‘It’s been quite a poor show’ – exploring whether practitioners working for Improving Access to Psychological Therapies (IAPT) services are culturally competent to deal with the needs of Black, Asian and Minority Ethnic (BAME) communities

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Abstract

Cultural competency is a core clinical skill. Yet, psychological therapists may be inadequately trained to deal with the needs of service users from Black, Asian and Minority Ethnic (BAME) backgrounds. This can lead to dissatisfaction with mental health services, disengagement from therapy, and poorer treatment outcomes when compared to the White British population. The aim of this study was to explore whether practitioners working for Improving Access to Psychological Therapies (IAPT) services are culturally competent to deal with the needs of diverse communities. Semi-structured interviews were carried out with a range of practitioners, from early career psychological wellbeing practitioners (PWPs) to senior cognitive behavioural therapists (n = 16). Reflexive thematic analysis (RTA) was used to analyse the data, guided by a six-phase process to produce a robust pattern-based analysis. Overall, three themes were generated: (1) encountering cultural dissonance within therapy; (2) challenges in making cultural adaptations to therapy; and (3) identifying cultural competency needs. Out of sixteen participants, only nine therapists received one-day formal training throughout their therapeutic career, whilst seven reported receiving no cultural competence training at all. Overall, it appears that there is an urgent need and desire for therapists to be offered cultural competency training so that they can better serve BAME communities. Clinical implications and future recommendations are made.

Key learning aims

1. To briefly introduce cross-cultural theoretical models that may assist mental health professionals to think critically about Western notions of therapy and whether they are suited to the needs of ethnic minority communities.
2. To consider challenges IAPT practitioners encounter during therapy and identify examples of good practice.
3. To explore to what extent IAPT practitioners feel culturally competent to deal with the needs of BAME communities.
4. To encourage IAPT services and decision makers (e.g. training bodies and commissioners) to enhance cultural competence training so that practitioners can better serve ethnic minority communities.

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

Cultural competence has received considerable attention in mental healthcare, particularly in relation to its usefulness when working with people from ethnic minority backgrounds (Clegg et al., 2016; Sue, 2006). Culturally competent care acknowledges and integrates culture when making considerations about assessment, treatment and outcomes (Castillo and Guo, 2011; Good and Hannah, 2015). Theoretical paradigms such as individualism-collectivism (Hofstede, 1980; Hofstede, 2011; Triandis, 1995) and self-construal theory (Markus and Kitayama, 1991) suggest that there are distinct cultural differences between individuals from Western societies and those who originate from non-Western cultures. Yet, Western psychological practices are rooted in a universal rhetoric that favours individualistic value systems over cultural particularism (Fenn and Byrne, 2013; Frese et al., 2001; Rogers, 2009). Typically, Western psychotherapy and clinical training programmes are developed from a Eurocentric gaze, which means that cultural diversity and inclusivity tends to be absent from traditional theory, procedures and practices (Kirmayer, 2012; Roy-Chowdhury, 2013; Sue et al., 2009).

The Office for National Statistics (2021) reports that England and Wales are more diverse than ever before, with approximately 15.2% of the population identifying from Black, Asian and Minority Ethnic (BAME) backgrounds. Given the substantial implementation of Improving Access to Psychological Therapies (IAPT) services across England (Clark, 2018), IAPT practitioners now serve an increasingly diverse clinical population. However, individuals from BAME communities continue to experience barriers in accessing mental healthcare, show increased disengagement from therapy, and poorer recovery outcomes when compared to the White British population (e.g. Baker, 2018; Harwood et al., 2021; Moller et al., 2019). Often, this is due to factors such as different cultural expressions of mental distress, therapeutic fears, and increased scepticism about the credibility of psychotherapy and mental health service providers (Beck and Naz, 2019; Christodoulou et al., 2018; Lamb et al., 2012; Prajapati and Liebling, 2021). Given the inherent over-representation of White therapists in clinical psychology (Lang, 2020), concerns are raised about Eurocentric practitioners misunderstanding cultural nuances, practices, and ways of living which can leave damaging effects for ethnic minority communities (Good and Hannah, 2015; Turpin et al., 2008). Thus, mental health practitioners are encouraged to consider patient lived experiences and culturally sensitive issues to maximise recovery goals (Dausch et al., 2012; Lawton et al., 2021; Tse and Ng, 2014).

In recognition of the importance of culturally competent care, many UK professional bodies such as British Association for Behavioural and Cognitive Psychotherapies (BABCP, 2021) have recommended cultural competency units as part of clinical training programmes (Ibrahim and Heuer, 2016). Cultural competency training can help improve the quality of care for people of diverse communities (Bhui et al., 2007) and allow therapists to offer culturally informed and empirically supported therapy (Kenneth, 2019; Leong and Lee, 2006; Sue, 1991; Yan, 2018). IAPT services appear to consider culture and diversity as part of low-intensity psychological wellbeing practitioner (PWP) training programmes (e.g. University of Central London, 2022), as well as the development of the BAME positive practice guidelines (IAPT, 2009; Beck et al., 2019). A key theme throughout the guidance is for therapists to offer culturally adapted and culturally responsive services that meet the needs of the local community (Beck et al., 2019). However, there is limited evidence supporting the success of such initiatives (Bhui et al., 2007; Clegg et al., 2016).

Research suggests that practitioners seldom receive adequate training that equips them to work with diversity (Clegg et al., 2016; Edge and Lemetyinen, 2019). Often training programmes fail to consider the role of the therapist and how their personal identity, stereotypes, biases, and positions of power and privilege interacts with the client (Bhui et al., 2007; Crawford et al., 2011; Ibrahim and Heuer, 2016; Sue, 2001). Despite IAPT therapists attempting to offer culturally sensitive care,
increased service demands mean that sessions are time limited, which makes it difficult to provide extensive adaptations to therapy (Bassey and Melluish, 2012). In some instances, BAME therapists are allocated complex caseloads without adequate support and resources, leaving them to feel responsible for the quality of care of ethnic minority patients (Naz et al., 2019). Given the systemic inequalities and poor treatment outcomes for ethnic minority service users, it is important to regularly review and assess the competencies of mental health practitioners (Clegg et al., 2016). To the author’s knowledge, this has not been explicitly investigated with the IAPT workforce. Therefore, this study aims to explore whether IAPT practitioners are culturally competent to deal with the needs of BAME communities.

Method

Participants

IAPT practitioners were recruited using snowball sampling methods commonly used as part of qualitative research methods (Bricki and Green, 2002). At the time of the study, practitioners were employed across a number of different IAPT services in England. Participant demographics are highlighted in Table 1. The mean age was 38.56 years \((SD = 9.65)\). Out of 16 therapists, 12 were female and four male. Most therapists identified as Indian, followed by Pakistani, White British, and White other. The religious orientation of the therapists was predominantly Muslim and Sikh. Others included Christian, Hindu, Buddhist and no religion. The large majority of participants were cognitive behavioural therapists (68.8%). Others included trainee PWPs (12.5%) and qualified PWPs (18.8%). The range in years of experience was between 1 and 10 years, with a mean of 4.44 years \((SD = 3.44)\).

Design and procedure

Qualitative research methods was chosen as it allows for in-depth exploration of participant experiences (Williams, 2015). Participants interested in the study were emailed the information sheet and consent form detailing the purpose of the study. Once agreed to participate, all interviews were carried out face-to-face. The author developed the topic guide by careful consideration of existing literature and by brainstorming ideas that would enrich understanding of the topic. The interview schedule consisted of 12 open-ended questions, with

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Therapist role ((n, %))</th>
<th>Number of years in role ((mean, SD))</th>
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<tr>
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<td>Gender ((n, %))</td>
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<td>12 (75%)</td>
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<tr>
<td>White British</td>
<td>4 (25%)</td>
<td>Hindu</td>
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<tr>
<td>White other</td>
<td>3 (18.8%)</td>
<td>Christian</td>
</tr>
<tr>
<td>Pakistani</td>
<td>4 (25%)</td>
<td>Buddhist</td>
</tr>
<tr>
<td>Indian</td>
<td>5 (31.3%)</td>
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Table 1. Mental health professional demographics

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use of prompts where needed, to allow participants to discuss their experiences (Braun and Clarke, 2013). Topics relating to therapists’ cultural competency, service user therapeutic engagement, cultural adaptations to therapy, and therapeutic effectiveness were core areas of interest. Examples of questions included ‘How flexible are you in tailoring therapy to the needs of BAME communities?’ and ‘Could you tell me about the training you’ve been offered to deal with cultural diversity?’. The researcher was conscious of her own biases and prior knowledge of the topic, so was cautious not to ask leading questions. The interview process was interactive and the author weaved in and out of topics to allow therapists the opportunity to talk about what was important and meaningful to them. Interviews were audio-recorded and lasted between 45 minutes and 1 hour 10 minutes. Once the interview was completed, participants were offered a verbal and written debrief, and given the opportunity to ask any questions. Audio files were transcribed verbatim and anonymised. Participation in the study was entirely voluntary and no payment or incentive was provided.

Analysis

Reflexive thematic analysis (RTA) was chosen as it is a flexible approach that does not confine to particular theoretical frameworks, philosophical positions, or ideologies (Braun and Clarke, 2013; Braun and Clarke, 2021). RTA involves reflexive engagement with the dataset, guided by a six-phase process to produce a robust pattern-based analysis (Braun and Clarke, 2006; Braun and Clarke, 2019). During the data familiarisation stage, the author immersed herself in the data by carrying out the interviews and repeatedly reading the transcripts. Notes on initial analytical observations and insights included participants’ feelings, discourse, and understanding of their world. The author also considered her positionality as someone from a BAME background working in the field, thus reflected on her own assumptions, biases and subjective knowledge by keeping a reflexive diary. Next, the author coded the transcripts and used the ‘comments’ function in Microsoft Excel to create side margins to highlight the relevant extracts and codes (Byrne, 2022). To generate initial themes, topic areas were clustered according to their shared meaning. The author recursively developed and reviewed themes to ensure that they addressed the research question (Braun and Clarke, 2013). To refine, define and name themes, the author went back and forth between the data to ensure that it told a ‘story’ and did not drift off topic (Braun and Clarke, 2019). Whilst the author recognises the added benefits of multiple coders and research triangulation (Nowell et al., 2017), the credibility of single coder analysis is not diminished. The main reason for this is because it impossible to avoid researcher bias and subjectivity on how the data is conceptualised and understood by multiple coders (Braun and Clarke, 2021). However, to enhance the credibility of the analysis, the author shared findings with the doctoral research supervisory team and a clinical expert for review. Following feedback, themes were further refined and defined. The thematic map is shown in Fig. 1. Finally, the report was written up to offer a narrative account of whether IAPT practitioners are culturally competent to deal with the needs of BAME service users.

Results

Three over-arching themes were generated: (1) encountering cultural dissonance within therapy; (2) challenges in making cultural adaptations to therapy; and (3) identifying cultural competency needs. Pseudonyms have been used to preserve participant anonymity. For consistency, the acronym BAME has been used throughout the interview extracts (where applicable).
The first theme considered the cultural dissonance encountered during therapy. This included cultural expression of distress, patient therapeutic expectations, and recognising cultural challenges beyond the therapy room.

Cultural expressions of distress: ‘How do we communicate these words to people?’

The first sub-theme describes the cultural expressions of distress that were discussed during therapy. All therapists raised concerns about how mental health was conceptualised in the West and the lack of terminology available to explain Western concepts to service users from BAME communities. Certain words such as depression and anxiety ‘did not exist in certain cultures’ which made it ‘difficult’ to explain mental health conditions to service users. Therapists discussed how certain cultures had ‘very negative words’ to describe mental health, which included ‘crazy’, ‘madness’ or ‘paagal [mad]’. This resulted in ‘shameful’ and ‘very embarrassing’ connotations. Bhavna (MHP1) talks about the barriers she’s encountered:

‘A big problem I want to highlight is there’s no word for depression and anxiety in certain languages. I think the Punjabi culture, even Muslim culture, because that’s a big thing. Because it’s about how do we communicate these words to people. You know, we can use similar words in the language, but it’s not exactly the same word.’

A couple of White therapists worried about how their ‘Westernised’ worldview of mental health would project onto patients who do not share similar understandings. For example, Simon (MHP5) mentions ‘... I’m worried about my very Westernised view of depression on the person, which might actually not resonate with them, they might not grasp it’. As a result, therapists had to resort to using ‘adjectives’ and ‘metaphors’ to describe disorders, such as ‘feeling stressed’ or ‘feeling down’. Scott (MHP16) talks about ‘mirroring’ the patient’s language:

‘And I think it’s making sure that you’re using their words. So that’s why you use the word sad, because I think that’s probably the most common. How do you feel? I feel sad. Right, I’m going to use that.’
Therapists found younger service users ‘a bit more broad minded’ than the older patients, particularly when it came to the understanding of mental health. Jess (MHP7) talks about the differences she’s encountered:

‘... The younger generation is more accustomed to that [mental health]. Now, if I see them, it’s more like normal in that it’s like seeing an English person. But when it comes to older community, they understand that there is other levels of mental health that you just try to push through. It can be harder in a sense.’

Therapists found it more ‘challenging’ to engage older patients as they often ‘somaticize’ their conditions, rather than attributing it to mental illness. Therapists felt this was more ‘acceptable’ than to be diagnosed with a mental health condition. Service users often used phrases such as ‘my stomach hurts’, ‘I can’t concentrate’, ‘my chest hurts’, ‘heart racing’, ‘getting headaches’ and ‘palpitations’ to describe their condition. Therapists felt that one reason for this was the adoption of the ‘medical model’ by many non-Western societies. This meant that there was an inherent reliance on physical sensations and medication over therapy. Sidra (MHP14) reflects on this:

‘... Depression is externalised, is not part of the person, it’s not that. Whereas in the Western world, I am depressed. Whereas in our world, in the sort of Asian world, it’s like, you know, is all to do with the heart. It’s like, oh, physical symptoms, they will pick up the physical symptoms. They won’t pick up the emotional symptoms because emotionally it’s not normal to feel like this.’

Most therapists had to explain that ‘thoughts, emotions, physical symptoms and behaviours are all connected’. Therapists felt that it was imperative to make those ‘links’ otherwise ‘there’s no point ... you’re going to struggle’. However, this took up a lot of therapeutic time, which led to therapists offering ‘psychoeducation’ before the designated therapy could begin. Some therapists struggled to explain therapeutic concepts such as ‘metacognitive thinking’, ‘flashbacks’ and ‘hyper vigilance’ which ‘slowed down the pace of therapy’.

Several therapists talked about patients’ beliefs about witchcraft, black magic and spiritual possession, particularly in Asian and Black communities. Some therapists were worried about how to approach these subjects and did not want to ‘dismiss [patient] religious or cultural views’. This made it difficult to navigate conversations around ‘self-sufficiency’ and ‘taking control of their lives’. A few therapists, particularly from BAME backgrounds, worried that their White colleagues may misinterpret black magic and ‘possession [jinn]’ as ‘psychosis’ as it this was not something that was readily discussed or included in Western models of mental health or therapy. For example, Bhavna (MHP1) mentions:

‘... In BAME cultures, that it might be down to giving evil eye or something bad might happen or, you know, this person’s been jinxed in some way. They rather prefer to believe that then there’s mental health involved. So that’s quite frightening. Then how do you say there’s this therapy that can help?’

Patient therapeutic expectations: ‘I’m going to just sit there and talk to somebody?’

This sub-theme describes BAME service users’ therapeutic expectations and the challenges therapists encountered trying to explain Western notions of therapy. Most therapists reported that there was a distinct ‘lack of awareness’ and ‘understanding’ of therapy in BAME
communities. Bhavna (MHP1) found that BAME service users often questioned the purpose of therapy and how it would help them to recover:

‘...What is it [therapy]? I’m going to just sit there and talk to somebody? So I think it can be difficult to encourage the patient to recognise therapy is helpful, especially when they’ve got external influences and maybe their own beliefs and values as well about what might be useful.’

Most therapists discussed the idea of service users ‘expecting a cure’ or a ‘magic pill’ when entering therapy. Whilst therapists encouraged service users to develop ‘self-resilience’, this was sometimes difficult to manage when there was a ‘reliance’ on the therapist to ‘miraculously change their circumstances’ than to ‘find the answer’ for themselves. Therapists reported that it was easier for some service users to get ‘an injection or taking medication’ than to ‘sit in sessions for six weeks, for one hour and talk the problem away’. Sikander (MHP4) mentions:

‘A lot of the times people come in and say, well, fix me, you know, or like wave your magic wand ... They give you the power to make them better ... And some people don’t take that very well, actually the idea that you have to do something about your mental health.’

Several therapists reported that service users were not fully informed about what to expect from therapy and saw it as ‘practical help’ for issues such as ‘immigration’, ‘benefits’ and ‘social services’. This meant that practitioners were often ‘signposting’ service users, which made them feel ‘frustrated’ and ‘angry’ at mental health services. Gina (MHP10) talks about her experience:

‘...And to the person who’s expecting let’s say a letter or practical support, and then I start talking about mood and behaviours and emotions they are like, what is this about? I expect you to sort out my benefits because somebody sent them to me. So it is important to clarify that and set the right expectations.’

Therapists felt that this ‘wasn’t a good experience’ for service users, therefore, patient expectations needed to be managed at first point of contact (e.g. by general practitioners and PWPs). Some therapists had to create their own ‘resource packs’ because it was not readily available from IAPT service. This meant that therapists had to do ‘a lot of research’ in their own time to help service users find appropriate services. Nadia (MHP9) talks about this:

‘Sometimes they [patient] think we fix all their problems from the socioeconomic to the needs of children. You know, I can’t put food on people’s table. I can’t fill out benefits forms ... But at the same time, if IAPT was getting it right at the early step of signposting, those issues would be sorted before they enter therapy.’

Recognising cultural challenges beyond the therapy room: ‘They [are] almost lost as to what we follow...’

This sub-theme describes cultural challenges beyond the therapy room that had both implicit and explicit implications for BAME service users. Family dynamics played an important role in the uptake of therapy and therapeutic compliance. Therapists reported that the majority of BAME service users felt ‘the family element’ of their lives caused them the most distress. Unlike their White counterparts, therapists reported that service users from minority groups were heavily influenced by their family which made it challenging to ‘sell’ concepts of ‘autonomy’, ‘self-reliance’ and ‘independency’. Therapists talked about the inherent familial ‘expectations’ and ‘responsibilities’ which made it difficult for service users to explain and justify the reasons for
‘engaging’ in treatment. As a White therapist, Alison (MHP6) worried that she might not be able to grasp to what extent cultural and familial pressures influenced BAME service users:

‘I can’t picture what it’s like for you to be in your environment and that power dynamic within your relationship, within your family, the pressure that you might have from in-laws as well, because people live in sometimes. You know that wider family lives in quite close proximity.’

Bhavna (MHP1) found that service users experienced cultural dissonance between Western upbringing and ‘traditional’ cultural values. This had implications for therapeutic engagement:

‘... You know, dad was always like get on with it or, you know, mom wouldn’t talk much about it [mental health problems]. Sometimes patients might struggle ... because it’s probably family, siblings, or maybe caregivers like grandparents which can influence how they feel and perceive. They [are] almost lost as to what we follow, this culture that we are brought up within or the culture that my parents are inflecting on me, or suggesting I should be adhere to keep those traditional values.’

Sidra (MHP14) further discussed how Western models of therapy were not so simple to ‘fit’ into their lives of individuals from BAME communities:

‘... Because in the Asian culture, the other thing is the “I” doesn’t exist. “We” exist in Islam. We as a family, an extended family. The husband or wife don’t really exist as a couple ... That can be confusing in the Western world, because in the Asian world, you have 10 caregivers for the child such as the grandmother, the aunties ... Whereas the Western world its mom, dad, that’s your family. So it’s very different. So those things need to be taken on board. All this is really complex.’

Therapists found that Asian and Black communities often used ‘faith’ as a ‘coping mechanism’ to deal with mental distress. Therapists felt it was ‘tricky’ to ‘challenge’ service users ‘world’ because they ‘were not in a position to say no to religion’. Therapists found that BAME service users often tried to ‘behave in an English way’ because they were ‘afraid’ to talk about their religion. Several therapists found that patients’ ‘culture is based around religion’ which led to ‘religious guilt’. Service users often relied on ‘prayer over therapy’ to show ‘devotion’ to God. Bhavna (MHP1) recognised this and felt that going back to religion may help patients move forward:

‘... And maybe they’ve been away from religion for so long that they feel depressed. They think about their values and maybe they do need to go back to religion and start praying again just to make them feel more connected to who they are.’

Challenges in making cultural adaptations to therapy
The second theme considered the challenges therapists encountered in making cultural adaptations to therapy. This included considerations of treatment fidelity, availability of culturally adapted resources, challenges in working with interpreters, and challenges in achieving recovery goals.

Considering treatment fidelity: ‘...There’s not always a one-size-fits-all’
This sub-theme describes the conflict therapists encountered in adhering to treatment fidelity and making cultural adaptations. A couple of therapists such as Simon (MHP5) felt that it was imperative to stick to guidelines to provide ‘effective therapy’:

‘It’s important I stick to the kind of fidelity of the model and not try and get into therapeutic drift and things like that.’
Generally, therapists understood the importance of evidence-based therapy but felt that there was ‘minimal research’ to support its ‘effectiveness with diverse communities’. Therapists felt that Western models of therapy did not ‘work for everybody’; therefore, it was important for IAPT to recognise that a ‘one-size-fits-all’ approach was not always useful. Gina (MHP10) was particularly conscious of this:

‘So we are working with an American and European model on different cultures with different influences. And even though there is a model and a manual, there’s not always a one-size-fits-all.’

Therapists felt that they ‘had to learn this the hard way’ during the early years of practice as there was ‘minimal guidance and training on how to adapt therapy’ for diverse clients. Jess (MHP7) reflects on this:

‘... There was nothing about, oh, if you do CBT [cognitive behavioural therapy] with an ethnic minority client they won’t understand some concepts, or maybe the homework, or how, you know, adapt it or work with that. That was more through just me doing my own kind of research into it, kind of looking online.’

Even though there was some ‘flexibility’ in making IAPT approved adaptations (e.g. appointment time and arranging an interpreter), therapy was too ‘prescriptive’ and ‘robotic’ which saw a number of service users ‘disengaging’. Scott (MHP16) felt that it was vital to have an ‘understanding’ of the needs of the community and not to treat the guidelines as the ‘law’:

‘I always say guidelines are guidelines. It’s not a law. I think there are clinicians who will stick to the theory, to NICE guidance, and whether that’s through personal choice, whether that’s through the organisation that they work through this model, I don’t know. But there’s certainly, I think a need to understand your community and have your management and your Trust or whoever it is, whether the third sector or charities, having an understanding of the needs of the people within the community that you’re working with ... So to be able to provide a successful treatment, you have to be flexible.’

Others such as Frankie (MHP13) worried that the need to ‘meet targets’ meant that practitioners had become ‘complacent’:

‘I see within the system people have become lazy, practitioners have become lazy ... we have become like prescribers. We have become automated services and in this enterprise, it doesn’t work like that. I believe that system should allow practitioners to be as creative as they can and to obtain multiple skills if they can ... I believe that the system is too tight, too controlling and somehow constraining practitioners and clients as well. I try to be as good as I can within the framework and code of conduct we have been taught by NICE guidelines. But I believe that we treat them like a religion. We are so afraid of coming out of them. In fact, the cruelty is not to harm anyone and be safe and be genuine, contrary to our beliefs.’

Most therapists felt there was ‘no need to reinvent the wheel’ but to be more ‘creative’ in explaining therapeutic concepts to BAME service users. For example, Gina (MHP10) talks about using a hands-on approach by incorporating ‘play’ within therapy:

‘... To build a therapeutic relationship rather than talking about BA [behavioural activation], well, I would probably ask the patient to think about what they are struggling with for 30 seconds or so and then get up and we would play with a piece
of paper throwing it to each other, kind of playing with a balloon or something. And I would ask them after whether they were thinking of their worry or their problems while we were doing that activity or doing a form of activity. And if they were saying no, that’s the rationale for BA to get to do more rather than sitting down and thinking about your problems.’

Availability of culturally adapted resources: ‘It’s been really difficult you know . . . ’

This sub-theme describes the challenges therapists experienced in getting appropriate culturally adapted resources. Whilst therapists acknowledged there was a range of material available, including ‘self-help books’ and ‘translated questionnaires’, they found it ‘really hard’ to readily find resources. Therapists felt that there was a need for a ‘central repository’ where all resources could be made accessible across IAPT services. Most therapists found it difficult to engage patients with limited reading and writing literacy. This predominantly related to older patients and newly arrived migrants and refugees who ‘couldn’t grasp the language’ of therapy, and often looked at therapists with ‘blank’ expressions. Therapists often used ‘pictures’, ‘drawings’ and ‘emojis’ to help patients ‘express how they are feeling’. Despite material being available in a range of languages, some clients were unable to read or write in their ‘mother tongue’. This presented greater ‘difficulties’ for therapists as they often relied on interpreters and family members to translate material. Sikander (MHP4) shares his experiences:

‘The biggest challenge I think, is utilising appropriate self-help materials for clients and trying to find what suits them. You want to use self-help books, but they don’t really like using them because of the language barriers. Videos are hard to get hold of. I’d love it if they were available for different types of therapy interventions in their own language. Especially for those who can’t read or write.’

Most therapists resorted to doing their ‘own research’ in their ‘own time’. BAME therapists often reflected on their own cultural upbringing and experiences to understand patient ‘cultural expectations’ and ‘religion’. With increased pressure to work and research outside their clinical role, this led to ‘burnout’. Nadia (MHP8) talks about this:

‘It’s been really difficult you know, not just myself but for other therapist too. I’ve got a lot of burnout. They [therapists] become really unwell because you’re expected to work with communities not being fully trained and supported to do the roles. And it knocks your confidence in your core clinical skills. And yeah, just bit relentless and tiring.’

Challenges in working with interpreters: ‘There are so many different dynamics . . . ’

This sub-theme describes the challenges therapists encountered when working with interpreters. Most services catered for patients with little English proficiency by offering interpreters and incorporating longer sessions to account for the relay of information. Whilst therapists valued interpreters, a number of challenges arose during therapy. Concerns were raised about the loss of ‘empathy’ when information was translated via a ‘third person’. Patients often got ‘attached’ to the interpreter, which strained the therapeutic relationship when ‘boundaries were blurred’. Nadia (MHP9) talks about the ‘dynamics’ of the therapy room:

‘. . . There are so many different dynamics happening in the therapy session. Because not only are you trying to deliver the intervention, you’re trying to contain the conversation between the interpreter and the service user. You’re also trying to translate materials. And you get distracted by so many different things.’
Therapists sometimes found themselves ‘psychoeducating’ and offering ‘quick training’ to interpreters as they did not have ‘mental health knowledge’. Most therapists questioned the ‘accuracy’ of translation and had to depend on non-verbal cues such as ‘body language’ and ‘expression’ to gauge how patients were responding. Whilst some interpreters were ‘good’ at ‘asking for further clarity’, others tended to ‘add bits’, particularly when the ‘conversations were lengthy’. Therapists felt it was important for interpreters to provide ‘verbatim’ responses to help them ‘formulate’ effectively. Hannah (MHP2) recalls on her experiences:

‘… I’m not fluent in Punjabi, so I had an interpreter come in. I can understand bits and I picked up on the fact that he was giving his opinion and telling her that she needed to go to the temple and the problem was because she wasn’t good enough Sikh that she doesn’t need therapy. So luckily, I was able to pause and stop that session and try to explain to the patient that that shouldn’t have happened. However, if I didn’t say, for example, at and my Polish patient, I wouldn’t have a clue that was going on.’

**Challenges in achieving recovery goals: ‘It’s a cultural and systemic problem…’**

This sub-theme describes the challenges therapists encountered in helping BAME service users achieve recovery. BAME patients who had an ‘understanding’ of Western concepts, values and upbringing were more likely to ‘actively’ engage with therapy. However, therapy was used as a form of ‘counselling’, regardless of therapy type. Given the ‘practical’ nature of CBT, some patients wanted to ‘just talk’ rather than ‘engage with the programme’. Service users often brought up ‘a lot of stuff from the past’, which meant that it was difficult to ‘move forward’ with therapy. Several therapists such as Gina (MHP10) raised concerns that this led to greater disengagement from therapy:

‘Yeah, but then sometimes people get it really quickly or they will disengage. You get the bigger figure of people disengaging because they cannot get on board because it’s not the right process or they do not get the model.’

Therapists reported that recovery outcomes became more ‘difficult’ when clients ‘were not willing to make certain changes’ or adhere to ‘homework tasks’. In instances where homework was not completed, therapists had to spend time explaining the ‘principles’ behind why it would be ‘helpful’. Whilst some patients were ‘accepting’ of the homework tasks, they faced barriers and challenges when they ‘went back into their home settings’. This included being ‘unable to talk to family about their problem’, ‘going out on their own’, or ‘taking time out for themselves’. For example, Alison (MHP6) mentions:

‘I still have lots of clients who are of different cultures and race who have difficulties with like family commitments … Maybe they don’t actually want to get their worksheets out in front of family members at home because they might be ashamed or because, you know, they might get criticised for doing it.’

Therapists felt that ‘Western practice is not really kind of working with those cultural needs and the values’. Sikander (MHP4) talks about the challenges in delivering Western models of therapy:

‘… We’re called collectives. You know, you do everything as a family culture … So, yeah, you do have to kind of tweak your therapy slightly to take into account those responsibilities they have … But on the other hand, when you’ve got so many responsibilities to manage, it’s hard to provide very individualised therapy for someone who is part of a collective.’
Bhavna (MHP1) echoes these concerns and felt that the inherent nature of Western society is to ‘look after yourself’ and consider ‘self-care’, but this tended to be absent in many BAME communities:

‘I have not been taught to do self-care, whereas in Western cultures, I guess that’s very common for yourself and making time for yourself and looking after yourself . . . So there might be a conflict. So you’re telling me something I should be doing, which I’ve been told all my life not to do. I put myself first whereas I’ve been always there for others . . . Sometimes people might find it a bit too much and might not engage with that.’

Moreover, therapists felt that service users found it ‘difficult’ to understand homework tasks such as ‘challenging thoughts’ and ‘putting it down on paper’. Given the literacy difficulties aforementioned, some therapists found it ‘disrespectful’ to ask ‘senior member of the community to do assignments’, whereas the ‘younger generation took it very well’. Therapists felt that BAME patients generally grasped ‘behavioural’ activities ‘quite quickly’, such as ‘breathing exercises’. On the other hand, cognitive tasks were not ‘thought about much’.

Most therapists discussed the importance of ‘being realistic’ when thinking about recovery goals. Therapists felt it was more important to consider what was ‘achievable’ for the client and use ‘small goals’ so that patients could achieve ‘enough empowerment at the end of therapy’. Given the ‘high caseloads and fast turnaround’, therapists could not always get into the ‘detail’. Therapists found that BAME patients needed ‘more time to talk about their problems and open up’ which made it difficult when sessions were ‘time limited’ and ‘short’. Therapists such as Nadia (MHP9) were particularly concerned about this:

‘The whole IAPT needs to review this agenda. It’s a cultural and systemic problem here because you can’t ignore the fact that ten years on, BAME people are still under-represented in primary care and over-represented in secondary care. And when then they enter primary care, they’re not getting the same recovery rates or the reliable improvements. You cannot ignore that. And to ignore that is a disservice to the community.’

**Identifying cultural competency needs**

The final theme considered therapists’ cultural competency needs. This included recognition of limitations in cultural knowledge, the need for cultural competency development as a shared endeavour, and the importance of training and supervision.

**Recognising limitations in cultural knowledge: ‘Don’t assume but also don’t be ignorant’**

This sub-theme describes therapists’ self-reflections about their cultural knowledge and understanding. A number of White therapists reported that they did not ‘feel comfortable’ in talking about cultural issues and were not fully equipped to work with different cultures. White therapists worried about not knowing what certain cultural implications meant for BAME patients, for example ‘if they hadn’t prayed’ or if they had experienced ‘racism’. A couple of White therapists ‘feared’ that they ‘might get it wrong’ or ‘come into conflict’ with their patients because these topics were ‘taboo’ in certain cultures. Greg (MHP12) shares his concerns:

‘Um, I think our culture in this country, you know, we are kind of very pc. We like to be politically correct. We don’t want to offend people . . . Don’t ask that question for fear of upsetting or maybe putting our foot in it and so you know, maybe we’re causing more harm by not asking those questions and not raising those topics . . .’
Given the limited training offered during clinical training programmes, some therapists talked about ‘trying to experiment and see what fits for that individual’ or ‘wing it’. Therapists recognised that this was not always ‘good practice’, but felt that IAPT did not give them enough ‘time to reflect and prepare’ for diverse clients. Therapists recognised that ‘building a therapeutic relationship took time’, and often ‘time limited sessions’ meant that they were not able to fully ‘explore the service user needs’. For example, Alison (MHP6) felt that due to the ‘fast paced’ environment of IAPT she may have ‘neglected’ the cultural needs of her clients:

‘I feel this sounds really bad, but I just I don’t know whether, um, we haven’t explored that [culture] as much as maybe we could have … But it’s hard because, you know, like I say, you’ve only got 30 minutes or so of the day and it’s almost like you’ve got everything to fit in. So probably I do feel that that side of things can be neglected.’

Whilst therapists recognised cultural similarities, they felt it was imperative to acknowledge the ‘every patient is different’ and there were ‘cultural differences within similar ethnic groups’. Simon (MHP5) felt it was important to ‘not to make too many assumptions’ about patients:

‘I think it’s hard because I suppose you can’t generalise to somebody that comes from a let’s say a Pakistani background that they are going to have these beliefs, this kind of family environment. Because everyone lives between the cracks in the pavement and, you know, no one lives in these neat boxes … So I think the awareness is really important.’

Nancy (MHP15) echoes these concerns:

‘Don’t generalize, it really winds me up … Always look at the person as an individual, which is the whole concept of IAPT having started the patient-centred interviewing. Don’t assume but also don’t be ignorant. Because, you know, the fact that you haven’t come across discrimination doesn’t mean that somebody else didn’t …’

**Cultural competency development as a shared endeavour: ‘So whose responsibility is it?’**

This sub-theme describes the innate responsibility that was placed on BAME therapists to serve ethnic minority communities and the implications that this had for practice. BAME therapists acknowledged the benefits of therapist matching, particularly when service users had ‘mistrust’ or a ‘bad experience’ with Eurocentric practitioners. Therapists recognised that by sharing similar collective identities, they were able to ‘empathise’ with patients more readily. Some BAME therapists were able to ‘speak the language’ and ‘understood the client’s upbringing’, ‘family structure’ and ‘dynamics’ better than their White colleagues. However, they felt that services should not ‘make assumptions a brown face or a black face is suited to a black or brown patient’. Some patients ‘did not want to be seen by someone from the same background’ because they wanted a ‘different viewpoint’, especially when it came to sensitive topics of ‘abuse’, ‘sexuality’ and ‘religion’. Therapists felt that patients may ‘fear that they will be judged’ by someone who is from the same religious or cultural background.

Several BAME therapists felt that they were allocated BAME service users because their White colleagues ‘didn’t feel comfortable’ or were ‘scared’ to deal with ‘people from different ethnic origins’. Nadia (MHP9) was particularly frustrated by this and felt that the ‘structural inequalities’ had considerable implication on her ‘mental wellbeing’, ability to ‘meet targets’ and ‘getting promoted’:

‘Look, I work with people from all sorts of communities. I work with British people. I tell you what works, you know, that’s because I respect them. I understand the culture. You know, I’ve never told them [IAPT] I can’t work with White British community because I’ve not been
raised in a White British family. You will never hear me say that. And I very much doubt you
would hear any of the BAME therapist say that. You do not always shy away from working
with White people. We just get on with it. Do you find that White therapists do that too? That
I do not feel confident about.’

BAME therapists felt that it was important for their White colleagues ‘to not be afraid’, but
‘understand that there might be challenges’ and to ‘seek advice’ when working with diverse
communities. Therapists felt that it was imperative to be culturally curious about ‘how things
work for them’ [patients] and ‘why they think in a certain way’. Some therapists reported that
service users were ‘quite happy to tell you their story if you ask questions’, but felt that it was
important to build ‘trust’ and ‘not rush’ the patient if they did not ‘feel comfortable’. Sidra
(MHP14) felt strongly about this:

‘The therapist [White British] will be like, this very complex, I don’t get it. I don’t have all this
going on. No, it’s complex for you because you’re not from that culture, but it’s not complex for
them [patient] because that’s their world. That’s how they live. But they don’t get them. They
don’t understand that because it takes them away from who they are. This gives them some
power on the subject that I know what I’m doing. But actually the experts is sat there, it’s the
patient. So you just need to look at what tools you’ve got and how to apply it to the
client’s world.’

Bhavna (MHP1) felt that asking ‘culturally sensitive’ questions to ‘get to know’ the patient were
important:

‘... We look at what’s really important for the patient and I always find value driven work
really helps. What are their core values? What do they see family as? What do they view
religion as? What do they view spirituality and culture and friendship and relationships
and parenting? What do they view that as and how far are they from that? And if it’s
really far off, we see there’s something that’s making them feel depressed or anxious about that.’

A common concern with BAME therapists was the intrinsic expectation by IAPT services for
them to undertake clinical duties as well as additional outreach work, which vastly differed
from their White colleagues. Sidra (MHP14) was particularly concerned about the
expectations placed on the ethnic minority workforce to juggle multiple roles:

‘... You can’t expect therapists to be clinicians and development workers. It’s normally the
clinicians who are from a BAME background which will end up to do all those extra things,
and it’s almost expected of them to do it. So it’s always our responsibility not their [IAPT
services] responsibility. And then they end up becoming clinicians and development
workers and access workers and all these other things that come with that.’

Contrary to beliefs, therapists felt there was ‘an appetite in the community for people wanting
more’; however, mental health provisions were geared ‘towards the English audience’.
Therapists reported that crucial community development workers were cut short or non-
existent due to ‘commissioning’ and ‘funding issues’. Therapists felt that ‘regularity’ of ‘mental
health promotion’ was ‘important’ rather than ‘tokenistic gestures’. This would ensure that the
information ‘stays in people’s mind and more start coming through the door’. Nadia (MHP9)
felt particularly strong about the lack of outreach work being done in the community:

‘And the problem is I work with BAME communities and you go into the community, you
create links, and IAPT services are not doing that. So whose responsibility is it? Who’s
getting the money to do this work? IAPT services. So our services need to factor this into their business plans, into the organisations. They’re not. You know, part of IAPT role is to do outreach work and I don’t think enough of it is being done . . . For goodness sake, ten years on, we’re still struggling!

Importance of training and supervision: ‘. . . It’s been quite a poor show’

This sub-theme describes the importance of cultural competency training and good supervision to support therapists to work effectively with BAME service users. Despite cultural competency training being regarded as an integral part of clinical training programmes, only nine out of sixteen participants received one-day formal training (often one hour to half a day) throughout their therapeutic career. Seven therapists reported receiving no cultural competency training at all. Those who received training, recalled a mandatory module on ‘working with diversity’, but this was not specifically tailored to ethnic minority communities. Topics such as ‘shame and stigma’, ‘working with interpreters’ and ‘access needs’ were ‘very briefly discussed’ as part of the overall course. Therapists reported that patient ‘cultural beliefs’ and ‘understanding of therapy’ were not considered as part of training. For example, Halima (MHP8) recalls the [limited] training she received throughout her clinical career from the role of a PWP to qualified CBT therapist:

‘In my PWP training, we did have a session on how to use translators or interpreters. I have to say this one. I was really surprised in the training that nothing on the course was mentioned about culture, which was very surprising because I thought it was a big part of it.’

Having worked in IAPT for over eight years, Scott (MHP16) questioned the intentions of the IAPT programme and lack of training offered to therapists:

‘I’ve been a bit bemused in a way. The fact that there hasn’t been the investment into providing more support for therapists to be able to have a better understanding for BAME groups across the country . . . I do wonder the way that IAPT was first put together was sort of a lot of very high academic people, predominantly White males who sat at the top and said is how it’s going to be and not really taking into account actually the inner cities . . . I personally don’t think they’re doing enough and there should be greater investment for the communities in those particular areas.’

Some therapists from BAME backgrounds questioned the ‘authenticity’ of cultural competency training. Most of therapists felt the trainers ‘did not really know much about culture’ given that it was delivered by ‘White’ lecturers and clinicians. Nadia (MHP9) raised her concerns:

‘When I did my CBT training, we had a one hour lecture, I believe it was delivered by service manager of a nearby IAPT service. And I just remember thinking, I know more than you and I haven’t learnt anything from you. You have given me nothing.’

Most therapists felt that it would have been useful to have service users from minority communities attend training sessions to discuss their experiences. Therapists felt this would be ‘more advantageous than to sit through a PowerPoint presentation’. Simon (MHP5) was particularly vocal about this idea:

‘So I think maybe getting people coming into training within a service or whether it’s within the IAPT training curriculum, someone coming in to discuss actually what they found helpful and what they didn’t find helpful . . . So more that kind of stuff. You know the expression “from the
horse’s mouth” as you move on. You know, a White lecturer learnt about it and then telling us, you know, and that it’s all second and third hand.’

A couple of therapists, particularly from the White British background valued the training they received, albeit minimal, as they had lived and trained in ‘non-diverse areas’ so it was ‘good to learn about marginalised groups and other cultures’. However, they felt that they were ‘unable to flex their muscles’ or ‘there wasn’t much focus’ on cultural training because their service was not ‘very diverse’. Those who worked in diverse communities felt they were readily able to get ‘advice’ from their colleagues when needed. Some therapists felt strongly about the need for White therapists to ‘experience’ working with diverse communities in order to ‘understand their perspective’. Sidra (MHP14) shares her ideas:

‘Working with different cultures, communities needs to be incorporated into the training. Understanding the power dynamics that can occur, whether it be due to gender, whether it be due to colour, whether it be due to an age, those things need to be understood. They need to be part of the training, not just the therapy protocols, because the therapeutic relationship is core to all that work.’

Therapists reported that ‘good supervision’ was vital for their development, particularly when working with diverse communities. Whilst some therapists were able to seek assistance for ‘complex cases’, others felt that more ‘representation’ was needed because ‘White, middle class’ supervisors were not ‘always confident in supervising people from diverse communities’. Sophie (MHP11) felt fortunate to have a good supervisor, but felt this was not consistent across services:

‘I think good supervision is actually somebody who’s an experienced practitioner, who has some knowledge of working with different cultures, I think it’s quite important, um, and we lucky we do have that here, but I don’t think everybody has.’

Given the ongoing concern about BAME service user needs since the early set-up of IAPT service, all therapists felt the urgent need and desire for more cultural competency training. Scott (MHP16) was particularly vocal about this:

‘So IAPT has been going since 2008, um, and you know, it’s been quite a poor show. I suppose from a national level, there needs to be a lot more specific training being made available. There is more research that’s being done, but the actual training is very thin, virtually non-existent.’

Discussion
The aim of this study was to explore whether IAPT practitioners are culturally competent to deal with the needs of BAME service users. Overall, three themes were generated: (1) encountering cultural dissonance within therapy; (2) challenges in making cultural adaptations to therapy; and (3) identifying cultural competency needs. Out of sixteen participants, only nine therapists received one-day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists reported receiving no cultural competency training at all. Overall, it was clear that there is an urgent need and desire to receive cultural competency training to better serve BAME communities.

Encountering cultural dissonance within therapy
The first theme highlighted the cultural dissonance therapists encountered when working with BAME service users. Given the theoretical concepts of individualism-collectivism (Hofstede,
1980; Hofstede, 2011; Triandis, 1995) and self-construal theory (Markus and Kitayama, 1991), it was evident that the values, beliefs and customs held by patients corroborated with collectivist societies. This often led to a cultural clash between Western practices rooted in notions of individualism and the need for independency and self-sufficiency (Frese et al., 2001; Fenn and Byrne, 2013; Rogers, 2009). In line with previous research, therapists reported that mental health concepts and terminology was often unrecognised in BAME communities (e.g. Aggarwal et al., 2016; Mohamed and Lowenthal, 2009). Therapists worried about dismissing service user cultural and religious views, and questioned whether Western notions of therapy were appropriate for BAME clients (Roy-Chowdhury, 2013). Some service users externalised their problems by using somatic symptoms and held beliefs in witchcraft, black magic and spiritual possessions (Kirmayer, 2001; Mallinson and Popay, 2007; Mohamed and Lowenthal, 2009). This was particularly more evident in older adults, which may explain poorer treatment outcomes (Gould et al., 2012; Ibrahim and Heuer, 2016).

Given the individualistic nature of therapy, therapists encountered a number of challenges beyond the therapy room. Therapists not only had to consider the patient as an individual, but also how their wider cultural, familial and religious beliefs interplayed in therapy. In line with theory, therapists recognised that BAME service users valued group cohesiveness, harmony and interdependence, which made it difficult to promote self-sufficiency, independence and autonomy (Hofstede, 1980; Hofstede, 2011; Markus and Kitayama, 1991). The inherent cultural stigma and shame towards mental illness led to patients feeling entrapped and often slowed down the recovery process (Tse and Ng, 2014). Therapists reported that some patients were bound to religious expectations, which made it difficult to deliver Western notions of therapy. Research shows that religious guilt can be prominent in BAME communities and have consequences for therapeutic engagement and success (Abouhendy and Jawad, 2013; Bhui et al., 2008; Fenn and Byrne, 2013; Lakeman, 2013; Singh et al., 2015).

Moreover, therapists reported that BAME service users often expected ‘a cure’ and questioned the purpose of therapy (Lakeman, 2013). This made it difficult to manage patient therapeutic expectations and the need for them to take control of their lives in order to achieve recovery (Frese et al., 2001). Some patients expected therapists to assist with social matters such as benefits and immigration issues. This led to increased dissatisfaction with IAPT services when those expectations were not met. Therapists felt that an efficient triage service was needed to manage patient expectations from the outset. Therapists felt there was a dire need for psychoeducation and community mental health awareness, especially as poor mental health literacy can lead to greater drop-out (Bristow et al., 2011; Mclean et al., 2003; Mofrad and Webster, 2012). Psychoeducation has shown to increase mental health awareness and improve therapeutic outcomes (Horrell et al., 2014; Jacob et al., 2002). Thus, the implementation of a progressive model may be useful in helping triage at an earlier stage, and therefore prove to be more cost and clinically effective in the long term (Boyd et al., 2019). However, the acceptability of such models need to be explored with a diverse range of clients.

**Challenges in making cultural adaptations to therapy**

Therapists experienced a number of challenges in making cultural adaptations to therapy. Even though culturally adapted and culturally sensitive therapies have shown effectiveness, the evidence base for this is limited and therefore not recommended as part of mainstream clinical practice (Hall, 2001; CG123: NICE, 2011). Therapists found themselves conflicted between adhering to therapeutic models and guidelines and the need to meet patient needs. Whilst therapists acknowledged the importance of treatment fidelity (Adams, 2008; Pawson and Tilley, 1997), they questioned whether the ‘one-size-fits-all’ approach was appropriate for all patients. Given the scarce inclusion of ethnic minority populations in clinical trials, therapists felt that
protocols and models should be treated as guidance, rather than the ‘law’. Whilst therapists recognised there was some flexibility in providing cultural adaptations to BAME service users (e.g. use of interpreters and longer treatment sessions), this was often ‘superficial’ and did not equip them to deal with more specific service user needs (Naz et al., 2019).

Despite culturally adapted resources such as self-help books and questionnaires being available in a range of languages, they were not always readily available. Therapists often spent their own personal time finding resources, which increased burn-out (Westwood et al., 2017). Therapists suggested that more resources for service users who had poor reading and writing proficiency should be made available, such as pictorial images and videos that depict emotions, cognitions and behaviours (Beck, 2019). Therapists felt that a centralised repository, accessible across IAPT services, would be useful. To the researcher’s knowledge, this is not currently available and should be considered by commissioners and service providers.

Therapists valued interpreters, but reported a number of challenges that this presented during therapy. Therapists sometimes found it difficult to manage group dynamics and worried about the accuracy of the message during the triangulation process (Costa and Briggs, 2014). Therapists reported that some interpreters did not have mental health literacy so they had to offer them psychoeducation before therapy could begin. This presented additional challenges in explaining therapeutic concepts and terminology to not only the patient, but also to the interpreter. This indicates a need for IAPT services to offer brief training to interpreters to enhance the therapeutic experience for everyone involved. Given the limited availability of interpreters in certain languages, therapists found that some service users refused to disclose information in case word would get out in the community (Sainsbury Centre for Mental Health, 2007). This delayed therapeutic care and led to disengagement from treatment (Bristow et al., 2011; Costa and Briggs, 2014).

Given that recovery is viewed from an individualistic gaze, therapists reported that BAME service users often ruminated over past issues, which made it difficult to move forward with therapy (Bristow et al., 2011; Costa and Briggs, 2014). Therapies such as CBT tend to focus on the ‘here and now’ which made it difficult to navigate conversations and led to increased dissatisfaction and disengagement from therapy (Beck and Naz, 2019; Fenn and Byrne, 2013; Williams, 2015). Homework adherence was a particular barrier to therapeutic success. Homework tasks often promoted independence and self-care, which were not always appropriate for BAME service users, particularly the older generation (Omylinska-Thurston et al., 2019). Therapists recognised the implications for collectivist societies being part of a family unit, which made it difficult to promote individualistic tasks (Hofstede, 2011; Markus and Kitayama, 1991). Therapists felt it was important to be realistic with what was achievable during therapy, even if this meant that recovery targets were not always being met. Given the increased service demands and caseloads, therapists were not always able to explore patient needs in more details (Bassey and Melluish, 2012). Some therapists felt this conflicted with their clinical integrity and was doing a disservice to BAME service users. Given the poor treatment outcomes for BAME service users, therapists felt that more needs to be done to consider the needs of disadvantaged communities (Naz et al., 2019).

**Identifying cultural competency needs**

Therapists recognised the limitations in their cultural knowledge. To be culturally competent, therapists should possess basic knowledge about patients’ culture, which includes their values, norms and practices (La Roche and Maxie, 2003; Sue, 1991; Wan and Chew, 2013). Some therapists from White backgrounds talked about not fully understanding the implications of social, cultural and religious factors for BAME patients. White therapists often feared that they would get it wrong which made them reluctant to explore such topics during therapy. Research shows that training programmes often fail to consider the role of the therapist and
how their own identity, stereotypes, biases, and positions of power and privilege interact with that of the patient (Beck and Naz, 2019; Crawford et al., 2011; Ibrahim and Heuer, 2016; Sue et al., 1996). It is vital that therapists recognise and reflect on their own ‘isms’ and manage ways to lighten feelings of White guilt (Crawford et al., 2011). This may be particularly important given that high degrees of mistrust and suspicion BAME service users experience with Eurocentric practitioners (Cook and Powell, 2013; Jones, 1997; McCrone, 2013).

BAME therapists felt that there was an innate reliance for them to take on complex caseloads. This compromised their mental wellbeing and opportunities for promotion because they were not always able to achieve the same recovery targets as their White colleagues. Therapists raised concerns about being allocated multiple clinical duties (e.g., outreach work) which was not expected from their White colleagues (Naz et al., 2019). Even though BAME therapists recognised the importance of therapist matching (Sue, 1991), they felt that assumptions should not be made about patient preferences, especially given the inherent stigma and fear of judgement in ethnic minority communities (Al-Krenawi and Graham, 2000). A number of BAME therapists felt frustrated by the reluctance of their White colleagues to take on ethnic minority patients. Therapists felt it was important to share the responsibility and for White therapists to seek advice, build trust, and consider value driven work to enhance their therapeutic encounters with ethnic minority service users.

Out of sixteen participants, only nine therapists said that they received one-day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists reported that they received no cultural competency training at all. Given the limited cultural competence training offered, therapists had to rely on their own research or ‘wing it’ (Clegg et al., 2016; Edge and Lemetyinen, 2019). It was recognised that this was not best practice, but therapists felt limited to what they could offer patients given service limitations (Bassey and Melluish, 2012). Therapists who received training, discussed a ‘working with diversity’ unit as part of their clinical training programme, but it was not specifically tailored to BAME communities. In instances where this was included, it was brief and did not consider cultural beliefs or patient understanding of therapy. Previous research echoes these concerns and indicates that clinical training programmes promote a universal rhetoric that seldom considers cultural particularism (Good and Hannah, 2015). Therapists felt that more representation was needed in clinical teaching teams, more opportunities to work with diverse communities, and hearing directly from service users about their experiences. Whilst therapists valued good supervision to help them deal with complex caseloads (La Roche and Maxie, 2003), they felt more representation in senior roles was needed to better serve BAME communities. Given that cultural competency development should be a continual and life-long process (La Roche and Maxie, 2003; Papadopoulos, 2006), IAPT services should actively seek ways to develop the skills of its workforce.

Limitations

Given that this study was a reflective account of therapists’ past training experiences, there is possibility of recall bias due to the length of time between receiving training and the interviews (Althubaiti, 2016). Thus, future research should consider interviewing trainee PWPs to gauge how well training programmes promote cultural competency training. In addition, whilst there was some attempt to discuss concerns of White and BAME therapists, this was not comparative. Future research may consider the needs of therapists to understand their cultural values, challenges and experiences in more depth.

Conclusion

This study aimed to explore whether IAPT mental health practitioners are culturally competent to deal with the needs of BAME service users. Findings from the study raise critical concerns about
the lack of cultural competency training offered to the IAPT workforce. Whilst it is acknowledged that active steps have been taken, such as the development of the BAME positive practice guidelines, more needs to be done (Beck et al., 2019; IAPT, 2009). It is clear that cultural competency training is still in its infancy within UK mental healthcare (Clegg et al., 2016), thus more investment is needed to diversify the IAPT workforce, provide appropriate training, raise community awareness, and include BAME service users as part of implementation plans. Perhaps then, IAPT services will be able to enhance access to care and its recovery outcomes for ethnic minority communities.

Key practice points

(1) To support therapists to identify and reflect on their own cultural competency needs.
(2) To help therapists recognise therapeutic challenges and consider examples of good practice.
(3) To encourage service managers, commissioners and training bodies to provide appropriate cultural competency training and resources so that BAME communities can be better served.

Further reading


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

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