different groups as well as between individuals.

Besides language as a major barrier to accessing therapy, the research provides some explanation for the smaller rates of PSY patients accessing therapy. One possible influence is that a single visit in some cases was enough to understand the patient's problem. Another explanation is the patient's lack of confidence in the suitability of treatment or its effectiveness, which may lead some patients to drop out of therapy. Moreover, some participants pointed out that some therapists were unable to understand or respond empathetically to their emotions and patients were able to find alternative treatments that were more applicable to their cultural and religious needs. These findings show that patients are able to construct their own understandings of the value of these services in responding to their needs and develop a positive or negative expectation depending on whether the situation closely conforms to their cultural values or not. At the same time, the findings draw attention to the importance of having programmes that directed towards having a greater impact rather than a "one size fits all" approach. These results point to the power dynamic exercised by medical health professionals in making decisions on behalf of PSY patients, controlling their course of treatment, and expecting the latter to comply with their decisions. Through a focus on language-use in such interactions, one can observe the hidden determinant for such relationships and the effect it may have on PSY groups (Fairclough, 1989).

## **9.5 Summary**

Participants' narratives and perceptions in the field of therapy are of profound importance since the ultimate aim of the medical profession is to provide high-quality care for patients. This research is believed to have given PSY participants, mainly those with basic English proficiency, the opportunity to voice their concerns and enhance the understanding of their perceptions around the language and cultural challenges they encountered within the IAPT programme. The findings are of immense value as they offer an insight into possible ways to improve communication between therapists and patients.

The present study has broadened the knowledge of the varying perceptions and attitudes towards seeking help that exist amongst the different groups as well as between individuals. These differences have direct relevance to therapists' clinical practice and should be taken into consideration when



offering different treatment modalities. Additionally, the research draws attention to the direct link between language and mental health and how the use of positive or negative vocabularies can affect patients' engagement and access to therapy. More importantly, the present study points out the need to examine the terms used among common people to refer to concepts of mental health in order to tackle issues around stigma and shame.

The current study further provides examples of the complexity involved in the intercultural communication encounter between therapists and patients through the discussion of the different emotional expressions used by PSY groups. Careful examination of these expressions reveals that in order for therapists to understand the underlying meaning of words they need to develop an understanding of the culturally specific meanings layered within words. Moreover, the findings of the present study emphasise the need to develop an understanding of the culturally-specific issues that are grounded in religion, as they can be interpreted differently by different individuals and groups. More importantly, understanding the religious beliefs and encouraging patients to talk about their beliefs can help build and maintain a good therapeutic alliance between therapists and patients.

# Chapter Ten

## Conclusion

### 10.0 Introduction

The present study is designed to explore PSY articulations of therapy in order to have a better understanding of the language and cultural challenges that patients may face when accessing IAPT services, with special emphasis on cultural references and emotional expressions. Participants' articulations are interpreted in relation to the social constructionism theory (Burr, 2015), which sees language and its symbolic systems as central to the process of creating meaning and the interpretive framework. The interpretive approach using qualitative data collection methods such as questionnaires, interviews, and observations has been used since it aims to understand the meaning within the intercultural communication encounter by exploring participants' perspectives in such encounters (Oetzel et al., 2016).

This chapter starts with a summary of the key findings of the current study in relation to the research questions and the studies presented in the literature. Next, the principal implications and contributions of this research to the literature are discussed and the strengths and limitations of this research are outlined. The chapter concludes with a set of recommendations for future research avenues.

### 10.1 Key Findings

#### 10.1.1 Perception of Therapy

One of the key findings of the current research shows that Western constructs such as “therapy” and “depression” are not familiar concepts amongst PSY groups, yet the study has shown that variations exist amongst the groups as well as between male and female individuals, in understanding the Western concepts and recognising symptoms of depression. These variations appear to influence the attitudes and misconceptions towards and associated with, seeking help. Some patients did not have the opportunity to consider what therapy might mean because therapy was not offered as a treatment option.

For that reason, patients' perception of therapy was in many cases limited. Other patients were offered therapy as a treatment option alongside medication, but not knowing what therapy might mean or involve, they were reluctant to access therapy. The study has also shown that PSY groups were reluctant to access therapy as they believed there was a direct link between the use of words that constituted markers of disgrace and the stigma surrounding accessing therapy. Furthermore, the findings show Pakistani groups to be better able to access the service and understand the terms used during therapy than Somali and Yemeni participants. Despite the evidence of some participants wanting support and attending therapy, the findings show that these groups were rarely offered information about the service (Section 6.1.5).

### **10.1.2 The Communication of Emotions and the Complex Relationship between Language and Culture**

One of the more significant findings to emerge from this study is that using physical complaints and both verbal and non-verbal communication to express the emotions unfolded layers of cultural and religious beliefs that regulated the expression of these emotions and provided an insight into PSY patients' feelings. For instance, the findings show that the research groups emphasised specific bodily complaints that appeared to be related to the holistic approach of healing the body and mind. However, this should be approached by therapists with caution and without prior judgment of patients' subjective experiences. The results have also shown that during the process of communicating their emotions, PSY groups used different sets of meanings and representations where they not only were able to engage in talk about different topics, but were able to negotiate their identity and exchange with therapists the different cultural views that were dependent on language use. It was shown that language use helped participants to articulate their emotions, establish their identities, and reveal power inequalities between themselves and therapists.

### **10.1.3 Understanding Cultural and Religious Beliefs and the Integration of Religious Practices as a Source of Help**

The study has found that generally PSY groups attributed distress to their cultural norms linked to family values, and religious beliefs, such as the “evil eye” and “black magic”. For that reason, religion is found to be an important source of help for PSY groups in order to reinforce their sense of meaning as well as to approach healing from their own perspectives. However, the findings suggest that religious beliefs represent a significant challenge for non-Muslim therapists as they are often entangled with cultural ones. Conceptualisation Islamic practices emerged as an added challenge for therapists. As a result, the research has shown that PSY participants prefer to work with therapists who are able to understand their cultural and religious beliefs. The findings also suggest therapists need to inquire about religious beliefs and incorporate patients’ religious coping practices in therapy while being mindful of any differences that may exist between the different groups.

### **10.1.4 Language as a Barrier for Effective Communication of Emotions**

The findings have shown that language is a major perceived barrier to effective communication in therapeutic encounters and contributes to patients’ reluctance to access IAPT. The use of interpreters, the translation of the PHQ, the use of activities that did not consolidate participants’ cultural beliefs, as well as therapeutic approaches that disregarded participants’ basic knowledge of ESL or failed to accommodate their different needs, all emerged as reliable predictors of negative impact on participants’ abilities to express their emotions and engage effectively with therapists.

## **10.2 The Implications of the Current Study**

The aim of the current study was to allow people with different first languages the opportunity to voice their concerns. As a result, this research has a multilingual context which has implications for language and intercultural communication studies, multilingual studies, teaching and training programmes for therapists and interpreters working with PSY groups as well as on policy makers’ decision-making.

### **10.2.1 Language and Intercultural Communication Studies**

The evidence from this study suggests that understanding the discourse in therapeutic encounters, constructing knowledge from experiences of patients and care providers to learn what happen in the setting can allow researchers to promote change and improve cross-cultural care provision collaboratively. This reinforces the findings made by Mercer (2004) who explained how a particular methodology was created to analyse the use of language in educational settings in order to tackle intellectual problems and improve the quality of classroom dialogue between teachers and students. Accordingly, the following conclusions can be drawn from the present study.

Issues around negative and positive language-use in therapy can be of great interest to discourse analysis researchers who may observe the hidden power in such interactions. As a result, they can develop new approaches to address these issues and promote change in thinking about mental health. Moreover, the study of language(s) in this context can broaden researchers' knowledge of the differences, as well as similarities, that may exist in the attitudes towards seeking help amongst the different groups involved here and enable them to address these issues in the different cultural contexts. The findings imply the need for researchers to recognise the important role of language(s) and how communication, including non-verbal elements, can lead to the understanding of different cultural meanings. This can have the potential to improve communications in intercultural settings and, in particular for this study, the practice of therapists. By learning how to observe communications during intercultural encounters, some of the barriers and cultural differences involved in these encounters can be overcome. This could lead to more effective engagements and provide participants with a more comfortable context in which to work together, e.g. learning more about the meanings of the non-verbal communications related to the specific groups and/or asking patients about their meanings.

### **10.2.2 Multilingual Research**

One of the challenges encountered in this research was the ability as an Arabic-speaking researcher to deal directly with the data arising from the

Yemeni Arabic-speaking participants but having to depend on interpreters with some Pakistani and Somali participants.

Doing research in more than one language with limited knowledge of the languages can lead to losing important information. Likewise, the lack of guidance in the process of interpretation and translation to find accurate corresponding constructs or equivalents to participants' emotional or religious terms can pose challenges or questions relating to the trustworthiness of the data reported. This research supports Holmes et al.'s research (2013) and points towards key implications that concern academic institutions and translation studies. The current study has revealed a number of complexities and challenges that researchers in similar positions may encounter. For instance, the results of this study indicate that language choice in reporting the findings, ethical issues involved in choosing one language over the other, and the interpretation and translation issues involved in reporting and disseminating the results, can pose real challenges for academic researchers. This is because using different languages may have different implications on academic research. For example, what might this thesis have been like if it had been written in Arabic? It might have been that different opportunities and/or challenges would have presented themselves in a way that the learning outcomes may have been altered and the thesis itself would have attracted different audiences.

Regarding the learning outcomes and drawing from this research on communicating emotions in different languages, the researcher believe that fulfilling the double role of both an Arabic interpreter and translator, and being able to mediate between the different linguistic worlds developed knowledge of other languages and honoured participants' voices (Gorter, 2012). However, with regard to attracting different audiences, there is an emphasis for academic researchers to write their research in English, the dominant language of reporting, in order to disseminate the research experience or communicate with wider audiences. This is a global linguistic inequality that needs addressing in order to build a strong justification to use other languages in publication and dissemination of results. The findings also suggest researchers need to report more on the translation and interpretation methods used in cross-language/culture research to enable other academic

researchers the ability to consult with literature and ensure validity and trustworthiness of the data.

### **10.2.3 Teaching and Training Programmes for Therapists Working with PSY Groups**

It is clear from the current study that therapists and professionals working in the counselling profession are expected to understand their patients and their use of language in such encounters. This study provides an insight into language-related issues that can have implications for the medical education curriculum.

Based on the communication challenges highlighted here, linguists can develop training sessions based on real-life experiences in the form of role play and highlight difficult to understand patients' expression that can arise within the situation. They can also develop creative resources and/or approaches such as word games, storytelling, or pictures that can serve as a medium of communication between therapists and patients to give further insights into patients' emotional experiences. Furthermore, through the use of video recording and clinical vignettes, linguists can teach trainee students in the counselling field a range of questioning techniques that can help them to generate a dialogue in regard to cultural and religious beliefs, and teach them how to clarify any points without causing a misunderstanding. Because participants continuously referred to therapists' non-understanding of their cultural and religious beliefs, the cultural elements in language and the differences in world views as well as the different meanings of non-verbal communications can be included in the teaching and training modules for therapists. This can provide therapists with an opportunity to better understand the cultural experience of patients and protect such beliefs from being misjudged by therapists. By carrying out a periodical review of the medical curriculum and working with counselling schools, this will ensure trainee therapists are aware of the varieties of meaning and challenges associated with language and cultural issues.

#### 10.2.4 Translation and Interpreting Teaching Programmes

One of the implications of the current study for the practices of interpretation is to take into consideration the different modes of interpretation to ensure effective communication and understanding between patients, therapists and interpreters in therapeutic encounters. This implies the need for interpreting teaching programmes to invest in practice-oriented assessments such as an on-going or periodic assessment of interpreters' actual job performance to assess interpreters' expertise using the strategies outlined in the current study. Considering the relationship between culture and communication, the findings suggest that explaining the context of the utterance can help therapists be more aware of any cultural meanings that may exist in participants' expressions. Therefore, interpreting programmes should be reviewed to ensure the inclusion of practical training for professionals working in this field to certify interpreters have the required expertise. The lack of such programmes to improve the standards of interpreters and the use of untrained interpreters who are either unfamiliar with mental health concepts or unaware of the counselling skills and interviewing techniques required for working in therapeutic settings can cause serious concerns. Finally, as the focus is on patients who use English as a second language, educational programmes for interpreters should focus on how language skills such as the ability to transmit the essential information for both patients and therapists and having an in-depth knowledge and extensive vocabulary in the subject areas are a must for communication because speaking the language is one thing, but the ability to communicate using the appropriate language is another.

The current study also has wider implications for translation study programmes that are looking into culturally specific terms and possible ways of dealing with issues of non-equivalence or untranslatability. The present study demonstrates that translating between languages in the field of psychology can be a challenge but is not impossible. This implies that in addition to the sound knowledge of subject matter in both Target Text (TT) and Source Text (ST), translating programmes should teach academic translators to foresee the ways in which culture can impact on the ST in order to translate proverbs and idioms of distress in an appropriate manner. In addition, practical training tasks that enable trainee translators to understand how the different parts of



the text work together are essential in order to deliver a message that is effective for the target audience. Translating programmes can create a resources bank and forums that trainee translators can consult in order to find answers to challenges involved in translating new concepts and identifying new ways to deal with this.

### **10.2.5 Policymakers and Decision-Makers**

The results of the current study have a number of implications for policymakers in order to tackle the disparities in mental healthcare provision amongst the different BME groups and address the linguistic and culturally specific issues related to IAPT service provision. One of the implications of this study is the possibility of developing new policies that aim to address language barriers in ESL teaching programmes. Such policies could incorporate cultural values as well as non-verbal communication styles of both the host country and those of the learners into ESL programmes. Decision-makers can also look into introducing art in language learning through the use of emotional objects and visual educational tools, which can play a vital role in enabling learning. Language barriers should not be taken as a reason to exclude BME groups from accessing mainstream services. For that reason, policymakers are required to engage with the different community groups and address the differences that exist amongst them to raise awareness about IAPT services. By drawing attention to the importance of having focused programmes that have greater impact rather than “one size fits all”, policy makers can reduce the inequalities associated with seeking help from these services in all workplaces and practices. Accordingly, IAPT services need to review the existing policy outlining Positive Practice Guidelines for BME clients (DH, 2009) and address the culturally-specific issues outlined in the current study by developing culturally appropriate approaches that take into account participants’ different cultural beliefs and religious coping techniques. In addition, decision-makers are required to assess the gaps in the online programmes and group therapy in order to accommodate the different needs of particular user groups and ensure equality of service provision.

### 10.3 Strengths and Limitations of the Study

The researcher's knowledge and experience of mental health provision was one of the main strengths of the present study, which enabled conducting the interviews in a manner receptive to participants' linguistic cues and allowed participants to share their experiences and feel more comfortable to open up about their feelings (see Section 5.4). The ability to speak the same language with a large number of participants and sharing their cultural and religious beliefs as well as the ability to relate to them and build rapport, improved insights into, and judgement of, their accounts. As pointed out by Witcher (2010) the ability to speak the language enables the researcher to remain faithful to the data and report the words as intended by participants. This can enhance the quality of the transcripts and accuracy of data interpretation. On the other hand, being an outsider to the community groups takes the pressure off the researcher to report on a number of issues related to the groups' cultures and allows her to feel less worried about their reactions. This enhanced the validity of the data and enabled a critical reflection on the researcher's positionality (Section 4.3.1), which in turn ensured rigour and reliability (Cormier, 2018).

There were some limitations in observing certain stages of participants' care pathway. The initial plan was to attend sessions with different professionals, as this may have given an opportunity to observe counselling in different contexts. Observing other professionals involved in therapy, like CBT and counsellors, might have given a different perspective on issues and additional information could have been obtained. Because it was difficult to gain permission to attend CBT and counselling sessions (Section 5.3), reliance on the small number of therapists who agreed to take part in this research was necessary. Despite the small number of therapists, their differing cultures, one being a Yemeni Muslim and the other of Western background turned out to be a great opportunity to witness the effect of this difference on patients

The use of "overt observation" also has its own limitations and ethical dilemmas, which can impose restrictions on researchers against achieving their objectives (Angrosino, 2005; Jupp, 2006). One of these dilemmas is the likelihood that therapy sessions involve talking about traumatic incidents and

possibly shameful or humiliating events. Thus, the researcher was conscious that her presence as a third party, might inhibit people and stop them from disclosing important information. There was also the concern that some participants might give false information or provide exaggerated reactions during the observed sessions to please the researcher. Also, it was acknowledged that therapists might become conscious of being observed, which may change their behaviour and impact on their practices. Such issues may affect the therapeutic experience for patients, put therapists under pressure, and be detrimental to the quality of research.

Another ethical issue is the likelihood of bias in the process of selecting what to report and the potential for deviation from the truth in favour of the researcher's own perspectives and experiences (Bickman and Rog, 2009). It was acknowledged that all information reported was filtered and interpreted through the researcher's understanding and subjectivity and as thus, every effort to achieve objectivity was made, such as being distanced from observational settings and allowing a reflexive practice on the research process as suggested by Bickman and Rog (2009), and explained in Section 4.3.1.

The use of interpreters in qualitative research is well documented as impacting on the collection and interpretation of data (Ingvardotter et al., 2010; Cormier, 2018). The present study is no exception. However, as outlined in Sections 4.3.1 and 4.6.3.6, the process involved in collecting, interpreting, and translating the information and the positionality of interpreters, translators, and the researcher as both insiders and outsiders of the research process, has been explained in detail. The concise detail with which the research design was reported and the thought given to the measures undertaken to eliminate any possible misunderstanding demonstrates the transparency of the researcher.

## **10.4 Recommendations**

The understanding of PSY perceptions with regards to IAPT services means that therapists, GPs and service providers are required to take into account a number of considerations to provide appropriate therapeutic care for PSY

groups. The following is a set of recommendations as a result of the current study:

- Therapists need to have better understanding of the cultural and religious beliefs of the different community groups seeking help and adapting their treatments to incorporate suitable religious practices that suit patients' needs.
- Therapists should seek clarification and gain insight into the implicit meaning of words used by PSY patients.
- Therapists should accommodate patients' different needs and make use of practical interactive activities such as word games, word meanings, and pictures, which are more appealing for patients and which can lead to better outcomes with those who have basic English proficiency and/or special needs.
- Therapists should avoid the use of language that is perceived to be stigmatising or discriminating and which may affect PSY engagement in therapy.
- GPs at first point of contact with patients need to be aware of the differences that may exist among the different PSY groups, particularly the question of presenting with physical symptoms, and they should educate patients about the available therapeutic services and their merits.
- Service providers should engage with PSY faith and community groups and increase group members' awareness about mental health and wellbeing programmes and how these could be relevant for them.
- Service providers should have more focused training programmes that address the stigma around mental health and encourage PSY groups to develop positive language use resources that can broaden their cultural perspectives.
- Service providers should ensure sessions involving an interpreter are extended to allow for the extra time taken in negotiating a triadic encounter.
- Service providers need to recruit more therapists from PSY groups to address language barriers.

## **10.6 Opportunities for Further Research**

Although the current study provided some answers to the research question(s), it has thrown up many more questions in need of further investigation. One avenue for future research would be research into the specific bodily complaints associated with depression amongst PSY groups and assessing the PHQ's suitability for such patients' descriptions of symptoms. Secondly, the researcher believe it would be valuable to evaluate the outcomes of group therapy and online programmes for BME groups in order to provide sound recommendations and maximise the benefits of these treatment approaches. Moreover, since NICE guidelines (2011) emphasised the importance of enquiring about religious beliefs and adapting therapeutic treatments to suit the spiritual needs of patients, future research into why non-Muslim therapists struggle to initiate discussion with Muslim patients about religion might prove valuable. It is also relevant to understand the qualities that form the basis of trust between therapists, patients, and interpreters so that these qualities can be incorporated into therapists' and interpreters' practices to improve therapeutic alliances. Finally, given the importance of non-verbal communication in therapy, future research into patients' perceptions of their experience of the use of silence in therapy can contribute to understanding the power dynamics in therapeutic encounters.

## **10.7 Conclusion**

Participants' perceptions of therapy, how they define mental illness, and their attitudes towards seeking help are not simply a matter of describing biological, emotional, or pathological symptoms. Rather, it is a matter that involves interpreting experiences that are deeply influenced by social, cultural, religious, as well as power-relational structures conveyed through the use of language. For that reason, the aims of this research were designed to explore Pakistani, Somali, and Yemeni patients' articulations and to have a clearer understanding of their experiences of IAPT.

The findings revealed that participants in the research engaged in reflective practice as they relayed their experiences, identifying problems as well as providing new ways of understanding their perspectives. Participants'

articulations of therapeutic experiences and perceptions of mental health varied and were dependent on how the different groups constructed meaning out of these experiences and which views offered them the best way of understanding themselves and others in therapeutic encounters. The evidence from this study indicates that participants used different communication methods to express their emotional feelings. These emotional expressions did not only consist of verbal and non-verbal expressions, but also bodily complaints and other conventional symbols that were linked with specific cultural and religious meanings. These meanings were not easily conveyed or translated into language(s) because of either the unavailability of equivalents or the untranslatability of concepts. These findings enhance our understanding of the complex relationship between language, culture, and religion in therapeutic encounters and show how such conflicts can affect the communication between therapists and patients. More importantly, the current findings add to the growing body of literature on the importance of understanding cultural and religious beliefs and the need for therapists to negotiate the making of meaning and language in context. In addition, the findings show a pressing need for non-Muslim therapists to incorporate religious practices in therapy and to expand their knowledge about the religious beliefs and the religious aspects of cultural beliefs of a society. Finally, language as a powerful vehicle for expressing emotions and the relevance of positive and negative language-use as a barrier to seeking help are clearly supported by the current findings, which also reveals the power inequalities between therapists and participants.

The evidence from this study suggests that understanding the various dimensions of languages and language use in different contexts and the knowledge of cultural and religious beliefs can not only lend researchers and health care practitioners a hand to engage with the different perspectives of participants, but can also broaden their knowledge of the different linguistic, social, cultural, and/or historical backgrounds that relate to the different groups. Conducting research studies into the proposed avenues of future research above would contribute further to the wealth of knowledge in this research area.

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# Appendix 1

## Questionnaire



School  
Of  
Languages &  
Cultures.

### Questionnaire

#### The impact of language and culture on Improving Access to Psychological Therapy (IAPT) for Black & Minority Ethnic (Pakistani, Somali and Yemeni) patients in Sheffield

You are invited to take part in a research study which is carried by the University of Sheffield, School of Languages and Cultures Department to understand if there are any language and cultural issues facing patients from Pakistan, Somali and Yemen when accessing IAPT service (Improving Access to Psychological Therapies in Sheffield). The research will take your views into consideration in order to adapt the services to be more appropriate for you.

Because you are at the point of accessing IAPT services, we would like to know your opinion. Please can you spare a couple of minutes to answer the following questions. This should not take more than 5 – 10 minutes to complete. Upon completion, please hand it back at the surgery reception desk.

1. Have you any concerns about language and communication?

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2. Have you any concerns about cultural and religious understanding?

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3. Have you any concerns about using IAPT service?

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Thank you for completing the questionnaire.

If you are interested in taking part in a one to one individual interview, please leave your details below and hand back into the reception. By leaving your details you are giving your consent for the researcher to contact you and talk to you further about taking part in the study. This study has been reviewed by the University of Sheffield Ethics Committee as well as the NHS independent Research Ethics committee to protect your interests.

Patient's Name:.....

Address: .....

Home telephone No.:.....

Mobile No. : .....

Patient's Signature: .....

Date:.....

Questionnaire  
Date: 26/05/2015

Version 1



## Appendix 2

### What to Observe during Participant's Observation

Date:

Observation start time:

End time:

GP practice location:

Patient Group:

Reference code for Patient being observed:

Name of researcher completing record: Nahed Arafat

1. Describe in details the setting of therapeutic session? (space)  
How close therapist and patient are setting and what does this mean in relation to the relationship or any cultural implications?
2. Describe the acts that is taking place in therapy  
How do patients describe their emotional problem  
What kind of language (metaphorical – representational etc...) they are using?  
How they express their emotions? What kind of words they are using to describe these emotions?  
How is the therapist approaching the patient?  
How do patients communicate and articulate their emotional distress  
Any non-verbal cues involved?
3. Describe the activity taking place (for example going through the questionnaire or homework diary activity)  
What do patient think about the homework tasks and how they respond to the questionnaire? Do they understand the questions? Do patients ask for any clarification? How does the therapist respond to questions raised by the patient?

4. Can you describe the event in details  
What precipitated the event? Why it is happening? What contributed to the event to happen in this way? Does therapist use other means of communication such as drawing or pictures? Why? How it is utilised?

5. Describe who is present in therapy ( patient, therapist, interpreter, any family member)  
Make notice of gender, age, ethnicity, profession if possible of patient and how this is affecting the understanding and perception of information and communication? Is the presence of an interpreter impacting on the patient? If a family member is present, does this influence the patient's presentation of his/her emotional expression? If yes to the questions, how

6. Do patients appear to understand the purpose of therapy? How can they articulate their understanding? Is there any cultural or religious issues impacting on this understanding? Does the therapist explain this in detail? Is their background and points of view taken into consideration?

7. How do patients use their bodies, tone of voice, facial expression etc...? to communicate the different emotions  
It may be harder to control involuntary signs of emotions compared to the uttering of emotional speech what does this display of emotion means?  
What do patients' behaviour indicate about their feelings?  
Do these behaviours carry any level of emotional expression or any cultural meanings? What kind of words used by [patients to describe their bodily complaints?

8. The language used by the actors (patients, therapists, interpreters) in the settings  
Any forms of cultural specifics found in these interactive patterns that may influence the communication process  
Any ideational elements such as beliefs, attitudes that may construct meaning?  
Any communication differences that may impact on therapy?

9. Post observation perceptions. Did actual activity differ from any plans?  
Researcher perception

10. Any other post observation notes

## Appendix 3

Date: 22/02/2015

Version: 1

### Observed Sessions – Participant’s Consent Form

**Title of Research Project: The impact of language and culture on Improving Access to Psychological Therapy (IAPT) for Black & Minority Ethnic (Pakistani, Somali and Yemeni) patients in Sheffield**

**Name of Researcher:** Nahed Arafat

**The purpose of this consent form is to ensure that the notes taken during therapeutic sessions gathered for the purpose of this study is permissible and that you agree for the information to be included in the research study. Your name or any personal identification will be removed prior to using the data. Please read the statements below and tick the boxes if you agree. .**

1. The purpose of the study has been fully explained to me prior the session and I have agreed for the researcher to attend the therapeutic meeting with the patient and take notes during the session.
  
2. I understand that all the information collected during the session will be used for the purpose of this study. However, my personal details will not be mentioned and will be kept confidential. All data from the study will be anonymous to everyone except the researcher
  
3. I agree for data collected from me to be used for future research and for the results to be published.
  
4. I agree to take part in the above study.
  
5. I would like to receive a summary of the results

Name of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Person taking consent: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## Appendix 4

02/06/2015

Version1

### Interview Topic Guide

#### Personal background

1. Before we start the interview I will just ask some background questions:
2. Could you tell me when your date of birth is?
3. What is your nationality?
4. Where did you study?
5. Did you go to university?
  - a. If no – just clarify highest level is secondary school
6. Did you learn English?
7. Do you use English here in the UK?
8. When do you use English?
9. Do you have any trouble speaking English?
10. How long have you been in the UK? / When did you come to the UK?
  - a. How was it for you?
  - b. Did you seek any help? → therapy
  - c. How did you find out about therapy?

#### Concept and content of therapy

1. In your own words, what does it mean to you to be in therapy?
2. What were your expectations when you came here/ what did you want to get out of therapy?
3. Can you explain further?
4. What usually happens in therapy session, (Prompt) take me through the stages, explain
5. How do your expectations affect your level of engagement with therapy?
6. What kinds of words do you use to express your emotions/feelings in therapy? How do you talk about/express yourself in therapy?
  - a. Do you find it difficult?
  - b. Do you have any problems finding the right words? Explain.
7. Expectation about questions related to anxiety and depression (prompt)
  - a. In the therapy session, the therapist will give you a questionnaire to fill out. Do you understand these questions? Do you understand why you do the questionnaire? How do you feel about filling the questionnaire? Does it help you?
  - b. Do you understand the scoring? What does it mean?
  - c. At the end of the scoring, the therapist tells you about some activities you should do. What are these? Do you understand them? Do you know why you are asked to do them?
8. Your feelings about the purpose of therapy (Prompt) what

#### Therapy experience

#### Working with therapist

1. Tell me about how you communicate with your therapist (prompt) what you mean
2. Language in therapy (prompt) how , why
3. Relation with the therapist, (prompt) how
4. Emotions received and explored (prompt) explain
  - a. Do you think the therapist understands your emotions? How do you know? Can you give me an example?
5. Language used to explore emotions(prompt) what
  - a. What kind of language do you use to express yourself? Does the therapist try to understand what this means? Do they try to find out more about the language you are using?
6. Reaction of the therapist to experience (prompt) how, why
7. therapist display appropriate emotions, empathy, bond, listening, non-judgemental, give example
  - a. How does the therapist react? Are they paying attention? How do you know?

Working through an interpreter (NB: put in methodology – issues of asking about interpretation if interpreter present during interview)

1. If you used an interpreter what was it like
  - a. In your therapy session, is there an interpreter present/do you use an interpreter?
2. Another person in therapy ( prompt) what, why
3. Expressing emotions when using an interpreter (prompt) how, why
  - a. Do you feel you are able to express your emotions? Is this therapist able to appropriately receive these emotions? Or do you feel that the therapist from your feelings? Explore
4. Tell me about your experience on receiving Information through the interpreter (prompt) give example, why, how
  - a. Do you feel that the interpreter is giving you all the right information? Are you able to understand? Does the interpreter explain more? E.g.
    - i. E.g. of misunderstanding? Missing info?
5. Understood the concept of therapy, (prompt) explain
  - a. Is the interpreter able to explain the purpose/objectives of therapy? Are they able to facilitate the therapy session? Explain
6. Use of interpreters and the decision to access or drop out therapy (prompt) how, why
  - a. Would the presence of an interpreter affect your decision to stay/drop out of therapy?

Diary/ therapy home work

1. In therapy, sometimes you are given tasks to do. How did you feel about the task given in therapy, (prompt) what was it like
  - a. Do you understand the purpose?
2. Relation of tasks to problems (prompt) How
  - a. Do you think the tasks are helpful in relation to your problems?

3. Therapist collaboration (prompt) how
  - a. Do you feel that the therapist is a collaborator in your therapy? That they are in a partnership with you? How?
4. Adaptation of the tasks to language limitation (prompt) how
  - a. Are the tasks appropriate for your language grade? Has your therapist taken into consideration language in setting tasks? E.g. drawing instead of writing. How do you feel about this?
5. Tell me about the tasks and their appropriateness to culture (prompt) explain
6. Writing a diary (prompt) what, why
7. Recording your emotions ( prompt) How, give example

#### The role of culture and religion

1. The role of culture and religion, what is their role, is there anything you would like to say (prompt) explain
  - a. How does your culture influence your decision to access therapy?
2. Cultural understanding of illness (prompt) what (use of word illness – be sensitive)
  - a. How do you understand your illness?
  - b. Does your culture provide any explanation for your illness? Explain
  - c. How do you deal with your illness?
3. Cultural impact on presentation of feelings,(prompt) how, explain
  - a. Does your culture impact on how you talk about your feelings? How you present your symptoms? How?
4. Describing distress (prompt) how, why, give example
  - a. What kind of words?
5. The difficulties of meaning intended (prompt) what , why,
  - a. Have you ever had difficulties explaining your meaning? Finding the right words to describe your feelings? When, why, what happened?
6. Cultural understanding of therapist (prompt) how, give example
  - a. Do you feel that the therapist understands your cultural background? Takes this into consideration? Does the therapist explore this further with you? Explain.

#### What made therapy work

1. Do you feel that therapy for you is successful? Why?
2. Tell me what you attribute to the success of your experience with therapy to Do you have any additional comments about the conversation/do you have questions do you want to ask?



## Appendix 5

### Participants' Consent Form



The  
University  
Of  
Sheffield.

School of  
Languages &  
Cultures

**Title of Research Project:** The impact of language and culture on Improving Access to Psychological Therapy (IAPT) on Pakistani, Somali and Yemeni patients in Sheffield: an exploration of BME patients' views on IAPT services.

**Name of Researcher:** Nahed Arafat

Participant Identification Number for this project:

Please initial box

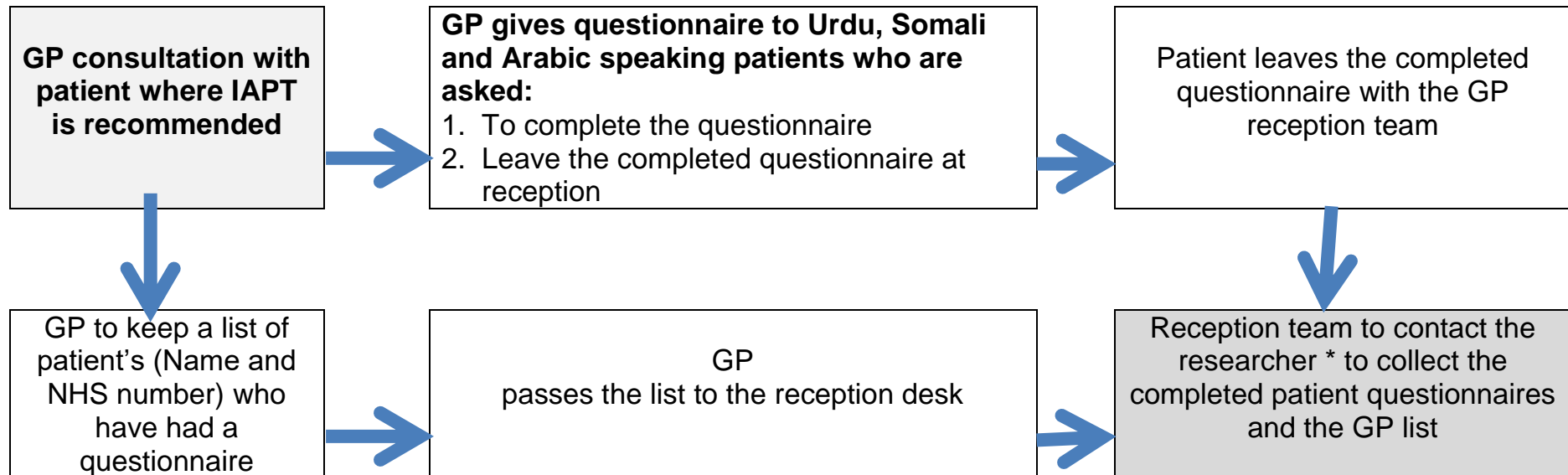
**The purpose of this consent form is to ensure that the written notes or audio record gathered for the purpose of this study is permissible and that you have received complete information about the study. Please read the following statements and put your initials in the box provided to show that you have read, understood and agree with them.**

1. I confirm that I have read and understood the information sheet for the above project, Version 3, dated 17<sup>th</sup> August 2015
2. The purpose of the study has been fully explained to me and I had the opportunity to consider the information, ask questions and had these answered satisfactory.
3. I understand that my participation is voluntary and I am free to withdraw at any time without giving any reasons and without my medical care or rights being affected. In addition If I do not wish to answer any questions, I am free to do so.
4. I understand that if I withdraw from the study, all my identifiable answers will be destroyed.
5. I am withdrawing from the study but I give consent for the Researcher to use the information collected up to my withdrawal.
6. I understand that the information collected will be audio recorded and I give permission for the researcher and individuals involved in the study to have access to this information and records.
7. I understand that all my information collected during the study will be kept in a safe place and that my name will not be linked with the research material and will not be identified in any reports or publications that result from this study.
8. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Sheffield University, from regulatory Authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
9. I agree to relevant sections of my anonymised data collected during the study to be used to support other research in the future and for the results to be published.
10. I agree to take part in the above study.
11. 'Optional' if you would like to receive a summary of the results, please leave your contact details to be used for this purpose only and if you do not wish to receive a copy, please leave it blank .....

## Appendix 6

### Role of GP GP Requirement

To hand a questionnaire to Urdu, Somali and Arabic speaking patients who have been recommended to access the IAPT service:



**\*Researcher details are:**

Nahed Arafat; West Community Mental Health Team; 45 Wardsend Road; Sheffield  
Mobile 07812087734

*This research is designed to identify the obstacles and barriers that some people experience in trying to access help from IAPT; the researcher is working in conjunction with Sheffield IAPT – Thank you for your help and cooperation.*

## Appendix 7

### Check List of Documents Sent with First REC Application

Date: 31/03/2015

Reference:  
15/YH/0195

Online Form

#### APPLICATION TO RESEARCH ETHICS COMMITTEE

**All studies except clinical trials of investigational medicinal products**

REC Ref: 15/YH/0195

Short Title of Study: BME experiences of language and cultural barriers when accessing IAPT

CI Name: Mrs Nahed Arafat

Sponsor: Sheffield University

**Please complete this checklist and send it with your application**

- Except where stated, send ONE hard copy of each document to the REC office by the agreed submission date.
- Check that the submission code appears on each page of the application form before sending. It is acceptable to send hard copies of signature pages only, as long as the submission code at the top of the page is the same as on the electronic version.
- All documents must bear version numbers and dates (except where indicated).
- Documents marked as mandatory must be submitted in all cases for the application to be valid. Other documents should be submitted if relevant to the application.
- When collating please do NOT staple documents as they will need to be photocopied.
- This button  allows you to add extra documents of the same type. Include subtitles if appropriate, e.g. "Information sheet for relative".

Document	Subtitle	Enclosed	Date	Version	Office Use	Reason not supplied
Covering letter on headed paper		No				
Research protocol or project proposal	research proposal	Mandatory	16/01/2014	1		
Summary CV for Chief Investigator (CI)	Chief Investigator (CI) CV	Mandatory	26/03/2015			
Summary CV for supervisor (student research)	Summary CV For Supervisor	Yes	26/03/2015			
Summary CV for student	summary CV for student (chief investigator)	Yes	26/03/2015			
Participant information sheet (PIB)	Patients information sheet	Yes	22/02/2015	1		
Participant information sheet (PIB)	Therapist/Counsellors information sheet	Yes	22/02/2015	1		
Letters of invitation to participant	information sheet for therapist/counsellors	Yes	01/04/2015	1		
Letters of invitation to participant	letter of invitation to participant - patients	Yes	01/04/2015	1		
GP/consultant information sheets or letters	GP information sheet	Yes	22/02/2015	1		
Evidence of Sponsor Insurance or Indemnity (non-NHS Sponsors only)	Non NHS indemnity insurance	Yes	25/03/2015			
Letter from sponsor	Sheffield university offer letter	Yes	19/08/2014			
Participant consent form	Patients individual interview consent form	Yes	22/02/2015	1		

Participant consent form	consent for (Patient's observation)	Yes	22/02/2015	1		
Participant consent form	Therapist/counselor observation consent form	Yes	22/02/2015	1		
Letter from statistician		No				
Letter from funder	letter from funder	Yes	03/06/2014			
Referee's report or other scientific critique report	Sheffield university ethics committee confirmation letter	Yes	12/03/2015			
Referee's report or other scientific critique report	confirmation of scientific approval of the research project by Sheffield university	Yes	12/03/2015			
Summary, synopsis or diagram (flowchart) of protocol in non-technical language		No				
Interview schedules or topic guides for participants		No				
Validated questionnaire		No				
Non-validated questionnaire		No				
Copies of advertisement materials for research participants		No				
Instructions for use of medical device		No				
<b>Other documents</b>						
Other (please specify)	White Rose college of Art and Humanities studentship offer on letter head	Yes	23/07/2014	1		
Other (please specify)	Risk assessment for patients participating in the individual interviews	Yes	09/02/2015	1		
Other (please specify)	Declaration from translators/Transcribers	Yes	21/02/2015	1		
Other (please specify)	Declaration and guidelines for interpreters	Yes	22/02/2015	1		
Other (please specify)	Second supervisor - Bethan Davies CV	Yes	02/04/2014	1		

## Appendix 8

### First letter from REC



## Health Research Authority

### NRES Committee Yorkshire & The Humber - South Yorkshire

Unit 001  
Jarrow Business Centre  
Rolling Mill Road  
Jarrow  
Tyne and Wear  
NE32 3DT

12 May 2015

Mrs Nahed Arafat  
Transcultural Mental Health Worker, PhD Student  
Sheffield City Council  
West Community Mental Health Team  
45 Wardsend Road  
Sheffield S6 1LX

Dear Mrs Arafat

**Study title:** The impact of language and culture on Improving Access to Psychological therapy (IAPT) for Black and Minority Ethnic (Pakistani, Somali and Yemeni) patients in Sheffield: An exploration of patients' views

**REC reference:** 15/YH/0195

**Protocol number:** 144103[##IfProtocolRef##]

**IRAS project ID:** 179036

The Research Ethics Committee reviewed the above application at the meeting held on 30 April 2015. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Helen Wilson, nrescommittee.yorkandhumber-southyorks@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### Ethical opinion

The members of the Committee present decided to issue an unfavourable opinion for the following reasons:

1. The Committee was of the clear opinion that the research proposal as submitted had major inadequacies in its design and planned execution therefore it was highly likely that it would be unable to achieve its objectives.
2. The Committee acknowledge that this proposal is a valuable piece of research and

- would recommend a pilot study with one ethnic group.
3. Suitable support in the design and support from Mental Health Services is required.
  4. Suitable PPI groups to be involved in contributing to the study design, recruitment processes and participant documentation prior to REC re-submission.
  5. The Committee require an opt-in approach to the study for participants rather than the applicant contacting the potential participants.
  6. The Committee require that discussions with the IAPT Manager are undertaken prior to any REC submission.
  7. A semi-structured topic guide to be produced.
  8. A flowchart outlining the study process to be created.
  9. Details are required of the translators/interpreters to be involved in the study.
  10. Details of safeguarding adults issues to be included in the Participant Information Sheet.
  11. The penultimate paragraph of the Participant Information Sheet to be re-written.
  12. The Summary at A8-1 to be re-written to give a better understanding of the research process, numbers, data analysis and likely benefits as it currently contains a background to the study.

I regret to inform you therefore that the application is not approved.

**If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Mrs Helen Wilson, REC Manager, in the first instance.**

#### **Options for further ethical review**

You may submit a new application for ethical review, taking into account the Committee's concerns. You should enter details of this application on the application form and include a copy of this letter, together with a covering letter explaining what changes have been made from the previous application.

We strongly recommend that you submit the new application to this REC. In order to arrange for the new application to be reviewed by this REC, please contact Mrs Helen Wilson, REC Manager ([nrescommittee.yorkandhumber-southyorks@nhs.net](mailto:nrescommittee.yorkandhumber-southyorks@nhs.net)) when you have prepared the new application in order to book a slot at the meeting. If you prefer, you may submit the application to a different REC by contacting the Central Booking Service. Please note, you must be able to submit the application on the same day as making the booking.

Alternatively, you may appeal against the decision of the Committee by seeking a second opinion on this application from another Research Ethics Committee. The appeal would be based on the application form and supporting documentation reviewed by this Committee, without amendment. If you wish to appeal, you should notify the relevant Research Ethics Service manager (see below) in writing within 90 days of the date of this letter. If the appeal is allowed, another REC will be appointed to give a second opinion within 60 days and the second REC will be provided with a copy of the application, together with this letter and other

relevant correspondence on the application. You will be notified of the arrangements for the meeting of the second REC and will be able to attend and/or make written representations if you wish to do so.

The contact point for appeals is:

Catherine Blewett  
HRA Improvement & Liaison Manager  
National Research Ethics Service

Email: [catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)

## Appendix 9

### Check List of Documents Sent with Second REC Application

Date:

Reference:

Online Form

**APPLICATION TO RESEARCH ETHICS COMMITTEE**

**All studies except clinical trials of investigational medicinal products**

REC Ref:

Short Title of Study: BME experiences of language and cultural barriers when accessing IAPT

CI Name: Mrs Nahed Arafat

Sponsor:

Please complete this checklist and send it with your application

- Except where stated, send ONE hard copy of each document to the REC office by the agreed submission date.
- Check that the submission code appears on each page of the application form before sending. It is acceptable to send hard copies of signature pages only, as long as the submission code at the top of the page is the same as on the electronic version.
- All documents must bear version numbers and dates (except where indicated).
- Documents marked as mandatory must be submitted in all cases for the application to be valid. Other documents should be submitted if relevant to the application.
- When collating please do NOT staple documents as they will need to be photocopied.
- This button  allows you to add extra documents of the same type. Include subtitles if appropriate, e.g. "Information sheet for relative".

Document	Subtitle	Enclosed	Date	Version	Office Use	Reason not supplied
Covering letter on headed paper	Cover letter response for Ethical committee recommendations	Yes	19/06/2015			
Research protocol or project proposal		Mandatory	16/01/2014	1		
Summary CV for Chief Investigator (CI)		Mandatory	16/01/2014			
Summary CV for supervisor (student research)		Yes	26/03/2015			
Summary CV for student		No				
Participant Information sheet (PIB)	Participant information sheet	Yes	22/02/2015	1		
Participant Information sheet (PIB)	Participant information sheet (Therapists)	Yes	22/02/2015	1		
Participant Information sheet (PIB)	Participant information sheet	Yes	26/05/2015	2		
Participant Information sheet (PIB)	Participant information sheet (Therapist)	Yes	31/05/2015	2		
Letters of invitation to participant	letter of invitation to participants	Yes	01/04/2015	1		
Letters of invitation to participant	Letter of invitation to Participants (Therapist)	Yes	01/04/2015	1		
Letters of invitation to participant	Letter of invitation to Participant	Yes	27/05/2015	2		
Letters of invitation to participant	Letters of invitation to participant (Therapist)	Yes	31/05/2015	2		



Date:

Reference:

Online Form

GP/consultant information sheets or letters	GP Information sheets	Yes	22/02/2015	1		
GP/consultant information sheets or letters	GP Information sheets	Yes	31/05/2015	2		
Evidence of Sponsor Insurance or Indemnity (non-NHS Sponsors only)	Evidence of Sponsor Indemnity	Yes	25/03/2015			
Letter from sponsor	Offer Letter from University of Sheffield	Yes	19/08/2014			
Participant consent form	Participant consent for for Individual Interviews	Yes	22/02/2015	1		
Participant consent form	Observed Session - Participant consent form	Yes	22/02/2015	1		
Participant consent form	Observed session - Participant consent form (Therapist)	Yes	22/02/2015	1		
Participant consent form	Participant consent form for Individual Interviews	Yes	22/02/2015	2		
Letter from statistician		No				
Letter from funder	Letter from funder - WRoCAH studentship offer	Yes	23/07/2014			
Referee's report or other scientific critique report	University of Sheffield-confirmation of scientific approval	Yes	12/03/2015			
Referee's report or other scientific critique report	WRoCAH Support letter	Yes	11/06/2015			
Referee's report or other scientific critique report	Academic Supervisor support letter	Yes	11/06/2015			
Summary, synopsis or diagram (flowchart) of protocol in non-technical language	Flow chart of the study: recruitment and data collection	Yes	02/06/2015	1		
Summary, synopsis or diagram (flowchart) of protocol in non-technical language	Time line of the study	Yes	02/06/2015	1		
Interview schedules or topic guides for participants	Individual interview topic guides for participants	Yes	03/06/2015	1		
Validated questionnaire	Validated questionnaire	Yes				
Non-validated questionnaire		No				
Copies of advertisement materials for research participants		No				
Instructions for use of medical device		No				
<b>Other documents</b>						
Other (please specify)	Second supervisor - Bethan Davies CV	Yes	02/04/2014	1		
	Risk assessment form					

Date:

Reference:

Online Form

Other (please specify)	for patients participating in the individual interviews	Yes	09/02/2015	1		
Other (please specify)	WRoCAH offer on letterhead	Yes	03/06/2014	1		
Other (please specify)	Declaration and guidelines for Interpreters	Yes	22/02/2015	1		
Other (please specify)	Declaration from translators/Transcribers	Yes	21/02/2015	1		
Other (please specify)	Interpreters/Translators quality check form	Yes	02/06/2015	1		
Other (please specify)	Permission to be contacted form	Yes	06/06/2015	1		
Other (please specify)	Permission to be contacted form for Voluntary organisations	Yes	02/06/2015	1		
Other (please specify)	Phd Advisory Group - email to Paul to comment on flow chart and timeline	Yes	04/06/2015	1		
Other (please specify)	Phd Advisory Group communication with MAAN	Yes	02/06/2015	1		
Other (please specify)	PhD Advisory group - Paul 2nd meeting correspondence	Yes	26/05/2015	1		
Other (please specify)	Phd Advisory group - Paul feed back about flow chart and time line	Yes	08/06/2015	1		
Other (please specify)	PhD advisory group - Bev Allasopp correspondence	Yes	17/06/2015	1		
Other (please specify)	PhD advisory group - Email To Joe Curran	Yes	22/05/2015	1		
Other (please specify)	Phd Advisory group - outcomes of meeting with Joe Curran	Yes	06/06/2015	1		
Other (please specify)	Phd Advisory group - outcome meeting with Mark IAP manager	Yes	04/06/2015	1		
Other (please specify)	PhD advisory group - Meeting with Rabia and Zaynab	Yes	26/05/2015	1		
Other (please specify)	PhD advisory group - contact with Mark IAPT manager	Yes	27/05/2015	1		
Other (please specify)	Advisory group PhD study- Mark Knowell 2nd meeting response	Yes	27/06/2015	1		

## Appendix 10

### Approval Letter from REC



## Health Research Authority

**NRES Committee Yorkshire & The Humber - South Yorkshire**

Unit 001  
Jarrow Business Centre  
Rolling Mill Road  
Jarrow  
Tyne and Wear  
NE32 3DT

Telephone: 0191 4283563

10 August 2015

Mrs Nahed Arafat  
Transcultural Mental Health Worker, PhD Student  
Sheffield City Council  
West Community Mental Health Team  
45 Wardsend Road  
Sheffield  
S6 1LX

Dear Mrs Arafat

**Study Title:** The impact of language and culture on Improving Access to Psychological therapy (IAPT) for Black and Minority Ethnic (Pakistani, Somali and Yemeni) patients in Sheffield: An exploration of patients' views

**REC reference:** 15/YH/0330

**Protocol number:** 144103

**IRAS project ID:** 185244

The Research Ethics Committee reviewed the above application at the meeting held on 30 July 2015. Thank you, Ms Jane Woodin, and Mr Mark Knowles for attending to discuss the application.

#### Provisional opinion

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

#### Further information or clarification required

1 The Participant Information Sheet to be amended:-

## Appendix 11

### Patient Health Questionnaire



Foundation Trust  
For Gloucestershire



#### IAPT Questionnaire 1 PHQ-9

Over the <b>last 2 weeks</b> , on how many days have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

A11 – PHQ-9 Total Score

#### IAPT Questionnaire 2 GAD-7

Over the <b>last 2 weeks</b> , on how many days have you been bothered by any of the following problems?	Not at all	Wk..... Date.....		Nearly every day
		Several days	More than half the days	
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

A12 – GAD-7 Total Score

## Appendix 12

### Example of Participant Observation Analysis

#### 1 What to observe during participant observation

2 Date: 27<sup>th</sup> June 2016

3 Observation start time: 11:30 am End time: 12:30 pm

4 GP practice location: Park Health Medical centre

5 Patient Group: Pakistani

6 Reference code for Patient being observed: PI5

7 Name of researcher completing record: Nahed Arafat

#### 8 1. Describe in details the setting of therapeutic session? (space)

9 How close therapist and patient are setting and what does this mean in  
10 relation to the relationship or any cultural implications?

11  
12 Patient is a Pakistani Muslim in his late thirties. He is quite pleased to see a  
13 Muslim therapist as I can see a sign of relief in his face. Therapist is a  
14 Yemeni Muslim female dressed in Islamic clothing and in her late forties.  
15 Therapist welcomes patient and explains her role, work and confidentiality  
16 issues and that she will be using a questionnaire to measure the patient's  
17 anxiety and depression and it is not intended to give any diagnosis. Before  
18 starting the session, therapist introduces the researcher to the patient and  
19 explains that the researcher will be taking notes during the observation. She  
20 explains that the data collected from the observation will be used in a  
21 research study aiming at improving the services for Pakistani, Yemeni and  
22 Somali patients. Finally, therapist informs patient that the results will be  
23 published. Patient gives consent.

24 Therapist explains process of therapy and that the treatment is based on CBT  
25 Model. When therapist asks patient about the problem, patient is quite  
26 relaxed to inform her about the issue causing him distress. He starts by  
27 addressing therapist as sister. He then says 'you are a Muslim and you know  
28 how we care about our daughters and how we look after them'. He continues  
29 'the issue is very much related to how Muslim people care and raise their  
30 daughters in a foreign country'.  
31 Therapist in turn is very understanding to the issues raised by the participant  
32 and allows him the space to talk about his worries.

#### 33 34 2. Describe the acts that is taking place in therapy

35 How do patients describe their emotional problem

36 What kind of language (metaphorical – representational etc...) they are  
37 using? How they express their emotions? What kind of words they are using  
38 to describe these emotions?

39 How is the therapist approaching the patient?

40 How do patients communicate and articulate their emotional distress

41 Any non-verbal cues involved?

42  
43 Therapist asks patient about the problem. Patient says he is a Muslim and he  
44 care for his daughters as a Muslim. Patient says that the prophet peace be

**Commented [NA1]:** This was very obvious on the patient facial expression. He was smiling and talked with ease to the therapist about the issue.

**Commented [NA2]:** Explaining the role of the researcher Obtaining verbal consent

**Commented [NA3]:** Religious and cultural understanding in this therapy session played a very important role and the fact that therapist is a female herself has also helped the patient to talk more about the problem.

**Commented [NA4]:** I can see that therapist nodding and acknowledgement of the issues allowed the person to talk about his problem.

**Commented [NA5]:** The process of therapy always starts with a general question about the problem

**Commented [NA6]:** Emphasis on the identity of Muslims and their religious beliefs

45 upon him said that 'whoever has three daughters and is patient with them and  
46 treats them kindly, he will be rewarded with Paradise for that' therefore, he did  
47 his utmost to raise them and teach them good manners in accordance with  
48 Islamic teaching. He starts addressing his problem. 'I have asked an Imam  
49 (sheikh) who is a well-respected religious person in the community, aged 65  
50 to come and teach my daughter who is 12 years old the Quran. But my  
51 daughter went to school and claimed this person is touching her  
52 inappropriately. He continues 'I was then called to school and was accused of  
53 not taking care of my daughter. I was quite angry at the beginning as I  
54 couldn't believe that and explained that I was only trying to help raise my  
55 daughter in accordance with the religious beliefs. But a social worker was  
56 called and involved in the case and he was kicked out of his house. Social  
57 worker claimed he wasn't a good father. Patient informs therapist that he  
58 won't allow anything to happen to his daughter and says that he won't allow  
59 the imam to enter his house again but the social workers decided to kick him  
60 out of the house saying he is not a good father and that he should be away for  
61 45 days excluding weekends. Patient hasn't seen his daughters and family  
62 now for almost 3 months. He is told he has anger issues and should attend a  
63 counselling session before he can return to his house. Patient says that his  
64 problem is that he is a Muslim and his culture is different from this country,  
65 and if anything happens to a Muslim person it is exposed to the media and it  
66 is taken against the person. So the main reason for attending therapy is that  
67 he was asked to solve his anger issues in order to be able to get his family  
68 back.

69  
70 Therapist is considerate of the patient's problem and is understanding of his  
71 problem. She asks the patient about his feeling.

72  
73 Patient says he is feeling like dying, he is stressed and starts to have lots of  
74 shoulder pain and his blood pressure has been high, he is unable to do  
75 anything. He says 'if you break the law, they use their power against you and I  
76 can't return to my house, I don't know why I got the 45 days, they claim I have  
77 anger problem, I am a father of five kids, a Muslim father who is trying to give  
78 guidance to his children. It is our culture and religion. They think I am going  
79 to take them to Pakistan and force them to marriage. I don't do that. I went to  
80 a solicitor and he advises me not to submit a complaint at the minute as social  
81 workers have power and submitting a complaint won't help right now'

82  
83 Patient also says 'I am happy to talk to you because you are a Muslim, you  
84 understand, I can't show my daughter anything and I can't even shout at  
85 them, I can't use my power. Kids need their parent's attention, I don't want to  
86 lose my kids'

87  
88 Therapist asks if patient has anyone to talk to but patient says 'I don't want to  
89 talk to friends as this is my secret life, this is my family, I need to be careful, I  
90 am a taxi driver, how can I be angry'

**Commented [NA7]:** The emphasis of religious upbringing. The patient is talking and sharing these issues with therapist giving full details. He is feeling that therapist is sharing the same understanding and beliefs.

**Commented [NA8]:** This is really a very interesting case as it shows many things to be taken into consideration. If therapist wasn't a Muslim how will the person act on the occasion, will he inform the therapist with all the details? Will he explain all the cultural and religious issues to enable therapist to understand? Will therapist be able to fully understand the case and help overcome cultural issues? All these questions were going into my mind and I decided to ask the person if he would agree to take part in the interview to give me an opportunity to find out more about such issues.

**Commented [NA9]:** The behaviour of the social worker is quite questionable as well? Is this a precaution procedure normally taken or is it the misunderstanding of the events? Again this is something that worth investigating as it has its impact on the patient

**Commented [NA10]:** Impact of problem on the person emotional wellbeing

**Commented [NA11]:** Portray of Muslim in the media and racial discrimination feelings

**Commented [NA12]:** Reasons for seeking help and attending therapy is to go back to his family

**Commented [NA13]:** Sharing similar religious beliefs helps the person to talk about related issues.

**Commented [NA14]:** Impact of problem on physical health

**Commented [NA15]:** Non understanding of the system and being a foreigner can escalate issues. Also the non-understanding of cultural and religious issues can have severe consequences on the person.

**Commented [NA16]:** The impact of living in another culture who are unable to understand or work with religious and cultural beliefs

**Commented [NA17]:** Having no one to talk to about problem can also impact on the person. Fears of stigma Impact on work

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Therapist provides information about anger management service at MIND.  
Patient talks about how this issue has affected his health and that he is suffering high blood pressure now. He added 'if you can't see your kids for three months, you will feel very upset'

Muslim father I can't do that, it is so private'. Patient is feeling quite relieved that the therapist is a Muslim as he feels she is able to understand his pain better.

Therapist gives details about the anger management course and how the patient can book a place. She adds if the patient still needed one to one contact, he can ring the surgery and arrange an appointment.

**Commented [NA18]:** Physical health issues increase the problem

**Commented [NA26]:** Again this is cultural beliefs and understanding and how the differences can have unexpected consequences.

**Commented [NA27]:** Religious matching  
Positives

**Commented [NA28]:** Outcome of assessment  
Referral to anger management

4. Can you describe the event in details  
What precipitated the event? Why it is happening? What contributed to the event to happen in this way? Does therapist use other means of communication such as drawing or pictures? Why? How it is utilised?
5. Describe who is present in therapy ( patient, therapist, interpreter, any family member)  
Make notice of gender, age, ethnicity, profession if possible of patient and how this is affecting the understanding and perception of information and communication? Is the presence of an interpreter impacting on the patient? If a family member is present, does this influence the patient's presentation of his/her emotional expression? If yes to the questions, how  
  
As both patient and therapist were from the same culture and religious background, she is able to understand the patient problem and act accordingly and patient is feeling quite relaxed talking about his problem to therapist as he feels she can understand this better.
6. Do patients appear to understand the purpose of therapy? How can they articulate their understanding? Is there any cultural or religious issues impacting on this understanding? Does the therapist explain this in detail? Is their background and points of view taken into consideration?  
  
The main reason for attending therapy was that he was asked to solve his anger issues in order to be able to get his family back.
7. How do patients use their bodies, tone of voice, facial expression etc...? to communicate the different emotions  
It may be harder to control involuntary signs of emotions compared to the uttering of emotional speech what does this display of emotion means?  
What do patients' behaviour indicate about their feelings?  
Do these behaviours carry any level of emotional expression or any cultural meanings? What kind of words used by [patients to describe their bodily complaints?
8. The language used by the actors (patients, therapists, interpreters) in the settings  
Any forms of cultural specifics found in these interactive patterns that may influence the communication process  
Any ideational elements such as beliefs, attitudes that may construct meaning?

184 Any communication differences that may impact on therapy?

185

186 9. Post observation perceptions. Did actual activity differ from any plans?

187 Researcher perception

188

189 This session was very unique as it touches on many issues that Muslim people may  
190 encounter in a foreign country where they have different cultural or religious beliefs.  
191 It also talks about social workers power and how this can be used. I think it will be  
192 worth understanding the system before judgement. I am going to talk to someone  
193 working in the field to have better understanding before making any judgement about  
194 social worker and school behaviour and decide if it is an act of racism and portray of  
195 Muslim as the patient think or it is just his beliefs about the incident. This session  
196 also show how important to provide therapist who share similar cultural and religious  
197 background who are able to deal with such complicated issues. The patient agreed  
198 to have an interview with me so this is will be an interesting interview and it will allow  
199 me to have better understanding of the issues.

200

201 10. Any other post observation notes

202

203 Unfortunately patient has refused to carry out the interview once knowing it will be  
204 audio recorded. He didn't mind to have the interview with notes but explained he  
205 doesn't want to have a recorded interview. It is a shame as I felt I would have been  
206 able to clarify more things and have better understanding of the events.



## Appendix 13

### Examples from my Reflective Dairy of Work as an Interpreter and as a Mental Health Worker

Date:	21 <sup>st</sup> February 2016
Setting:	Home office - Sheffield
Identifier:	Syrian client
<b>Discription of the Encounter:</b>	
<p>I am at Sheffield Home office centre where I am interpreting for a Syrian person through video conferencing. I am told that the person is a transgender but no further information is given as to whether the person is transferring gender from a male to female or vice-versa or any additional details about the nature of the interview. When the call started, I can see the person is dressed in black, has long hair, wearing a blouse that has some flowers at the top. At the start of the interview, the case owner, a female worker, asks the person to confirm his name. The applicant confirms his male name. Accordingly, I start addressing the person as a male person but he stops me at one point and asks if I can address him as a female as he feels more comfortable being addressed as a female. In addition, The person is quite knowledgeable in English as she has a PhD in Economic which she completed recently in UK with the help of an organisation that help academic refugees to complete their education. Yet, she requested my stay in case she needs some help particularly with the legal terms. However, the case owner advises the applicant to stick to one language as the applicant is only allowed to use one language in the interview. Accordingly, the applicant used my help to express herself. Yet some parts of the interview particularly those related to explaining and relating to giving more information about her sexuality, the applicant asks the permission to talk about these in her own words and using the English language to describe and express herself. The applicant asks for a permission to talk about her inner feelings by herself as no one can understand her feelings. The applicant uses many expression to talk about her transgender issues and explains in detail how she becomes to think of herself the way she is now and how she has suffered from the society and family because of her decision to get transferred to the opposite sex. At many occasions, she is questioning her thoughts and decisions about her decisions and how she managed to reach her decision to accept herself the way she is now. She also talks about the role of religion and how religion both Islam and Christianity are against transgender. She expresses her wishes to express herself directly when she talks about religion. She says, she became an atheist because she felt that she either have a mental illness or God is unfair to create her in a man figure with a women thoughts and feelings. She explains that after reading a lot, she finally came to the decision that God is unjust and that whoever wrote the Bible or Quran must be a man as there is a lot of things against women in both religions and both are unjust to women. Another part of the discussion is with regard to the issues and feelings the applicant felt as a man where she expresses how she used to be a feminine boy. She also talks about her feelings when she was arrested and raped as a male. These feeling were repeated when the applicant starts to talk about her fears to go back to Syria in case she gets raped but this time the emphasis is on being a woman and the risks women face in war zone areas with Muslims such as ISIS who are controlling the country. Towards the end of the interview, the applicant thanks the interpreter for being her voice and for respecting her and addressing her as woman throughout the interview.</p>	
<b>Reflective notes and Issues identified:</b>	
<p>This interview was a learning curve to me in many ways:</p> <ul style="list-style-type: none"> <li>- I tried very hard to be the voice of the applicant but I still had my own views and opinions about transgender issues as a Muslim. I was quite aware of my own</li> </ul>	

beliefs and I tried very hard not to pass any judgment. I believe this helped the applicant to express herself fully. (something I should be aware of when I observe sessions)

- I was quite interested in the fact that the applicant insisted to express the sexuality issues by herself using her own words particularly when she was talking about her inner feelings. She explained that no one would have understood her like she does to herself and it will only be fair to let her express herself using her own words. This fact was really quite interesting and it shows that whatever language one uses, the person is the only one who is able to understand and express what goes in his/her mind and even if the interpreter was very experienced in the field, the person can only trust but oneself (issues of trust).
- The applicant raised a very important aspect about how people from the East in particular feels about gay, lesbian and transgender related issues and how they are more likely to open up about these issues in front of Western workers. Due to how the society may consider such issues, she wasn't able to open up even after she left the country. She dreaded her elder brother's reaction to kill her. These are important issues to be further explored if encountered during observation.
- When the applicant raised a number of questions about religion and informed of her own beliefs against all religion. This allowed me to be more aware of my own beliefs and not to let them impact on my role as a researcher.
- When the person talked about her feelings as a man who was raped and then brought the subject of rape again and talked about her fears as a woman. It is interesting to find out whether when she expressed her emotional feelings initially as a man, was there any differences?
- As the applicant understood the language very well, I was how does this impacted on me as an interpreter, did I felt judged all the time about my weary of my interpreting skills and in fact tried to ensure I am the voice of my applicant. How can this help strengths the relationship between interpreters and clients? I hope I will be able to find some answers to these questions.

Date:	10.02.2016
Setting:	Limbrick
Identifier:	AJ therapeutic assessment
<b>Discription of the Encounter:</b>	
<p>AJ attends the session for assessment regarding panic attack and anxiety. She is asked about her panic, she states she has been quite well recently. In fact she says she is happy and never been happy like that before. She wants to enjoy the time of happiness. When asked about any reasons for feeling so happy, she says she has been doing what the prophet peace be upon him used to do prior to going to sleep that is reading certain verses of Quran three times, blow in the hands and then rub (apply to) these verses to all the body (this keeps her protected all night). She talks about doing what her mother advises her to do and says she is feeling quite peaceful. AJ says by following her mother's advice, she is sleeping peacefully and is not having any panic attack or night mares. At the start of the assessment, therapist was looking down at her notes. She is writing down the notes, then she looks at AJ. AJ asks why she is referred to therapy. Therapist explains the difference between psychology and psychiatry and role of therapy. After some time, therapist explains to the patient who seems uncertain why she is referred to therapy the difference between psychology and psychiatry and the role of therapy. During the therapy session AJ is using different terms to talk about her emotional feelings and describes her anxiety and panic attack. Some of the terms she is using are (someone push you down) to indicate her feeling quite low, (When each door is closed and you try to open them) to indicate her panic, (someone stamping on you) to refer to the intensity of her anxiety, (friends putting pressure on my life and doing me headache, I was able to bottle things up) to show her anger and</p>	

losing control of herself. Patient is smiling while talking about significant sad events in her life which is not quite normal.

**Reflective notes and Issues identified:**


I have noticed that that when the therapist called AJ in, she starts with making introduction asking a general question which replicates what happens in IAPT.

The patients used many different words and terms to explain her anxiety and panic attack, words like 'someone push you down', 'when each door is closed you try to open them', someone stamping on you, all indicates her worries and anxiety about certain issues in her life. These are powerful terms that I need to be aware of during observational sessions and to find out if therapists tries to ask about what they mean to the person. While the patient was talking I have noticed that she used her hands to describe the intensity she is feeling and pointed most of the time to her heart to refer to her anxiety and talk about her feelings (are these gestures any indication to Islamic thoughts?) AJ drew on her religious beliefs and talked about some of the techniques passed to her by her mother. Numerous study in psychology showed that true believers when carrying out daily prayers this can help them feel relaxed. However what was interesting to note is that the therapist didn't seek any clarification about these religious beliefs. It will be interesting to find out how patients feel about this issue. Also, when AJ was asked about her understanding of therapy, she wasn't sure. Although the therapist explained the term, there was no questioning about what it meant for the patient to be in therapy. I believe this is quite important and should be further explored in interviews with patients.

The patients displayed different facial expression which was not appropriate to her feeling, for example when she talked about significant sad events in her life she was smiling which is not the norm, (yet this wasn't explored) she continuously pointed to her heart when she talked about her fears. Her voice tone was also high when she talked about her anger and panic and low when she was talking about her happiness. These issue are important to be observed in observational sessions and how they are explored by therapists.

# Appendix 14

## Example of Initial Coding of Questionnaire Data



The University  
Of  
Sheffield.

1  
2  
3

School  
Of  
Languages &  
Cultures.

4 Questionnaire

5 **The impact of language and culture on Improving Access to Psychological Therapy**

6 **(IAPT) for Black & Minority Ethnic (Pakistani, Somali and Yemeni) patients in Sheffield**

7 You are invited to take part in a research study which is carried by the University of Sheffield,  
8 School of Languages and Cultures Department to understand if there are any language and  
9 cultural issues facing patients from Pakistan, Somali and Yemen when accessing IAPT  
10 service (Improving Access to Psychological Therapies in Sheffield. The research will take  
11 your views into consideration in order to adapt the services to be more appropriate for you.  
12 Because you are at the point of accessing IAPT services, we would like to know your  
13 opinion. Please can you spare a couple of minutes to answer the following questions. This  
14 should not take more than 5 – 10 minutes to complete. Upon completion, please hand it  
15 back at the surgery reception desk.

16 1. Have you any concerns about language and communication?

17 I am an illiterate person. The terms used are quite difficult. But I used to feel quite  
18 relaxed when talking to the therapist and I could trust them. It was difficult to express my  
19 feelings and some issues I wasn't able to talk about. I didn't want to use an  
20 interpreter. I don't like to have a mediator as I felt I will lose the direct connection with  
21 the therapist. I had depression. I wasn't able to talk or express the emotional feelings.  
22 Yet the body language expressed by the therapist was excellent. She was quite  
23 understanding and I felt the openness of the therapist. Her body language was the  
24 most important her eye contact, attention and interest in my story was the most  
25 important. انا لست متعلمة والتعبير كانت صعبة ولكنني كنت ارتاح عندما اتكلم مع الأشخاص واثق فيهم. كان التعبير  
26 عن مشاعري صعب وبعض الأشياء لم استطع التكلم عنها ولم اكن اريد المترجم. لا احب ان يكون هناك وسيط لانني  
27 احس بانني لن اكون متواصلة بطريقة مباشرة مع العاملة. كنت اعاني من الاكتئاب. لم استطع التعبير عن المشاعر  
28 العاطفية ولكن ما كان يهمني هو الحركات الجسدية التي كانت تظهر انتباه العاملة، اصغافها لما اقوله ومن ابقاء نظرها  
29 علي واهتمامها بقصتي كل هذا كان مهم جدا بالنسبة لي.  
30

31 2. Have you any concerns about cultural and religious understanding?

32 I knew I was seeing a therapist and there was no concern with regard to culture. However,  
33 religion play a big role. If the therapist uses verses of Quran and spiritual talk it is usually  
34 better. كنت اعرف بانني ذاهبة للطبيب النفسي ولم يكن هناك مشاكل ولكن الامور الدينية تلعب دورا كبيرا خصوصا عندما يستخدم  
35 المعالج كلام الله والاحاديث النبوية يكون افضل  
36

37 3. Have you any concerns about using IAPT service?

38 I knew what therapy means and I understand what therapy is but I don't like talking about  
39 myself, therefore, when the talk is about me, I used to stop therapy and continue with my life. 2011

40 I used to talk and the therapist used to listen to me and record some information but I didn't  
41 want to continue. The most important thing to me was to talk to someone, and to be listened  
42 to and to feel the empathy. The most important thing was to get things out (to offload – to  
43 loosen). كنت منظمه كثيرا وكنت اطعم ما معني المعالجة ولكنني لا احب ان اتكلم عن نفسي ولذلك كنت اتوقف عن المتابعة  
44 وامضي في حياتي وكنت فقط اتكلم وكانت تسمعي وتسجل بعض الامور ولكنني لم اتواصل. اهم شين بالنسبة لي كان ان اتكلم مع  
45 شخص ويستمع لي وتحس بالرحمة كان افضل شين هو الفضفضة  
46

47

48 Thank you for completing the questionnaire.

49 If you are interested in taking part in a one to one individual interview, please leave your  
50 details below and hand back into the reception. By leaving your details you are giving your  
51 consent for the researcher to contact you and talk to you further about taking part in the  
52 study. This study has been reviewed by the University of Sheffield Ethics Committee as well  
53 as the NHS independent Research Ethics committee to protect your interests.

54 Patient's Name:.....

55 Address: .....

56 Home telephone No.:.....

57 Mobile No. :.....

58 Patient's Signature: .....

59 Date:.....

60

61

Commented [NA1]: Communication difficulties

Commented [NA2]: Therapy and terminology

Commented [NA3]: Relationship with Therapist

Commented [NA4]: Emotional expression

Commented [NA5]: Experience of having an interpreter

Commented [NA6]: Emotion and therapy

Commented [NA7]: Skill, Body language of therapist

Commented [NA8]: Role of religion in therapy

Commented [NA9]: Reasons for leaving therapy

Commented [NA10]: Perception of therapy

Commented [NA11]: Articulation of therapy

Commented [NA12]: Concept of therapy

## Appendix 15

### Semi-Structure Interviews Coding Using NVivo

#### Articulation of therapy

- Concept of therapy
- Content of therapy
- Expectation of therapy
- Experience of therapy
- Perception of therapy
  - o Perception of help

#### Culture

- Challenges beyond patient capacity
- Cultural beliefs and perceptions
- Cultural match – advantages
- Cultural match – disadvantages
- Family understanding
- Other cultural issues impacts
- Therapist cultural understanding

#### Current events

- Impact of illness
- Impact of life incidents
- Physical health

#### Fear of prejudice – assumptions by patients

#### Language and therapy

- Emotional expression
- Emotions in other languages
- English as a second language
  - o Impact of illness on learning English
- Language and identity
- Language and power

#### Role of interpreter

- Impact of mis-interpretation
- Interpreter's cultural/gender and ethnic match advantages and disadvantages
- Interpreter's experience
- Interpreting challenges
- Relatives as interpreters

#### Patients' backgrounds

- Educational background
- Employment background
- Life in the UK
  - o Comparison with life in original country
- Personal interest
- Reason to leave original country
- Physical symptoms

#### Process of therapy

- Group therapy
- Online therapy challenges

- Open question
- Questionnaire
  - o Explanation of questionnaire – Language
  - o Purpose of questionnaire – understanding
  - o Repetition of questionnaire – feelings
- Reason for referral
  - o Behavioural
  - o Emotional
  - o Family responsibilities
  - o Physical
  - o Structural
- Referral process
- Therapeutic tasks/techniques – understanding the purpose
- Treatment options

#### Recommendations

#### Relationship with therapists

- Gender match – advantages/disadvantages
- Non-verbal communication

#### Role of religion

- Beliefs and their interpretations
- Religion non- understanding

#### Service provision challenges

## Appendix 16

### Example of an Interview Initial Coding- Extracts from Noor's Interview

Nahed: Ok Noor we have just gone through the paper work and I have given you a lot of information about the study and you have the time to ask me if you have any questions about that. Before we start do you have any further queries?

Noor: ahh will you keep this for your study or what will you do with it?

Nahed: Yes, this is will be all for my study

Noor: ok.

Nahed: It will be anonymous and nobody will know anything about it. It is only me who will be accessing these recordings and my supervisors will only be looking at the transcripts. So no one will be looking at these recordings except me. Once the recording is transcribed, all the recording will be discarded. So no one will have access to it except myself.

Noor: Ok

Nahed: I know it is quite important for you Noor. So just before we start a general question to warm together can you tell me about yourself?

Noor: I am a mother, I am a worker, I am on my own (laughing) I am having my parents, elderly parents, my mother and my father, and I am the main governor of the family.

Commented [NA1]: Perception of the self

Commented [NA2]: Background information

Nahed: Ok ok, you said you are a mother, can you tell me more about this?

Noor: I am a mother having four children, my youngest child is thirteen and he has got a disability and my youngest daughter, she is nineteen and she is at the university. My parents live in their own but no far from me so they are close to me and two of my children are married and they have their own children as well so I am already a grandma too.

Commented [NA3]: Family background

Nahed: Okay can I ask have you been here for long?

Noor: well when I came to England I came as a joining partner,

Commented [NA4]: Reason for leaving original country

Nahed: Okay

Noor: Joining my partner who has been living here. My husband and I have been here nearly twenty five years.

Commented [NA5]: Length of staying in England

Nahed: Ah

Noor: so I have been here for 25 years and all my children are brought up here.

Nahed: so all your children are brought up here, can you tell me more about your growing up?

Noor: I was living with a large family in my country. I am the oldest and I have two sisters and seven brothers.

Commented [NA6]: Family background in Yemen

Nahed: Okay (encouraging the participant to continue)

Noor: and I have my mother and father as well. I asked them to come to attend my daughter's wedding and then because of what is happening abroad and the conflicts, they ended up staying up with me.

Commented [NA7]: caring for elder parents

Nahed: Ok, You said you have been living in your country, can I ask what your country is?

Noor: Yemen

Nahed: Ah so it is in Yemen. So how was it, how was your life when you were living in Yemen?

Noor: my child life, I was brought up within a middle class family. We had our own home and my father was a farmer and my brothers have their own businesses but because of the conflict everything just disappeared. Even our home has been bombed and everything. So we have lost everything.

Commented [NA8]: The war impacts

Nahed: Oh so this must be really hard for all of you.

Noor: It is very hard, one of my own brothers managed to escape to Saudi Arabia so he is there with nothing, no status nothing, and the rest of my brothers are in Yemen fighting with, for their lives but I tried to help them from here. Me and my parents and my children.

Commented [NA9]: Supporting family

Commented [NA10]: Impact of war in Yemen

Nahed: so are you the only one who is helping your family to go over all these issues.

Noor: Yeh

Nahed: How do you help them?

Noor: it could be like physical or sometimes emotional, I send them some money helping them. My parents when they came here they did help as well because we had to take a loan through them and myself to support them to build few rooms to live in because they have lost everything. Everything is gone.

Commented [NA11]: Impact of war in Yemen

Nahed: that must be hard for them.

Noor: very hard especially for my parents. They are in a shock particularly my mother. She is more aware of what is going on and keeping things and my father, he is got problem with his memory so sometimes he is okay and the next minute he doesn't know what is going on.

Commented [NA12]: Impact of war

Commented [NA13]: Impact war in Yemen

Nahed: (sympathising with the participant)

Commented [HG14]: Family issues

Noor: so it is quite difficult for me to discuss things with him or to take his opinion so I am the one who makes decisions.

Commented [HG15]: Role in family; decision-maker in family

Nahed: so you said it is difficult for him and you are the one who is taking decisions for them. So how are you helping them?

Noor: well I help them not only myself but even my children because I work some sessional work as well and my children does help. My daughter has just recently moved next door to my dad so that was really, really a big help. It wasn't planned, it just happened like that Subhan Allah and Alhamdulillah and the other daughter who is married too, she has moved next door to me, so it came more handy for me, you know I got my child coming back from school and he got some disability, so she looks after him and she watches him or if I got my mum, she has got appointments with GPs or any appointments she



stays in my house and then my daughter took responsibility over her. So it gets quite handy when you have got other children.

Nahed: so you are saying that you are actually providing help...

Noor: providing help near care and even responsibility towards paying bills and everything myself. So I make sure their appointments are in place or asking for appointments.

Nahed: so how you feel about doing all this?

Noor: I am over whelmed with too much pressure

Nahed: over whelmed with too much pressure. Can you explain more, how do you feel about it?

Noor: I feel like sometime I am drown in and I am drown that I don't think about myself because my thinking is my parents, my child and the needs and thinking for the worse all the time and I tend to forget things about myself and I don't realise like I am harming myself and I don't realise but I need to be capable because if I am not capable everything could flush. So I need to be capable so that's why I needed to see the GP because I was over whelmed with stress, anxiety and I started biting my nails, start thinking I can't sleep, I couldn't you know I have some problem with my arm after the incident I had. I had a car accident about three years ago and it took my really a time to recover. I had to lie to my parents I was in a training somewhere in a different city for about two weeks (laugh) and they didn't see me. But my family you know and my kids and my cousins they all were doing things for them like I just weren't there.

Nahed: so what was wrong with you?

Noor: I was not at home I was at hospital?

Nahed: Ah so you were at hospital?

Noor: I was off work for two months

Nahed: Okay

Noor: because I got cast I couldn't move at all.

Nahed: so what about your family did they know about the accident?

Noor: No

Nahed: Oh they didn't know about the accident?

Noor: No I didn't tell them anything until I was a bit able to move?

Nahed: did they miss you, did they ask about you?

Noor: they did, they did but I tried to deny things and I told them I was in training somewhere in a different city.

Nahed: I see okay, so this must be ... (interrupted)

Commented [NA16]: Coping with problems

Commented [NA17]: Family support

Commented [NA18]: Caring for the family

Commented [HG19]: Financial support; as well as organising appointments

Commented [NA20]: Feelings towards family responsibilities

Commented [NA21]: Distressful emotional feelings

Commented [HG22]: Needing to feel capable

Commented [NA23]: Reasons for seeking Therapy

Commented [NA24]: Physical symptoms

Commented [NA25]: Coping with stress

Commented [NA26]: Family support

Commented [HG27]: Not being able to work for 2 months

Commented [NA28]: Coping with stress

Noor: I tried to hide things but you can't hide and then I think once they were walking with one of our community people around the area and they said they wanted to pass to my home and they saw me and I was lying down in bed.

Commented [NA29]: Coping with problems

Nahed: Oh.

Noor: but I was able to move but then my neck, I can't move my neck at all or my arm at all and I used to have that thinking of my neck and they ask what happens to your neck and I said someone hit my car and then I just went to the doctor so they said when did this happen and I said yesterday, yesterday, so they start to cry.

Commented [HG30]: Physical symptoms

Commented [HG31]: Personal problems and impact on family

Nahed: Ohhh, this must be difficult.

You said that you had quite a lot of stress in life and this is why you went to the GP, can you tell me more about this?

Noor: well I had a lot of stress from my son behaviour at school, medication, side effects, problems, you know, keep going in and out of hospital, Children's hospital, all the time. My father missing his appointments or forgetting his appointments, his letters get home and I don't know about these appointments then missing these appointments and they discharge him and having to follow this back again, and then my mother on the other hand is not saying anything about herself, she is not expressing herself, she is getting herself really down, she is locking herself and I wanted to help her to entertain, to get out, to do something and I don't know what to do and then I had pressure from work. if I don't submit some certain training paper work I don't get paid or anything because I am only sessional so I am not constantly working there and I just over whelmed and I just feel like I can't sleep, I can't think, headache for 24 hours, biting my nails, doing all sorts of things and I couldn't take it anymore. I was thinking to end my life to be honest but if I ended my life, all this, what they can do?

Commented [NA32]: Reasons for being in therapy

Commented [NA33]: Anxiety over the family

Commented [NA34]: Anxiety physical symptoms  
Thoughts and behaviours  
Emotional expressions

Commented [HG35]: Suicidal thoughts; thinking about impact on family

Commented [NA36]: Seeking GP help

Commented [NA37]: Process of referral

Commented [HG38]: Previous experience with counselling

Commented [NA39]: Experience of Therapy

Nahed: Okay so what did you do then?

Noor: I went to the GP and I expressed myself and he said you need to seek counselling about it, that it (participant sighs) and I said what they are going to do about it and he said when you come for assessment, they will assess what you need if it is going to work with you, but I think you need it, because before I went to the GP I had counselling after I did the accident straight away you know about 4 – 6 weeks I couldn't sleep I keep think about the crash, I keep thinking, so my insurance had recommended that I seek counselling as well.

Commented [NA40]: Reasons for counselling

Commented [HG41]: Reasons (physical trauma)

Nahed: so you sought counselling because of ... (interrupted by participant)

Noor: because of the accident

Nahed: because of the recommendation of the insurance company after the accident

Noor: Yeh

Nahed: and also because of the problems that ... (interrupted by participant)

Noor: around myself and health and pressure and caring and so I was doing from kind of both ways.

Commented [NA42]: Reason to access therapy

Nahed: Okay

Commented [NA43]: Reasons for seeking therapy

Noor: because the appointment with the NHS takes really a while to get it.

Commented [HG44]: Reasons (stress)

Nahed: Okay

Commented [NA45]: Services – provision, length, availability of therapist

Noor: so I did it through the insurance was a couple of sessions somewhere private and is paid for so I think I did about 8 sessions now

Nahed: so you did 8 sessions.

Noor: Yes I did it privately nothing to do with the NHS.

Commented [HG46]: Seeking private care

Nahed: but it was the GP who referred you?

Lena: No.

Nahed: Ah

Noor: I referred myself through the insurance. I told them because it wasn't my fault and the person who hit me his insurance was following me, how my condition because they didn't want me to go through solicitor and stuff, so they said they will do it themselves and tried to sort it out, calling me and taking reports from me and took me for scans and MRI, they did me checks and gave me a courtesy car and give me everything then paid me back for the car. They did look after me to be honest and they did me a session for physiotherapy. I think I did about 20 or 21 physiotherapy through them private in Hilton, they used to pay for this. And Alhamdulillah everything was going smooth, I don't know Subhan Allah.

Commented [NA47]: Self-referral to therapy

Commented [NA48]: Benefit of therapy

Nahed: Alhamdulillah. You said when you went to the GP as well with the problems, he actually suggested it as well, and so did you go then through the GP to therapy?

Noor yes I went through the GP and yes I have been waiting for nearly 2 years

Commented [NA49]: GP referral

Nahed: Ah

Commented [NA50]: Delay in Service provision

Noor: I have been waiting for nearly two years after which I came to the stage where I went to the GP and said all right it has taken too long and I want to make a complaint.

Commented [NA51]: Reaction for service provision delay

Nahed: Okay

Noor: because I took it really serious and I said why it is taking that long and then one of the receptionist she told me look the person who is dealing with these issues is off sick and I said how long is she going to be off sick? Six months? Eight months? Can you employ another person and she said we can't help you do that until you write a complaint letter.

Commented [NA52]: Services – provision, length, availability of therapist

Nahed: I see

Noor: so I did a complaint letter to the surgery of what's happened and I have been waiting long and I have stressed about it and I don't know where to take it

Commented [NA53]: Taking action against delay

Noor: I was thinking I could do it verbally,

Nahed: I see

Noor I spoke to them verbally and they said we are sorry we can't accept verbally but if you want to make a complaint it is got to be in writing, so I just went on line and check the procedure of the medical centre and I then just followed the procedure and did it.

**Commented [NA62]:** Language and communication  
Complaint procedures  
Accessing information

Nahed: Yes, so speaking the language... (Interrupted by the participant)

Noor: is very important.

Nahed: you felt it was very important to ... (participant completed the sentence)

Noor: with the special terms as well.

**Commented [HG63]:** Importance of speaking the language; ability to access language and understand special terms

Nahed: Okay

Noor: because some of the terms and terminology sometimes you use it and you don't realise it doesn't fit in some particular way.

**Commented [NA64]:** Terms/terminology  
Non equivalence  
Terminology/denote same meaning

Nahed: Okay can you give me an example of that.

Noor: Yes, for example when you say you wanted to make a complaint and they were say what has happened, they give you a wrong medication? What's happen if you don't have your medication? I said it doesn't have anything to do with that, it is the fact the waiting list with you and they were a bit shocked about that.

**Commented [NA65]:** E.g. Complain of an illness, complain about service

**Commented [HG66]:** Issue with waiting list/delay in access to therapy

Nahed: Why?

Noor: because they said no body has done a complaint against them.

Nahed: Okaay. Did they feel...? (Interrupted by participant)

Noor: they felt like I am the first person and I think they have to attend to it. I felt like they were thinking er I don't know, I was going to think like it is because I am black they were treating me different

**Commented [NA67]:** Treatment as an ethnic person

Nahed: say that again.

Noor: they were afraid of that I think because they were thinking I am a foreigner

**Commented [NA68]:** Treatment as a foreigner

Nahed: Yes

Noor: I am a foreigner they might think like because she is different, she is not, you are not our priority like an English person who is living in this country, they are going to give them the priority, we are black people we might be in the last list, (participant switch to Arabic) Allah knows more, I don't know that's how they thought of it and then I just thought this is what they call equality

**Commented [NA69]:** Perception of being different  
Feelings of being discriminated at

**Commented [NA70]:** Perception of being different  
Equality interpretation

Nahed: is this how you felt about it or this is your interpretation (interrupted by participant and spoke at the same time)

Noor: this is how I felt about it from the way they were talking to me, yes

**Commented [NA71]:** Feelings about being treated differently

Nahed: I see

Noor: the accident, the place

Nahed; I see

Noor: the place every time I passed the place, this is where I got hit, and this is where I got hit.

Nahed: I see

Noor: it is always in my head and I can't avoid that place because that place will direct me to my work, to my son's school and that place will direct me next to my father's home. I just can't avoid it. It is a roundabout and you can't avoid it because they were telling me in the therapy can't you find another alternative road. There is no other alternative, there is an alternative but it is a long distance and it will cost money and petrol so they said, you always got an answer for something so I said it is a common sense.

Commented [NA82]: Challenging thoughts in Therapy

Nahed: so when you went to therapy, can you tell me about the stages of therapy?

Noor: at the beginning when I started the therapy I had a short conversation with the person over the phone about what is happening and then I came for an assessment and the assessment took about 40 minutes. She went through my personal information, personal history, facing difficulties, any obstructs, any kind work, things that interest me, just collecting all the information and I didn't feel so bad and then the second session was kind of breaking up the information and how we are going to go through them bit by bit in more depth and details.

Commented [NA83]: Stages of therapy

Commented [NA84]: Explanation of therapy process

Nahed: so how did they start then? You said that the first session was about collecting information, so when you did the second session what was the second session about?

Noor: it was about my, what do I do.

Nahed: Okay

Noor: things that I do, I said I am a carer, I am a worker, I am a mother, I am everything, then she break it up into what I do for my son, what do I do for my parents, what do I do for family and then she came to what I do for myself, Nothing. No time. (Participant go slightly upset)

Commented [NA85]: Process of therapy

Nahed: and how did she do, I mean, work with you about it?

Noor: at the beginning I felt like I am just wasting the time, because talking, talking there is no actions. The first session, the second session, then the third session I said to myself let's see what she is trying to get out of my head, what she is wanting to do. So I went to the third session. The third session was about how can you tap in the barriers and sometimes it is quite difficult and you can't avoid it. Say one of the barriers I need to get everything ready for my son, his lunch, his stuff, my papers and what I need to get ready and I don't have time to have breakfast. How can I stop myself this happen and change it and have breakfast because breakfast is the main course of the day and I did find it really, really difficult to tackle that. I tried couple of times with her techniques. She told me try to make sure to take a snack, a bar or a

Commented [NA86]: Articulation about therapy  
Expectation of therapy  
Therapy as talk/wasting time

Commented [NA87]: Expectation of therapist  
Perception of therapy

Commented [NA88]: Applying therapy techniques in life

snack, anything to take with me in the car while I am going and then eat it when I arrive work. I tried to do this the first day, the second day it was ok then I told myself why I can't have a time because it makes you think. Why don't I have the time? I know, I understand it takes me an hour to wake my son up, and drag him out of bed and end up putting his clothes on. He put on his clothes on but sometimes it goes on and none stop and then make sure he got his lunch, his pass bus, everything in there because sometimes he didn't listen and I need to follow him again and then I forget myself. Then I thought between that time giving him that space, I will go and warm the kettle on and then I will have something and get it ready and once he goes, I will have my breakfast. I have given myself about 5 minutes just this is me, for me and I tried it a couple of times and it worked.

Nahed: Okay

Noor: I have to be firm, I thought I need to be firm of things because sometimes you think it is ok, it is ok I will have something later in the snack time or my break time but actually I don't have that time.

Nahed: Okay

Noor: So I felt the third session I have to be firm with myself. This is me, this is I need to do it, I have to do it because if I don't have that energy, I will be grounding and I will be overwhelmed, I will have a headache because no eating properly, no time to eat, and alhamdulillah I stick to that and now that's it, it is a habit, I've got to have breakfast every morning. If I don't have breakfast, that's it I feel something is missing.

Nahed: ok so when you said she gives you some techniques, so what was the other techniques she gave you?

Noor: one of the techniques she told me is be firm. You've got to do it even if you got something. No this is my time and I have to do it. Because if you think, because she told me if you feel like it is not important then it might be not important for you to have it at any time, but it is important, you have to notice it and be firm, just challenge it. And I did challenge it.

Nahed: Okay

Noor: Alhamdulillah

Nahed: Alhamdulillah. You sad initially that it was talk, talk, talk, so what was this talk?

Noor the third or fourth session, we were talking about the feeling, the emotional feelings. I start crying at this session.

Nahed: Okay (empathetically)

Noor: I just couldn't take it anymore. I said to her, she said to me if you don't want to speak about it, it is fine. I said no I felt now relief when I get it out.

Nahed: Okay

Noor: I felt more relief someone is listening to me because I never express it to anyone because I don't want to upset them, especially, particularly my

**Commented [NA89]:** Collaboration work with therapist and understanding the activity

**Commented [NA90]:** Understanding therapy tasks/activity  
Collaboration work patient/therapist

**Commented [NA91]:** Difficulties to achieve tasks

**Commented [NA92]:** Feelings about the tasks  
Learning from the tasks

**Commented [NA93]:** Understanding of therapeutic tasks

**Commented [NA94]:** What is talking therapy

**Commented [NA95]:** Talking to someone is relief

**Commented [NA96]:** The importance of listening