DPsych thesis

Cultural differences impacting on therapists' interpretation and understanding of clients' appraisals in post-traumatic stress disorder

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Cultural Differences Impacting on Therapists' Interpretation and Understanding of Clients' Appraisals in Post-Traumatic Stress Disorder

by

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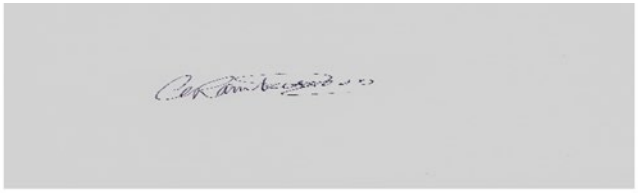
Declaration

I solemnly declare that the thesis titled “Cultural Differences Impacting on Therapists’ Interpretation and Understanding of Clients’ appraisals in Post-Traumatic Stress Disorder” is based on my own work carried out during my study under the supervision of Professor Simon Du Plock and Dr Margarita Chacin Fuenmayor, Metanoia Institute and Middlesex University. The statements made and conclusions drawn are an outcome of my research work.

Signature: 

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Abstract

The primary aim of this study is to explore the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in post-traumatic stress disorder (PTSD). A review of the literature provides only limited information on how therapists interpret and understand clients' appraisals in PTSD. Most of the studies reviewed indicate that cultural differences impact clients' appraisals in PTSD. Thematic analysis has been selected as the research methodology for this study. A qualitative approach is employed, with data collected through semi-structured interviews from the lived experiences of therapists from various modalities. Eight participants were selected from different organisations, including the independent sector, Improving Access to Psychological Therapies (IAPT) within the National Health Service (NHS), and a third sector charity/voluntary organisation. A thematic approach was used to analyse the data obtained from the therapists' lived experiences. The emerging themes are critically analysed and discussed in the context of exploring how cultural differences impact therapists' interpretation and understanding of clients' appraisals in PTSD. The findings indicate that cultural differences affect therapists' interpretation and understanding of clients' appraisals, as evidenced by the emerging themes of cultural differences in clients' appraisals of their trauma. As this study is only an exploration of how cultural differences impact therapists' interpretation and understanding of clients' appraisals in PTSD, further research is required in this area of psychotherapy.

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Chapter 1

1.0 Introduction

This exploratory study investigates the impact of cultural differences on therapists' interpretations of clients' appraisals in post-traumatic stress disorder (PTSD). The thesis includes the following sections: personal background, literature review, research proposal, ethical considerations, research methodology, data analysis, reflexivity, discussion, and conclusion. As my speciality is Cognitive Behavioural Therapy (CBT), I am approaching the topic from a cognitive perspective for the following reasons.

Firstly, CBT emphasises the role of cognitive appraisals in shaping emotional responses, behaviours, and cognitive changes (Ehlers & Clark, 2000; Kim & Sasaki, 2014). By exploring how cultural factors influence these cognitive appraisals, we gain insight into how individuals from different cultural backgrounds perceive and interpret traumatic events. This understanding is essential for providing effective therapeutic interventions.

Secondly, approaching the topic from a cognitive perspective helps us understand that individuals from different cultural backgrounds may have distinct cognitive schemas, beliefs, and coping strategies. These differences can significantly influence how individuals appraise and respond to traumatic events. By acknowledging and addressing these cultural differences, therapeutic interventions can be culturally sensitive and relevant to the client's experience (Hinton & Lewis-Fernández, 2010).

Thirdly, research suggests that cultural factors can impact the effectiveness of PTSD treatment. By examining how cultural differences influence cognitive appraisals, CBT techniques can be adapted to better meet the needs of diverse populations (Patel & Patel, 2014). This may involve modifying cognitive restructuring exercises,

incorporating culturally relevant examples, and adjusting treatment goals to align with the client's cultural values and beliefs.

Fourthly, recognising the influence of culture on cognitive processes can strengthen the therapeutic alliance between therapist and client. When clients feel understood and respected within the context of their cultural background, they may be more willing to engage and motivated to participate in therapy. This can improve the therapeutic alliance and recovery rate (Sue & Zane, 1987).

The aims of this study are as follows:

i) To explore the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in PTSD.

ii) To explore the impact of cultural differences on clients' appraisals in PTSD.

iii) To generate knowledge relevant to the training and professional development of psychotherapists and other therapists involved in talking therapies.

iv) To contribute to the existing body of knowledge in the field of psychotherapy.

At this stage, it is important to understand the meaning of PTSD and its impact on individuals who have been diagnosed with it. In the study, a historical perspective of PTSD is provided, and the diagnostic criteria of PTSD, as well as existing major models of PTSD, are critically analysed.

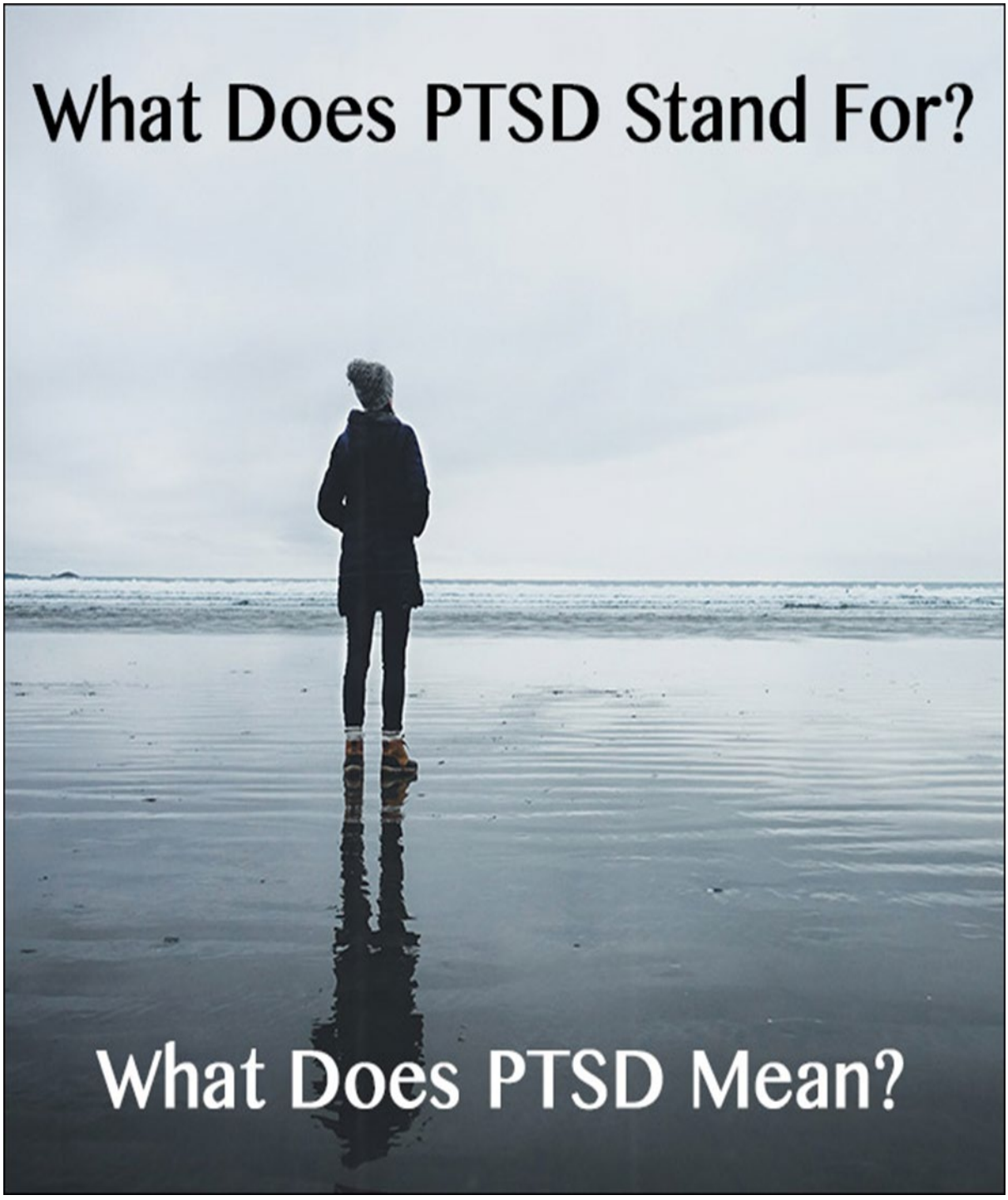

Figure 1: What does PTSD stand for

Source: Alorecovery.com

1.1 What does PTSD Mean and Stand For?

According to the American Psychiatric Association (APA), for someone to be diagnosed with PTSD, they must have been exposed to a life-threatening event, or an event perceived as such, with symptoms persisting for at least one month (APA, DSM, 2013). From my personal clinical experience, PTSD stands for a serious mental condition that individuals develop after a shocking, terrifying, fearful, or dangerous event (DerSarkissian, 2021). This means an individual has suffered a traumatic event, having been subjected to one or more nerve-wracking, life-threatening experiences; they are traumatised and find it hard to move on from the event, eventually developing PTSD (Smith, 2020; Smith et al., 2021).

PTSD is defined as "an anxiety disorder that may develop because of an event that is experienced or witnessed and involves actual or perceived threat to life or physical integrity" (Foa et al., 2007: 3). PTSD develops because of a stressful event or a situation of "an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost everyone" (NICE, 2005: 6). PTSD can affect people from different cultural backgrounds (Bracken, 2001). The symptoms of PTSD run deep and include persistent recollections or reliving of the traumatic event, nightmares, flashbacks, intense psychological or physiological distress, detachment or estrangement, amnesia, sleeping problems, irritability or angry outbursts, hypervigilance, hyperarousal, problems concentrating, and suicidal ideation.

In addition to the symptoms of PTSD, individuals experience more severe problems that greatly impact the self, causing intense sadness, upsetting memories, and issues in their daily life, work, and physical health (Smith, 2020; DerSarkissian, 2021; Campbell and Renshaw, 2018). As PTSD is a serious mental health concern, it is of

paramount importance to explore the historical perspective of this condition. PTSD is a common reaction to traumatic experiences and events associated with extreme threats, including domestic violence, war, road traffic accidents, natural disasters, or sexual/physical abuse. PTSD is a disorder that can affect people from different cultural backgrounds.

1.2 Social Construction of PTSD

The social construction of Post-Traumatic Stress Disorder (PTSD) involves understanding how societal factors influence the perception, diagnosis, treatment, and experiences of individuals with PTSD (Horwitz, 2002). The understanding and recognition of PTSD have evolved over time, reflecting changes in diagnostic criteria and societal attitudes towards trauma and mental health. Historically, PTSD was predominantly associated with combat experiences, leading to terms like "shell shock" or "combat fatigue." It now encompasses a broader range of traumatic experiences, including natural disasters, accidents, and interpersonal violence (Friedman, 2015).

Summerfield (2001) examines the historical and political factors that shaped the emergence of PTSD as a diagnostic category, arguing that PTSD served political purposes by providing a medical label for the psychological effects of war, thereby legitimising claims for disability compensation and veterans' rights. The diagnostic criteria for PTSD, as outlined in the DSM (Diagnostic and Statistical Manual of Mental Disorders), are socially constructed and influenced by cultural, political, and economic factors (Young, 1995). These criteria may not adequately capture the diverse ways in which people experience and cope with trauma, leading to misdiagnosis, particularly among marginalised communities (Roberts et al., 2011).

Cultural beliefs play a significant role in shaping how PTSD is understood and experienced. The expression of distress and coping mechanisms vary across cultures, leading to differences in symptom presentation and treatment-seeking behaviours (Hinton et al., 2010). Cultural stereotypes and stigmatization can act as barriers to accessing care and contribute to disparities in diagnosis and treatment (Williams & Mohammed, 2009).

Hinton et al. (2010) highlight the cultural variability in the manifestation of PTSD symptoms and the importance of considering cultural context in diagnosis and treatment. For example, individuals from collectivistic cultures may emphasise somatic complaints rather than psychological symptoms, leading to potential misdiagnosis of PTSD. Rousseau et al. (2011) illustrate cultural variations in the expression and interpretation of PTSD symptoms, arguing that cultural context significantly contributes to the social construction of PTSD by shaping individuals' perceptions of trauma and their responses to distress.

Herman (1992) and Green et al. (2010) argue that trauma is socially constructed through narratives influenced by cultural, political, and institutional contexts. Institutional responses, such as the availability of support services and community resources, can influence individuals' perceptions of social support and their ability to cope with trauma. According to Kaniasty and Norris (2008), institutional support can minimise the impact of trauma and facilitate recovery, whereas the lack of support may exacerbate symptoms and delay recovery.

A study by Kirmayer et al. (2014) examined cultural variations in the experience and expression of trauma-related distress among Indigenous communities in Canada. They found that traditional healing practices and cultural beliefs significantly influenced

individuals' perceptions of trauma and coping strategies. This research highlights the importance of considering cultural context in understanding and responding to trauma. Kirmayer et al. (2014) concluded that the construction of PTSD is shaped by cultural beliefs, norms, and values, which influence how individuals interpret and respond to traumatic experiences.

Marshall et al. (2005) examined cultural variations in the expression of PTSD symptoms among survivors of interpersonal violence. They found that cultural beliefs and norms influenced how individuals interpreted and communicated their experiences of trauma, leading to differences in symptom presentation and coping strategies. Understanding cultural variations in symptom expression is essential for providing culturally sensitive and effective treatment.

Brewin et al. (2000) examined the impact of social support on the development and maintenance of PTSD symptoms following traumatic events. They found that social support played a significant role immediately after trauma exposure, buffering against the development of PTSD symptoms over time. Social support networks, including family, friends, and community resources, play a critical role in facilitating coping and recovery (Norris et al., 2002; Kaniasty & Norris, 2008). The construction of PTSD is influenced not only by individual characteristics but also by the availability and quality of social support systems.

Rzeszutek et al. (2016) examined the portrayal of PTSD in mainstream media and its impact on public perceptions and stigma. They argued that media representations contribute to the social construction of PTSD by framing it within specific narratives and images. Media representations often sensationalised and stigmatised PTSD, reinforcing stereotypes of individuals with the disorder as violent or unstable.

Bonanno and Mancini (2008) also examine the concept of PTSD in media and its impact on public perceptions. They argue that media representations can stigmatise PTSD, shaping societal attitudes and influencing individuals' self-perception and help-seeking behaviours. Media representations contribute to the social construction of PTSD by disseminating dominant narratives and stereotypes about trauma-related distress (Bonanno & Mancini, 2008; Rzeszutek et al., 2016).

Social constructivism posits that reality, including concepts like mental illness, is socially constructed through shared meanings, language, and interactions within a particular cultural and historical context (Conrad & Schneider, 1992). Neisser (1982) and Fivush (2011) suggest that memory is reconstructive and influenced by social and cultural factors. Traumatic events are not objectively recorded but are constructed and interpreted based on individual and collective narratives. According to Ehlers and Clark (2000), traumatic events are shaped by cultural norms, societal values, and individual interpretations. They argue that the social construction of traumatic events influences how individuals perceive, remember, and narrate their experiences, impacting the development and manifestation of PTSD symptoms. Language and discourse shape the social construction of PTSD by providing frameworks for interpreting and communicating traumatic experiences (Summerfield, 2012).

In conclusion, the social construction of PTSD significantly shapes individuals' perceptions of trauma and their responses to distress. Social stigma, cultural influences, media representations, institutional responses, and social support networks all contribute to the construction of PTSD and influence how individuals interpret, cope with, and seek help for trauma-related distress. Understanding these social

influences is essential for providing effective and culturally sensitive trauma care and support.

1.3 Cultural Background to the Rise of PTSD

Since 1980, this condition has become an ongoing concern in mental health, resulting in increased research on trauma (Blake et al., 1992). It was initially assumed that PTSD symptoms are the same regardless of cultural background or historical period (Bracken, 2001). However, Bracken and Petty (1998) argue that PTSD counselling programs based on Western concepts have been ineffective when applied to non-Western communities experiencing war trauma. This suggests that the assumption that PTSD symptoms are uniform across cultures may be inappropriate. This has become more evident as research emphasizes the complex relationships between culture, trauma, and healing (Marsella et al., 1996). The increase in trauma-related research has highlighted the effects of trauma on individuals, giving rise to the term PTSD.

Due to the decline in the influence of psychoanalytical theory over the last 30 years as an explanatory model for early traumas, McFarlane (1989) argues that traumatic life events have increased. Herman (1992) contends that traumatic events should be viewed not only as individual experiences but also as part of social consciousness. She attributes the emergence of PTSD to political developments, such as the rise of feminism and the women's movement in Europe and North America, which encouraged psychiatrists to examine the effects of trauma on victims of rape, domestic violence, and other forms of sexual abuse. According to Herman (1992), the Vietnam War provided a medium to examine wartime traumas experienced by soldiers. She argues that PTSD has always existed but was not fully recognized as a syndrome. O'Brien (1998) disagrees, believing that PTSD is an old condition that has been

renamed. There is evidence to suggest that PTSD has not always existed, as earlier conditions like 'irritable heart syndrome' or 'shell shock' are not the same as PTSD (Bracken, 2001).

Regarding the Second World War, Grinker and Spiegel (1945) recorded symptoms such as restlessness, irritability, fatigue, disturbed sleep, and anxiety, but not the intrusion and avoidance symptoms central to PTSD. This suggests that somatic symptoms were more common. Based on the evidence, it is not appropriate to conclude that PTSD has always existed. By contrast, Young (1995) argues that PTSD has evolved over time, tracing its origins to the late 19th century when trauma was recognized in medicine. He believes that PTSD has developed as a classification in American psychiatry, shaped by theoretical developments and adopted by DSM-III (APA, 1980). From Young's study, it can be deduced that PTSD has progressively manifested over time. Herman and Young's accounts are persuasive but incomplete (Bracken, 2001).

Over the last decade, the diagnosis of PTSD has become popular in Western societies (Bracken, 2001; Summerfield, 2001). Socio-economic development and industrialization have led more people in Western societies to seek psychological intervention for occupational stress. According to Giddens (1991), this trend reflects a growing dependence on experts for psychological intervention related to traumatic experiences. Consequently, the concept of post-traumatic conditions is becoming well understood by professionals such as police officers, firefighters, ambulance workers, and military personnel.

From this perspective, Bracken (2001) argues that PTSD is culturally bound within Western societies, as the nature of certain jobs exposes individuals to risks and

dangers. Culture may be important in shaping an individual's understanding and perception of the world. Anthropological research suggests that basic aspects of reality and existence are culturally constructed (Kleinman, 1988). This affects our understanding of the self and emotional responses to traumatic events. For instance, Jenkins (1996) argues that collective trauma should be considered, as individual accounts may be insufficient. Kirmayer (1996) adds that there are cultural differences in how individuals deal with distress, highlighting the social and cultural embedding of distress concerning traumatic experiences and symptoms. Kirmayer's analysis suggests that the DSM's intrusion-avoidance symptom complex for PTSD differs significantly across cultures. Bracken's (2001) study on post-modernity and PTSD shows that the condition is a product of trauma and culture intertwined. With global integration, PTSD has emerged as a universal phenomenon, affecting individuals across different cultures (Breslau, 2004).

1.4 Appraisal – what does it mean?

Appraisal is a key feature in understanding an individual's experience with PTSD. Engelbrecht and Jobson (2016) state that "appraisals enable an individual to derive or construct meaning from a traumatic event that is potentially meaningless or arbitrary." Nugent (2013) defines appraisal as the cognitive evaluation and interpretation of a phenomenon or a traumatic event. A cognitive appraisal is an interpretation of an emotional situation wherein a person evaluates how the event will affect them and their behaviour, arriving at a response or decision based on the interpretation (So et al., 2015). Appraisal is paramount in evaluating how individuals navigate unwanted experiences, thoughts, emotions, and behaviours. Kleim et al. (2007) state that appraisals aid in understanding post-traumatic psychological adjustment and recovery.

Shaler (2005) argues that a traumatic event should not be perceived as affecting only the victims but should be viewed as affecting humans in their context. Context is the environment in which humans live, interact, and engage with others and the world around them. It is important to note that most people exposed to traumatic events do not develop PTSD; however, others do. This may be due to different trauma thresholds; some individuals are more protected from trauma, while others are more vulnerable to developing clinical symptoms after exposure to extremely stressful situations. Alternatively, individuals may be vulnerable due to previous traumatic experiences such as historical abuse, a family history of PTSD or depression, substance abuse, poor coping mechanisms, a stressful environment, and lack of social support. Although there is renewed interest in the subjective aspects of traumatic exposure, it must be emphasised that events such as sexual violence, torture, genocide, and severe war zone stress are experienced as traumatic. As PTSD is classified as a Trauma-and Stressor-Related Disorder (APA, 2013), it is crucial to critically analyse the meaning of appraisal from a clinical perspective. For this purpose, I draw upon the cognitive model of PTSD by Ehlers and Clark (2000). They identified four types of appraisals in their model:

i) Appraisal of the Trauma and/or its Sequelae: Individuals negatively appraise the traumatic event and/or its sequelae, creating a sense of serious current threat. This threat can be external (viewing the world as more dangerous) or internal (questioning one's capability and acceptability in achieving important life goals).

ii) Appraisal of the Traumatic Event: Different types of appraisals can produce a sense of current threat. Overgeneralisation leads individuals to perceive normal activities and catastrophic events as more dangerous, believing they are more vulnerable to trauma

than others. Examples include avoiding driving after a road traffic accident or severely restricting social life after a sexual assault. Long-term implications of these appraisals can result in feelings of shame and guilt.

iii) Appraisal of Trauma Sequelae: Negative appraisals of the sequelae can produce a sense of current threat and contribute to persistent PTSD. Misinterpreting PTSD symptoms, others' reactions, and the impact on various life aspects can worsen PTSD. Relationships with trauma victims can be difficult, and misinterpretations can lead to further distress and social withdrawal.

iv) Appraisals and Emotional Responses: Emotional responses play a crucial role in the appraisal of traumatic events. Emotions like fear, anger, sadness, guilt, or shame influence how victims perceive their safety and self-worth. Cultural background significantly affects appraisals, as it provides a context for meaning and engagement.

In my doctoral thesis, appraisal forms a key component of the semi-structured interview, focusing on the cultural differences impacting the therapists' interpretation and understanding of clients' appraisals in PTSD.

Chapter 2

2.0 Personal Context of my Study

In preparing for my doctoral journey, I have reflected on my background, education, and experience as a cognitive behavioural therapist. I have an Indo-Asian background, originating from Mauritius, an island off the coast of South Africa. Mauritius is a multicultural society, and through my process of socialisation, I have concluded that my notion of the 'Self' is predominantly based on a collectivist culture. According to Engelbrecht and Jobson (2016), a collectivist culture is perceived as being interdependent. Collectivism is a cultural value characterised by an emphasis on cohesiveness among individuals and the prioritisation of the group over the Self (Markus and Kitayama, 2010).

I came to England in 1974, and over the years, I have undergone a continuous process of socialisation into Western cultures. In my roles as a nurse, educator, and psychotherapist, I have learned about the individualistic Self. Exposure to an individualistic society and reflection on my years in England have led me to recognise that I am now an independent individual, adhering to individualistic principles. Engelbrecht and Jobson (2016: 2) state that in individualistic cultures, the Self is perceived as an 'independent, autonomous, and self-determining unit'. These cultural influences have significantly impacted my way of thinking.

Exploring cultural differences in therapists' interpretations of clients' appraisals of PTSD is a complex and important area of research, and my heritage can provide valuable insights into this topic. As a CBT therapist with an Indian Mauritian upbringing, I bring a unique perspective shaped by a variety of cultural backgrounds. Mauritius is a culturally diverse island with influences from Africa, Asia, Europe, and

other regions of the world. This diversity provides an understanding of how cultural factors may influence my therapeutic process, including the interpretation of clients' appraisals of PTSD. I have had the opportunity to be exposed to various cultural beliefs, practices, and norms, making me more sensitive to the cultural nuances that affect how individuals perceive and respond to traumatic experiences. My understanding of these nuances can help me identify how therapists from different cultural backgrounds may interpret clients' appraisals differently. Growing up in a vibrant environment of cultures, religions, and ethnicities has enabled me to appreciate the interconnected nature of social categorizations such as race, ethnicity, gender, and socioeconomic factors. My background in Mauritius may have equipped me with the ability to interact effectively with people from diverse cultural backgrounds. The experiences and observations of growing up amidst such diversity provide valuable personal insights into the cultural factors influencing individuals' responses to trauma. As a CBT therapist, drawing on these insights enriches my contribution to a deeper understanding of the topic. My heritage from Mauritius places me in a unique position to explore the impact of cultural differences on therapists' interpretations of clients' appraisals of PTSD.

Based on my current experience as a therapist, I thought that by examining my experiences, thoughts, beliefs, and socialisation process, I could uncover the origins of my philosophy. This reflection has led me to conclude that my philosophy originated from a combination of experiences during my upbringing in an Asian culture and a patriarchal society, where men are dominant, and women are subservient. In such societies, there are often inequalities and unfairness in the distribution of estates, with favour being given to a particular male child. Growing up in this cultural background, I developed a resistance to inequality and unfairness, which gradually shaped my belief

that men and women should be equal and share responsibilities and rights equally within the family and wealth. This upbringing instilled in me a connection to people who are treated unfairly and whose individual and human rights are compromised.

As I grew and became socialised within this cultural context, my perspective shifted, and instead of adhering to patriarchal principles, I began to develop a philosophy centred on fairness and equality for both men and women. In 2006, I enrolled in a master's course in Cognitive Behavioural Psychotherapy, where I developed an interest in cognitive appraisals, cultural influence, and PTSD. To further explore these interests, I chose to conduct an intensive critical literature review for my dissertation on cultural differences and their impact on cognitive appraisal following PTSD. One of the outcomes of this review indicates that cultural influences significantly impact clients' cognitive appraisals following PTSD. Reflecting on my clinical experience, I am curious to explore how therapists appraise their clients' trauma following a PTSD diagnosis and whether cultural background influences this process. Accurate cognitive appraisal of a client's trauma is crucial for determining appropriate cognitive behavioural interventions and strategies. Without it, clients may struggle to adjust to life after treatment and are more likely to experience persistent trauma symptoms and seek further treatment through private practice or IAPT Services (Joint Commissioning Panel for Mental Health, 2014).

My observations indicate that clients wait between four and six months for a referral to an IAPT service, or about one to two weeks for private practice, with therapy sessions often being costly (Cooper, 2018). In a social and political context, I have observed an increase in referrals of clients from diverse ethnic backgrounds, often from regions experiencing conflict and displacement. There is political pressure on

therapists in IAPT Services to improve recovery rates and performance within a short period (Dormon, 2015), raising ethical concerns about whether sufficient time is allocated for comprehensive therapy.

From my clinical experience, I have observed that traumatised individuals from non-Western cultures often find it difficult to adjust psychologically after treatment. This difficulty may stem from how their issues are conceptualised by existing PTSD models. This raises the question of whether using Ehlers and Clark's (2000) PTSD model is justified and appropriate for treating traumatised individuals from non-Western cultures. Critics of this model have strongly suggested that it is inappropriate for such individuals (Jobson, 2009; Jobson & O'Kearney, 2009; Figueira et al., 2007). Guided by my philosophy, I have developed a passion for researching the impact of culture on cognitive appraisal in PTSD among individuals from Western and Eastern cultures. My literature review during my master's course revealed that in collectivistic societies, individuals often do not receive appropriate treatment following PTSD. This raises ethical concerns about whether traumatised individuals with PTSD are receiving suitable treatment to empower them to adjust psychologically and reclaim their lives (Bracken, Giller, & Summerfield, 1995; Jobson & O'Kearney, 2009).

In supervision, I have observed differing perspectives from therapists regarding how they interpret clients' traumas. Cultural background and its influence on appraisals in individuals with PTSD are often overlooked due to insufficient training in addressing cultural issues from a therapeutic standpoint (Joint Commissioning Panel for Mental Health, 2014). This oversight can adversely affect treatment and recovery rates, potentially diminishing clients' confidence in seeking further psychological intervention from IAPT Services or private practice (Hilton et al., 2012). This brings

me back to my philosophy of fairness, equal rights, and respect for individuals. As a practitioner-researcher, I believe this issue needs to be addressed so that relevant models can be utilised, and appropriate treatment provided to traumatised individuals from non-Western cultures. There is a strong need to design a framework suitable for treating individuals with PTSD from non-Western cultures, as their cognitive appraisal of trauma may differ from existing models. Based on findings from the critical literature review, it can be argued that there is a justified need to research differences in cognitive appraisals between traumatised individuals from Western and Eastern cultures. Hence, I am committed to continuing my research in this area to improve treatment for traumatised individuals from diverse cultural backgrounds.

There is a growing body of knowledge on cultural differences and cognitive appraisals of clients with PTSD (Jobson, 2009; Jobson & O'Kearney; Engelbrecht & Jobson, 2018), but no direct study on therapists' interpretation and understanding of clients' appraisals following a PTSD diagnosis. Reflecting on my personal and professional experiences, I can conclude that I am at a crossroads in my journey. Despite having knowledge and skills in research, culture, cognitive appraisal, and PTSD, there is still much to learn. People are socialised differently in various cultures and environments (Jobson & O'Kearney, 2009), which directly impacts the construct of self and how people view themselves. If individuals are traumatised, their cognitive appraisal of themselves will differ based on their cultural background, socialisation process, and environmental influences (Markus & Kitayama, 2010; Jayawickreme et al., 2015; Engelbrecht & Jobson, 2018). It can be argued that traumatised individuals are at a disadvantage if treatment protocols do not consider their self-concept, environment, social construction, and cultural background, leading to unfairness and inequality.

The aim of my study is to investigate whether cultural background plays an important role in how therapists interpret and understand clients' appraisals in PTSD. This doctorate study will enable me to work towards becoming a practitioner-researcher, contributing to the existing evidence base and incorporating my philosophy of fairness and equality through research. Therefore, I am keen to proceed with this study to discover how therapists from different cultures interpret and appraise clients' trauma cognitively. Additionally, I intend to evaluate whether culture influences therapists' interpretations of clients' trauma appraisals.

2.1 What Motivated Me for my Doctoral Journey?

At the early stages of my studies, I questioned my decision to pursue a doctorate, as I was resistant to a traditional PhD and wondered what it truly meant to embark on such a long journey. The idea of becoming a psychotherapist first occurred to me during my college years. However, I did not follow the path of psychotherapy initially, as I wanted to enter the field of medicine, which led me to a career in nursing and nurse education. It was not until I began providing pastoral care to nursing students that my aspiration to train as a psychotherapist was reignited, motivating me to embark on a master's course in Cognitive Psychotherapy in 2006. My clinical experience continues to motivate me to work in psychotherapy.

Prior to 2006, I yearned for new knowledge and skills in a different domain where I could be actively involved and engaged professionally. I felt that I had reached my peak in nursing and nurse education. The choice of a professional doctorate, rather than a traditional PhD, appealed to me and motivated me to begin my doctoral journey. I was particularly fascinated by the Professional Knowledge (PK) seminars and the collaborative learning opportunities involving academic consultants, advisers, and

experts in psychotherapy. The PK seminars within the doctoral programme offered an opportunity I could not resist, motivating me to explore how cultural influences impact therapists' understanding and interpretation of clients' appraisals following a diagnosis of PTSD.

I found that studying at the doctoral level can be a reasonably long journey, and maintaining motivation can be very challenging. During the pandemic, I struggled to stay motivated and found it difficult to focus on my journey, losing control and direction. At a crossroads, I gradually disengaged from my studies, uncertain of which path to take. To further my understanding of the situation, I attended Dr Livholts' PK seminar, "Narrative Life-Writing Genres as Tools for Academic and Professional Development." According to Dr Livholts (2020), academic novellas, different writing strategies, and visual representations can help one engage in analytical reflexivity, critical thinking, and creativity. Some examples of these strategies, inspired by post-structuralist and post-colonial feminist theory, include diaries, letters, memories, poetry, and photography (Livholts, 2013). Her second novella, "The Professor's Chair," reflects on analytical reflexivity and reveals how Dr Livholts viewed her chances of becoming a professor: "but if I wanted, would I need to 'steal' the professor's chair to find courage and confidence? Would I have to follow some 'strict academic format' in my writing to create collective belonging and identity," as the hero in "The Professor's Chair" thinks is necessary (Halldorsdottir, 2010:169).

"The Professor's Chair" became a symbolic act that influenced my way of thinking, positioning, and representing myself in my studies. My critical reflection on Dr Livholts' reflexivity changed my academic approach, transforming the 'symbolic act' into an 'act of meaningful action' necessary to take control of my studies. I felt that I

had regained my motivation and began to embrace my studies, setting targets to achieve my objectives, joining peer research groups, and attending more seminars. I actively participated in disseminating my research to peers and responded positively to constructive feedback. I embraced my determination, belief, and judgement, driven to take control. I felt empowered by the professional knowledge acquired from the PK seminars of Dr Evans, Dr Andrew, and Dr Harrison, which motivated me to continue my journey (Evans, 2013; Andrew, 2013; Harrison, 2018). Reflecting on my progress, I became cognitively engaged with my project, aiming for its completion.

2.2 Integrating my Learning into my Clinical Practice

When I began my doctoral journey, I realised the influence my learning could have on my clinical practice. I found myself immersed in new professional knowledge and theoretical concepts in psychotherapy. Despite having completed a master's course in psychotherapy, I began to understand, absorb, and internalise this new knowledge, realising how I could benefit from the process, including the integration of my learning into clinical practice. As a student, I developed my critical thinking skills and was motivated to apply my learning to improve my clinical ability to deliver effective therapeutic practice. Through self-reflection, I have immersed myself in my studies and observed that my doctoral journey has influenced my clinical practice in the following ways:

i) Fascination with psychotherapy and acquiring new knowledge: I shifted my focus towards my lived experiences while working with my patients.

ii) Application of my knowledge on cultural differences, models of PTSD, and the appraisal of trauma to improve my clinical practice.

iii) Awareness of the importance of being mindful of my own mental, emotional, and physical experiences as a clinician: I have noticed that understanding my own experiences while working with my patients is integral to understanding their diagnoses and the overall therapy process.

Enrichment of my doctoral journey through expert knowledge, skills, and personal growth, and their impact on my ability to inform my practice:

"My journey has created an environment where I could progress as a reflexive practitioner and has enriched my professional knowledge in the field of psychotherapy. As I progress through my thesis, I will revisit the integration of my learning and engage in a more profound critical analysis to demonstrate the impact of my doctoral journey on my clinical practice. In the next chapter, I will provide an in-depth critical review of the literature on cultural differences, appraisals in PTSD, and the rationale for my chosen title."

2.3 My Perspective as a Therapist

Viewing through the lens of my perspective as a therapist, it is important at this stage to discuss the implications of prioritising aetiology in psychotherapy. As a cognitive behavioural therapist, I understand that an accurate diagnosis is crucial, as it can positively impact therapeutic formulation and intervention.

My understanding of an accurate diagnosis through the lens of psychopathology is based on how diagnostic practices are shaped by wider social, cultural, and systemic factors. Research within critical psychopathology has indicated that psychiatric diagnoses are not purely categorised but are shaped by cultural norms, power dynamics, politics, and historical contexts. Kirmayer et al. (2015) state that psychiatric diagnoses are socially constructed and influenced by cultural norms and values. This

suggests that diagnostic categories can vary across different cultural contexts. Alarcón et al. (2002) found significant differences in the presentation of depressive symptoms among Hispanic/Latino populations compared to non-Hispanic white populations, underscoring the importance of considering cultural factors in diagnosis. Bäärnhielm et al. (2017) emphasise the importance of cultural competence in diagnosis and treatment. They found that clinicians who received cultural competence training were more likely to accurately diagnose and provide appropriate treatment for individuals from diverse cultural backgrounds.

The intersectionality of identity factors such as race, gender, sexuality, and socioeconomic status shapes mental health experiences and diagnostic processes. Bowleg (2012) found that individuals who belong to multiple marginalised groups (e.g., LGBTQ+ people of colour) may experience unique mental health challenges that are often overlooked in traditional diagnostic frameworks. Similarly, Shipherd et al. (2010) examined the experiences of transgender individuals in mental healthcare settings and found that many were exposed to discrimination and mistreatment, leading to misdiagnosis and inadequate treatment. Research within critical psychopathology reinforces the need for systemic change to consider the social determinants of mental health and improve diagnostic practices. For instance, studies have highlighted the importance of policies and practices that promote equity, diversity, and inclusion in mental healthcare settings.

An understanding of the importance of accurate diagnosis in CBT through a critical lens of psychopathology recognises the influence of social construction, the incorporation of cultural considerations into practice, the intersectionality of clients' identities, and systemic change to promote equity and justice in mental healthcare. By

integrating these perspectives and findings into clinical practice, accurate diagnosis can be achieved for appropriate treatment (Williams and Mohammed, 2009 & Snowden, 2001).

In contrast, an inaccurate diagnosis can lead to an incorrect formulation of the current problems, which may cause distress to the client and delay recovery (Laidlaw et al., 2003). I find this aspect of psychotherapy challenging in the sense that I am required to use my clinical skills to assess clients competently. As a therapist, and in relation to my studies, this means that I need to understand the aetiology of PTSD, as well as the client's experiences, to accurately conceptualise their current needs and difficulties. From my therapeutic work and the literature, I observe that clients experience PTSD due to threatened death, serious injury, sexual violation, and physical abuse (Roth et al., 1997; Kilpatrick et al., 2003). Based on personal experience, I find that the effects of PTSD on traumatised individuals can be devastating, with an increased risk of anxiety, depression, reliving of the trauma, and the occurrence of severe nightmares. All these symptoms can significantly impact the individual's day-to-day functioning. My understanding is that an accurate diagnosis and understanding of the aetiology of PTSD will influence the urgency and direction of appropriate treatment (Laidlaw et al., 2003). If aetiology and correct diagnosis are not prioritised in psychotherapy, it could lead to delayed recovery, prolonging the agony and distress for traumatised clients (Beck, 2013).

During therapeutic sessions, I observed a difference in how clients from different cultural backgrounds appraised themselves cognitively. Reflecting on this observation, my initial thought is to consider whether culture plays a role in cognitive appraisal. In support of this idea, I argue that clients come from diverse cultural backgrounds,

upbringings, and value systems. It remains unclear whether cognitive appraisals are culturally determined (Figueira et al., 2007; Vinck et al., 2007). Based on my clinical observation and the literature, investigating the impact of cultural differences on cognitive appraisal is something that interests me; it is an area that has not yet received sufficient attention in the field of psychotherapy. At this stage, it is useful to explore the meaning of 'cognitive appraisal' in the context of PTSD. From my understanding, 'cognitive' relates to mental processes, including perception, memory, judgement, thinking, and remembering. For appraisal to take place, a cognitive change must occur. In the context of PTSD, cognitive change is seen as a negative perception of oneself, with negative changes occurring physically and emotionally within the self (Foa et al., 2009). 'Appraisal' involves attaching meaning to cognitive change, altering beliefs, and viewing the world as seen by traumatised individuals (Park et al., 2008). In my therapeutic work, and at the initial assessment, traumatised clients have previously described avoiding going out due to the nature of their trauma, such as physical attack, sexual abuse, or involvement in a road traffic accident. Being traumatised and frightened, they avoid going out on their own; they cognitively appraise themselves by thinking and/or saying things like, 'I am a weak person', 'I can't defend myself', 'I blame myself for being attacked', or 'the world is a dangerous place'.

The protocol for treating clients with PTSD involves, for example, case formulation based on Ehlers and Clark (2000); narrative and interaction; imaginal and in vivo exposure; rescripting; and reclaiming their lives (Foa et al., 2009). During therapy, my initial review of progress involves assessing for gradual cognitive change in their appraisals. At the end of treatment, when I review their progress, clients appraise themselves positively, with statements such as, 'I am strong', 'I can cope with my day-to-day activities', or 'the world is no longer a dangerous place for me'. Reflecting on

this process of change, and from my experience as a therapist, I can infer that cognitive development plays an important role in psychological readjustment and recovery following therapeutic intervention (Jobson and O'Kearney, 2009).

Chapter 3

3.0 Literature Review

3.1 Introduction

There is a body of research indicating that PTSD is a universal phenomenon affecting people worldwide (Jobson and O'Kearney, 2009). It is unknown whether the psychological processes involved in the aetiology and maintenance of PTSD are culturally different or similar. For the literature review, it is important to define the meaning of culture. Featherstone (2002) suggests that culture is an integral part of every society, wherein individuals learn patterns of behaviour and live according to their traditions, families, and environments. It is a cultural process of socialisation through which individuals interact with others in society. In this process, the self is socially constructed with a set of cultural values, beliefs, and perceptions of others and the world.

While reviewing the selected literature on cultural differences, cognitive appraisals, and PTSD, two important concepts emerge: individualistic (independent) and collectivistic (interdependent) cultures. These concepts need to be defined so that each can be understood in its own context, as well as its impact on cognitive appraisals in PTSD. Individualistic cultures are those that stress individual goals and the rights of the individual. The needs of the individual are seen as more important than the needs of the group. In such cultures, the person is independent and autonomous. Individuals value their independence, self-reliance, and self-determination over communal or societal interests. The following countries have been identified as highly individualistic: the United States, Australia, the United Kingdom, Canada, the Netherlands, New Zealand, Ireland, Germany, and South Africa. Individualistic

cultures stress the importance of each person taking care of themselves without depending on others for assistance (Markus and Kitayama, 1991, 2010; Ford and Mauss, 2015).

In comparison, collectivistic cultures emphasise the needs and goals of the group over those of individuals. In such cultures, relationships with other members of the group and the interconnectedness between people play a key role in each person's identity. Collectivistic cultures, such as China, Korea, Japan, and other Asian countries, emphasise family and workgroup goals above individual needs or desires. Individuals in collectivistic cultures may instead stress sharing the burden of care with the group (Hofstede and Hofstede, 2004; Markus and Kitayama, 2010; Engelbrecht and Jobson, 2016).

3.2 Rationale for Chosen Topic

Accumulating research (Figueira et al., 2007; Paunovic and Öst, 2001; Pham, Weinstein, and Longman, 2004; Vinck, Pham, Stover, and Weinstein, 2007) indicates that several factors in Western cultures impede post-trauma recovery, maintain post-traumatic symptoms, and influence the treatment process and the development of ongoing PTSD. Kleim et al. (2007) argue that these factors include the history of psychological problems, previous trauma, trauma severity, quality of social support, and cognitive factors, such as appraisals of self and personal actions during the trauma, and how therapists perceive them after the traumatic event. These form part of the theoretical model put forward by Ehlers and Clark (2000), which emphasises the role of self-relevant appraisals of the trauma experience and its sequelae in the maintenance of PTSD.

Despite this model and an advanced understanding of the psychological processes in PTSD, the applicability of this model to survivors experiencing trauma and distress from different non-Western cultures remains relatively unknown (Jobson and O'Kearney, 2009).

Distress manifests differently across cultures due to diverse belief systems, social norms, and cultural practices. Understanding how distress is conceptualised within specific cultural contexts is important. Non-Western cultures may have frameworks for understanding distress that do not align with Western diagnostic categories. For instance, in some indigenous cultures, distress might be understood as a spiritual imbalance or a disruption in community harmony rather than solely as a psychological problem. Non-Western cultures often address distress through various modalities such as rituals, ceremonies, storytelling, and community support (Gone, 2013; Bolton et al., 2003).

Marsella et al. (1996) conducted a comparative study of psychological symptoms across 14 cultural groups, identifying significant variability in symptom expression. While Western cultures often emphasise emotional symptoms like sadness and anxiety, non-Western cultures may express distress through somatic complaints such as dyspnoea, palpitations, and chest tightness. Good et al. (1989) examined cultural scripts and narratives surrounding mental illness in different societies, finding that cultural norms and storytelling shape the experience and expression of distress. In some cultures, mental distress may be viewed as a spiritual crisis or community disharmony rather than a biological and psychological issue (Kirmayer and Bhugra, 2009).

Kirmayer et al. (2011) found that individuals from collectivist cultures tend to express distress through bodily symptoms rather than psychological symptoms. For example, in Korean culture, "hwa-byung" is characterised by anger, resentment, seeking behaviour, and somatic symptoms (Park et al., 2013; Han et al., 2008). Hinton and Lewis-Fernández (2010) note that Cambodian cultural beliefs may involve concepts like karma and spirit possession. In Latino cultural beliefs, distress may revolve around concepts such as "mal de ojo" (evil eye) or "nervios" (nerves). Cultural nuances are crucial to addressing stigma and promoting help-seeking behaviours. For example, in Cambodian culture, men often experience more physical symptoms and women more emotional distress. In Latino mental health, machismo can influence men's reluctance to seek mental health care due to fears of appearing weak or vulnerable (González et al., 2009).

In Japan, distress is characterised by extreme social anxiety and fear of offending others. Individuals with Taijin Kyofusho, a culturally specific syndrome, experience distress about their physical appearance, fearing they might embarrass or harm others (Kirmayer, 2001; Ryder et al., 2008; Wig et al., 2014) and Grover et al. (2017) explored Dhat Syndrome, a culture-bound syndrome in South Asian countries like India, finding that distress is characterised by anxiety about the loss of semen and associated somatic symptoms such as fatigue, weakness, and sexual dysfunction.

Studies by Kleinman et al. (1995) and Yang et al. (2004) investigated Shenjing Shuairuo, a specific syndrome in China, highlighting the influence of Confucian values, rapid socio-economic changes, and stigma surrounding mental illness. They found that distress is characterised by weakness of the nerves, fatigue, dizziness, headaches, and other somatic symptoms triggered by stressors such as work pressure,

family conflicts, or social expectations. These studies emphasise the importance of understanding cultural beliefs and practices in interpreting distress symptoms outside the framework of PTSD.

From my perspective, there are three main reasons for choosing this topic. First, to date, there have been no empirical studies on the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in PTSD. Secondly, a literature review on the impact of cultural differences on the relationship between cognitive appraisals and post-traumatic stress disorder provides a foundation to justify my chosen topic. Thirdly, the review explores the extent to which cultural differences in appraisals influence the subsequent affective response and psychological adjustment in PTSD. I am hopeful and optimistic that my study will contribute to the existing body of knowledge on how cultural differences impact PTSD.

3.3 Literature Search Strategy

Many studies have been published in the last three decades investigating various types of post-traumatic stress disorders arising from sexual and physical abuse, road traffic accidents, war, domestic violence, natural disasters, and physical conditions. Extensive electronic searches of four databases—namely CINAHL, Medline, PsycINFO, and Google Scholar—were conducted within the date parameters of 2000 to 2021. Due to the complexity of PTSD and cultural variation, the following key terms were used for this literature review: cultural sensitivity, post-traumatic stress disorder, cultural differences, culture, cognitive appraisal, individualistic and collectivistic cultures, understanding, interpretation, therapist, trauma, and client. Manual searches of articles related to PTSD were also conducted.

A total of 6,150 articles on post-traumatic stress disorder, 394 articles on cognitive appraisals, 64 articles on culture and post-traumatic stress disorder, and 9 articles on cultural sensitivity/differences and post-traumatic stress disorder were found through electronic and manual searches. From this search, only one article was identified on the impact of cultural differences in self on cognitive appraisals in PTSD. An advanced search on EBSCOhost, using Alternative Medicine and CINAHL, yielded 21 articles on post-traumatic stress disorder and cognitive appraisals, and 3 articles on post-traumatic stress disorder and culture (see Figure 2, p. 47).

Further searches in CINAHL/Medline, using the SmartText searching method, provided the following results for the key terms: 154,706 articles on post-traumatic stress disorder, cognitive appraisals, and culture; 29 articles on post-traumatic stress disorder and culture; and 7 articles related to cultural differences in relation to PTSD. No specific empirical studies were found on the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in PTSD. From the literature search, I have selected 10 studies for review on the impact of cultural differences on psychological processes in individuals with PTSD, namely self, memory, identity, cognitive appraisals, and autonomous orientation (see Figure 3, p. 48).

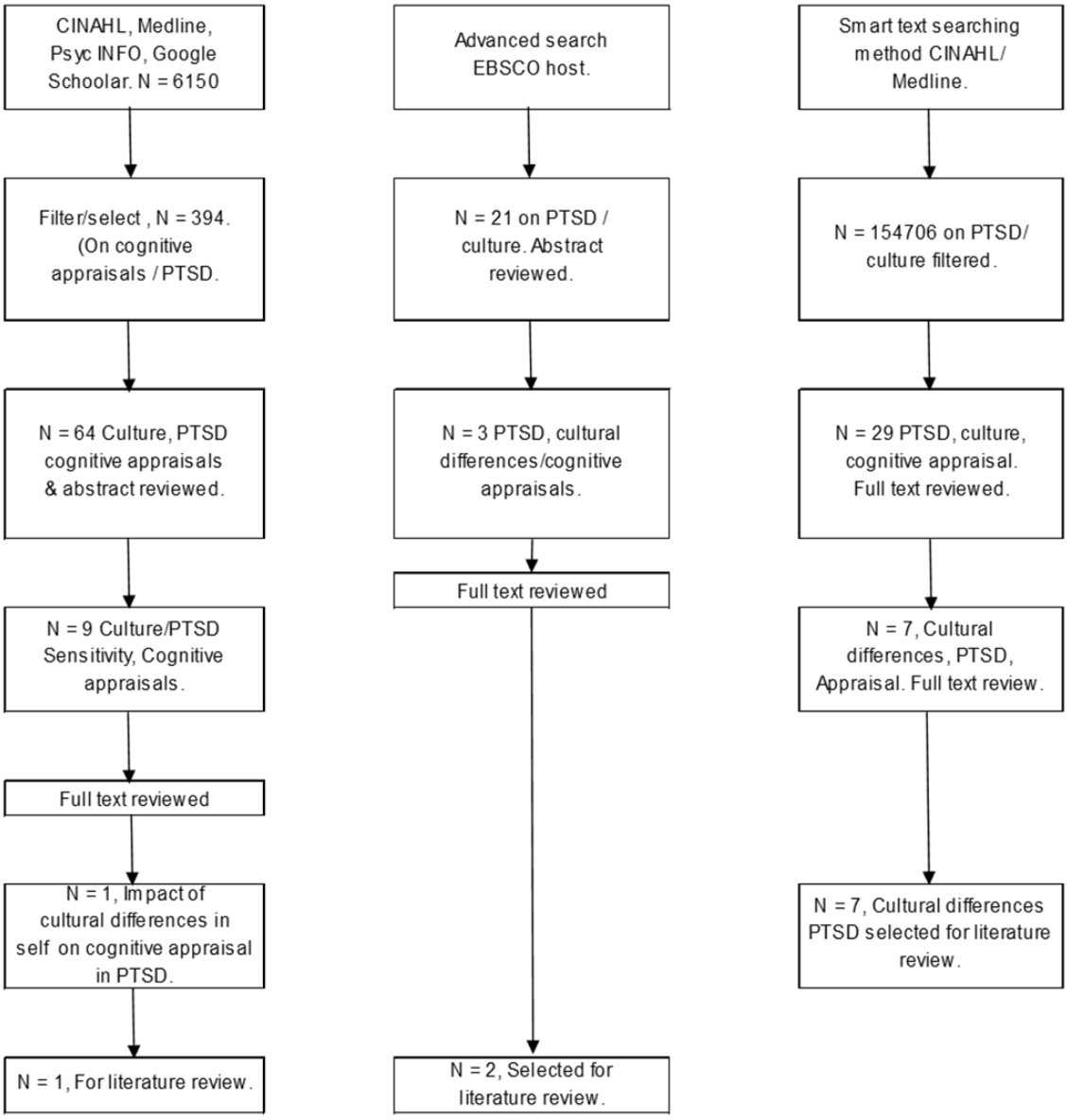

Figure 2: Literature Search – diagrammatical presentation

(I selected 10 studies for literature review, i.e., (N=1 + N=2 + N=7) = 10)

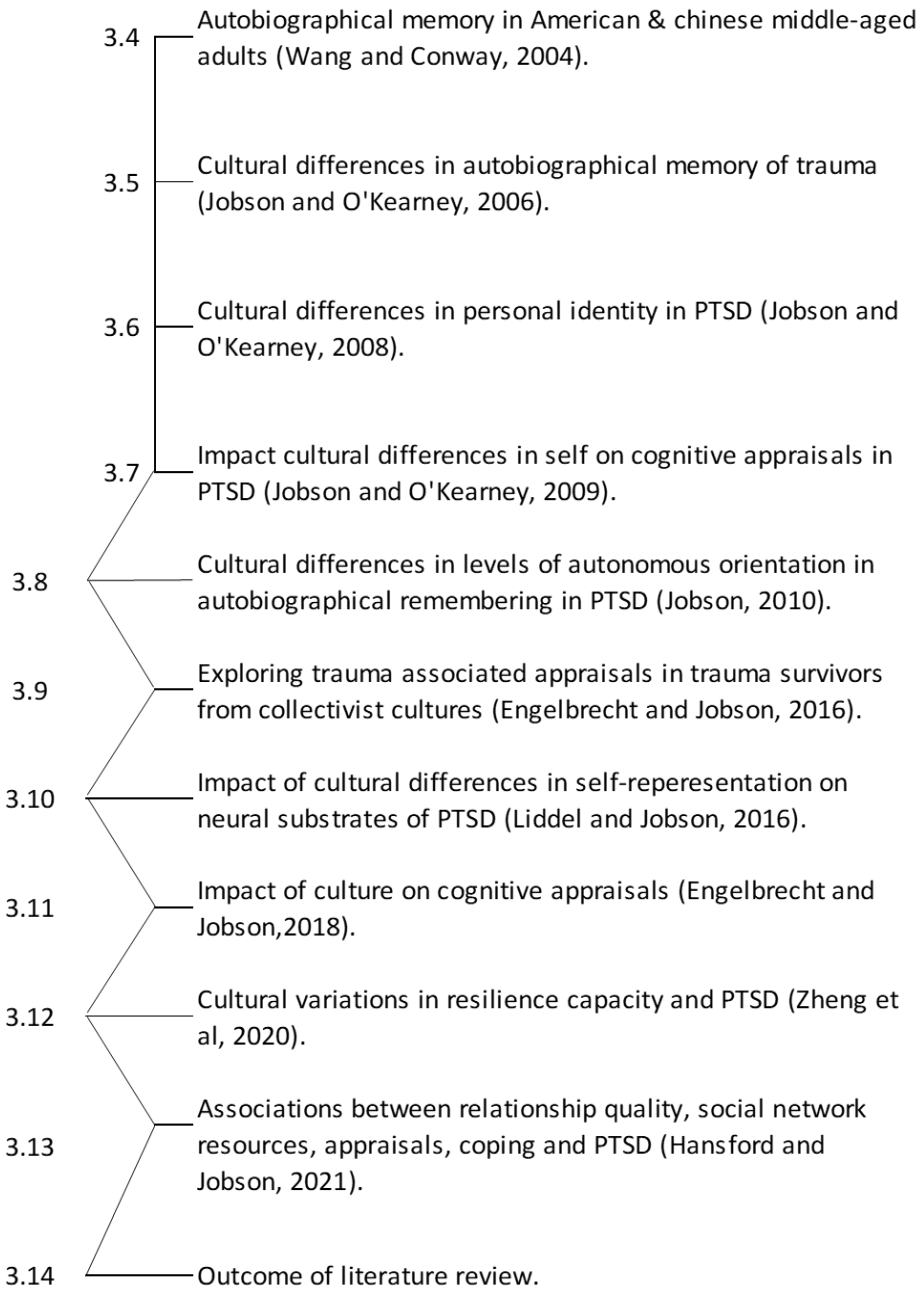

Figure 3: List of studies that I reviewed

Incorporating a Wider Literature Review to Include the Following:

* Decolonising Western psychopathology

* Transcultural psychiatry

* Social inclusion -work of Jed Boardman

* The Empire of Trauma: An Inquiry into the Condition of Victimhood by Didier Fassin & Richard Rechman

* Psychology, Mental Health and Distress by David Harper, John Cromby, and Paula Reavey

* Power, Resistance and Liberation in Therapy with Survivors of Trauma: To Have Our Hearts Broken by Taiwo Afuape

* The Myth of Mental Illness by Thomas Szasz

* The Politics of Experience and The Bird of Paradise by Laing, R.D.

* Madness and Civilization by Michel Foucault

* Madness Explained: Psychosis and Human Nature by Richard Bentall

* Madness and Subjectivity: A Cross-Cultural Examination of Psychosis in the West and India by Ayurdhi Dhar

* Posttraumatic Stress Disorder: Issues and Controversies by Gerald Rosen

3.4 The Stories We Keep: Autobiographical Memory in American and Chinese Middle-aged Adults – A critical review

I have included this study in my literature review as it is important to understand the self and autobiographical memory, and their relationship with PTSD (Brewin, 2007). In their study of autobiographical memory in American and Chinese middle-aged adults, Wang and Conway (2004) state that autobiographical memory functions at the individual level to maintain 'current goals, self-theories, attitudes, and beliefs', and, culturally, it enables the individual self to be 'congruent with their culture's goals, values, and belief system' (Wang and Conway, 2004: 912). Based on their study, it can be argued that there is a unique and cultural relationship between the self and its autobiographical memory. The self is a key component in the encoding, organisation, and retrieval of autobiographical memories. From their perspective, the function of autobiographical memories is 'to develop, express, and maintain the culturally sanctioned self' (Wang and Conway, 2004: 912). In this context, it can be argued that the independent-interdependent difference can impact autobiographical memory, meaning that this process will be culturally shaped according to the specific cultural group. This is supported by the study undertaken by Nelson and Fivush (2004) on the sociocultural developmental theory related to the emergence of autobiographical memory. Other studies (e.g., Choi, 1992; Mullen and Yi, 1995; Wang and Fivush, 2005; and Wang, 2007) have indicated that mothers from collectivistic (interdependent) cultures encourage their children to reminisce about past events, which helps their children construct personal stories and promote social interactions.

In comparison, the study by Wang and Fivush (2005) points out that mothers from individualistic (independent) cultures tend to encourage their children to actively participate in the establishment and creation of their own life story. In these cultures, the development of self-construal is of paramount importance as it reinforces self-autonomy. These studies indicate that in individualistic cultures there is a greater emphasis on the notions of self, self-definition, self-revelation, and self-story. The self is seen as an entity and an active mediator in shaping one's life direction. A large body of research indicates that individualistic cultures are more self-focused, self-dependent, and self-revealing than collectivistic cultures (Jobson and O'Kearney, 2008; Wang, 2008; Wang and Conway, 2004; Wang et al., 2006). In contrast, collectivistic cultures focus on collective activities, significant others, and social and historical events. In individualistic cultures, the self is seen as an autonomous unit with self-understanding, self-determination, and self-affirmation. Wang and Conway (2004) point out that autobiographical memory is functional at both the individual and cultural levels. From the studies, it can be suggested that the mechanism of autobiographical memory is culturally determined and instrumental in the reaffirmation of the self as a cultural entity.

As autobiographical memory is a central psychological process in PTSD (Brewin, 2007), it is crucial to consider whether the autobiographical memory of trauma reflects the cultural differences seen in the autobiographical memories of individuals from both independent and interdependent cultures on a day-to-day basis. Based on the research so far, it can be argued that cultural variation tends to influence the nature of the conceptual self, which depends on the distinction between an independent and interdependent social orientation. In their study on the construction of autobiographical memories in the self-memory system, Conway and Pleydell-Pearce

(2000) state that the working self is comprised of a motivational hierarchy of goals and sub-goals that function to enable cognition and behaviour to operate effectively within the individual and in the world. Markus and Kitayama (1991) argue that the culturally appropriate self-influences cognition and behaviour, whereas goals and motivations are influenced by the nature of the self-schema. Following the argument from related studies (Conway, 2005; Jobson and O'Kearney, 2006, 2008), it can be proposed that cultural variation in autobiographical remembering results from cultural variation in the self, which also impacts the working self. Jobson (2009) states that the working self-comprises an autonomous hierarchy of goals and sub-goals, meaning the storage of autobiographical information is organised and involves different areas.

3.5 Cultural differences in Autobiographical Memory of Trauma – A critical review

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3.6 Cultural Differences in Personal Identity in PTSD – A critical review

Jobson and O'Kearney (2008) investigated cultural differences in personal identity in PTSD. Several studies indicate a significant relationship between changes in self-concept and personal identity following traumatic experiences and post-traumatic psychological adjustment (McNally et al., 1995; Sutherland and Bryant, 2006). Berntsen and Rubin (2006, 2007) have demonstrated a significant correlation between traumatic memory being a key component of personal identity and the increased severity of PTSD symptoms. They state that change occurs in the self because traumatic memories can be easily accessed and evoked. Over time, the trauma is perceived as 'a major causal agent' in the autobiographical self (life story) and 'thus a highly salient turning point in the person's life' (Berntsen and Rubin, 2006: 221).

Culturally, individuals undergo role changes, such as choosing a job, marriage, and parenthood. These are seen as transitional events that provide individuals with self-definition and identity. The perception of a traumatic event is seen as a turning point in the life story of individuals and becomes 'a salient and important component of identity' (Jobson and O'Kearney, 2008: 96). The maintenance of this trauma-centred identity is linked to 'culturally sanctioned role transitions' and 'personal identification with the social roles that are culturally expected' (Berntsen and Rubin, 2007: 420). This is also evident in studies by Conway (2005) and Conway and Pleydell-Pearce (2000), which suggest that the trauma event and the existing self-definition or identity initiate change by distorting memories to integrate the trauma memories (based on the Conceptual Self in Conway's model). The model also suggests that self-consistency may need to be maintained by changing the person's self-construct, which may lead to

the development and change in self-identity, e.g., ‘being a victim of trauma’, ‘I have changed since the traumatic event’, or ‘I cannot cope as a mother’.

Jobson and O’Kearney (2008) state that self-change is likely to be motivated by the need for self-coherence and self-consistency. Cross-cultural researchers argue that self-consistency needs vary based on cultural context (Suh, 2002; Kanagawa, Cross, and Markus, 2001). Suh (2000) states that an internally coherent self-identity is vital for maintaining mental health in independent cultures. A person needs to integrate various components of the self to function and remain consistent across challenging situations. If there is a lack of integration, it can be argued that self-consistency is disrupted and misaligned with the self. Regarding self-consistency, more emphasis is placed on autonomy, as the individual is centred around behaviour, thoughts, and feelings rather than situations (Jobson and O’Kearney, 2008). Critically, this means that the self will use internal resources to control and guide behaviour and derive meaning from thoughts in independent cultures.

This is not the case in interdependent cultures, where the focus is not on the self but on the social context, social roles, and interactions with others in communities. In such cultures, there is a sense of duty towards one’s group, interdependence on others, and a need for social harmony, where social status is defined within the group (Green et al., 2005; Sato, 2001). In these cultures, the individual’s life story, personal identity, self-consistency, and uniqueness may be seen as culturally inappropriate (Sato, 2001; Suh, 2000). The independent self is not important; more emphasis is placed on the communal self (Nelson and Fivush, 2004; Wang, 2001). This has implications for trauma survivors who have experienced trauma types, such as rape and domestic violence, that can disrupt group and community harmony. In such cases, trauma

survivors may be seen as guilty and receive less assistance or acknowledgment, or they may be rejected by their communities. Instead of being blamed or fearing rejection by others in the group or community, trauma survivors in interdependent cultures tend to suppress 'trauma-related cognitions pertaining to such trauma types due to these cultural sanctions' (Jobson and O'Kearney, 2008: 97).

Varma et al. (2007) state that domestic violence is seen as a private matter and should be kept secret by Indian women. In their study of battered Indian women, Panchanadeswaran and Koverola (2005) argue that many Indian women may be prevented from seeking help due to the cultural belief that they need to be subordinate and maintain peace and family honour. This cultural belief can lead to the internalisation of their stress and suppression of traumatic experiences instead of seeking help. There is a fear that they could be victims of their trauma events and be victimised by their own group. Hence, this internalisation of stress manifests as somatic symptoms such as headaches or body pain (Ahmed-Ghosh, 2004).

3.7 The Impact of Cultural Differences in Self on Cognitive Appraisals in Post-Traumatic Stress Disorder – A critical review

Based on previous studies and the literature reviewed so far, there are strong indications suggesting that cultural differences influence the shaping of the self and the psychological processes involved in the aetiology and maintenance of PTSD (Jobson and O'Kearney, 2006). From a Western cultural perspective, there have been significant theoretical and empirical advances in understanding the development and maintenance of PTSD in trauma survivors. Jobson and O'Kearney (2009) argue that there is little empirical evidence on the applicability of these Western concepts to the understanding and maintenance of PTSD in non-Western trauma survivors.

Jobson and O'Kearney (2009) contend that cognitive appraisals are of particular interest because they are key components influencing clinical models of PTSD (e.g., Ehlers and Clark, 2000). Cognitive appraisals can be targeted to develop strategies for the prevention or reduction of psychological disability and to enhance psychological adjustment following trauma. Empirical evidence suggests that cognitive factors are of paramount importance in identifying chronic PTSD (Kleim et al., 2007). Jobson and O'Kearney (2009) highlight that the model of PTSD proposed by Ehlers and Clark (2000) emphasises the role of self-relevant appraisals of trauma experience and/or its sequelae in the maintenance of PTSD. The model indicates that appraisals sustain a feeling of threat in the survivor's life and promote the use of maladaptive strategies to control its symptoms. There are significant implications for trauma survivors based on a critical evaluation of the four theoretically derived cognitive appraisal domains operating in PTSD. For example, mental defeat and control strategies, which are two of the four domains, are linked to survivors' appraisals of their cognitive, emotional, and behavioural responses during the traumatic experience. The other two domains, permanent change and alienation, refer to survivors' appraisals of themselves and their interactions with others following traumatic events (Jobson and O'Kearney, 2009). It can be argued that these domains will be critically and negatively appraised by trauma survivors with PTSD, which will, in turn, increase the severity of symptoms.

Several studies have found that mental defeat is responsible for the severity of PTSD following an assault (Dunmore, Clark and Ehlers, 2001; Ehlers et al., 1998). In their study, Ehlers et al. (2000) found that political prisoners with chronic PTSD were more likely to critically appraise themselves as being more inclined to perceive mental threat, feelings of alienation, and permanent negative changes in their personalities. Similarly, in rape survivors with PTSD, there is substantial evidence of memories

reflecting aspects of mental defeat, absence of mental planning, and control strategies. Critically, this results in impaired psychological adjustment following exposure to therapy and reinforces an overall feeling of alienation and permanent change following the traumatic event (Ehlers et al., 1998).

There is strong evidence suggesting that specific appraisal factors may be influenced by the trauma survivor's previous experiences, background, and beliefs (Jobson, 2009; Varma et al., 2007). Based on these studies, Jobson and O'Kearney (2009) believe that cultural differences in self and self-construal may play a vital role in reinforcing the importance of appraisal domains in PTSD. They state that all four domains proposed by Ehlers and Clark (2000) focus on the self and its relationship with others. Critically, this could have implications for how trauma survivors with PTSD appraise themselves following a traumatic event. There is a strong argument supporting the fact that these clients will negatively appraise the self as 'I am weak,' 'I deserve this to happen,' 'I am incompetent, inferior, unworthy,' 'I am permanently damaged,' and their relationships as 'Others know that I am a trauma survivor,' 'I will always be alone and no one understands,' and 'Others think I cannot cope' (Jobson and O'Kearney, 2009: 251).

Ehlers and Clark (2000) state that appraisals are centred on the self and PTSD, as trauma survivors perceive current situations as dangerous and threatening because they are unable to cope with these circumstances. They point out that appraisals concerning others play an important role in the withdrawal of trauma survivors from social interactions, diminishing opportunities for them to receive social support and failing to correct negative beliefs about how others view them and their perceptions of themselves. Jobson and O'Kearney (2009) argue that the appraisal and relationship of

the self with others draw Ehlers and Clark's model (2000) into the cultural sphere. The development of the self occurs through socialisation processes and is influenced by cultural background (Breslau, 2004; Kirmayer et al., 2007).

From a critical point of view, it can be argued that cultural differences in self-construal can impact appraisals of the self-following exposure to traumatic events. Mesquita and Walker (2003) found that cultural variations in self-construal tend to foster specific appraisals linked to distinct cultural orientations in emotional experience. According to Markus and Kitayama (1991), independent cultures appraise success based on personal accomplishment, independence, and control. In contrast, in interdependent cultures, the appraisal of the self as being in control and independent has very limited significance. In these cultures, the relationship of the self with others is more significant.

From the literature review so far, and the indication that cultural differences in self-construal impact appraisals, based on Ehlers and Clark's model (2000), it is hypothesised that the differences in cognitive appraisals between trauma survivors with and without PTSD will differ culturally (Jobson and O'Kearney, 2009). It is predicted that appraisals of self, independence, and control (i.e., mental defeat, control strategies, and permanent change) following the traumatic event will have a greater impact on the psychological treatment and adjustment of trauma survivors from independent cultures than on those from interdependent cultures. It can be argued that the difference in these appraisals between those with and without PTSD will be more pronounced for trauma survivors from independent cultures than for those from interdependent cultures. On the contrary, it can be predicted that trauma appraisals (i.e., alienation) that focus on the self and the relationship with others will have a

greater impact on the psychological treatment and adjustment of trauma survivors from interdependent cultures than those from independent cultures.

This provides a strong argument suggesting that the difference in these appraisals between those with and without PTSD will be more apparent for trauma survivors from interdependent cultures than for those from independent cultures. Jobson (2009) argues that everyday accounts of trauma survivors from individualistic cultures are more significantly autonomously oriented compared with accounts of traumatic experiences from individuals with a collectivistic cultural background. As far as traumatic experiences and trauma narratives are concerned, Jobson (2009) states that both individualistic and collectivistic cultures are equally oriented in autobiographical memories. However, in individualistic cultures, the 'working and independent conceptual self' works in parallel on autobiographical remembering of trauma, while in collectivistic cultures, the interdependent conceptual self gives way to the autonomous working self (Jobson, 2009: 374). This means that individualistic cultures have almost comparable levels of autonomous orientation in both their trauma and everyday memories. This is different in collectivistic cultures, where there are greater levels of autonomous orientation in their trauma memories than in their day-to-day memories.

3.8 Cultural Differences in Levels of Autonomous Orientation in Autobiographical Remembering in Post-Traumatic Stress Disorder: A critical review

Jobson's (2010) study investigates the cultural differences in levels of autonomous orientation in autobiographical remembering in individuals with and without PTSD. There is an increasing body of empirical work aimed at establishing the role of autobiographical memory in understanding post-traumatic stress disorder (Rubin et al., 2008; Conway, 2005; Dalgleish, 2004; Ehlers and Clark, 2000; McNally et al., 1995). Jobson (2010) states that these studies have not considered the influence of cultural differences in self-construal on autobiographical remembering. There is a growing body of knowledge and research supporting the notion that culture influences the self in different societies. For example, in individualistic (Western) cultures, the self is perceived to be independent, autonomous, and self-reliant. In collectivistic (non-Western) cultures, the self is seen as a related unit, interdependent on others in society (Markus and Kitayama, 1991; Wang and Conway, 2004).

Wang and Conway (2004) argue that there is a unique relationship between the culturally construed self and autobiographical memory. This relationship is based on how contents are organised in autobiographical memory. They can provide more self-revealing, self-directed, and autonomously oriented autobiographical memories than those from collectivistic cultures (Wang, 2008; Wang et al., 2006; Jobson and O'Kearney, 2008). Mothers in these cultures tend to encourage their children to focus on collective activities, social interactions, and significant others. In contrast, children in individualistic cultures are guided to actively participate in creating their own life stories, being more autonomous and self-defined.

From the literature review, Jobson (2010) highlights the centrality of autobiographical memory in PTSD. This raises the question of whether autobiographical memory of trauma is influenced by cultural differences and to what extent trauma memories reaffirm the identity of the self. Such considerations have critical implications for the self. The maintenance of the self depends on goals related to survival, personal safety, and personal control. In traumatic events, these key components of the self are challenged (Dalgleish, 2004). Jobson (2010) hypothesises that there will be cultural differences in the autobiographical memory of everyday activities, but this might not be the case for trauma memory. She suggests that trauma memory might contain culturally similar levels of autonomous orientation. In relation to the psychological processes in PTSD, schemas can also be culturally influenced and interlinked with levels of autonomous orientation.

There is evidence to suggest that people have schema-driven expectations regarding appropriate levels of autonomous orientation in autobiographical remembering. These expectations are derived from the cultural self (Markus and Kitayama, 1991; Nelson and Fivush, 2004; Wang and Conway, 2004; Berntsen and Rubin, 2007). A critical review of the literature indicates that the independent self in individualistic cultures is oriented towards schema-driven expectations of high levels of autonomy in autobiographical memory, reaffirming personal control. This differs in collectivistic cultures, where the emphasis is on an interdependent self with schema-driven expectations of low levels of autonomous orientation in autobiographical memory. In these cultures, autonomous orientation is not valued and is seen as a potential threat to group harmony. This means that the autonomous self does not fit within the group and

can undermine interdependence within the social norm (Wang and Conway, 2004). Research has found that memory is enhanced when information deviates from schema-driven expectations, making the information clearer, more vivid, and more detailed (Brewer and Treyens, 1981; Rubin and Kozin, 1984).

In traumatic experiences, Berntsen and Rubin (2007) state that trauma memory deviates from schema-driven expectations, making information about the trauma highly accessible and a cognitive reference point for other autobiographical memories. This psychological process influences the meaning attached to other, less significant memories and expectations of future events. From the trauma survivor's perspective, current situations are perceived as current threats, resulting in the maintenance of PTSD symptoms (Ehlers and Clark, 2000). From this theoretical perspective, Jobson (2010) argues that in some trauma survivors, the level of autonomous orientation in their autobiographical remembering of traumatic experiences may deviate from schema-driven expectations at an appropriate level in their autobiographical memory. Such deviation enhances the memory of the traumatic event, making it a cognitive reference point for autobiographical remembering. Other psychological processes, such as memory and appraisals, contribute to interpreting the effect of trauma on the self. The influence of trauma on these psychological processes leads to the development and maintenance of PTSD symptoms.

Firstly, Jobson (2010) hypothesises that trauma survivors from independent (individualistic) cultures with PTSD will have lower levels of autonomous orientation in their trauma memories compared to those without PTSD. Secondly, she hypothesises that trauma survivors from interdependent (collectivistic) cultures will

have higher levels of autonomous orientation in their trauma memories than those without PTSD.

Thirdly, she hypothesises that the central trauma memory will influence the relationship between autobiographical memory and the self. She states that the central memory and its level of autonomous orientation will influence the expression, integrity, and development of the self. Sutherland and Bryant (2006) indicate that self-defining memories are a measure of changes in self-concept. From this perspective, Jobson (2010) argues that trauma survivors from individualistic cultures with PTSD will have lower levels of autonomous orientation in self-defining memories compared to those without PTSD. In collectivistic cultures, she argues that trauma survivors will have higher levels of autonomous orientation in self-defining memories than those without PTSD. Her fourth hypothesis is that those from individualistic cultures will have lower levels of autonomous orientation in their everyday memories compared to those without PTSD. According to Jobson (2010), trauma survivors from collectivistic cultures with PTSD will have higher levels of autonomous orientation in their everyday memories compared to those without PTSD.

3.9 Exploring Trauma-associated Appraisals in Trauma Survivors from Collectivistic Cultures – A critical review

According to Engelbrecht and Jobson (2016), culture influences our thinking, emotions, behaviour, and interactions with the outside world. The foundation of this influence lies in the extent to which a culture promotes interdependence or independence (Markus and Kitayama, 1991, 2010). In individualistic cultures (Western), the self is seen as independent and autonomous, perceived as a self-determining unit. In contrast, in collectivistic cultures, the self is viewed as interdependent, relying on others (Hofstede and Hofstede, 2004; Markus and Kitayama, 2010).

For example, when traumatised by physical violence, research indicates that East Asian/interdependent cultures are less likely than European/independent cultures to discuss their stressful events and seek treatment (Jayawickreme et al., 2015; Robert et al., 2011). In such scenarios, individuals from collectivistic cultures might appraise themselves as "others think I cannot cope" and "others think I am weak". It can be argued that the self is seen as part of the community or a group (Liddell and Jobson, 2016). In collectivistic cultures, appraisal is interpreted based on how a person is perceived by others within their community, which differs from individualistic/independent cultures. In the latter, the self is autonomous, and in similar traumatic situations involving physical violence, one might be more likely to appraise the self as "I am weak", "I deserve this and I am incompetent", and "I can’t defend myself" (Jobson and O’Kearney, 2009).

Engelbrecht and Jobson (2016) state that cultural differences and self-construal characteristics impact the very nature of individual experience and appraisals. Cultural differences in self-construal have been found to affect appraisals of events and life encounters (Mesquita and Walker, 2003). It is important to note that there is variation in the way individuals from both independent and interdependent cultures appraise themselves. Markus and Kitayama (1991) state that individualistic cultures appraise success through personal achievement and a sense of personal control. In collectivistic cultures, Mesquita and Walker (2003:785) point out that "agency is differently instantiated… or is not valued as much". There is more emphasis on the interdependence of an individual and their interaction with their social environment. Mesquita and Walker (2003) state that a key aspect of Western cultural models, such as in America, is success through independent and personal accomplishment. In contrast, they argue that East Asian cultural models are based on the interdependence of an individual and their (social) environment.

There is an increasing number of studies investigating cultural differences, cognitive appraisals, and recovery rates in individuals with PTSD (Engelbrecht and Jobson, 2016, 2014; Liddell and Jobson, 2016; Trepasso-Grullon, 2012). Appraisals are a key component and form part of the assessment of individuals with PTSD. The role of the therapist is crucial in this process. It is not known whether cultural differences play an important role in how therapists interpret and make sense of clients' appraisals in PTSD. Although there is substantial cross-cultural literature examining appraisals in PTSD, to date, there is only one study that mentions the illuminative role of practitioners in meeting the needs of individuals with PTSD from collectivistic cultures (Engelbrecht and Jobson, 2016; Basoglu et al., 2007; Duffy et al., 2007; Engelbrecht and Jobson, 2014).

The study provides valuable insights into how trauma is experienced and appraised in collectivistic cultures, which often prioritise group harmony and interdependence. This aligns with previous research by Markus and Kitayama (1991), who proposed that people from collectivistic cultures are more likely to define themselves in relation to others. The study addresses an important gap in the literature by focusing on trauma survivors from collectivistic cultures and highlights the need for cultural sensitivity in understanding trauma.

The study employs qualitative methods, incorporating semi-structured interviews that allow for in-depth exploration of participants' experiences and perceptions. However, the small sample size and potential for researcher bias may limit the generalisability of the findings. This methodological choice offers the researcher an opportunity to capture rich and in-depth data that quantitative methods may omit. A larger and more diverse sample would enhance the study's validity and allow for more conclusive findings. Engelbrecht and Jobson identify themes such as shame, guilt, and the importance of social support in trauma survivors from collectivistic cultures. These findings align with previous research by Wong and Tsai (2007), who found that individuals from collectivistic cultures are more likely to experience shame in response to their traumatic experiences.

The study highlights cultural variations in coping strategies, with participants recognising the importance of family and community support. This supports the cultural value of collectivism, where individuals draw strength from their community. This study aligns with research findings by Kim et al., (2007) on Asian American trauma survivors, providing further insights into cultural coping mechanisms. This study has implications for practice. Engelbrecht and Jobson (2016) suggest that

interventions should address shame and guilt while raising awareness of cultural strengths such as family and community support. This is supported by the recommendations of Sue and Sue (2012) for culturally competent counselling. The study acknowledges several limitations, including the lack of diversity within the sample and the potential influence of the researchers' cultural backgrounds. It is suggested that future research should address these limitations by employing larger, more diverse samples and using mixed method approaches to triangulate findings. The study is limited in its scope as it focuses on a specific cultural group or groups, and it may not fully capture the diversity of collectivistic cultures. A wider range of participants from collectivistic cultures would provide richer data and a better understanding of trauma appraisals. Despite its limitations, the study provides valuable insights into the intersection of culture and trauma and offers a platform for future research to build upon, ultimately advancing our understanding of trauma appraisal and intervention in diverse cultures.

3.10 The Impact of Cultural Differences in Self-representation on the Neural Substrates of Post-Traumatic Stress Disorder – A critical review

Liddell and Jobson (2016) state that there is a significant body of literature on the neural mechanisms involved in the development and maintenance of post-traumatic stress disorder (PTSD). However, there is very little empirical work investigating the influence of culture on these underlying mechanisms. According to Liddell and Jobson (2016), cultural neuroscience research indicates that cultural differences in self-representation modulate many of the same neural processes proposed to be aberrant in PTSD. In their review paper, they consider how culture may impact the neural mechanisms underlying PTSD. The study identifies five key affective and cognitive functions, along with their underlying neural processes, that are disrupted in PTSD: (1) fear dysregulation; (2) attentional biases towards threat; (3) emotion and autobiographical memory; (4) self-referential processing; and (5) attachment and interpersonal processing (Liddell & Jobson, 2016). In the study, prominent cultural theories and empirical research reviewed indicate that cultural variations influence self-representation and the neural substrates of these five affective and cognitive functions. Liddell and Jobson (2016) propose a conceptual model suggesting that these five processes are crucial for understanding how culture may influence the neural processes underpinning PTSD. They argue that cultural variations in individualistic versus collectivistic self-representation modulate many of the same neural and psychological processes disrupted in PTSD. The affected processes include fear perception and regulation mechanisms, attentional biases towards threat, emotional and autobiographical memory systems, self-referential processing, and attachment systems (Liddell & Jobson, 2016). A conceptual model is proposed whereby culture is integral to the development and maintenance of PTSD and its neural substrates.

This study is a significant contribution to understanding the complex interplay between cultural factors and neural mechanisms underlying PTSD. The study bridges the gap between neuroscience and cultural psychology, facilitating the understanding of the multifaceted nature of PTSD. By considering the integration of cultural perspectives with neurobiological mechanisms, the study provides a comprehensive understanding of how cultural differences may influence the neural substrates of PTSD. This study offers a non-invasive method, using functional magnetic resonance imaging (fMRI) to examine brain activity. It provides valuable insights into the neural correlates of PTSD, and how cultural differences may manifest at the neural level. Neuroimaging studies have identified specific brain regions implicated in PTSD, such as the amygdala, hippocampus, and prefrontal cortex (Morey et al., 2012). It can be argued that cultural factors may modulate the activity of these brain regions through their influence on self-representation, as suggested by Liddell and Jobson's study.

Studies have also shown variations in the prevalence and expression of PTSD symptoms across different cultural contexts, suggesting that cultural factors play a significant role in shaping the experience and expression of PTSD (Hinton & Lewis-Fernández, 2010). The sample size is small, and it lacks diversity within the cultural groups studied, limiting the generalisability of the findings. Larger and more diverse samples would provide a more in-depth and robust understanding of the cultural influences on the neural substrates of PTSD. The study of cultural differences is complex and multifaceted, making it challenging to isolate their effects on neural substrates. The study may not establish a relationship between cultural differences in self-representation and the neural substrates of PTSD. It is possible that the observed data and differences in brain activity could be influenced by other factors not accounted for in the study design.

Liddell and Jobson's study provides valuable insights into the complex relationship between cultural differences in self-representation and the neural substrates of PTSD. While the study has several strengths, such as its interdisciplinary approach and cultural sensitivity, it also has limitations, such as sample size and methodological challenges. Further research addressing these limitations is required to fully clarify the role of cultural factors in formulating the neurobiology of PTSD.

The study recognises the importance of cultural context in understanding PTSD. The comparison of individuals from different cultural backgrounds highlights the variability in self-representation and its neural correlates across cultures, reinforcing the need for culturally sensitive approaches in diagnosing and treating PTSD.

3.11 The Impact of Culture on Cognitive Appraisals: Implications for the Development, Maintenance, and Treatment of Post-Traumatic Stress Disorder - A critical review

Bernardi, Engelbrecht, and Jobson (2018) state that cognitive appraisals play a central role in the development, maintenance, and treatment of post-traumatic stress disorder (PTSD). Cross-cultural psychological research demonstrates that culture affects the way individuals cognitively appraise everyday experiences (Jobson, 2008, 2009). However, there is little empirical work exploring the influence of culture on cognitive appraisals in PTSD and the implications for treatment. In their review, Bernardi, Engelbrecht, and Jobson (2018) consider how culture may impact cognitive appraisals central to PTSD. The objectives of the review are as follows: Firstly, the role of appraisals in the prominent cognitive models of PTSD is considered.

Secondly, the cross-cultural psychology literature on the influence of culture on appraisals is discussed. Thirdly, the impact of culture on trauma-related appraisals and associated clinical implications is examined. Finally, the implications for tailoring clinical treatment for individuals from diverse cultural backgrounds are explored.

The results indicate that culture influences appraisals, a key psychological process highlighted by cognitive models as predictive of PTSD. Bernardi, Engelbrecht, and Jobson (2018) argue that cultural differences in self-understanding influence how individuals appraise experiences in terms of agency, control, mental defeat, and negative independent appraisals of self, all of which are central to PTSD. Further empirical work is needed to investigate the influence of culture on trauma-related appraisals in the context of PTSD to improve theoretical models and clinical treatment (Bernardi, Engelbrecht, and Jobson, 2018).

This study offers valuable insights into the different cultural factors and psychological responses to trauma. It adopts an interdisciplinary approach by integrating insights from psychology and cultural studies, providing a comprehensive understanding of how cultural factors influence cognitive appraisals in the context of PTSD. The authors demonstrate sensitivity to cultural differences in the experience and expression of trauma. The study aligns with the research by Kim et al. (2016), which demonstrates how cultural values influence the appraisal of trauma and coping strategies among Asian Americans. By acknowledging the role of culture in shaping cognitive processes, the study contributes to a more in-depth understanding of PTSD across diverse populations. The study builds upon existing theoretical frameworks, such as Lazarus and Folkman's transactional model of stress and coping, providing a solid foundation for their analysis and interpretation of findings.

The authors discuss the implications of their findings for the development, maintenance, and treatment of PTSD. By recognising the influence of culture on cognitive processes, they propose the application of culturally sensitive interventions that address the specific needs of diverse populations. This study aligns with the research undertaken by Hinton et al. (2013), which recommends culturally sensitive treatment approaches that address the unique cognitive appraisals of trauma within specific cultures. While the study acknowledges the importance of cultural diversity, its findings may not be generalised to all cultural groups. The sample may be limited in representing the full range of cultural diversities and manifestations of trauma.

The study may oversimplify the role of culture by focusing primarily on broad cultural categories such as ethnicity, religion, and socioeconomic factors, potentially omitting various dimensions such as beliefs, community, and social factors. While the study discusses treatment implications, it may not provide specific guidance on how clinicians can effectively integrate cultural factors into PTSD interventions. More research is needed to develop evidence-based, culturally sensitive treatments. Bernardi, Engelbrecht, and Jobson's study provides valuable insights into the impact of culture on cognitive appraisals in PTSD.

3.12 Cultural Variations in Resilience Capacity and Post-Traumatic Stress: A tri-cultural comparison – A critical review

Zheng et al. (2020) conducted a pilot study to investigate cultural variations in resilience capacity and post-traumatic stress disorder (PTSD). According to Zheng et al. (2020), resilience capacity is associated with individuals' flexibility and coping in response to potential trauma. Culture-related appraisals influence interpretations of the aetiology of PTSD, perceptions of the severity of PTSD symptoms, and coping strategies (Jobson, 2009; Oakley et al., 2021). Zheng et al. (2020) state that there is inadequate research on the mechanisms by which culture may affect the relationship between resilience and PTSD. The study undertaken by Zheng et al. (2020) focused on whether and how culture (specifically in America, Hong Kong, and Mainland China) influences the relationship between resilience capacity and the severity of post-traumatic distress. They collected data from three research sites (America, Hong Kong, and Mainland China) where 558 trauma survivors were recruited. Measures included the Life Events Checklist (LEC-5), the PTSD Checklist for DSM-V (PCL-5), and the Revised Connor-Davidson Resilience Scale (CD-RISC-R). A one-way analysis of variance (ANOVA) was used, and the results indicated that American participants were more resilient than participants from Hong Kong and Mainland China. The findings also revealed a weaker moderating effect of Hong Kong versus American culture on the relationship between resilience capacity and PTSD. This pilot study highlighted the impact of cultural differences on baseline resilience capacity and post-traumatic stress. It can be argued that there is a strong case for clinicians and researchers to re-evaluate Western diagnostic criteria for the conceptualisation and treatment of psychological trauma in non-Western populations.

Zheng et al. (2020) conducted a study across three different cultures, providing valuable insights into how resilience and post-traumatic stress vary across different cultural contexts. While Zheng et al. provide insights into resilience and PTSD across cultures, Bernardi et al. (2018) offer a more specific examination of cognitive processes within the context of PTSD. The study likely benefited from a large sample size across the three cultural groups, enhancing the statistical power and generalisability of the findings. While the tri-cultural comparison is informative, there's a risk of over-generalising findings to other cultures not represented in the study. Each culture is unique, and results may not be universally applicable.

The study may not capture the full complexity of cultural variations within each cultural group, potentially overlooking important factors that influence resilience and post-traumatic stress. Kim et al.'s study (2017) on cultural variations in the experience of trauma and PTSD symptoms among Asian, Latino, and White college students could complement Zheng et al.'s research by offering additional insights into cultural differences in PTSD prevalence, symptom presentation, and help-seeking behaviour. Zheng et al.'s study may face challenges in fully capturing the diversity and complexity of cultural experiences within each group. Zheng et al.'s study provides valuable insights into cultural variations in resilience capacity and post-traumatic stress across three distinct cultural groups. However, it is important to consider the limitations of generalisability and cultural specificity. Cross-referencing with other relevant studies can help to address the limitations and provide a more comprehensive understanding of the complex interplay between culture and mental health outcomes.

3.13 Associations between Relationship Quality, Social Network Resources, Appraisals, Coping, and Post-Traumatic Stress Disorder symptoms – A critical review

Hansford and Jobson (2021) conducted a study to explore whether post-trauma cognitions and maladaptive coping strategies mediated the association between perceived social support and post-traumatic stress disorder (PTSD) symptoms. Social support is understood as the availability of a social network and the quality of specific relationships, such as those with family and friends within the community. Data were collected from a community sample. Trauma survivors (N = 67, 84% female) from the community were selected to complete self-report measures assessing relationship quality, perceived availability of social network support, PTSD symptoms, negative post-trauma appraisals, and maladaptive coping strategies. Using a community sample (N = 67, 84% female) is advantageous for generalisability, capturing a diverse range of individuals who have experienced trauma. However, it is essential to note potential biases inherent in community samples, such as the underrepresentation of certain demographics or specific types of trauma experiences. The gender imbalance in the sample (84% female) may also influence the generalisability of the findings to male trauma survivors.

The results indicate that post-trauma appraisals were influenced by the association between the quality of relationships (support, conflict, and depth) and PTSD symptoms, as well as between the availability of social network support and PTSD symptoms. Furthermore, the results show that negative cognitive appraisals and maladaptive coping strategies were linked to social support (quality of relationships and availability of social network) and PTSD symptoms. The study's focus on

relationship quality is critical, as it reflects the specific ways in which interpersonal dynamics post-trauma can either support or delay recovery. High-quality relationships characterised by trust, empathy, and practical support are associated with lower PTSD symptom severity (Brewin et al., 2000). Conversely, poor relationship quality or a lack of perceived support can exacerbate post-traumatic stress and hinder recovery (Ozer et al., 2003). In addition to social support, the study considers negative post-trauma appraisals and coping strategies. Negative appraisals (e.g., self-blame, perceived permanent damage) are linked to increased PTSD symptoms (Ehlers & Clark, 2000). Maladaptive coping strategies (e.g., avoidance, substance use) often co-occur with more severe PTSD symptoms and poorer recovery outcomes (Brewin et al., 2000; Ozer et al., 2003).

Hansford and Jobson (2021) concluded that the results are consistent with theoretical predictions that socially supportive and unsupportive (conflict) relationships are associated with PTSD through cognitive appraisal and coping processes. Understanding these interrelationships informs intervention strategies. For example, interventions that enhance social support networks or improve relationship quality post-trauma may reduce symptoms of PTSD. Cognitive-behavioural interventions targeting negative appraisals and promoting adaptive coping strategies have also been shown to be effective in trauma recovery (Ehlers & Clark, 2000).

This study indicates that there are clinical implications for integrating interpersonal support into cognitive therapies for both individualistic and collectivistic cultures. The critical analysis of the community sample study highlights the multifaceted impact of social support on trauma survivors' outcomes. Future research could benefit from longitudinal designs to explore how changes in social support and relationship

dynamics over time influence recovery rates. Furthermore, according to recent research (Smith et al., 2020), targeted interventions designed to strengthen social support networks and mitigate negative perceptions could significantly improve the effectiveness of treatments for trauma survivors.

3.14 Incorporate the Widespread of Literature Review

i) Decolonising western psychopathology

In "Decolonizing Trauma Work: Indigenous Stories and Strategies," Linklater (2014) examines how colonisation has inflicted lasting trauma on Indigenous communities through displacement, cultural assimilation, and systemic violence, affecting mental health and well-being. She highlights the need to incorporate Indigenous perspectives and practices into trauma assessment and treatment, focusing on reclaiming cultural identity and resilience. Decolonising Western psychopathology involves integrating Indigenous knowledge into trauma care, acknowledging the historical trauma from colonisation, and addressing PTSD within this context. Linklater (2014) advocates for community-led initiatives and collaboration with mental health professionals to enhance cultural responsiveness and effectiveness in treatment (Crenshaw, 1989).

Western approaches to psychopathology may be biased and not fully address the experiences of diverse communities. Decolonising PTSD includes revising assessment tools and treatment methods to reflect cultural diversity and adopting community-based care models (Kirmayer, Gone, & Moses, 2014). This means recognising the value of social support and collective healing, using cultural group interventions, and integrating traditional practices with Western therapies (Gone, 2019; Duran et al., 2019). Additionally, cultural stigma and taboos can hinder trauma survivors from seeking help (Kirmayer et al., 2017). Decolonising PTSD involves addressing these barriers by providing culturally sensitive services and involving traditional healers in the treatment process. In essence, decolonising Western psychopathology and PTSD requires re-evaluating traditional trauma approaches to include diverse cultural

perspectives, challenging biases, supporting community-based methods, and fostering cultural safety in mental health care.

ii) Transcultural Psychiatry

Transcultural psychiatry examines cultural factors influencing mental health, emphasizing how cultural backgrounds, beliefs, values, and practices shape experiences of mental health conditions and treatment responses (Antic, 2021; Ayonrinde & Pringle, 2020; Antic, 2019). Specifically, in PTSD, it explores the impact of cultural factors on the expression, recognition, and treatment of the disorder across different populations (Kirmayer, Gone, & Moses, 2014).

The field aims to provide culturally sensitive assessments, diagnoses, and treatments by considering the cultural context of PTSD. Traditional healing practices, such as meditation, mindfulness, ceremonies, and herbal remedies, are often integrated into mainstream PTSD treatments (Barnes & Orme-Johnson, 2012; Kirmayer et al., 2017). Community-based interventions involving collaboration with local leaders, organizations, and cultural brokers show promise in addressing PTSD in diverse populations through culturally relevant components like storytelling, peer support, and rituals (Kirmayer et al., 2017).

Kirmayer and Minas (2000) advocate for a "contextualist" approach, recognizing both universality and diversity in mental health, stressing the importance of cultural, social, and historical contexts while acknowledging common underlying processes. They critique the DSM (Diagnostic and Statistical Manual of Mental Disorders) for its Western-centric diagnostic criteria, which may not accurately reflect non-Western experiences (Kirmayer & Minas, 2000).

Transcultural psychiatry faces criticism for its colonial ties and for pathologizing non-Western cultures, often leading to the disappearance of Indigenous healing practices and reinforcing colonial power dynamics (Kirmayer, Gone, & Moses, 2014; Summerfield, 2001). Ethical concerns arise regarding power dynamics, informed consent, cultural sensitivity, and potential harm, particularly when research lacks community involvement and understanding of local contexts (Hinton & Jalal, 2014).

To promote equitable and culturally responsive mental health care, transcultural psychiatry must adopt a contextualist approach, confront colonial legacies, prioritize ethical considerations, and embrace community-based methods that empower marginalized communities (Kirmayer, Gone, & Moses, 2014).

iii) Jed Boardman's Work on Social Inclusion in PTSD

Boardman (2011) emphasizes the importance of social determinants in mental health, particularly in PTSD recovery. He highlights the significance of support networks, stable housing, and employment opportunities. His advocacy for policies promoting social inclusion has influenced policy development at various levels. Boardman underscores the need for a holistic approach to mental health care, addressing social determinants alongside clinical interventions. He advocates for initiatives like reducing stigma, increasing access to mental health services, and creating supportive environments for trauma survivors. His research has identified barriers to social inclusion and strategies to overcome them, emphasizing the role of stigma, discrimination, and structural inequalities.

Boardman engages diverse stakeholders, including individuals with lived experience, carers, and community organizations. He ensures that trauma survivors and their support networks are involved in decision-making, fostering effective recovery. His

comprehensive support services include trauma-informed therapy, housing assistance, vocational rehabilitation, and peer support programs. Critics argue that Boardman's work may not fully address the unique challenges faced by individuals with PTSD, such as symptoms impacting social engagement. His efforts to reduce stigma must also address misconceptions and stereotypes. Furthermore, his work may not adequately consider the experiences of marginalized groups, including race, ethnicity, gender identity, sexual orientation, and socioeconomic status, which can exacerbate social exclusion.

While Boardman acknowledges the impact of social factors on mental health, he may overlook broader structural issues like poverty and unemployment, requiring systemic interventions. His emphasis on individual resilience and recovery might neglect systemic barriers perpetuating social exclusion for marginalized groups.

Bowleg (2012) argues that Boardman's framework may not fully address the intersectional nature of PTSD in marginalized groups. Ensuring diversity and inclusivity in research and advocacy is crucial to address various forms of discrimination and exclusion. Despite identifying promising strategies for social inclusion, applying these findings to effective policies and practices for PTSD remains challenging. Critics argue that community-based services may overlook the need for specialized, trauma-focused therapies.

In conclusion, Jed Boardman's work on social inclusion in mental health has been instrumental in raising awareness and shaping policy. However, ongoing efforts are needed to address structural inequalities, empower marginalized voices, and translate research findings into meaningful policy and practice changes.

iv) Empire of Trauma: An Inquiry into the Condition of Victimhood

In "Empire of Trauma," Fassin and Rechtman (2009) critically examine the conceptualisation and institutionalisation of trauma in contemporary society, focusing on its implications for understanding and managing human suffering. They argue that trauma has become a dominant framework for perceiving and addressing suffering, with institutions and discourses significantly shaping and controlling narratives of victimhood. This review evaluates their arguments and provides evidence to support or challenge their claims.

Fassin and Rechtman (2009) assert that trauma has been institutionalised and medicalised, emerging as a central category for understanding human suffering. They describe how a standardised narrative of trauma has been created and recognised by various institutions, medical establishments, humanitarian organisations, and the media. They point out that some forms of trauma are legitimised over others, creating hierarchies of victimhood influenced by political and social factors, which leads to the privileging of some victims while marginalising others (Ticktin, 2011).

Research supports the increasing medicalisation of trauma, as seen in the expansion of the PTSD (Post-Traumatic Stress Disorder) diagnostic category in the DSM (Diagnostic and Statistical Manual of Mental Disorders). Studies by Young (1995) and Summerfield (2001) suggest that medicalising trauma can result in standardised treatment approaches that may overlook the diverse experiences and needs of trauma survivors.

The concept of hierarchies of victimhood is supported by evidence that certain traumatic events receive more attention and resources than others. Western media and humanitarian organisations often prioritise specific conflicts and disasters, leaving

others with minimal attention (Cohen, 2001; Kinnvall & Rydgren, 2012). This selectivity influences which victims are seen as deserving of sympathy and aid, reinforcing hierarchies among survivors.

Fassin and Rechtman (2009) argue that the depoliticisation of suffering is evident in critiques of humanitarian interventions, which often address individual trauma without considering broader social and political contexts. Research by Bracken et al. (1995) and Pupavac (2001) indicates that such approaches may ignore the root causes of violence and suffering, perpetuating existing power imbalances.

The authors propose that trauma is intertwined with social, cultural, and historical factors and can be utilised by powerful institutions to advance their agendas. By situating trauma within broader structures of power and inequality, Fassin and Rechtman (2009) highlight how certain groups are disproportionately affected and often denied recognition, resources, and support. They advocate for a more inclusive and intersectional approach to understanding and addressing human suffering.

However, some critics argue that "Empire of Trauma" may be limited by its theoretical framework. Critics like Das (2015), Ticktin (2014), and Biehl & Petryna (2013) suggest that the reliance on poststructuralist and postcolonial theory could restrict its accessibility. Additionally, there may be an overemphasis on institutional roles in shaping trauma narratives, potentially neglecting the agency of individuals and communities (Kirmayer, 2007).

Fassin and Rechtman's focus on the social construction of trauma might also underplay biological and psychological aspects. Research by Van der Kolk (2014) shows that trauma can significantly affect the brain and body, indicating that a comprehensive understanding of trauma should integrate both social and biological perspectives

(Cloitre et al., 2013; McNally, 2003). Moreover, their analysis might not fully address how different cultural and historical contexts influence the understanding and management of trauma (Kirmayer et al., 2007). While the concept of the "empire of trauma" is useful for understanding global trends, it may overlook local practices and cultural beliefs about suffering and healing. Fassin and Rechtman (2009) challenge practitioners to reconsider their assumptions about victimhood and seek more just and equitable responses to human suffering.

v) Psychology, Mental Health, and Distress

Harper, Cromby, and Reavey (2013) are influential figures in critical psychology who have made significant contributions to challenging traditional understandings of mental health, including post-traumatic stress disorder (PTSD). Their work offers a critical perspective on the socio-political and cultural dimensions of PTSD. They highlight how psychiatric diagnoses and treatments can pathologize normal human experiences and perpetuate social inequalities (Wilkinson & Pickett, 2018). Additionally, Harper, Cromby, and Reavey identify the limitations of diagnostic categories and advocate for a more holistic and contextualized approach to understanding psychological distress. They propose moving away from the medicalization of mental health toward more collaborative and empowering models of care that prioritize individuals' agency and autonomy (Perkins & Repper, 2016; Frances, 2013).

By deconstructing dominant narratives of mental illness, they create opportunities for more nuanced understandings that consider the broader socio-cultural context. A key aspect of their work is the critique of the medicalization and individualization of PTSD, demonstrating their strength in this area (Conrad, 2007). They argue that

mainstream approaches to PTSD often pathologize normal responses to trauma and overlook the socio-cultural factors that shape individuals' experiences of distress (Cromby, Harper, & Reavey, 2013). Emphasizing the social construction of PTSD, they highlight the importance of considering broader contextual factors such as social inequalities, power dynamics, and cultural differences (Harper, 2016).

Moreover, their work questions the prevailing portrayal of PTSD as a fixed and universally applicable diagnosis. They argue that PTSD is not a fixed entity but rather a dynamic and multifaceted phenomenon shaped by individual experiences and sociocultural contexts (Harper & Speed, 2012). This perspective underscores the diversity within PTSD and emphasizes the necessity for individualized approaches to assessment and intervention.

Harper, Cromby, and Reavey's critique of trauma-focused interventions prompts significant inquiries into the effectiveness and ethical considerations surrounding traditional treatments for PTSD. They argue that interventions such as exposure therapy and cognitive-behavioural therapy may not be suitable or beneficial for all individuals, particularly those from marginalized groups and non-Western cultures. This critique advocates for a more pluralistic and inclusive approach to PTSD treatment, recognizing the diversity of individuals' experiences and preferences. They argue that psychological experiences are deeply intertwined with social structures, power dynamics, and cultural norms. This viewpoint highlights the importance of addressing social inequalities and advocating for social justice as integral elements of mental health interventions. Conversely, Hofmann et al. (2012) and Leucht et al. (2013) argue that evidence-based treatments such as cognitive-behavioural therapy (CBT) and pharmacotherapy have demonstrated significant efficacy in treating various

mental health disorders. Therefore, these approaches, which often originate from a biomedical understanding, should not be dismissed in favour of purely sociocultural models.

However, some critics have raised concerns about the potential limitations of their approach. While their emphasis on the socio-political dimensions of PTSD is valuable, there is a risk of underestimating the biological and neurological aspects of trauma and distress (Craddock & Sklar, 2009). Critics have also questioned the practical implications of their theoretical framework. While their critiques of mainstream psychology are insightful, there is a need for more concrete strategies for transforming clinical practice and mental health policy. Additionally, the focus on social and cultural factors could potentially overlook the role of individual biology and genetics in shaping psychological experiences (Sullivan, Kendler, & Neale, 2003). The focus on social constructionism and critical theory may limit the applicability of their work to clinical practice and policy development.

In summary, the collective work of David Harper, John Cromby, and Paula Reavey significantly enriches critical psychology and enhances our understanding of mental health and PTSD. By questioning established paradigms and emphasizing the socio-political aspects of psychological phenomena, they pave the way for new avenues in research, application, and advocacy within the mental health field. Nonetheless, further inquiry is needed to bridge the gap between theoretical insights and practical implementation, aiming for a more comprehensive approach.

vi) "Power, Resistance, and Liberation in Therapy with Survivors of Trauma: To have our hearts broken"

In Power, Resistance, and Liberation in Therapy with Survivors of Trauma: To Have Our Hearts Broken (Afuape, 2011), Afuape critiques traditional trauma therapy by emphasizing the need to address power dynamics, resistance, and social justice. As a systemic psychotherapist and scholar, Afuape argues that conventional approaches often reinforce power imbalances, with therapists exerting control over clients. She advocates for a collaborative, egalitarian therapeutic model that respects the autonomy and expertise of PTSD survivors. This perspective aligns with Empowerment Theory (Perkins & Zimmerman, 1995), which focuses on helping individuals regain control and access resources, supporting Afuape's vision of therapy as a tool for both personal healing and social transformation.

Afuape (2011) argues that resistance in therapy is a natural reaction to oppression and injustice. Rather than seeing resistance as an issue, she views it as a means for individuals to assert their dignity and control. This perspective aligns with Liberation Psychology, which sees resistance as a healthy response to social and political oppression (Martín-Baró, 1994). The Trauma-Informed Care framework (Harris & Fallot, 2001) acknowledges that resistance can help trauma survivors protect themselves and maintain control. Addressing clients' resistance can enhance trust, collaboration, and empowerment in therapy. Afuape (2011) highlights how power dynamics, driven by systemic inequalities and social injustices, can worsen trauma. Recognising these dynamics helps therapists create a more supportive environment for survivors. The Critical Social Work approach (Fook, 2016) also supports this, focusing on systemic inequalities and promoting practices that empower clients

Moreover, Afuape highlights that personal trauma is often connected to larger social and political issues. She emphasizes how structural violence, racism, sexism, and other forms of oppression negatively impact mental health. Afuape urges therapists to consider these factors when working with trauma survivors. Studies have shown that structural violence, such as poverty and discrimination, significantly impacts mental health, exacerbating trauma and hindering recovery (Farmer, 2004). Research indicates that racism contributes to chronic stress and mental health issues, reinforcing the need for therapists to address racial trauma in their practice (Carter, 2007). Similarly, studies reveal that sexism and gender-based violence negatively affect women's mental health, supporting the need for gender-sensitive approaches in therapy (Kimerling et al., 2009).

Research supports Afuape's assertions about the interconnectedness of personal and collective trauma and its contextual influences. For example, studies have consistently shown that individuals from marginalized and oppressed communities, such as racial minorities, LGBTQ+ individuals, and socioeconomically disadvantaged groups, experience disproportionately higher rates of trauma and PTSD compared to the general population (Williams et al., 2007; Breslau et al., 1998). Furthermore, research shows how social, cultural, and historical factors shape experiences of trauma within these communities. A meta-analysis by Kira et al. (2010) highlighted that exposure to discrimination, violence, and structural inequalities significantly increases the risk of PTSD among minority groups. This exposure not only impacts individual mental health but also perpetuates cycles of trauma within communities over generations (Kira et al., 2019).

Therapeutic approaches that acknowledge these systemic influences have been shown to be more effective in addressing trauma within marginalized groups. For instance, interventions that incorporate a culturally sensitive and trauma-informed framework have demonstrated better outcomes in reducing PTSD symptoms and promoting recovery (Hinton et al., 2013; Sue et al., 2009). Afuape's insights into the connection between personal and collective trauma, influenced by social, cultural, and historical contexts, align with empirical evidence highlighting the impact of systemic factors on trauma experiences. Understanding these dynamics is crucial for developing interventions that support social justice and create equitable environments for trauma survivors.

Research offers insights into critiques of the emphasis on power, resistance, and social justice in therapy, as advocated by Afuape, and its implications for understanding trauma and therapeutic practice. Critics argue that focusing primarily on social justice and systemic factors might overlook the complexity of individual psychological processes in trauma. For instance, Cloitre et al. (2009) emphasize the variability in trauma responses among individuals, highlighting the need for personalised therapeutic approaches that address both social contexts and individual psychological dynamics.

Ethical and boundary issues can also arise; integrating social justice principles into therapy can present ethical challenges for therapists. Gelso and Hayes (2007) discuss the complexities therapists face when advocating for systemic change outside the therapeutic relationship, including navigating professional boundaries and potential role confusion. While Afuape's approach emphasizes social and cultural factors in

trauma, critics argue it is important not to overshadow the individual's unique experiences.

Lewis-Fernández et al. (2016) emphasize the importance of cultural competence in therapy, focusing on individual psychological processes and trauma responses. Integrating social justice into therapy supports advocacy for systemic change, but addressing each person's feelings and navigating ethical issues remains essential.

In conclusion, Power, Resistance, and Liberation in Therapy with Survivors of Trauma: To Have Our Hearts Broken provides a thought-provoking perspective on trauma therapy. Afuape highlights power, resistance, and social justice, urging therapists to reflect deeply on their work and actively pursue healing, empowerment, and social change. While her ideas may spark debate, they significantly contribute to discussions about ethics, politics, and the therapist's role in social change.

vii) The Myth of Mental Illness

In his influential book "The Myth of Mental Illness" (1961), Thomas Szasz challenges the concept of mental illness and psychiatric treatment of psychological problems. Szasz argues that "mental illness" is a metaphor, not a genuine medical condition, asserting that psychological issues stem from personal or social conflicts rather than biological causes. Research in medical sociology and other studies support Szasz's view, showing that mental health is shaped by social and cultural factors. This suggests we need to understand psychological distress through personal experiences and social contexts, not merely biological factors (Horwitz, 2002; McLaren, 2003)).

Szasz also questions the ethics of labelling psychological distress as mental illness. He believes such labelling can stigmatise individuals, coerce them into treatment, and reduce personal freedom. Szasz highlights how psychiatric diagnoses and treatments

are influenced by social and political factors, warning of potential misuse of power in the mental health system. In contrast, Kendler (2005) criticises Szasz for oversimplifying mental health issues by neglecting genetic, biological, and environmental factors. Kendler emphasises the importance of a multifactorial model in understanding psychiatric conditions.

Sullivan et al. (2012) highlight the genetic underpinnings of psychiatric disorders such as schizophrenia and bipolar disorder, showing a significant heritable component. These findings suggest genetic factors contribute to the risk and manifestation of mental health disorders, challenging Szasz's view that mental illnesses are merely problems in living. Insel (2010) discusses the neurobiological aspects of schizophrenia, including abnormalities in brain structure and function. He argues that understanding these biological aspects is crucial for developing effective treatments, countering Szasz's claim that mental illnesses lack a biological basis. Paris (2015) acknowledges the importance of social context but argues that rejecting the medical model entirely ignores substantial evidence of biological contributions to mental illnesses. He advocates for a balanced perspective that integrates social and biological insights.

Thomas Szasz's seminal work, "The Myth of Mental Illness," presents a provocative critique of conventional psychiatric practices and concepts of mental health. While his ideas have influenced discussions on various mental health conditions, including PTSD (Post-Traumatic Stress Disorder), his views on mental illness and psychiatry require critical analysis, particularly regarding PTSD. Szasz might view PTSD through social constructionism, suggesting it is a label imposed by society to medicalise distressing responses to trauma. He might argue that involuntary hospitalisation or

medication could silence dissent or control individuals who challenge dominant social norms or political structures. However, this argument overlooks the genuine suffering experienced by individuals with PTSD and the benefits of psychiatric interventions in alleviating their symptoms and improving their quality of life.

Furthermore, Szasz's perspective downplays the biological and psychological underpinnings of PTSD. While social and cultural factors influence how PTSD is conceptualised and experienced, research consistently demonstrates the role of neurobiological mechanisms in trauma response and recovery (Kendler, 2005). Ignoring these biological factors oversimplifies PTSD and hinders the creation of effective treatments (Caspi & Moffitt, 2006).

In conclusion, while Thomas Szasz's critique of psychiatry and mental illness has sparked important debates, his perspective on PTSD and mental health requires scrutiny. Recognising the social and political dimensions of psychiatric diagnosis and treatment is essential, but so is acknowledging the biological and psychological realities of PTSD. An integrated approach considering both social context and individual experience is necessary for a comprehensive understanding of PTSD and for developing effective interventions and support systems.

viii) The Politics of Experience and the Bird of Paradise

"The Politics of Experience and The Bird of Paradise," written by Scottish psychiatrist R.D. Laing in 1967, critiques traditional psychiatric theories and practices. Laing presents a radical view on madness, sanity, and the individual's perception of reality, arguing that what society labels as 'madness' can often be a rational response to an irrational world. Supported by his extensive clinical observations, Laing critiques the

psychiatric establishment for pathologizing normal human experiences and suppressing individuality.

Laing argues that mental distress occurs when individuals cannot align their personal experiences with societal expectations. He introduces the idea that mental illness can be a response to social and family pressures, not just biological or neurological factors. This concept challenged the traditional medical views of psychiatry at the time. In "The Politics of Experience," Laing discusses "ontological insecurity," the deep anxiety people feel when their sense of self and reality is threatened. He believes that societal norms and institutions impose restrictive rules, leading to feelings of alienation, isolation, and confusion, often manifesting as symptoms of mental illness.

Studies support Laing's perspective. For example, the WHO (2014) found that social factors like poverty, violence, and discrimination significantly impact mental health. Wilkinson and Pickett (2009) showed that societies with high inequality have higher rates of mental illness, suggesting societal structures play a crucial role in mental well-being.

Laing also argues that psychiatry often maintains social order by controlling those who act differently, pushing them to the margins and stripping them of power (Boyle, 2013). He challenges psychiatric institutions' authority, advocating for a more compassionate approach to mental distress. However, Laing's work has faced criticism, particularly regarding its practical application. Critics argue that his emphasis on subjective experience and socially constructed reality might undermine psychiatric diagnosis and treatment, ignoring biological factors. Neuroscience and genetics research has shown that biological factors significantly influence mental health disorders (Kandel, 1998; Sullivan et al., 2000). Bentall (2004) points out that

while understanding patients' experiences is crucial, considering biological and medical aspects ensures comprehensive care. The National Institute of Mental Health (2020) emphasizes the need for understanding both biological and psychological aspects to develop effective mental health interventions.

Johnstone (2010) argues that Laing's dismissal of standard psychiatric methods can be neglectful, suggesting some conditions require medical treatment. Laing's concept of ontological insecurity is relevant to understanding PTSD, where trauma disrupts basic beliefs about safety, trust, and control, causing deep insecurity and disconnection (Herman, 1997). This aligns with Laing's views on the effects of societal norms.

Laing's ideas about social and family relationships contributing to mental distress are crucial for understanding PTSD. Traumatic events often occur in relational contexts, and societal influences shape responses to trauma. Research supports this, showing that social support and cultural context significantly impact trauma recovery (Norris & Aroian, 2008; Kirmayer et al., 2014).

Laing's critique of conventional PTSD treatment aligns with broader criticisms in mental health. Traditional treatments, such as medication and cognitive-behavioural therapy (CBT), focus on symptom reduction but may overlook deeper emotional and interpersonal dimensions of trauma. Research indicates that while medication can reduce acute symptoms, it may not address the underlying existential distress trauma survivors experience (Bisson et al., 2013). Similarly, CBT primarily focuses on restructuring negative thoughts and behaviours but may not fully address the profound disruptions caused by trauma (Schnyder et al., 2015).

Laing emphasizes that treating PTSD symptoms alone may neglect trauma survivors' deep sadness and identity loss (Laing, 1965). This underscores the need for therapy that addresses trauma comprehensively, helping survivors understand their emotions and repair relationships (Herman, 1997).

Critics of Laing's approach argue that it may ignore biological aspects of mental illness, such as in PTSD. They acknowledge the importance of psychosocial factors but emphasize that PTSD involves complex biological changes. Research shows PTSD affects brain areas like the hippocampus, amygdala, and prefrontal cortex, which are involved in memory, emotions, and stress (Bremner, 2006; Shin et al., 2006). Disruptions in neurotransmitters like serotonin, norepinephrine, and dopamine also play a role (Yehuda & LeDoux, 2007; Pitman et al., 2012). Advances in neuroimaging have provided insights into PTSD symptoms, highlighting the need to consider both psychosocial and biological factors in treatment (Etkin & Wager, 2007; Hayes et al., 2012).

In conclusion, "The Politics of Experience and The Bird of Paradise" offers a thought-provoking framework for understanding PTSD and psychological distress. Laing challenges us to view mental illness through a lens that incorporates biology, psychology, society, existence, and politics, advocating for a more comprehensive approach to trauma and recovery.

ix) Michel Foucault's "Madness and Civilization”

Michel Foucault's "Madness and Civilization," published in 1961, is a key work in critical theory and the history of psychiatry. It examines the evolution of Western society's treatment of madness from the Renaissance to modern times, emphasising how societal institutions have shaped and controlled perceptions of madness. Foucault argues that madness was used to control people, with asylums and prisons isolating and marginalising those deemed "mad" (Scull, 2011; Foucault, 1965). He demonstrates how power, knowledge, and societal views on madness are interconnected, suggesting that definitions and treatments of madness are more about power than the actual condition of individuals. He highlights how institutions maintain social order by defining what is "normal" and "abnormal."

However, critics question the scope and accuracy of Foucault's historical analysis. Some argue that his portrayal of pre-modern societies as tolerant of madness oversimplifies history. Roy Porter notes that while some societies were tolerant, others treated the mentally ill harshly (Porter, 1987). Scull (2015) supports this, indicating significant variations in the treatment of madness across cultures and periods, suggesting Foucault's view of pre-modern acceptance might be idealised.

Other critics contend that Foucault's focus on discourse and power neglects the personal experiences of those with mental illness. By treating madness solely as a social construct, he might overlook the real-life struggles of affected individuals. Davidson and Roe (2007) emphasise the importance of personal narratives in understanding mental illness, arguing for a balanced approach that includes both Foucault's views and individual experiences. Slade (2009) supports this, suggesting

that incorporating personal recovery narratives can improve mental health services and outcomes.

Foucault's work has also been criticised for not sufficiently addressing how gender, race, and class intersect with the understanding of madness. Critics argue that his analysis falls short in examining the specific impacts of racism and sexism on experiences of madness and marginalisation (Fraser, 1990; Nicholson, 1990). While Foucault does not directly address PTSD, his exploration of societal norms and their role in constructing and regulating madness offers a framework for understanding the historical conceptualisation and management of PTSD (Scull, 1989; Young, 1995). This reveals both the strengths and limitations of Foucault's work in understanding PTSD (Summerfield, 2001).

One of Foucault's strengths is his analysis of how societal institutions shape perceptions of madness and control those labelled mentally ill. He traces the evolution of psychiatric discourse and practices, showing how madness has been increasingly medicalised (Foucault, 1961). This historical perspective helps clarify how conditions like PTSD are framed within psychiatric discourse and institutional power structures. Foucault's focus on the social and cultural aspects of madness provides insights into the broader context in which PTSD is understood and treated.

However, Foucault's approach has limitations. His analysis, which primarily examines the historical treatment of mental illness in Western societies, does not focus extensively on trauma and its psychological effects (Foucault, 1961). While relevant, his ideas on power dynamics may not fully capture the complexities of trauma. Critics also argue that Foucault does not give enough importance to the personal experiences and choices of individuals with mental illness (Foucault, 1961; Van der Kolk, 2014).

His emphasis on power relations could overshadow the perspectives of those directly affected by PTSD, potentially neglecting their unique experiences.

x) Madness Explained: Psychosis and Human Nature

In "Madness Explained: Psychosis and Human Nature," Richard Bentall primarily discusses psychosis but also offers insights applicable to other mental health issues, such as PTSD. Bentall challenges traditional psychiatry, advocating for a comprehensive view that includes biological, psychological, and social factors, aligning with the biopsychosocial model used in modern psychiatry and psychology (Engel, 1977).

Research supports Bentall's approach, indicating that PTSD and other mental health issues stem from a mix of factors. Biological factors include genetics and the brain's response to stress (Yehuda, 2002). Psychological factors involve trauma response, coping methods, and personality traits (Brewin, Andrews, & Valentine, 2000). Social factors encompass support systems, cultural background, and ongoing stress (Charuvastra & Cloitre, 2008). Bentall's views on the complexity of mental illness are relevant to PTSD, which involves not just the traumatic event but also how individuals and their environments manage the experience over time. Studies show that integrating biological, psychological, and social approaches enhances the understanding and treatment of PTSD (Herman, 1992).

Bentall advocates for a biopsychosocial approach that recognises the influence of biological, psychological, and social factors on mental health outcomes. This perspective is particularly relevant to PTSD, where trauma exposure profoundly affects the brain, behaviour, and psychological well-being. PTSD often arises from events that challenge an individual's sense of safety, control, and trust. Bentall's

conceptualisation of mental illness as a response to distressing life experiences aligns with the understanding of PTSD as a natural reaction to trauma.

Bentall's critique of stigma and discrimination in mental illness is pertinent to PTSD as well. People with PTSD often face social stigma and misunderstandings, leading to feelings of shame and isolation. Bentall advocates for kinder, more supportive language about mental health to reduce stigma. His work promotes a compassionate view of PTSD and other trauma-related disorders, fostering acceptance and understanding. Research supports the idea that stigma significantly impacts people with PTSD. Hoge et al. (2004) found that social stigma worsens mental health outcomes and deters help-seeking. Another study showed that support and understanding improve recovery and overall health in PTSD sufferers (Pietrzak et al., 2010). These findings highlight the importance of reducing stigma and promoting a compassionate approach to mental health.

While Bentall's book mainly focuses on psychosis and does not cover all aspects of PTSD, it acknowledges that trauma and adversity can lead to psychosis. PTSD, however, has distinct symptoms like flashbacks, avoidance, and hyperarousal, requiring specific treatments not covered in Bentall's work (American Psychiatric Association, 2013). Bentall's research on psychosis emphasises trauma and adversity as significant risk factors, detailed in his book "Doctoring the Mind" (Bentall, 2009).

In conclusion, Richard Bentall's "Madness Explained: Psychosis and Human Nature" provides valuable insights into the biopsychosocial model of mental illness and the importance of contextualising individuals within their social and cultural environments. Bentall challenges conventional psychiatric paradigms by advocating for a holistic approach to mental health, highlighting the complexity of mental illnesses

beyond biological factors alone (Bentall, 2004). This perspective aligns with contemporary research emphasising the need for compassionate and culturally sensitive care in treating PTSD and other mental health conditions (Summerfield, 2001; Kirmayer et al., 2011). Bentall's contributions enrich the ongoing debate on mental illness, promoting an integrated approach that considers biological, psychological, and social dimensions (Bentall, 2004).

xi) Madness and Subjectivity: A Cross-cultural Examination of Psychosis

"Madness and Subjectivity: A Cross-Cultural Examination of Psychosis in the West and India" by Ayurdhi Dhar explores the cultural differences in experiencing psychosis in Western and Indian contexts. While the book primarily focuses on psychosis, it also provides insights into understanding PTSD across different cultural settings. Dhar's analysis highlights the diverse ways trauma is perceived and experienced across cultures, emphasizing the importance of cultural context in interpreting trauma responses. She critiques Western psychiatric frameworks for their limitations in addressing the needs of non-Western cultures, advocating for culturally sensitive and contextually informed approaches.

Luhrmann et al. (2015) demonstrate how cultural contexts influence the experience of hearing voices, a common symptom of psychosis, indicating that cultural beliefs significantly shape the interpretation and management of psychotic symptoms. Similarly, Hinton and Good (2016) show that cultural factors affect the manifestation and treatment of PTSD in Cambodian genocide survivors, even without psychosis.

Dhar examines different healing practices in Western and Indian cultures, stressing the need to respect cultural differences in trauma recovery. However, her discussion lacks clear practical guidelines for treating PTSD. Research supports the integration of

diverse healing methods for effective PTSD treatment (Bisson et al., 2013; Gone & Kirmayer, 2010). Additionally, cultural, social, and economic factors significantly influence how people experience and cope with trauma (Williams & Mohammed, 2009).

Dhar explores how cultural, social, and economic factors affect people's experiences with trauma and mental illness, noting that trauma often impacts marginalized communities more severely. She calls for a more inclusive approach to studying and treating trauma, recognizing the potential for cross-cultural collaboration in integrating diverse healing modalities (Jones, 2018).

Although the book primarily addresses psychosis, it provides valuable insights into how different cultures view psychosis and its connection to trauma. By critically examining Western psychiatric methods and exploring various cultural healing practices, Dhar broadens our understanding of trauma in different cultural contexts (Dhar, 2020; Smith, 2019; Jones, 2018).

xii) Posttraumatic Stress Disorder: Issues and Controversies

Gerald Rosen's "Posttraumatic Stress Disorder: Issues and Controversies" provides a comprehensive analysis of PTSD, exploring its history, diagnosis, prevalence, causes, and treatments. Rosen (2004) delves into both established facts and ongoing debates, emphasising the roles of biological, psychological, and social factors in understanding PTSD.

However, Rosen's work is highly specialised and often requires advanced knowledge in psychology or psychiatry. This aligns with Snow's (2010) findings on the challenges non-experts face with technical literature. Furthermore, the book's emphasis on controversies may detract from practical treatment strategies. Rosen scrutinises

contentious topics such as diagnostic criteria, trauma memory, and treatment efficacy, aligning with Hoge et al. (2004) and Brewin (2014), who highlight similar debates regarding PTSD diagnosis and memory complexities. This critical approach can enhance critical thinking, as suggested by King and Kitchener (1994).

Rosen's synthesis of empirical research provides a thorough critique of existing studies, identifying strengths and methodological flaws. He highlights significant gaps in PTSD literature, particularly the lack of longitudinal studies essential for understanding PTSD's chronic nature and long-term effects. Yehuda and LeDoux (2007) also stress the importance of such research for capturing the evolving impact of PTSD on health. Another critical issue Rosen highlights is the need for diverse sample populations in PTSD research. Current studies often rely on homogeneous groups, limiting their generalisability. Hinton and Lewis-Fernández (2011) advocate for including culturally diverse populations, emphasising that cultural factors significantly influence PTSD symptoms and experiences.

Rosen calls for more practical research approaches that account for cultural and socio-economic contexts. Traditional methodologies may miss unique stressors and coping mechanisms in diverse populations. Jones and Wessely (2007) and Marsella et al. (1996) support this, noting that cultural differences affect PTSD expression and coping strategies, necessitating specific research and clinical approaches.

Despite Rosen's comprehensive review, there are concerns about the applicability of findings across diverse populations. PTSD research often focuses on military personnel or disaster survivors, potentially overlooking groups like refugees or domestic violence victims. Rosen acknowledges this and calls for inclusive research designs that capture diverse experiences, supported by studies showing different PTSD

manifestations across cultures (Marsella, 2010; Hinton & Lewis-Fernández, 2011). The rapidly evolving nature of PTSD research is another critical point. Emerging findings, especially in neuroimaging and genetics, challenge previous beliefs and offer new insights into PTSD (Koenen et al., 2017). This dynamic field requires periodic updates to Rosen's synthesis to reflect the latest research findings.

In conclusion, Rosen's examination of PTSD is invaluable, offering a detailed synthesis of empirical research and critical evaluation of existing studies. While concerns about generalisability and the evolving nature of the field are valid, Rosen's work remains a crucial resource for clinicians, researchers, and students in trauma psychology. His balanced approach ensures the book is both informative and thought-provoking.

xiii) Eye Movement Desensitization and Reprocessing (EMDR) – conceptualise the phenomenon

Eye Movement Desensitisation and Reprocessing (EMDR) therapy, developed by Francine Shapiro, is a well-established approach for treating post-traumatic stress disorder (PTSD) and other trauma-related conditions (Shapiro, 2018). Although EMDR follows a structured therapeutic model, it recognises and incorporates the importance of cultural differences in therapy (Hofmann et al., 2016). EMDR therapists are encouraged to be mindful of and sensitive to their clients' cultural backgrounds. Understanding cultural contexts aids therapists in interpreting clients' experiences and responses more accurately. This cultural sensitivity fosters rapport and trust, which are essential for effective therapy (Sue et al., 2012).

Cultural backgrounds can affect how individuals perceive and interpret traumatic events. For instance, cultural norms, values, and beliefs can influence the meaning

clients attribute to their trauma and their coping mechanisms. EMDR therapists take these cultural factors into account when assessing the impact of trauma and during the desensitisation process (Shapiro, 2018).

While the core EMDR protocols remain consistent, therapists may need to adapt certain elements of the therapy to suit the client's cultural context. This may involve modifying language, examples, or even the implementation of specific protocols to better align with the client's cultural experiences and values (Shapiro & Laliotis, 2011). EMDR therapy is inherently client-centred, meaning that therapists focus on the individual experiences and perspectives of the client (Shapiro, 2018). This approach is sufficiently flexible to accommodate cultural differences, allowing therapists to tailor their interventions according to the client's unique cultural context.

By including cultural factors in the EMDR framework, therapists aim to offer better and more understanding care. This method helps in dealing with how cultural aspects affect trauma and healing, making sure therapy respects and meets the varied needs of clients.

xiv) Psychodynamic Therapy – conceptualise the phenomenon

In psychodynamic theory, cultural differences are recognised as significant factors that influence both the therapist's and the client's interpretations and understandings of experiences and appraisals (McWilliams, 2011). This theory emphasises how early experiences shape the development of the self, with cultural factors playing a crucial role in this process (Blass, 2004). For instance, values, norms, and family dynamics specific to a culture shape the formation of identity and interpersonal relationships (Rothbaum et al., 2000). Different cultures have unique ways of understanding and expressing emotions, norms for family dynamics, and attitudes towards authority and

autonomy (Kagitcibasi, 2007). These cultural elements can impact the client's internal world and their way of processing experiences (Marsella & Leong, 1996).

Clients may project culturally influenced expectations, beliefs, or experiences onto the therapist. For example, if a client comes from a culture that places a high value on respect for authority figures, they might unconsciously expect the therapist to adopt a more authoritative role (Hofstede, 2001). Therapists' own cultural backgrounds, biases, and experiences can shape how they respond to clients (Sue & Sue, 2016). A therapist's cultural assumptions might colour their interpretations of the client's behaviours and emotions (Paniagua, 2013). Psychodynamic therapists need to be aware of their own cultural biases and how these might influence their interpretations. This awareness aids in understanding clients' behaviours and narratives within their cultural context rather than imposing a potentially culturally biased perspective (Ting-Toomey, 1999).

Psychodynamic therapy often focuses on the relational dynamics between therapist and client. Cultural differences can affect these dynamics in various ways, such as how clients perceive the therapist's responses or how therapists interpret the client's communication styles (Gergen, 2001). Psychodynamic theory acknowledges that cultural differences significantly impact both therapists and clients. Effective psychodynamic practice involves being mindful of these differences, understanding how they influence internal processes and relational dynamics, and approaching therapy with cultural sensitivity and openness (Sue et al., 2012).

xv) Integrative Therapy – conceptualise the phenomenon

Integrative therapy combines elements from various therapeutic approaches to tailor treatment to individual needs and recognises the crucial role of cultural differences in the therapeutic process (Norcross & Wampold, 2018). It acknowledges that clients' cultural backgrounds can significantly influence how they perceive and express their experiences (Sue & Sue, 2016). Therapists trained in this approach are sensitive to these cultural contexts, helping to avoid cultural biases and misinterpretations (McGoldrick et al., 2005).

Rather than adhering to a one-size-fits-all model, integrative therapy employs a flexible framework, adapting methods to fit the client's cultural context (Jordan & Hinds, 2016). Therapists often collaborate with clients to explore how cultural values and beliefs impact their appraisals and therapeutic goals, ensuring that interventions remain relevant and respectful (D'Andrea & Daniels, 2007).

Therapists are encouraged to reflect on their own cultural biases to accurately interpret clients' appraisals and avoid imposing their own cultural norms (Atkinson et al., 2008). Developing cultural competence, which includes knowledge of various cultural practices and values, is essential for understanding clients' experiences within their cultural context and for strengthening the therapeutic alliance (Sue et al., 2019).

By integrating different therapeutic methods, therapists can address a broader range of issues influenced by cultural factors. For instance, combining cognitive-behavioural techniques with narrative therapy can enhance understanding and work with culturally influenced narratives (White & Epston, 1990). In summary, integrative therapy values cultural differences as crucial for understanding and interpreting clients' experiences,

aiming to provide respectful and effective care that honours each client's unique cultural background (Norcross & Wampold, 2018).

3.15 Outcome of Literature Review and Research Questions

Research is even more limited when examining the impact of cultural differences on how therapists interpret and understand clients' appraisals in PTSD. Therapists' understanding, interpretation, and making sense of clients' appraisals from a cultural perspective are crucial, as this could provide valuable information to enhance the quality of psychological adjustment for individuals with PTSD. A broader review of the literature encompasses decolonising Western psychopathology, transcultural psychiatry, social inclusion, victimhood, distress, resistance, liberation in therapy for trauma survivors, the myth of mental illness, politics, madness, and cross-cultural aspects. This provides a comprehensive historical and contemporary background for exploring the impact of cultural differences on how therapists interpret and understand clients' appraisals in PTSD.

My study aims to bridge the gap in knowledge and improve cognitive therapeutic interventions for clients with PTSD. Based on the literature review, the research questions are as follows:

i) To explore the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in PTSD.

ii) To explore the impact of cultural differences on clients' appraisals in PTSD.

At this stage, it is important to explain the research methodology and methods in the following chapter.

Chapter 4

4.0 Research Philosophy and Methodology

This section discusses the importance of research methodology in my study. After considering various methodologies, I have selected the most appropriate one and provided justification for my choice. The methodology chapter is crucial as it outlines the methods used to generate my results, explains my perspective, and provides the rationale behind my chosen approach. This demonstrates my competence and clarity in conducting the study.

Research methodology involves the methods used in psychotherapy as well as the underlying theories and principles that inform an approach aligned with my objectives. It is also known as the philosophical theory of how research should be conducted (Saunders et al., 2015). Including a methodology chapter in my thesis is essential as it details the methods, justifies them, and acknowledges their limitations.

Goundar (2012) defines research methodology as a coherent collection of theories, concepts, or ideas related to a specific discipline or field of inquiry. According to Goundar, research methodology encompasses a set of methods, the rationale, and the philosophical assumptions underlying a study. It may also explain the ontological or epistemological views of the researcher(s).

4.1 Consider a Research Philosophy

In the social sciences and humanities, particularly at the postgraduate level, it is crucial to present the research philosophy underpinning a study. When considering a research methodology, I reflect on my beliefs and assumptions to identify, explore, analyse, challenge, and develop my philosophical understanding. Saunders et al. (2015:124) define research philosophy as "a system of beliefs and assumptions about the development of knowledge."

In relation to my study, my interest in cognitive appraisals, cultures, and PTSD necessitates that I approach the process of 'knowing' from a researcher's standpoint. Otherwise, I risk being drawn into the role of a therapist, which would involve therapeutic intervention rather than focusing on my research work. As I examine my thoughts and feelings regarding the process of knowing, I am drawn to the philosophy of epistemology. According to Slevin (2001:144), epistemology concerns "what knowledge is, how we come to know, and the nature and forms that knowledge takes." Epistemology is about the nature of knowledge and how it is generated (Crotty, 1998).

Reflecting on this, it is crucial to determine the extent of knowledge: how much do we, or can we, know? To acquire knowledge, we use reasoning, our senses, and gather new information through research. The foundations on which social researchers work are based on their ontological and epistemological positions (Holmes, 2020; Andrew et al., 2011).

Ontology explores what is real and what it means to exist. It examines what things are and how we understand different realities. There are two main views: realism and relativism. Realism asserts that reality exists independently of our thoughts and can be observed objectively. Relativism argues that reality is shaped by social interactions

and can vary based on individual experiences. Understanding one's ontological position is crucial for designing research that aligns with their philosophical stance (Creswell & Poth, 2018). Ontological beliefs shape data collection and analysis, influencing how researchers interpret social phenomena (Guba & Lincoln, 1994).

According to Bryman (2007:453), any research methodology based on a philosophical position or theoretical perspective provides a foundation for 'what should be studied, how research should be done, and how results should be interpreted.' The concept of a paradigm was developed from the natural sciences by Kuhn (1962) and was further adapted for application in social science research by Guba and Lincoln (2005). They identified three main paradigms: positivism, post-positivism, and constructivism. The positivist paradigm, also known as the empiricist paradigm, holds that there is an objective reality (realist ontology). Positivists assume that people can know, explain, and describe this objective reality accurately. This reality is seen as separate from our knowledge of it, allowing us to compare our findings against it to establish the truth. Evidence to support the truth is obtained through statistical analysis of data collected from experiments and surveys using predetermined instruments (Guba and Lincoln, 1994; Creswell, 2003; Denzin and Lincoln, 2011; Al-Ababneh, 2020). Positivism is related to the epistemological stance that knowledge is factual, quantifiable, and trustworthy, employing quantitative methods associated with the positivist and empiricist fields of research (Winter, 2000; Creswell, 2003; Bryman, 2007).

In contrast, constructivist epistemology is a theory of knowledge that emerged in response to criticisms of positivist approaches to science and learning (Clark, 2004). Rejecting the idea of a single knowable truth, constructivist theorists believe that “knowledge is a process of actively interpreting and constructing individual

knowledge representations" (Johnson, 1991: 5). Constructivists argue that knowledge is constructed through experiences rather than discovered; thus, the researcher or participant plays an active role rather than being a passive observer (Andrew et al., 2011). To understand how knowledge is acquired, researchers use qualitative methodologies to examine the experiences and contexts of research subjects to form an opinion. According to Bryman (2007), qualitative methodology differs in several ways from quantitative methodology and maintains that the "sine qua non (without which nothing) is a commitment to seeing the social world from the point of view of the actor, a theme rarely omitted from methodological writings within this tradition" (Bryman, 2007:77). Qualitative research is more fluid, emphasising unanticipated findings compared to quantitative research, which focuses on fixed measurements, hypothesis testing, and involves less fieldwork engagement from the researcher (Marsh and Furlong, 2002).

Bryman (2007) suggests that a qualitative approach generates data that is 'rich' and in great depth. Mason (2006) points out that interviews, surveys, life histories, and participant observation are appropriate routes to data collection in qualitative studies. Constructivism proposes that each person mentally constructs their world of experience through cognitive processes (Freedman and Coombs, 1996; Young and Colin, 2004). Mertens (2005) argues that meanings and understandings are constructed from data derived from interviews, narratives, case studies, and stories.

I consider myself independent in my study, using a deductive approach to draw new knowledge from the interpretation of results and findings (Crowther and Lancaster, 2008; Collins, 2010). Adopting a positivist position, I approach my study from a distance from the participants to avoid subjective biases and achieve objective reality

(Wilson, 2010). To maintain and uphold an objective reality, I regard quantitative methods as the appropriate tool for my study. The results and findings of research studies are usually observable and quantifiable, leading to statistical analysis, which aligns with the empiricist view. This represents an ontological view (realism) of 'the world as comprising discrete, observable elements and events that interact in an observable, determined, and regular manner' (Collins, 2010: 38). Positivist approaches depend heavily on experimental and manipulative methods. Reflecting on the discussion so far, I understand that quantitative methodology is embedded in the positivist epistemological stance, while qualitative methodology is firmly rooted in the constructivist epistemological stance. My justification for selecting a quantitative approach to my study proves challenging, leading me to reject this method.

Constructivism proposes that each person mentally constructs their world of experience through cognitive processes (Freedman and Coombs, 1996; Young and Colin, 2004). In my professional practice, I engage with clients, unpacking their stories and collaboratively constructing meaning to understand their trauma. Consequently, clients can cognitively appraise the effects of their trauma. Mertens (2005) argues that meanings and understandings are constructed from data derived from narratives, case studies, and stories. This data is obtained from interactions between the therapist and the client.

According to Creswell (2003), constructivism is seen as a social medium in which participants construct the meaning of a situation—meanings and themes that emerge from discussions or interactions with others who seek to understand the world in which they live and work, and who develop subjective meanings of their experiences. From a constructivist perspective, my role as a researcher is to make sense of meanings from

the data and interpret how the clients see the world (Creswell, 2003; Balbi, 2008). The qualitative data for the study will be collected from participants, and an inductive approach will be used to generate meanings and develop themes or patterns of meanings. In constructivism, from an epistemological standpoint, knowers do not discover objective reality as it is; instead, they mentally construct their own subjective 'realities' through the interpretation of stories (Wilson, 2010). From this epistemological position, there is no objective truth. According to Held (2006), truth is negotiated through dialogue and interaction between researchers and clients (in therapy). Based on this argument, the research paradigm and methodology shift towards a qualitative approach. In therapy, I interact with clients and collaboratively construct the meaning of their narratives through interviews and case formulations (Creswell, 2003). For example, I work collaboratively with clients through their narratives to co-construct (i.e., reveal clients' life stories from past and present experiences), deconstruct (i.e., unpack stories and appraise meanings cognitively from different perspectives), and construct (i.e., create new meanings and more productive stories to reclaim their lives) (Brott, 2001).

To make sense of the social world we live in and interact with, the concept of social constructionism cannot be ignored. My reflections lead me to believe that in psychotherapy, this perspective emphasises the importance of the acquisition, creation, and change of emotional behaviour, therapeutic ability, and ways of interpreting things and people (Owen, 1995). Social constructionism has a social rather than an individual focus, being the medium in which knowledge and truth are created rather than discovered (Schwandt, 2003). This differs from the constructivist perspective, in which the individual mentally constructs the experience of the world through cognitive processes (Young and Colin, 2004). While they share common philosophical roots

(Charmaz, 2006; Schwandt, 2003), social constructionism is distinct from constructivism. From a social constructionist perspective, therapy concentrates on socialisation, interaction, changes in meaning, and ways of acting in the world (Andrews, 2012). According to Owen (1995), social constructionism views therapy as having different functions, such as finding personal truth, reducing anxiety and guilt, solving problems, and reducing alienation from self, others, and society. Taking an interpretivist/constructivist stance, social phenomena do not exist abstractly and cannot be known objectively. Social phenomena are constructed by society; their meaning can only be interpreted.

4.2 Research Methodology and Rationale

As stated in my critical analysis in the research philosophy section, I have chosen a qualitative approach for this study. Qualitative research offers exploratory capabilities, facilitating the necessary investigation for my study. It also allows me to apply my interpersonal and subjective skills (Alase, 2017). For this study, I have selected thematic analysis. Thematic analysis (TA) is widely used in qualitative research to identify, analyse, and report patterns (themes) within data due to its flexibility and ease of use (Braun & Clarke, 2006). The justification for choosing TA is as follows:

i) Theoretical Flexibility: TA is not tied to any specific theoretical framework, allowing researchers to apply it across different philosophical paradigms, including realism, constructivism, and pragmatism (Braun & Clarke, 2006; King, 2004). In a realist paradigm, themes identified through TA may reflect objective realities. Constructivists view themes as co-constructed meanings, and pragmatists use TA to identify actionable themes for real-world applications (Patton, 2002). This flexibility is one of TA's strengths but can also lead to inconsistent application and interpretation of results (Nowell et al., 2017).

ii) Epistemological Pluralism: TA can be used within both positivist and interpretivist paradigms (Braun & Clarke, 2013). Positivists see themes as reflecting reality, while interpretivists view themes as emerging from the interaction between the researcher and the data. This diversity of approaches enhances TA's adaptability but can complicate the integration of findings across studies (Braun & Clarke, 2006).

iii) Co-constructed Knowledge: TA assumes that knowledge is co-constructed by the researcher and participants. Themes are constructed through the researcher's interaction with the data, influenced by their perspectives and preconceptions (Braun

& Clarke, 2013). This aligns with the constructivist view that reality is subjective and multiple.

iv) Phenomenological Compatibility: TA aligns with phenomenological approaches when the research focuses on understanding the lived experiences of individuals. It can be used in both descriptive and interpretative phenomenological research (King, 2004). While TA may not have the depth of phenomenological analysis, it provides a practical tool for engaging with phenomenological data.

v) Potential for Bias: Given that TA involves significant interpretation by the researcher, there is potential for bias. Themes identified can be influenced by the researcher's preconceptions, affecting objectivity and validity (Nowell et al., 2017). Reflexivity and transparency are crucial to mitigate this issue. Establishing clear guidelines and criteria for conducting TA can help address this limitation (Braun & Clarke, 2013).

Critics argue that TA's flexibility sometimes results in superficial analyses lacking theoretical depth. Themes identified may not always provide insights into underlying social or psychological processes compared to methods grounded in more robust theoretical frameworks. Braun and Clarke (2006) emphasise that themes do not passively emerge from data but are actively constructed by researchers, and this active role must be acknowledged to ensure rigorous analysis.

In summary, thematic analysis is a popular and flexible method in qualitative research. It accommodates different approaches and viewpoints, but its flexibility also presents challenges, such as limited theoretical depth, potential bias, and consistency issues. By recognising and addressing these challenges, researchers can use thematic analysis to create valuable and thorough qualitative studies. Based on the argument above, I chose

thematic analysis as my methodology to explore the cultural differences impacting therapists' interpretation and understanding of clients' appraisal in PTSD.

4.3 Consideration of other Research Methodologies?

I considered the following research methodologies listed below for my study, and I rejected each one of them, providing a critical discussion in the next section.

i) Action research

ii) Experimental research

iii) Descriptive research

iv) Applied research

v) Fundamental research

vi) Exploratory research

vii) Conclusive research

viii) Grounded theory

ix) Foucauldian discourse analysis

In this section, I aim to justify the rejection of various research methodologies. Action research generates knowledge through inquiries in specific, practical contexts, focusing on learning through action for personal or professional development (Cohen et al., 2017). It involves considering actions, implementing them to improve practice, and reviewing these actions through data analysis. However, I concluded that action research is unsuitable for my study, as it requires the researcher to intervene and influence change, which does not align with my aim to collect data on therapists' lived experiences (Clark et al., 2020). A qualitative approach is more appropriate.

Research involves investigating phenomena, creating new knowledge, and applying existing knowledge creatively to generate new concepts, methodologies, and

understandings (Ferran and Brem, 2017). The quantitative approach, dominated by experimental design for decades, involves a hypothesis, manipulated variables, and measurable outcomes. Data collected either supports or rejects the hypothesis (Sung et al., 2019). However, experimental research, which requires a controlled environment, is unsuitable for my project and is more suited to quantitative research (Saunders and Thornhill, 2007). A qualitative approach is more appropriate for collecting therapists' lived experiences and understanding their interpretation of clients' appraisals in PTSD.

I considered using an ethnographic approach for my study but ultimately decided against it. Ethnography involves the researcher becoming an active participant observer in the group being studied, focusing on direct observation in natural environments rather than in a laboratory. This method aims to understand how participants interact within their surroundings through observations, interviews, and documents, producing detailed narratives of social phenomena (LeCompte and Schensul, 2010; Hammersley, 2016). However, for my research on cultural differences and therapists' understanding of clients' appraisals, semi-structured interviews were more suitable for collecting in-depth data.

Descriptive research, a quantitative method, involves using surveys, case studies, and naturalistic observation to study phenomena. Surveys require a representative sample and are unsuitable for my study. Descriptive research focuses on what has happened, using observation and survey tools to gather data, which is often analysed quantitatively (Gall, Gall, and Borg, 2007). In contrast, qualitative research, such as thematic analysis, gathers rich data from various sources to understand participants'

perspectives, identifying recurring themes and patterns (Nassaji, 2015). Thus, I chose a qualitative approach for my study.

In considering applied research methodology, I discovered that this approach is used to resolve specific, practical issues affecting individuals or groups. This scientific method is prevalent in business, medicine, and education research, aiming to improve health, solve scientific problems, or develop new technology. For instance, in psychology, applied research enhances workplace commitment by identifying practical worker-motivation strategies and examining treatment and management options for anxiety and panic attacks. As my objectives were to gain in-depth insights and richer data from therapists' lived experiences, I opted for a qualitative methodology.

Given the exploratory nature of my study, it is essential to adopt an exploratory research methodology and critically analyse this approach. This allows researchers to creatively gain profound insights into a subject, aligning with my objective of collecting data in sufficient depth for a comprehensive analysis of the phenomenon under investigation. Comparing and contrasting different techniques, such as secondary research, discussions, or qualitative research through focus groups, surveys, or case studies, will be beneficial.

Qualitative research is primarily exploratory, aimed at understanding underlying reasons, opinions, and motivations, providing insights into the problem or aiding the development of ideas or hypotheses for potential quantitative research (McLeod, 2017). This aligns with exploratory research surveys that include open-ended questions such as what, why, and how, found in cross-sectional surveys, customer experience surveys, employee feedback surveys, and business surveys. These methods

involve collecting data using questionnaires and quantitative measurements and analysis. Exploratory research studies serve three main purposes: satisfying the researcher's curiosity and need for greater understanding, testing the feasibility of a more in-depth study, and developing methods for future research projects. These purposes are relevant to my study, which explores the phenomenon and cultural differences influencing therapists' understanding and interpretation of clients' appraisals in PTSD.

Considering data collection methods such as focus groups, surveys, and case studies, I selected semi-structured interviews. This method enabled me to gather in-depth data on therapists' lived experiences. It provided an environment for exploring issues in more depth, connecting with participants, and allowing them to express themselves freely, thereby facilitating the collection of rich data. In addition to the methodologies examined thus far, I considered conclusive research as an approach for my study. This methodology provides information useful for reaching conclusions or making decisions related to the phenomenon under investigation. It involves quantifiable data that can be summarised to draw conclusions. Conclusive research employs highly structured methods such as questionnaires with closed questions and statistically representative samples. Hypotheses are tested, proven, or rejected. This method is suitable for research involving case studies, experiments, observational studies, surveys, or content analyses. However, conclusive research poses challenges for my study, which is more qualitative in nature. This approach does not align well with my goal of gathering in-depth and rich data on the lived experiences of therapists providing therapy to clients with PTSD. Conclusive research is best suited for generating findings that are useful for reaching conclusions or making decisions. In

contrast, qualitative research is typically exploratory or investigative, and its findings are often not conclusive or automatically generalisable.

In addition to conclusive research, I consider Grounded Theory (GT) a valuable methodology in qualitative research, especially for generating new theories from data. However, when examining cultural differences in cognitive appraisal related to PTSD, GT may not be the most suitable approach for several reasons. First, GT is inherently inductive, focusing on theory generation rather than theory testing or application. This can be limiting when existing cultural and psychological theories are crucial for understanding complex phenomena. As Charmaz (2006) notes, GT aims to "construct theories grounded in data," which may overlook established theoretical frameworks critical in cross-cultural psychology.

Cultural differences and their impact on cognitive appraisal in PTSD are complex and multi-layered. Although GT is flexible, it might not provide the necessary tools to explore these cultural complexities in depth. Methods like ethnography or phenomenology, designed to handle cultural data, might be more suitable. GT's strength lies in its flexibility and openness to emerging data patterns, but this same flexibility can be a weakness when specific, theoretically informed insights are needed. For example, Markus and Kitayama's (1991) theory on cultural influences on the self-concept highlights specific cognitive patterns that differ across cultures. Using Grounded Theory without established theories might result in incomplete or biased views of cultural differences in PTSD.

The iterative process of GT is also time-consuming and resource intensive. Researching cultural differences in PTSD already demands significant time and effort to ensure cultural sensitivity and accuracy. Adding the complexities of GT might make

the research process overly burdensome without providing proportional benefits. While GT is strong for generating theories from data, its inductive nature, potential for researcher bias, and complexity may limit its appropriateness for studying cultural differences in cognitive appraisal in PTSD.

Research on cultural differences requires a deep understanding of the specific cultural and psychological constructs involved. Cross-cultural psychology offers theoretical frameworks that can help decipher these complex interactions. According to Matsumoto and Juang (2016), utilising these frameworks is essential for accurately interpreting themes and comparing cognitive appraisals across cultures. GT's lack of a guiding theoretical structure might result in an inadequate exploration of these complexities. In summary, while Grounded Theory is a powerful method for generating new theories, its inductive approach might not be the most effective for studying cultural differences in cognitive appraisal in PTSD.

Another method considered is Foucauldian Discourse Analysis (FDA), which can be useful for studying how cultural differences affect therapists' understanding of clients with PTSD (Willig, 2013). FDA, based on Michel Foucault's work, examines how knowledge and power are shaped through language and social practices (Foucault, 1972). This makes it well-suited for exploring how cultural contexts influence therapy. FDA examines how discourses—ways of talking and thinking—shape reality, create subjects, and establish power relationships. It highlights that meanings are contingent on historical and cultural contexts and are actively constructed rather than just reflected.

PTSD is greatly influenced by cultural contexts. Cultural beliefs and practices affect how trauma and mental health are experienced, expressed, and understood. Research

shows that cultural differences can influence how psychological distress is manifested, such as somatisation (Gureje et al., 1997; Kirmayer & Young, 1998). Cultural narratives and values shape the interpretation of trauma and the meaning given to traumatic events. Cultural norms and stigmas around mental health also impact whether and how people seek help (Gone, 2013).

FDA is particularly adept at examining power relationships between therapists and clients. In PTSD treatment, therapists' interpretations are influenced by their own cultural backgrounds and professional training (Herman, 1992; Sue & Sue, 2012). FDA allows researchers to explore how these cultural discourses and professional training affect therapists' interpretations of clients' stories. While FDA focuses on language and can provide insights into how therapists and clients use language to make sense of trauma, it might not be ideal for studying cultural differences and their impact on therapy and PTSD symptoms. FDA primarily examines how power, knowledge, and discourse shape social practices and identities, rather than focusing on cultural contexts and individual variations in language use (Willig, 2013). Thus, FDA is not the method of choice for this study.

Considering all the approaches, the qualitative method will be used to explore cultural differences that impact therapists' understanding and interpretation of clients' appraisals. The aim is not to reach a conclusion or seek specific results but to gain knowledge and understand what the data reveals, including emerging themes and sub-themes. The inclusion and exclusion criteria will be outlined in the next section.

4.4 Inclusion and Exclusion Criteria

Before designing my research method, I established the inclusion and exclusion criteria outlined in Table 1 (p129). According to Patino et al. (2018), setting these criteria for study participants is standard and necessary practice. The inclusion criteria encompass key features of the target population, such as demographic and clinical experience. Conversely, the exclusion criteria identify characteristics of potential participants who meet the inclusion criteria but have additional traits that could compromise the study's success (Patino et al., 2018; Polit & Beck, 2018; Gray et al., 2017).

My rationale for combining the organisational sector, type of therapist, and therapeutic approach in the design method is as follows:

i) Different types of organisations, such as those focused on public health, private practice, or non-profits, have distinct operational methods and serve varied populations. This can significantly influence therapists' perceptions and understanding of their clients' thoughts and feelings in PTSD (Glisson & James, 2002; Aarons & Sawitzky, 2006).

ii) Therapists, whether psychologists, psychiatrists, or social workers, possess unique training and therapeutic philosophies. These shape how they listen to and assist clients with PTSD. For instance, a cognitive-behavioural therapist might concentrate on how a client's thoughts cause stress, whereas a psychodynamic therapist might explore deeper, underlying reasons (American Psychological Association, 2017).

iii) The type of therapy used, such as CBT or psychodynamic therapy, directly impacts the approach to treating PTSD. Different cultures may favour various therapeutic modalities. Some therapies may emphasise individual importance, while others focus on group dynamics, affecting how therapists view and treat trauma and PTSD (Hinton & Lewis-Fernández, 2011).

iv) By considering the type of organisation, therapist, and therapy together, researchers can ensure their findings are more accurate and applicable. This helps them better understand how therapists from diverse cultures and settings perceive their clients' thoughts and feelings in PTSD (Wang & Tsai, 2017).

The inclusion and exclusion criteria are provided in Table 1(p129) on the following page.

4.5 Inclusion and Exclusion Criteria Table

Table 1

Inclusion Criteria
1. The research sample will consist of**:** cognitive behavioural therapists**,** psychotherapists, clinical psychologists, and therapists from other modalities such as psychodynamic, psychoanalysis, humanistic, and integrated therapies, as well as those specializing in trauma. These therapists practise in diverse settings, including IAPT NHS services, private/independent psychological services, and third-sector organisations such as charities and voluntary organisations Rationale: **i)** Enhance and broaden data collection by comprehensively gathering data from therapists' lived experiences. ii) Include therapists from various sectors: private practice, NHS IAPT, and third-sector organizations. iii) Private practice therapists typically treat clients with PTSD from road traffic accidents. iv) NHS IAPT therapists primarily work with patients who have experienced child sexual abuse, adult survivors of sexual abuse, and victims of domestic violence. v) Third-sector therapists often support clients affected by war, social unrest, and torture. vi) Involving therapists from different modalities and services will enrich the data and enhance study credibility.

vii) With a small sample size of 8 participants, representing 4 modalities is essential.

viii) Select two participants per modality, representing different cultural backgrounds (Eastern and Western).

Rationale and research question:

i) Explore how cultural differences influence therapists' interpretations of clients' PTSD appraisals.

ii) Explore the impact of cultural differences on clients' appraisals

2. Participants who have more than 12 months of experience and work with individuals diagnosed with trauma/PTSD are sought to meet the research objectives.

Rationale: The goal is to collect rich, in-depth "lived experience" data from individuals who have had extensive client interactions over an extended period.

3. Participants from diverse cultures – Western and Eastern backgrounds. Participants come from diverse cultural backgrounds: the Western Group includes individuals from the UK and Europe, while the Eastern Group comprises participants from India and Sri Lanka.

Rationale:

i) According to Shaler (2005), traumatic events should be understood within the context of cultural influences.

ii) Culture significantly shapes individuals' thoughts, feelings, and behaviours (Ford and Mauss, 2015).

iii) The framework for cognitive and behavioural patterns depends on whether a culture promotes interdependence or independence (Markus and Kitayama, 1991, 2010).

iv) Engelbrecht and Jobson (2016) argue that different cultures influence the self in distinct ways—emphasising individuality (independent self) or collectivism (interdependent self).

v) In individualistic cultures, typical of the West, the self is viewed as autonomous and self-determining.

vi)In contrast, collectivistic cultures, such as those in the East, see the self as interdependent, defining individuals in relation to others within a cohesive unit (Engelbrecht and Jobson, 2016).

vii) Engelbrecht and Jobson (2016) suggest that this culturally divergent self-construal significantly affect cognitive appraisals of traumatic events.

viii) Evidence indicates that trauma-related appraisals differ between individuals from individualistic and collectivistic cultures (Fiske et al., 1998; Engelbrecht and Jobson, 2016).

ix) Normative differences between these cultural orientations have substantial implications for how trauma impacts the self, with collectivistic cultures leading

to a devalued self both individually and collectively, while individualistic cultures primarily affect the individual self.

Therefore, participants from Western and Eastern cultures have been selected, excluding other cultural diversities.

Exclusion Criteria

1. Participants who are not engaged in treating individuals diagnosed with trauma/PTSD are not included**.**

Rationale: **i**) limited lived experience in relation to the treatment of individuals with PTSD.

ii) The collected data may not be appropriate for the exploratory work, as it could be inadequate and not yield conclusive results.

iii) Due to the limited scope of the study, I will be unable to gather meaningful data for analysis and will therefore fail to achieve the study's aims and objectives.

2. Participants with less than 12 months experience are not considered

Rationale: They are excluded due to their limited experience working with clients diagnosed with PTSD, which may not have provided them with the opportunity to work with various types of traumas.

3. Participants from specific cultural diversity are excluded - Rationale: i) Afana (2012) argues that while the PTSD diagnostic construct captures universal trauma responses, it overlooks variations in appraisals and presentation.

ii) In Arab culture, trauma often manifests as anxiety and depression (Ghubash & Abou-Saleh, 1997; Al-Krenawi & Graham, 2000), with metaphors describing internal feelings of trauma. Afana (2012) notes the concept of self is not emphasised in cognitive trauma assessments. For example, the phrase "my heart is dead" can signify resilience or high distress tolerance (Abdel-Khalek, 2011).

iii) Gathering data from diverse cultures is challenging due to limited literature and research. Unlike individualistic or collectivistic cultures with well-defined self-construal, other cultural contexts lack a clear framework. Research shows significant differences in self-construal between individualistic (independent/Western) and collectivistic (interdependent/Eastern) cultures (Jobson & O'Kearney, 2009; Jobson, 2010; Jayawickreme, Foa, & Jayawickreme, 2015; Engelbrecht & Jobson, 2016).

iv) No specific studies offer clear distinctions or findings on self-construal, independent or interdependent selves, and cognitive appraisal in trauma and PTSD. Due to the lack of research and frameworks on appraisal in trauma/PTSD, other cultural diversities are excluded from the study. For example, Sulaiman et al. (2001) identified 22 expressions for depressive states post-PTSD, while Hattar-Pollara et al. (2003) found that Egyptian women described guilt, anxiety, and dissatisfaction as failing to meet their goals. No clear distinction exists regarding cultural impacts on cognitive appraisal post-PTSD.

4. Using other formulations, e.g., Foa et al. (2007) – The use of various approaches for intervention may not involve mental defeat, alienation, control, or permanent change, which are common in trauma and PTSD and influenced by cultural differences (Ehlers et al., 1998, 2000; Jobson and O'Kearney, 2009)

Rationale: This suggests that alternative approaches or formulations might not lead to a framework centred on these aspects. Collecting suitable data for the study could be challenging.

4.6 Definition of Sampling

Sampling is the process of selecting a representative group from the population under study. The target population is the entire group of individuals from which the sample may be drawn. Sampling involves obtaining participants for research from this target population. For instance, I selected my sample from therapists, identifying them as my target population. The purpose of sampling is to enable researchers to choose participants for their study (Gill, 2020).

4.7 Rationale for the Chosen Sampling

Qualitative researchers often employ multiple sampling approaches in their studies (Berndt, 2020). For this study, purposive and convenience sampling were chosen. Participants were selected based on their shared characteristics, such as working in the same therapy field and treating clients with PTSD, to gain a deeper understanding of their perceptions and experiences. Purposive sampling enabled the selection of individuals who could provide relevant and insightful information. In qualitative research, purposive and convenience sampling are popular because they align well with most research designs (Gill, 2020). This approach simplifies conducting semi-structured interviews and gathering detailed data from therapists about their experiences. Patton (2002) highlights the importance of purposive sampling for in-depth data collection and rich insights into participants' experiences.

Purposive sampling ensures that participants have direct experience with the phenomena under investigation, enhancing the data's relevance and specificity. This is particularly useful for understanding how cultural differences affect PTSD interpretation and cognitive appraisals. Palinkas et al. (2015) argue that purposive sampling allows for selecting therapists with specialised expertise in PTSD and cultural competence, which improves the likelihood of obtaining comprehensive and detailed information on how cultural differences impact therapeutic practices.

Convenience sampling further aids researchers by providing access to readily available participants, leading to quicker and more efficient data collection. Therapists within a particular network or geographic area may be more accessible. Mertens (2019) discusses the benefits of convenience sampling for efficient data collection. Given constraints such as time, budget, and logistics, a convenience sample can simplify the study (Etikan et al., 2016). By selecting therapists from diverse cultural backgrounds with experience working with culturally diverse clients, the study can incorporate a wide range of perspectives. Therapists who are conveniently located and purposefully selected are also more likely to be willing and motivated to participate, thus improving response rates and data quality. Building professional relationships with participants often fosters trust and openness, leading to more honest and detailed responses (Lewicki & Tomlinson, 2003).

It is crucial to address biases and their impact on the study to ensure credibility and reliability. With a small sample size, it is important to discuss selection bias, which occurs when participants are not representative of the larger population, potentially leading to skewed results (Heckman, 1979). To minimise selection bias, inclusion and exclusion criteria are applied to ensure participants are chosen based on relevant characteristics. For instance, requiring therapists to have over a year of experience with PTSD clients helps ensure relevant expertise. Rigorous application of these criteria reduces selection bias and improves result generalisability (Deaton & Cartwright, 2018). Additionally, employing diverse recruitment strategies from various modalities—such as NHS IAPT, voluntary/charity organisations, and the private sector—helps achieve a representative sample (Rothman et al., 2007). Creswell (2013) underscores the importance of diverse sampling to enhance the representativeness and generalisability of research findings.

Avoiding confirmation bias, the tendency to seek information that confirms preconceptions, is also essential. To mitigate this, researchers should avoid

approaching colleagues with similar views. Morrow (2005) suggests that critical self-reflection and avoiding close colleagues can help reduce confirmation bias. Expert sampling, which includes individuals with specific expertise, ensures the sample is both targeted and relevant while providing a comprehensive understanding of the issue (Patton, 2002; Palinkas et al., 2015).

For this exploratory study, a small sample of eight participants was selected to:

i) Gather in-depth data on cultural differences, therapists' understanding, and clients' appraisals in PTSD.

ii) Ensure the data is manageable for thorough analysis.

iii) Allow the study to be completed and findings presented within a reasonable timeframe.

Background information about the participants is included in *Table 2 and Tables 3 to 9.* Essential workplace information is restricted to maintain confidentiality.

Table 2: Participants who took part in this study.

Therapist	Modality	Interview	Clinical Practice
Participant 1	Cognitive Behavioural & EMDR/Trauma focused therapist	Face to Face	In practice
Participant 2	Cognitive Behavioural/EMDR therapist	Face to Face	In practice
Participant 3	Psychotherapist & EMDR/Trauma focused therapist	Face to Face	In practice
Participant 4	Psychotherapist & EMDR therapist	Face to Face	In practice
Participant 5	Humanistic, Psychodynamic and Integrative therapist	Face to Face	In practice
Participant 6	Psychodynamic and CBT therapist	Face to Face	In practice
Participant 7	Psychologist, CBT, Integrative Counselling	Face to Face	In practice
Participant 8	Psychologist, CBT, Counsellor, Integrative therapist	Face to Face	In practice

Participants and their backgrounds

Table 3: Participant 1

Participant	1
Data collected	31/01/2020
Age range	40 to 50 years old
Ethnicity	Indian
Gender	Female
Practice/experience	16 years working as an independent practitioner Experience as a therapist in the following: • Counselling /Behavioural Counsellor • EMDR Working with the following client groups: - White Caucasian from UK - Afghanistan, Somalian and other African nationals - Asian to include Pakistani, Indian, Chinese

Table 4: Participant 2

Participant	2
Data collected	30/02/2020
Age range	40 to 50 years old
Ethnicity	British/ Italian background
Gender	Female
Practice/experience	14 years working as a High Intensity therapist and an independent practitioner Experience as a therapist in the following: • Cognitive Behavioural therapy • EMDR • Trauma focused therapy Working with the following client groups: - White Caucasian from UK - Asian to include Pakistani, Indian, Chinese and Sri Lankan

Table 5: Participant 3

Participant	3
Data collected	14/02/2020
Age range	35 to 45 years old
Ethnicity	British Asian/Sri Lankan
Gender	Female
Practice/experience	15 years working as an independent practitioner Experience as a therapist in the following: • Cognitive Behavioural Therapy • EMDR • Trauma focused Working with the following client groups: - White Caucasian from UK - African - Asian to include Pakistani, Indian, Chinese - Tamil refugees from Sri Lankan

Table 6: Participant 4

Participant	4
Data collected	11/03/2020
Age range	60 to 70 years old
Ethnicity	British
Gender	Male
Practice/experience	28 years working as a psychotherapist Experience as a therapist in the following: • Cognitive Behavioural Therapy • EMDR therapy • Trauma focused therapy Working with the following client groups: - White Caucasian from UK - African - Asian to include Pakistani, Indian, Chinese

Table 7: Participant 5

Participant	5
Data collected	25/09/2020
Age range	20 to 30 years old
Ethnicity	Black British
Gender	Female
Practice/experience	15 years working as an EMDR and CBT practitioners Experience as a therapist in the following: • Cognitive Behavioural Therapy • EMDR therapy • Trauma focused therapy Working with the following client groups: - White Caucasian from UK - African - Asian to include Pakistani, Indian, Chinese - Tamil refugees from Sri Lankan

Table 8: Participant 6

Participant	6
Data collected	29/09/2020
Age range	50 to 60 years old
Ethnicity	White British
Gender	Female
Practice/experience	20 years working as a counsellor, psychodynamic and integrative therapist Experience as a therapist in the following: • Integrative therapy •Counselling and behavioural Counsellor • Psychodynamic therapy• Working with the following client groups: - White Caucasian adults -depressive disorders - Afghanistan - Asian to include Pakistani, Indian, Chinese - other ethnic minorities

Table 9: Participant 7

Participant	7
Data collected	20/11/2020
Age range	40 to 50 years old
Ethnicity	Asian/Indian background
Gender	Female
Practice/experience	10 years working as an integrative and CBT therapist Experience as a therapist in the following: • CBT therapy • Integrated Counselling therapy • CBT therapy • Psychological therapy Working with the following client groups: -White Caucasian adults -Pakistanis -Somalians -Sri Lankans -Indians

Table 10: Participant 8

Participant	8
Data collected	26/11/2020
Age range	50 to 60 years old
Ethnicity	White/British
Gender	Female
Practice/experience	10 years as an integrated Counselling and CBT therapist Experience as a therapist in the following: • Integrated Counselling therapy • CBT therapy • Trauma therapy Working with the following client groups: • University traumatised staff • Children/sexual abuse

4.8 Research Design

Careful design, planning, and rigour are essential for ensuring the dependability of a study. If the research design is poorly constructed and executed, the findings may not withstand scrutiny (Maxwell, 2012). Therefore, meticulous planning and design of the study, along with the implementation of relevant procedures, are crucial to ensuring its rigour and credibility. Rigour in research should be a primary concern for qualitative researchers.

To design the research tool for collecting qualitative data, an appropriate framework was carefully selected. To ensure the rigour of the study, considerations included selecting the appropriate research philosophy and methodology, formulating research questions, identifying participants with relevant expertise, and choosing a method for data collection (Creswell and Poth, 2016).

The research design aimed to collect 'lived experience' data from therapists practising in various modalities, such as cognitive behavioural therapy, integrative therapy, eye movement desensitisation and reprocessing (EMDR) therapy, psychodynamic therapy, trauma-focused therapy, counselling, and humanistic therapy. A non-probability purposive sampling method was employed to select participants who were available for semi-structured interviews (Henry, 1990). Despite the small sample size, the research design ensured diversity among therapists by considering their cultural backgrounds (Lewis, 2015). The study included a sample size of n=8, recruited from NHS IAPT services, private practices, and third-sector organisations in the outer London areas. Additionally, the sample of eight participants was divided into two groups: four from Western backgrounds and four from Asian and African backgrounds (refer to diagrams 1 & 2 on pages 144/145). By dividing the sample into two groups

of four participants each from distinct cultural backgrounds (Western vs. Asian and African), the study aimed to achieve a balanced representation. This approach helps to explore potential cultural influences on the variables under investigation.

The division into Western and Asian/African groups allows for a comparative analysis, enabling the researcher to explore how different cultural contexts might influence perceptions, behaviours, or outcomes related to the study's focus. Having an equal number of participants from each group (four from Western backgrounds and four from Asian and African backgrounds) helps control variability attributable to cultural differences. This balance minimises the risk of bias and enhances the study's internal validity. Including participants from diverse backgrounds increases the generalisability of the findings, providing insights applicable across different cultural contexts rather than being confined to a single group (Smith et al., 2019). In summary, dividing the sample into these two distinct groups facilitates the exploration of cultural influences and strengthens the study's methodological rigour and the applicability of the findings across different cultural backgrounds.

Diagram 1. Diagrammatical presentation of Research Methodology

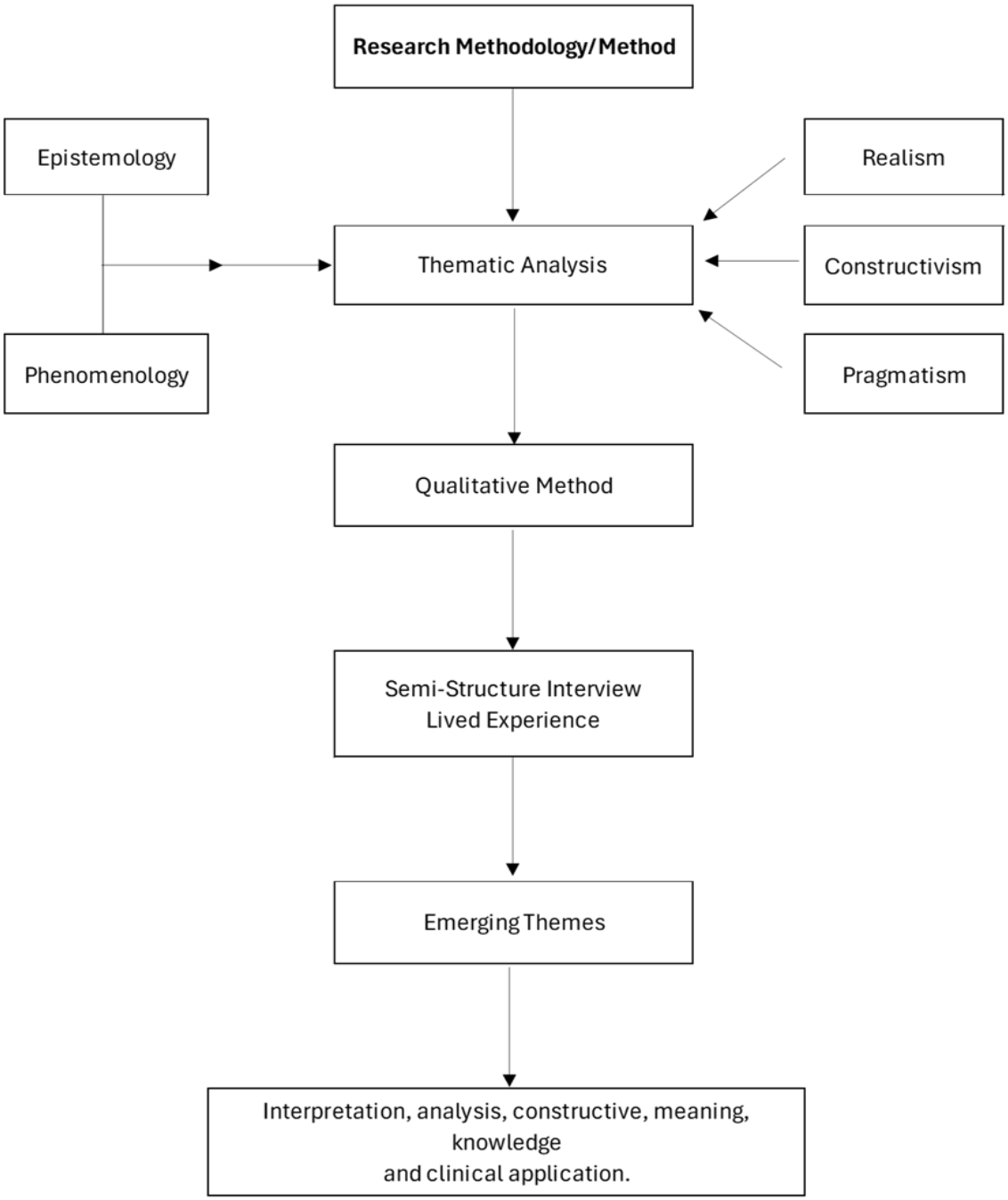
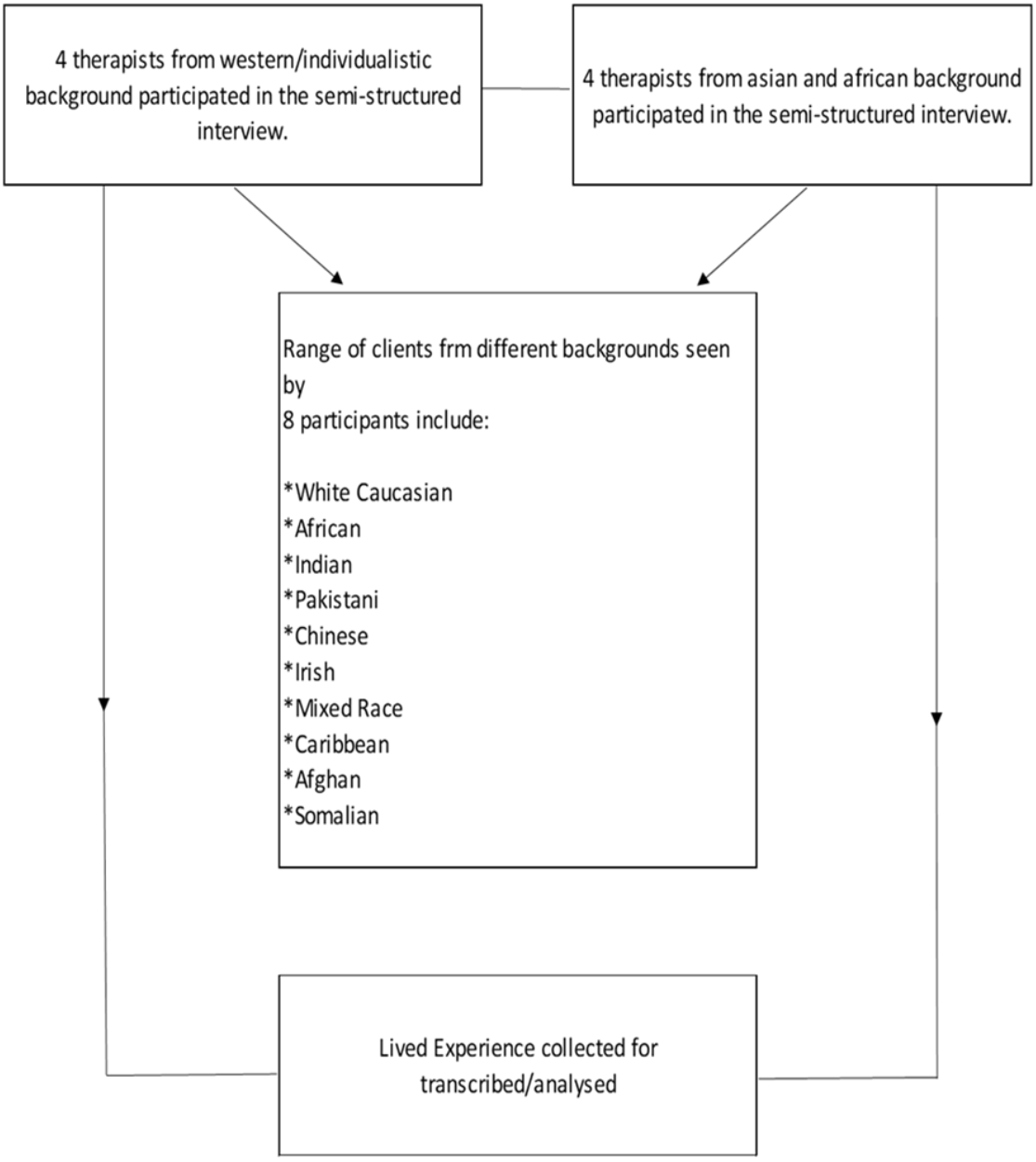


Diagram 2. Research design



4.9 Data Collection and 10-Page Manual of PTSD

From a quantitative approach, data collection is the process of gathering, quantifying, and assessing information using systematic methods that ensure research integrity (Paradis et al., 2016). Researchers use this data to validate, uphold, or reject a hypothesis, or to evaluate an outcome. Qualitative data, which is non-numerical, is collected through methods such as observations, one-to-one interviews, or focus groups. Good data collection requires a structured process to ensure the data is clean, consistent, and reliable. I used a structured approach to collect data based on these steps:

i) Determine the information to be collected.

ii) Establish a timeframe for data collection.

iii) Identify the data collection method.

iv) Collect the data in an appropriate environment.

A semi-structured interview was chosen to collect data on participants' 'lived experience'. These interviews were conducted one-to-one, lasting up to an hour. The questions were based on Jobson and O'Kearney's (2009) work on the 'impact of cultural differences in self on cognitive appraisals in post-traumatic stress disorder'. Ehlers et al.'s (1998, 2000) 10-page manual of PTSD was used as a guideline for the semi-structured interview questionnaire based on mental defeats, control strategies, alienation, and permanent change as per table 11 on pp147 & *see appendix iii/p330*.

Table 11 Criteria for Ehlers et Al's 10-page manual of PTSD

Mental defeats: - Loss of psychological autonomy - No sense of being human - Threat to self/lack of autonomy - Mentally giving up - Loss of identity - Loss of will power - Loss of being a person
Control strategies: - Lack of control and thinking strategies - Lack of planning in one's mind about minimising physical or psychological harm - Ability to tolerate trauma experience - Lack of planning thoughts - Lack of exerting control over the situation
Alienation: - Alienated from the world and others - Feelings of others after the trauma - Interaction with others in a negative manner - Lack of interaction with others
Permanent Change: - Changes in their life being permanent - Changes in themselves - Changes in personality - Changes in life goals

Jobson and O'Kearney (2009: 254) defined mental defeat as "the perceived loss of psychological autonomy, the sense of no longer being human, the threat to the self as an autonomous human being, the state of mentally giving up, and the loss of all efforts to retain one's identity as a human being with an individual will." Examples include "I thought my life was over" (rated 2) and "It looks like my time is up" (rated 2), contrasting with an autonomous mindset, e.g., "I knew I could help them and support them. I was powerful" (Jobson and O'Kearney, 2009: 254).

Control strategies were coded based on the level of planning or thinking to minimise harm or influence the situation. Narratives received a score from 0 (no evidence of control strategies) to 4 (strong evidence of control strategies). Examples include "He [husband] stabbed me below the eye. I resisted and screamed as blood ran down my face onto my dress … so I left him" (rated 4) and "I felt that if I am an adult, I may stop the man from beating the woman. I also felt I could kill the man" (Jobson & O'Kearney, 2009: 254).

Alienation was coded as a general feeling that the participant felt alienated from others. Examples include "I feel betrayed, unloved, and unsupported by my family" and "I was ignored by others…disregarded completely" (Jobson and O'Kearney, 2009: 254). Permanent change was coded as "an overall sense that participants viewed their life as having been changed forever in a negative way" (Jobson & O'Kearney, 2009). Evidence against permanent change was a sense that participants saw the event as an isolated bad experience or felt they had grown from the experience.

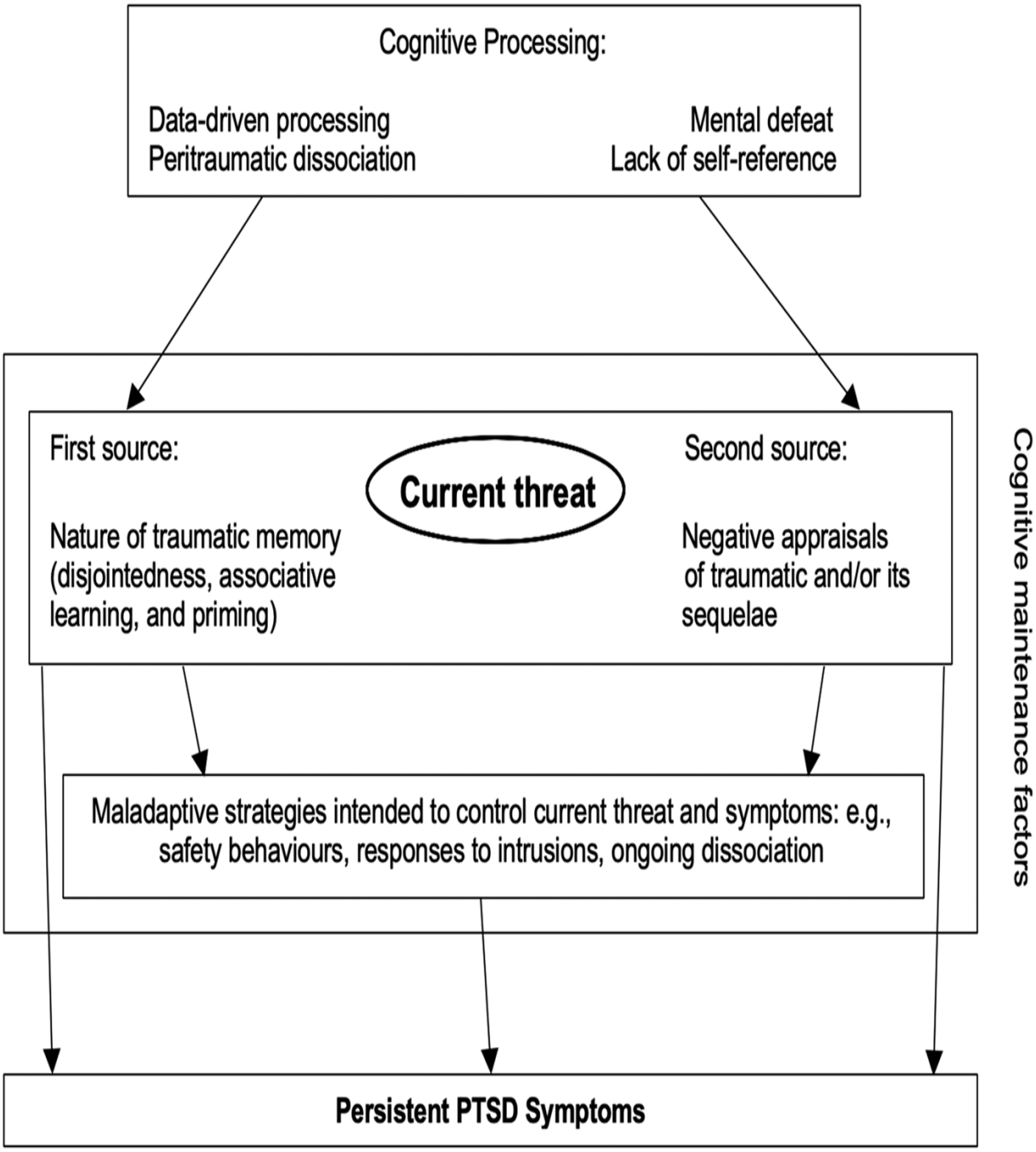
To explore how cultural differences impact therapists' interpretations of clients' appraisals in PTSD, I adopted findings from Jobson and O'Kearney (2009) on mental defeat, control strategies, alienation, and permanent change (see table 11/p147, diagrams 3/p150 & 4/p151). Their research provides a robust framework capturing nuanced experiences. By incorporating their validated constructs into the semi-structured interview questions, I aimed to elicit rich, detailed responses reflecting participants' narratives and psychological states. Cultural contexts significantly influence how individuals perceive and articulate their experiences of trauma. Grounding interview questions in Jobson and O'Kearney's work ensures data

collection is sensitive to diverse backgrounds, enhancing the reliability and validity of the findings.

Interviews were recorded and transcribed accurately. The flexible questions encouraged participants to express themselves freely (Creswell and Poth, 2016; Paradis et al., 2016). My role as the researcher was to ask questions, explore issues in depth, clarify unclear statements, actively listen, probe, and prompt further to collect richer data. Interviews are ideal for documenting participants' narratives, perceptions, or stories about attitudes and responses to certain situations (Lewis, 2015). The collected data will be analysed to understand how cultural differences impact therapists' interpretations of clients' appraisals in PTSD.

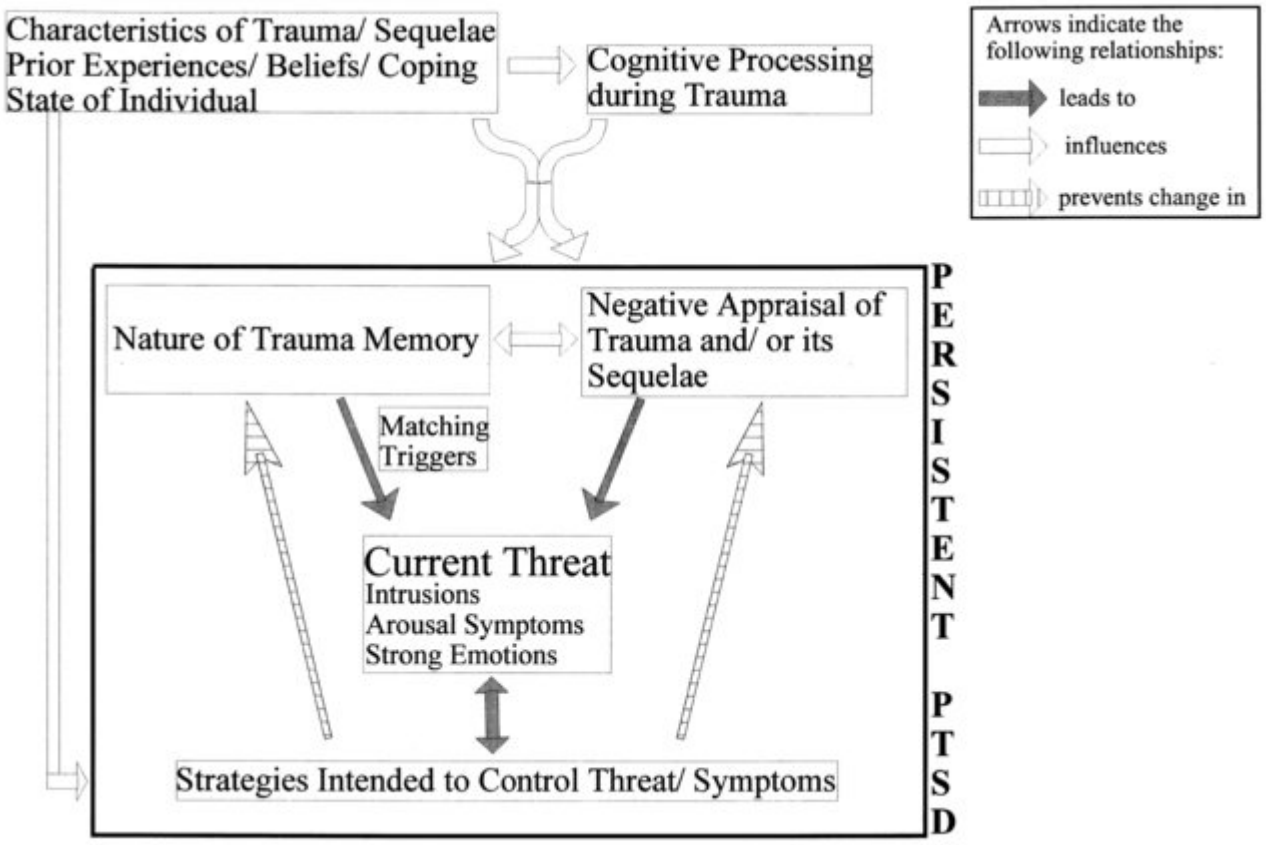
A debriefing session addressed any questions or concerns after the interview, with support mechanisms available if necessary. For instance, if a therapist was traumatised during the interview, they were advised to contact their General Practitioner for a referral to Counselling Services or use self-referral contacts for NHS IAPT services in their locality (*see ethical considerations and stakeholders - Appendix iv/p331).*

Diagram 3. Formulation of PTSD re: Mental defeat



Source: Ehlers and Clark (1998, 2000)

Diagram 4. Formulation of PTSD re: Control strategies



Source: Formulation 2: Ehlers and Clark (1998, 2000)

Chapter 5

5.0 Ethical Considerations and Challenges

5.1 Introduction

Ethics are of paramount importance in the research process, embodying the moral and legal rights of participants. Resnick (2020) defines 'ethics' as the norms of conduct that distinguish between acceptable and unacceptable behaviour. Ethics are the moral principles that govern a person's behaviour. Research ethics involve doing what is morally and legally right in the conduct of a study (Parveen et al., 2017). Reflecting on the planning of my research proposal, I took particular care to ensure that ethical principles were upheld throughout the process.

5.2 Why are Ethics Important?

Reflecting on my experience as a researcher and based on the work of Resnik (2020), I understand the importance of ethics as follows:

i) Ethics promote the aims of research, such as generating new knowledge, seeking truth, and avoiding error. Ethics serve as a barrier against fabricating, falsifying, or misrepresenting research data.

ii) Ethical standards create an environment that fosters values essential to collaborative work, including trust, accountability, mutual respect, and fairness. They ensure the protection of intellectual property, copyright, and patenting policies.

iii) Ethical norms ensure that researchers can be held accountable and responsible for their work, particularly in cases of research misconduct, conflicts of interest, human subject protection, and animal care.

iv) Ethical norms help build public confidence, trust, and support, thereby encouraging public funding for research projects.

v) Ethical norms in research promote moral and social values, such as social responsibility, human rights, animal welfare, compliance with the law, and public health and safety (Resnik, 2020; Arifin, 2018). Without ethical norms, significant physical, psychological, and social harm can be caused to participants. Resnik (2020) states that a researcher who fabricates data in a clinical trial may harm or even kill patients, and a researcher who fails to abide by regulations and guidelines relating to radiation or biological safety may endanger their health, public safety, or the health of others involved in the research.

5.3 Ethical Principles

Reflecting on the importance of ethics in research, I considered and followed the ethical principles based on the work of Shamoo and Resnik (2015) during data collection and will continue to maintain these principles throughout my research career. The ethical principles are as follows:

i) Honesty – Do not fabricate, falsify, misrepresent data, or deceive colleagues, research sponsors, or the public.

ii) Objectivity – Strive to avoid bias in data analysis, data interpretation, personal decisions, and maintain objectivity throughout the study.

iii) Integrity – Maintain agreements, act with sincerity, be consistent in thought and action, and respect colleagues.

iv) Carefulness – Critically examine my work, avoid careless errors, and keep accurate records of research activities, including research design, data collection, transcription, confidentiality, and correspondence with participants, agencies, or journals.

v) Openness – Be transparent and share data, results, and discussions through publication.

vi) Accountability – Be responsible for my part in the research, ready to provide an account, explanation, or justification of my actions.

vii) Intellectual Property – Abide by copyrights concerning intellectual properties and acknowledge the sources of materials used in my work.

viii) Confidentiality – Maintain the confidentiality of participants and other stakeholders, such as workplaces and institutions. Request permission from participants before publishing my work.

ix) Legality – Be aware of and abide by relevant laws, institutional regulations, and governmental policies.

5.4 Ethical Approach to the Study

On the day of the interview, after welcoming the participants on each occasion, a clear explanation was given regarding the differences between research and treatment. They were informed that the research involved a semi-structured interview lasting one hour and were asked to narrate their appraisals of clients' traumas using a set of prearranged open questions (*see semi-structured interview questionnaire - Appendix iii/p330)*. My approach involved researching my fellow therapists, which inevitably presented ethical challenges (Bond, 2004). Although I met the standards required by the Metanoia and Middlesex University ethics bodies, this challenge required me to confront personal difficulties. I was highly conscious of the dilemma of imposing my needs on therapists to participate in the study. Did I feel comfortable asking the therapists to do something for me during what was often a difficult and busy time for them? This was clearly an entirely subjective decision on my part, but at the end of the day, I had to consider the timeframe for completing my study and the fact that participation was entirely voluntary. I initially recruited four participants who agreed to volunteer for the study. The dates, times, and venues for the interviews were organised, and invitation letters were sent to each participant.

On the day of the interview, after welcoming the participants on each occasion, a clear explanation was given regarding the differences between research and treatment. They

were informed that the research involved a semi-structured interview lasting one hour and were asked to narrate their appraisals of clients' traumas using a set of prearranged open questions (*see semi-structured interview questionnaire - Appendix iii/p330).* Participants were advised that they could opt out of the study at any stage without negative consequences, and personal details from the semi-structured interviews would be encrypted and stored securely. They were requested to sign the consent form if they agreed to participate in the study *(see consent form - Appendix i/p319 & Appendix v/p334).*

Confidentiality, safeguarding good scientific practice, and data protection were always maintained according to the policies and guidelines issued by Metanoia Institute, Research Councils (2000), and the General Data Protection Regulation (Gov.uk, 2018). Participants were informed of how to seek support if they were negatively affected. Ethical considerations, support, and procedures for filing complaints are included in the table (*see Appendix iv/p331).* Ethical approval for the study was sought from the NHS Health Research Authority (HRA), but it was not required (*Appendix vi/p336)*. Approval was also sought from the Departmental Research Ethics Committee (DREC) through Metanoia Institute and Middlesex University *(see the application for ethical approval in Appendix vii/p337).*

The ethical application considered issues of obtaining consent and volunteerism, beneficence and non-maleficence, participants' right to access study findings and their dissemination, following the principles of research governance as stated by the Department of Health (DoH) (2003, 2005). I was aware of other ethical concerns that might arise at all stages of my study. I considered and applied the main issues identified by Saunders et al. (2003: 131), which are as follows:

i) The rights of privacy of individuals

ii) Voluntary nature of participation, and the rights of individuals to withdraw partially or completely from the study

iii) Consent and possible deception of participants

iv) Maintenance of the confidentiality of data provided by individuals or identifiable participants and their anonymity

v) Reactions of participants to the ways in which researchers seek to collect data

vi) Effects on participants of the way in which data are analysed and reported

vii) Behaviour and objectivity of the researcher

Clear protocols for dealing with distress should be in place so that both parties involved in research can use them if necessary. It is not usually easy to predict what topics are likely to lead to distress, and researchers should therefore receive sufficient training in predicting traumatic situations. It is argued that qualitative research that deals with sensitive topics in depth can pose emotional and other risks to both participants and researchers (Sanjari et al., 2014). Anxiety became an issue around halfway through data collection. My anxiety was compounded by the pandemic in March/April 2020 when lockdown was imposed throughout the country. Prior to the pandemic, I completed four interviews. During the lockdown, I was unable to continue with the collection of data until the restrictions were lifted. Reflecting on my own concerns regarding Covid-19, I did not feel comfortable recruiting and requesting participants to participate in the study other than to consider whether they wanted to be interviewed by me, which was a face-to-face interaction. My dilemma was that face-to-face interviews might prove to be difficult to organise, meaning that I had to revise my

methodology with reference to the collection of data and required approval by the Panel Approval Body at Metanoia Institute and Middlesex University ethics bodies.

This was clearly an entirely subjective decision on my part, but I had to consider the timeframe to complete my study. I needed to continue with my study, and I had to feel, in my personal ethical core, that there was no way I would delay my project or put my colleagues at risk, or that I was asking them to decide when they might not be able to make an appropriate choice. It can be argued that one ethical challenge to consider is that participants will be requested to volunteer and take part in the research (Arifin, 2018). It was a difficult time for me, and I felt that as a researcher, I needed to collect data for the study with the aim of generating new knowledge and attempting to improve recovery rates. In this process, I had to ensure the participants' rights to autonomy, general well-being, and their protection. I adhered to the ethical principles of the British Association for Behavioural and Cognitive Psychotherapies (BABCP, 2017). I considered the potential risks regarding Covid-19, and how to minimise and prevent those risks; and ensure that no unjustifiable physical, psychological, or emotional harm occurred to myself or participants. When restrictions were eased, I invited four participants for further interviews, explaining to them that the Covid-19 protocols, i.e., guidelines on hand sanitiser, social distancing, and wearing of a face mask, would be strictly followed (Gov.uk, 2020; Irwin, 2021). Applying the Government guidelines on Coronavirus (Covid-19), I completed the data collection for the study. I was relieved and my anxiety reduced.

Chapter 6

6.0 Thematic Analysis Process

6.1 Introduction and thematic analysis process

In this section of the study, the data analysis process is described in sufficient detail to ensure it is replicable and transparent. In the qualitative study, data were collected through semi-structured interviews. The recorded information was fully transcribed into written form for detailed examination. Analysing qualitative transcribed data involves a systematic approach to extract meaningful insights and patterns (Krippendorff, 2004; Braun & Clarke, 2006). The process is often iterative and involves several key steps as follows:

Step 1: Familiarisation with Data

To achieve a comprehensive understanding, the transcribed interview data were read and re-read, as recommended by Braun and Clarke (2006). The recordings of the eight participants were listened to multiple times, using a play/pause technique to ensure accuracy. The data were meticulously transcribed to capture key features of the conversations, including initial impressions, emerging themes, emphasis, tone of voice, timing, and pauses. These elements were essential for the accurate interpretation of the data (Jacob, 2019; Bailey, 2008).

Step 2: Coding

Significant portions of text were identified and labelled. Open coding was used to break down data into manageable segments and apply descriptive labels (Charmaz, 2006).

Step 3: Developing Themes

The codes were organised into broader themes that captured the essence of the data. Similar codes were grouped together, and overarching themes were developed. These themes represented the main ideas or patterns that emerged from grouping similar codes. By identifying commonalities and trends across different codes, these themes provided a higher-level understanding of the data. This process allowed the findings to be interpreted and explained coherently and comprehensively. It helped to condense the data into key insights that were more manageable and meaningful (Braun & Clarke, 2006).

Step 4: Reviewing Themes

The themes were refined and validated to ensure they accurately represented the data. They were reviewed in relation to the coded extracts and the entire data set, ensuring coherence and consistency (Nowell et al., 2017).

Step 5: Defining and Naming Themes

Each theme was clearly defined and named to convey its meaning, ensuring it encapsulated the key aspects of the data (Braun & Clarke, 2006).

Step 6: Writing the Report

A detailed account of the analysis process and findings was compiled. A comprehensive report that included examples from the data, descriptions of themes, and interpretations was written (Creswell & Poth, 2016).

6.2 Reliability and Validity

For the research design and analysis stage, two checks of reliability and validity were conducted. First, a set of topic guides in the form of open-ended questions was discussed and explored with each participant. Second, the primary researcher (S.R.) defined and named themes. Additionally, the transcripts were coded by two raters (T.R. & S.S.) to ensure trustworthiness. Discrepancies between the researcher and the raters were resolved through discussion before arriving at a final set of codes and recoding the transcripts (Creswell & Miller, 2000). Reliability was maintained through member checking, which involved participant (M.B. & T.R.) in the validation of data and interpretations to ensure accuracy (Chilisa, 2019) *(feedback attached/see appendix ii/p323 – p329)*. A journal was kept to document reflections, biases, and decision-making throughout the research process (Ortlipp, 2008).

6.3 Coding Data and Thematic Approach

Having completed the transcription of recorded interviews and familiarised myself with the qualitative data, I proceeded to the next step: qualitative coding. Data from the semi-structured interviews were coded and recoded to identify emerging themes and patterns for thematic analysis. The first stage involved organising, cleaning, and coding the data into meaningful groups (Tuckett, 2005). In this process, the units were effectively labelled with a short description attached to a specific code, capturing the essence of what was being coded. I followed Charmaz's (2008) guide for qualitative coding, which is as follows:

i) What process is at issue here? How can I define it? Considering cultural differences and appraisals.

ii) Under what conditions does this process develop? Considering the nature of the interview and responding to the semi-structured format.

iii) How does the research participant think, feel, and act while involved in this process? Sharing their 'lived experience' and providing the space to think and share information.

iv) When, why, and how does the process change? During the process of interpretation and depending on the nature of the inquiry.

v) What are the consequences of the process? Units attached to specific codes generate main and sub-themes.

(Charmaz, 2008: 96)

For the coding induction process, a series of relevant data features were assembled. Themes were identified inductively from the data rather than being imposed by the researcher (Braun and Clarke, 2006; Creswell, 2013). Applying the inductive process and cleaning the data, initial codes were created, reviewed, and combined into themes and sub-themes (Kriukow, 2019; Saldana, 2016; Stuckey, 2015). This process involved the primary researcher (S.R.) defining and naming themes. Additionally, the transcripts were coded following discussion with the primary researcher (S.R.) and the two raters (T.R. & S.S.) to ensure accuracies and trustworthiness. Discrepancies between the researcher and the raters were resolved through discussion before arriving at a final set of codes and recoding the transcripts (Creswell & Miller, 2000). The identified themes and sub-themes were presented cohesively as findings generated from the research (Belotto, 2018; Smith and Firth, 2011). Examples of the actual clean-up code are found below in Tables 12 (p. 163), with amendments shown in red. Allen (2017) defines data cleaning as a process of improving data quality by correcting

inaccurate records from a record set. An accurate code is attached to the emerging themes from qualitative interview data (Kriukow, 2019).

Table 12: Transcribed Interview Participant 1 (example clean- up)

Table 12: Transcribed interview data Participant 1	Coding number/ emerging theme Raters: SR, TR & SS
B4. Do you see any differences of how clients from different cultural backgrounds appraised themselves? response/unit: From my interpretation this is only in their mind and the negative way of thinking about their situation. In the Sri Lankan Tamil community, the traumatised individual is seen as being 'mad', an 'outcast', and they are ostracised. In such community the impact is on the family, i.e., other members look down on them. In that culture, they understand mental health and perceive mental health differently – 'it is not how we understood it in this culture, understood it very differently'. Their view of mental health is that people stay in hospital or institution, kept away from their family. In western society stigma is attached to the individual- 'something wrong with them'. It is more on an individual basis, appraised themselves as, 'I am to be blamed', 'I am in danger', 'I am guilty'. They blamed themselves, appraised self as 'weak; my fault', 'I went outside and was attacked'. Clients from eastern cultures appraised differently and the collectivistic approach became	B4.1 ~~Understanding mental health in the community~~. B4.1 Perception of mental health by the community B4.2 Rejection by family/ community B4.3 Cultural differences in impacting on clients' appraisal ~~B4.4 Collective approach Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals~~ B4.4 cultural differences impacting on clients' appraisal. B4.5 ~~Individualistic approach~~ B4.5 cultural differences

clear – 'community/others see me as a weak person'. I believe that clients in this group are concerned of not being part of the community or family, they feel being mistrust by members and family. They are isolated and the focus is on losing a lot of things.	impacting on clients' appraisal - West

A full list/tables of the process of clean-up of the units with codes is provided in Appendix (viii) to appendix (xi)/ (p354- p430).

6.4 Clean up Data and Coding using Raters

The codes were recontextualised, rearranged, and assembled into titled themes, matched with the transcribed texts of the 'lived experience' data (Kriukow, 2019; Stuckey, 2015). Inappropriate codes were eliminated with the help of the raters. Appropriate codes/themes were assigned to match the related transcribed data (*see Appendix viii/p354 – p377).* These themes were re-coded to arrive at the final coding of the transcribed data. The codes/themes for each participant are presented in a structured manner, as shown in Appendix (*see appendix ix/p378 – p413*).

6.5 Developing a Thematic Framework to Identify Main, Sub and Stand-alone Themes (*see appendices ix, x, xi / p378 – p430*)

After the clean-up process and recoding, the themes emerging from questions A3, B4, C5, D6, E7, F8, G9, and H10 were collated, and the frequency of each theme was noted and quantified *(see Appendix x/p414 – p427).* This was done to generate the main themes, sub-themes, and single (stand-alone) themes for the findings. This process facilitated the development of a framework to identify these themes. It is crucial to select the main themes, sub-themes, and single themes for critical analysis and discussion (*see Appendix xi/p428 – p430).*

Anwar et al. (2015) and Chi (2009) argue that quantifying qualitative data provides a formulation for understanding the representation of knowledge and the phenomena being studied. The main goal is to validate the cognitive processes of human performance as quantifiable measures with a recognisable scientific basis. Shemmings (2008) argues that quantifying qualitative data complements other qualitative analytic methods. Maxwell (2010) states that the use of numerical and quantitative data in qualitative research studies has been controversial.

Based on the frequencies of each theme, main, sub, and single themes were generated. This process facilitated the research findings and aided qualitative interpretation and thematic analysis. Maxwell (2010: 480) argues that the use of numbers 'is a legitimate and valuable strategy' for qualitative researchers to adequately assess the amount of evidence in the data. A list of main, sub, and single (stand-alone) themes identified is presented as the results and findings of the study in Chapter 7.

Chapter 7

7.0 Results and Findings

7.1 Introduction

Results and Findings Presentation

In this chapter, the results and findings of the exploratory study examining how cultural differences influence therapists' interpretations of clients' appraisals in the context of PTSD are presented. The analysis revealed a range of themes that capture the complexity of this interaction. These themes are categorised into main themes, sub-themes, and stand-alone themes, each illuminating different aspects of the therapists' interpretative processes and their cultural underpinnings.

The main themes represent the broad categories that emerged from the data, highlighting the significant areas of the impact of cultural differences on therapists' interpretations. These themes provide a structural framework for understanding the core dimensions of the study. The sub-themes offer a more detailed exploration of specific aspects of the main themes, providing deeper insights into how cultural differences manifest in therapeutic settings. The stand-alone themes are distinct findings that emerged independently from the main themes but are nonetheless crucial for a complete understanding of the study.

By presenting the results and findings in this structured manner, the aim is to provide a comprehensive understanding of the multifaceted ways in which cultural differences impact therapists' interpretations of clients' appraisals of PTSD. The themes are as follows:

Main Themes:

i) Therapists' interpretation and understanding of cultural differences impacting clients' appraisals

ii) Cultural differences impacting clients' appraisals

iii) Clients' appraisals of their trauma

iv) Therapists' difficulties in therapy

v) Lack of support, family, and community rejection

Sub-Themes:

i) Language barriers in therapy

ii) Alienation towards others and the world

iii) Models of PTSD not meeting the needs of clients from non-Western cultures

iv) Lack of understanding of mental health/PTSD

v) Lack of control

vi) Family support for clients

vii) Community support for trauma victims

viii) Effectiveness of EMDR in the treatment of clients from different cultural backgrounds

Stand-Alone Themes:

i) Secondary traumas occurring due to the lack of understanding by the organisation

ii) Racial discrimination, verbal abuse, personal attacks, and traumatised non-white individuals

iii) Perception of mental health by the community

iv) Similarities regarding alienation and avoidance in both cultures

v) Similarities in appraisal from both cultures

vi) Trauma impacting clients, family, and community

vii) Community support for both Western and Asian cultures

viii) Therapist's understanding of family support in white society

ix) The Stone/Net framework helping clients from non-white backgrounds

x) Psychodynamic therapists' views on models of PTSD being inappropriate across cultures

xi) Cultural differences impacting referrals to NHS IAPT services

7.2 Interpretation of Findings : Managing my Biases

Managing my biases as a researcher with a diverse cultural background is essential for ensuring the validity and reliability of my research findings. Acknowledging and reflecting on my biases, shaped by my cultural background, helps me interpret data more objectively.

As someone from an Asian background, I may have ingrained biases related to cultural views on trauma and mental health. For instance, there may be a tendency to perceive individuals who have experienced trauma as weak or to stigmatise mental health issues. This cultural perspective could impact how I interpret participants' experiences with trauma, particularly in cases where cultural norms strongly influence attitudes towards mental health. For example, in certain Asian cultures, people might avoid public spaces like temples due to trauma-related guilt and feeling like a burden on their family. My bias might lead me to interpret this as families needing to be more supportive, influenced by my cultural values.

Navigating both Eastern and Western cultures, I encounter a spectrum of values, including collectivism versus individualism. Eastern cultures often emphasise family and community support, while Western perspectives might prioritise individual coping mechanisms. My cultural identity could influence how I view participants' responses, especially if they conflict with my own values.

Personal experiences with trauma or PTSD could shape my empathy and expectations regarding participants' coping mechanisms. If I have found certain therapeutic techniques beneficial, there is a risk of overemphasising their importance in my data analysis, potentially skewing results. Cultural differences in communication styles can also affect my interpretation. For instance, indirect communication common in some

Eastern cultures might be misinterpreted if my expectations are based on Western directness.

I regularly engage in self-reflection to assess how my personal experiences and cultural perspectives might affect my interpretation of data. This includes considering whether my cultural values or personal experiences are influencing how I analyse participants' responses. For example, in some Asian cultures, a sense of not being in control and feeling powerless might be related to religious beliefs, such as the acceptance of God's will. My Western values, which emphasise individualism and independence, might influence my interpretation of this. Therefore, I must be objective in my approach, respect the values of others, and interpret the data objectively.

To balance my perspective, I collaborate with researchers and participants from different cultural backgrounds. Presenting my work and engaging in constructive discussions helps me gain a broader view and mitigates my individual biases. I keep a reflexive journal to document my thought processes, decisions, and interpretations as I work with data. This helps me track how my background might influence my analysis and ensures transparency in my research methodology.

Participating in cultural competence training helps me better understand and navigate cultural differences, reducing the impact of my biases. Attending a course on "unconscious biases" was particularly beneficial when interpreting my data. I actively seek feedback and involve two independent members to check my transcripts, review coding, and themes to ensure objectivity and accuracy in my analysis. Constructive criticism helps identify and address potential biases, leading to more accurate and culturally sensitive interpretations.

I also engage participants in reviewing the transcripts and findings to ensure that my interpretations accurately reflect their experiences and perspectives. By implementing these strategies, I aim to manage my biases effectively and produce balanced, objective research findings.

7.3 Impact of Cultural Differences on Therapists' Interpretation and Understanding of Clients' Appraisals

The findings indicate that cultural differences significantly impact therapists' interpretation and understanding of clients' appraisals of post-traumatic stress disorder. Focusing on a Sri Lankan community, Participant 1, a Cognitive Behavioural Therapist (CBT) with over ten years of experience and an Asian cultural background, illustrates through her lived experience the impact of cultural differences on her clients' appraisals.

"In such communities, the impact is on the family, i.e., other members look down on them. In that culture, they understand and perceive mental health differently—it is not how we understand it in this culture; they understand it very differently. In the Sri Lankan Tamil community, the traumatised individual is seen as being 'mad', an 'outcast', and they are ostracised" (B4.4 Participant 1, p378).

Drawing from her lived experience, it is noted that her interpretation of clients from Western societies was entirely different. The findings ssuggest that Participant 1 provided invaluable insights into how cultural contexts shape clients' perceptions of trauma. It is understood that these clients' appraisals on an individual basis, emphasising a culturally centred perspective.

"I am to be blamed, I am in danger, I am guilty. They blamed themselves, appraised themselves as weak, thinking 'my fault, I went outside and was attacked'. Clients from Eastern cultures appraise things differently, and the collectivistic approach made it clear that the community/others see me as a weak person" (B4.4 Participant 1, p378).

From her extensive experience, it is understood that these clients focus heavily on their personal failings and vulnerabilities. It is noted that her perspective resonates with her own lived experience, highlighting a cultural inclination towards prioritising individual responsibility and navigating personal mental health challenges. The findings suggest that there is a strong emphasis on self-assessment and striving for personal growth within this cultural framework. Her lived experience highlighted the differences in interpreting and understanding clients' appraisals of trauma following PTSD across cultures. Her lived experience shows that there are concerning and disturbing aspects regarding sexual assault and rape.

"A lot of people I worked with felt that there is no future for them to get married, especially female clients because they are seen as 'damaged', 'having been raped', 'everyone knows about it in the community', and 'it is their fault'. Being culturally aware of the Asian culture, she interpreted and understood that this situation was a grave concern for female members of the Asian community" (C5.1, Participant 1, p379).

The findings indicate that, concerning sexual assault and rape, there is a deep-seated cultural stigma within the Asian community.This participant's narrative highlights several critical points about the intersection of cultural awareness and the impacts of sexual violence on victims' social identities and prospects. The statement "it is their fault" reflects a victim-blaming mentality that is prevalent in the community. It is

noted that internalised blame exacerbates the trauma of the assault and can lead to feelings of shame and isolation.

The belief that "*there is no future for them to get married*" underscores the long-term consequences of sexual assault on victims' lives. The findings suggest that in the Asian community, marriage is a significant social milestone, and being seen as "*damaged*" can exclude victims from this institution, thereby affecting their social and economic stability.

The participant's lived experience indicates that there is a "grave concern" within the Asian community, which demonstrates her cultural sensitivity. The participant's insight shows that there is a need for culturally competent support services that acknowledge and address the specific stigmas and challenges faced by victims within their cultural contexts. A similar traumatic event related to Western culture reveals that there were similarities in that clients were concerned about their future, relationships, and partners.

'Similarly, in Western culture, clients are equally concerned about their future, including relationships, intimacy, and the need to find a partner, rather than focusing solely on family.' (C5.1, participant 1, p. 379)

In Western cultures, as indicated by the participant 1's lived experience, there is a pronounced emphasis on personal relationships and the search for intimacy and partnership. The findings suggest that relationship differs from some other cultural contexts where family might be the central focus. The participant 1's insight highlights that trauma impacts individuals in ways that transcend cultural boundaries, bringing to light shared human experiences and concerns. The data from Participant 2, who

worked with both cultures, show that cultural differences impact clients' appraisals of their identity.

'Western people have the very sense of their identity – my goal is to get back to the person I used to be before the trauma and to view themselves as an individual capable person… whereas people from the eastern cultures are more often about being accepted in the community. I think westerners is much more about what I need to do to get myself back to normal whereas I think, they view themselves as being abnormal compared to as they were. Sometime there is a belief the way I see myself, meaning important change that can affect me. Whereas in the eastern cultures is about how I am being perceived by others now having gone through the trauma. (D6.2, participant 2, p383)

The lived experience of participant 2 in this section highlights the significant impact of cultural differences on her interpretation of the clients' appraisal on the concept of identity, particularly in the context of trauma. Participants 2, working with white British clients, perceives identity as a complex and deeply ingrained aspect of self, significantly affected by traumatic experiences. The data show that this perspective is rooted in her own cultural understanding, where identity is integrated with personal and social perceptions, leading individuals to view themselves as fundamentally changed by trauma.

In contrast, the participant 2's lived experience suggest that in a small Sri Lankan village, where the community's way of life is centred around farming and where individuals have faced torture due to war, the layers of identity might not be as deeply embedded. The data indicate that the impact of trauma on identity is perceived to be less profound compared to those in Western societies. This difference could be

attributed to the varying degrees of emphasis placed on individual identity in different cultures. It is noted that in Western societies, personal identity is often seen as a core component of one's existence, heavily influencing self-perception and social interactions. On the other hand, in the described Sri Lankan context, the findings point out that identity might be more closely tied to communal and familial roles, with less focus on individualism, potentially leading to a different experience of trauma's impact on identity.

The participant's lived experience highlights the importance of cultural sensitivity and awareness in therapeutic settings. It demonstrates how cultural background can shape the understanding and interpretation of identity and trauma, suggesting that participant 2 needs to consider these cultural dimensions to provide more effective and empathetic care.

With reference to her lived experience, Participant 2, specialised in EMDR, it is found that cultural differences impacted her interpretation and understanding of how she should appraise Muslim girls' negative thoughts. The data indicate that this type of negative thoughts was too rigid and would be considered extreme even within Islamic culture. It is noted that her interpretation and understanding of her Muslim clients' negative thoughts and their appraisal validate these thoughts beyond their religious beliefs, as they exceed what the religion requires. The data reveal the importance of being careful not to undermine someone's religion in therapy and to seek appropriate religious help and support.

'We need to expand the way we work to include members of the community, which might help to understand the clients and provide better therapy' (H10.3, Participant 2, p386).

The findings suggest that it is crucial to consider the impact of cultural differences on the therapist's interpretation and understanding of clients' appraisals following PTSD. Considering the lived experience of Participant 3, specialised in CBT, there are clear indications of the impact of cultural differences on interpretation and understanding. The findings show that Tamil refugees from Sri Lanka, who had been affected by bombings and tortured during the war, appraised themselves from a cultural perspective. Her lived experience indicates that the clients utilised Hindu philosophy, faith, and destiny to cope with their trauma.

'We are destined, it is our faith – a kind of appraisal, using a community approach.' (A3.6, Participant 3, p387).

The data reveal that, based on her experience working with refugees, secondary appraisal occurred while the trauma was happening, with pre-cognitive appraisal evident, as illustrated by the statement: *'This is the end, my fate, my karma – I see this.' (A3.6, Participant 3, p387)*

Reflecting on the data, the pre-cognitive appraisal can be seen as a generalisation of the clients' fear and anxiety related to authority, police vehicles, and blue light vehicles:

'Meaning that I have to hide, reminding them of what was happening in their home country, the military regime, the tortures, and the bombing environment.' (B4.7, Participant 3, p387)

According to participant 3's lived experience, it indicates that the secondary appraisal *'keeps the trauma going, self-agency is weak, and clients see these triggers as a threat.'*

The data show that the client lost autonomy, control, and identity and presented with various trauma-related issues. Participant 3's lived experience reveals the client's appraisal as a loss of control*:*

"'I am not in control' is a common theme – 'I feel the trauma; it is overwhelming me,' 'I can't have control,' 'I can't trust myself to make the right decision independently,' 'I need somebody else to help me.'" (B4.7, Participant 3, p387).

Participant 3's lived experience provides deeper insight into the cultural differences impacting her interpretation and understanding of her clients' appraisals and how they felt after the traumatic events.

Based on the lived experience of Participant 4, who specialises in EMDR, the impact of cultural differences is particularly evident in how clients appraise their trauma. The data reveal that military culture is prevalent, and it is observed that many ex-soldiers find it challenging to report mental health problems. The data provide insight into how military culture influenced the ex-soldiers' behaviour towards trauma.

'Because of the culture of needing to be strong, reporting a problem is seen as a sign of weakness' (B4.10, Participant 4, p391).

Reflecting on this example, culturally, and coming from the military, the data suggest that in the military, one would expect to be strong in nature and not showing their weaknesses.

Participant 4's lived experience provides a similar understanding of the traumatic experiences within the African Caribbean community, specifically the perception of being mentally weak. The data reveal that friends and family members in the community were afraid of mental health services, noting:

'If you are involved in mental health/have a mental health issue, there is the danger of being sectioned.' (C5.6, Participant 4, p391).

It is observed that the clients saw themselves as traumatized and affected, with a weak sense of self in the context of PTSD. In comparison to individuals from Western cultures, the data show:

'They were high-functioning and psychologically minded, presenting with the least problems associated with PTSD, and able to differentiate and perhaps more likely to say, this happened to me, it was not my fault and there is no shame associated with it'. (C5.6, Participant 4, p391).

Participant 4's lived experience shows that people of Asian and African backgrounds revealed different perceptions of mental health services. They felt isolated and helpless. Tamil people were alienated within their own community, avoiding association with other members out of fear that messages about them could get back to their own country, which could have implications for them and their families. The data indicate that they did not trust the translator:

"Having a translator to act on their behalf can trigger the fear of information getting back to their own country." *(F8.9, Participant 4, p393).*

Lived experience from Participant 5, an integrative therapist specialising in integrative and humanistic therapy, provides profound insights into how cultural differences shape the interpretation and understanding of clients' appraisals of PTSD. It shows the significant role culture plays in the experience and treatment of trauma.

'It remains a secret, but this is not so much in Western society, where it is more transparent and family supportive.' (E7.12/14, Participant 5, p397).

The data reveal a notable disparity between how traumatic experiences are managed and perceived in Asian and African cultures compared to Western societies. In Asian and African cultures, there appears to be a tendency to conceal traumatic events, treating them as secrets to avoid shame and protect the family's reputation. This secrecy contrasts with the more open and supportive approach observed in Western cultures, where family support and transparency are more common. From a therapeutic standpoint, Participant 5's lived experience highlights the importance of cultural sensitivity and awareness in trauma therapy.

Participant 5's lived experience highlights the significant role cultural differences play in the interpretation and understanding of clients' appraisals, particularly in the context of mental health and trauma.

'Clients complain of somatic symptoms such as headaches and back pain rather than opening up and talking about their sexual abuse and its impact on them. Clients from these groups have a negative opinion of themselves, feeling weak and out of control, especially when they experience flashbacks – they can't control this experience and are helpless.' (E7.12/14, participant 5, p. 397)

Regarding the somatisation of psychological distress, the data indicate that clients often manifest psychological pain through physical symptoms such as headaches and back pain, rather than directly discussing their trauma, such as sexual abuse. It is suggested that this phenomenon, known as somatisation, can be more prevalent in certain cultures where discussing mental health issues is stigmatised or considered taboo. Her insights reveal the intricate interplay between culture and mental health, stressing the importance of culturally informed therapeutic practices to adequately address and support the mental health needs of diverse client populations.

The lived experience from participant 6, specialised in psychodynamic, highlights the significant role cultural differences play in the interpretation and understanding of clients' appraisals in therapy. The case of the Indian woman who was sexually abused by her uncle illustrates how cultural norms and family dynamics can profoundly influence the client's perception of her trauma and the subsequent impact on her mental health.

'Disturbing and heart-breaking as she had to carry this trauma for a long time until she had therapy with me. I know that I will not get a direct answer to these questions, just assume that it is a cultural issue within the Asian community'. (F8.14, Participant 6, p401)

The data reveal that cultural expectations within the Indian family such as keeping incidents secret, likely due to feelings of guilt or shame, led the client to feel unsupported and distrustful of those around her. An insight is gained from the data, showing the secrecy and the pressure to maintain family honour, thus compounding the client's trauma, causing her to view the world as unsafe and untrustworthy.

Participant 6's data show how these cultural factors affected the client's experience and her emotional response and interpretation of the situation. She found it "disturbing and heart-breaking" that the client had to endure her trauma in silence for so long, which suggests deep empathy and a recognition of the additional burden imposed by cultural expectations.

The impact of cultural differences on therapists' interpretation of clients' appraisals is further demonstrated by Participant 6's lived experience with people of Afro-Caribbean origin, and it reveals:

'a strict upbringing, and they felt isolated and alienated when exposed to trauma and clients from this community always appraised themselves as being badly treated and giving up -life can treat you badly, whereas I observed not so much in the western cultures. From my experience working with Asian clients, I found that in Asian Pakistani culture, clients appraised themselves as being mentally weak'. (C5.10, participant 6, p400).

Furthermore, Participant 6's experience with clients from different cultural backgrounds, including Afro-Caribbean and Pakistani communities, shows a broader pattern of how cultural upbringing shapes individuals' responses to trauma. She observed that Afro-Caribbean clients often felt isolated and alienated, viewing life as treating them badly, which contrasts with her observations of Western clients. Similarly, she noted that Asian Pakistani clients tended to appraise themselves as mentally weak when faced with trauma.

These insights demonstrate the importance of cultural competence in therapy. Understanding the cultural context of clients' experiences allows therapists to better interpret their appraisals and provide more effective support. Participant 6's experiences emphasise the need for therapists to be aware of and sensitive to cultural differences, as these differences can significantly impact clients' mental health and their responses to therapy.

Religion and faith play a significant role in the lives of clients from collectivistic cultures. Data obtained from Participant 7, a specialist in integrative therapy and counselling, indicate that cultural differences influence her interpretation and understanding of her clients' appraisals in PTSD. Her interpretation of one client

losing faith in God was seen as negative behaviour and a sign that God was punishing the client, leading to rumination and a deeper impact on the client.

Her lived experience provides an insight into the permanent changes in clients from both cultures—there were instances of self-blame, a loss of self-control, and diminished strength, all lasting for a long time. In some Asian cultures, the data show that the clients felt alienated within their own group for extended periods, and were negatively appraised:

'*In the Pakistani culture, clients were frightened of being judged negatively by their community. Based on my clinical experiences, cultural differences have impacted individuals in various ways.' (G9.22/23, Participant 7, p407)*

Compared to individuals from Sri Lanka, Afghanistan, and other war-torn countries, the participant's lived experience resonates with clients' accounts of escaping war and the myriad terrible events they endured. Her focus is on their acts of fleeing rather than surrendering. She realised that, at the time, the connection to PTSD or other anxiety and mental disorders related to their journey was distant and insignificant—the priority was to escape danger. Given the cultural background and war-like conditions, she felt that the connection to the trauma would take time to manifest.

"It takes a bit of time to connect to the trauma and its impact on them. Why they are experiencing what they have experienced." (A3.11, participant 7, p411)

In her experience, both cultures experienced permanent change, but in different ways. Clients from collectivistic cultures appraised their life change as *'I have changed forever', 'Who I was, I am broken', 'I am damaged' – this was particularly evident among women from Asian cultures – 'I can't get married', 'I am not the same person',*

'Others see that I am impure', 'My family and community reject me' (G9.23/24, participant 7, p407).

The data reveal that negative appraisal could have severe implications for the clients' future and ongoing low self-esteem. It is noted that drawing on her ability to interpret and understand her clients' appraisals would require her to adjust her treatment plan to address her clients' problems. In Western culture, she observed that the focus was more on an individualistic approach, and she understood her clients' appraisals as 'not the same person', 'not their fault'. Asian clients might come up with appraisals such as *'I should not be living anymore'; her interpretation was that her clients might have suicidal ideation associated with rape. 'I would rather die than live', 'I am alone', and 'I am not pure' (G9.23/24, participant 7, p407).*

She observed that clients avoided religious places, such as temples, as they felt '*I am impure'. From the clients' perspective, they were not 'pure' and felt that they should not be there. They felt isolated, something they valued had been taken away from them, and they were separated from their family and community, leading to separation anxiety (G9.23/24, participant 7, p407).*

Similarly, the data show that in Western culture, i.e., isolation, separation, and alienation following sexual assault. Cultural differences impact her interpretation and understanding of her Asian clients' appraisals. The data suggest that the impact of cultural differences is not understood by therapists, this could have severe implications for psychological readjustment, delaying treatment and recovery.

7.4 Cultural Differences Impacting on Clients' Appraisal

Cultural differences impacting clients' appraisals are a significant theme. In this section, the findings for each participant are presented. Considering Participant 1's lived experience of the client's appraisal in one situation:

"Allah designed for me what I deserve, acceptance of God's will as they think they are helpless. It does not matter if someone else designs my future for me, I am going to do it, believe in God – I can't physically or emotionally go against God's will." (E7.1, Participant 1, p. 379)

Reflecting on the client's belief in God and the way they appraised themselves indicates that being a follower of Islam influences their thoughts, emotions, and decision-making. Participant 1's lived experience highlights how their faith provides a framework for understanding and accepting their circumstances, emphasising a reliance on divine will and a sense of helplessness in altering their fate. Additionally, in some Eastern cultures, there is a perception that the victim's behaviour and approach towards society may trigger trauma, indicating a cultural lens that can impact self-appraisal and the interpretation of events.

Participant 1 commented on the case of sexual assault, emphasising significant cultural differences in the perception and impact of such experiences. In Eastern cultures, based on her lived experience, it reveals that clients often internalise blame, feeling that the assault is their fault. Community members or family may reinforce this by attributing blame to the victim's behaviour or attire, suggesting they deserved punishment. In contrast, Western society tends to focus more on the individual's self-appraisal, where victims might see themselves as weak or taken advantage of. Participant 1's lived

experience highlights how cultural context profoundly influences the way individuals perceive and internalise their experiences of trauma:

"Their view of mental health is that people stay in hospital or institution, kept away from their family. In western society stigma is attached to the individual- 'something wrong with them'. It is more on an individual basis, appraised themselves as 'I am to be blamed', 'I am in danger', 'I am guilty'. They blamed themselves, appraised self as 'weak, my fault', 'I went outside and was attacked'" (B4.4 Participant 1, p378).

Participant 2's experience shows significant cultural differences, particularly highlighting the challenges faced by individuals from Middle Eastern communities. These individuals often experienced difficulties and isolated themselves from their own culture due to fear and social stigma associated with their trauma. The participant noted that these individuals came from close-knit communities where interactions with other community members could lead to people back home learning about their traumatic experiences. This could result in feelings of shame and guilt.

Participant 2's lived experience, stating,

"They did not want to be dishonoured, and they thought that people would know that 'something bad had happened to them'. So, in some ways, they withdrew from the community because of that fear. This is not an issue with Westerners; there is no such thing as a tight-knit community" (G9.3/G9.4, participant 2, p384).

This quote highlights a clear and noticeable difference between Middle Eastern communities and Western societies in terms of community dynamics and the impact of trauma on social interactions. Additionally, the refusal to work with interpreters from the same community highlights the profound fear of their trauma being exposed within their tight-knit circles. They worried that interpreters might know someone

from their community back home, potentially spreading word about their trauma, further contributing to their sense of isolation and vulnerability. These cultural differences significantly impact the clients' appraisal and coping mechanisms, demonstrating the importance of culturally sensitive approaches in addressing trauma within diverse populations.

Considering the lived experience from Participant 3, it is evident that cultural differences significantly impact her comprehension of the clients' expressions of distress. Participant 3 noted that the clients are not particularly psychologically minded and often somatise their psychological problems. The data suggest that, instead of reporting psychological symptoms, they tend to report physical symptoms. Reflecting on this observation, it shows that their cultural background and lack of awareness about the concept of dysfunctional thoughts, emotions, and behaviour lead them to perceive their issues as primarily physical. Consequently, they seek cures through medication rather than therapy.

Participant 3 stated, *"They see medication as the answer to get cured, not necessarily to challenge thoughts, explore emotions, and behaviours" (H10.10, Participant 3, p. 390).* This highlights a significant cultural difference in understanding and addressing psychological issues. In some Middle Eastern cultures, there is a tendency to prioritise physical health and view psychological issues through a medical lens. This cultural perspective can lead to an underutilisation of therapy and a preference for medical treatments, which may hinder the effective management of their distress.

Participant 5's observations highlight significant cultural differences in the interpretation and understanding of trauma-related thoughts and experiences among clients from African backgrounds. This perspective points out how cultural beliefs and

values shape the way individuals internalise and make sense of their traumatic experiences.

In the first observation: *'People coming from certain places of Africa might interpret these thoughts and nightmares as being struck by black magic or demons and they are being repossessed'. (H10.17, participant 5, p398)*, the findings indicate that some people from certain African backgrounds might view trauma-induced thoughts and nightmares through the lens of black magic or demonic possession. The data show that this interpretation is deeply rooted in cultural and spiritual beliefs that attribute unexplained or distressing phenomena to supernatural causes. Such interpretations can impact how individuals perceive their mental health and their willingness to seek help. In cultures where supernatural explanations are prevalent, individuals might view their experiences as a spiritual crisis rather than a psychological issue, which can influence their coping mechanisms and the types of support they seek.

The second observation, *'I am weak, and others see me as a weak person, how am I going to be perceived by people closed to me'. (B4.12, participant 5, p395)* reveals another layer of cultural influence, where trauma and its psychological effects are internalised as a personal weakness. Participant 5 indicates that individuals may fear being perceived as weak by others, reflecting a cultural stigma associated with mental health issues. Data may suggest that in many African cultures, there is a strong emphasis on communal identity and social perception. Being seen as weak can threaten an individual's social standing and relationships within their community. This concern about perception can hinder open discussions about mental health and discourage individuals from seeking the help they need. These observations by participant 5

illustrate how cultural context shapes her interpretation in relation to clients' appraisals of trauma and mental health.

Participant 5's data of her interpretation of clients' appraisals highlights significant cultural differences in how people of colour and white clients perceive and experience familial expectations and support in the context of trauma. Considering her lived experience below several key point are revealed.

'*I find that people of colour put more weight on the family. They feel the shame, guilt, disobedience and lack of control as not following the family expectations. They feel that 'I am done, what my family would expect more of me that I want to do', I hear that in my work with the clients. I find that clients are rejected more by family and losing control, common in people of colour whereas for the white clients, family can be devastated, but the focus is on the impact of the trauma on the individual, i.e., how the client will be affected, family plays a minor role, but can be supportive'. (E7.9, participant 5, p396).*

Participant 5 observes that clients from ethnic minorities often place substantial importance on family expectations and the collective experience of shame, guilt, and disobedience. The data indicate a broader cultural value of family honour and cohesion is prioritised. Individual actions are seen in the context of their impact on the family unit, leading to a heightened sense of responsibility and pressure to meet family expectations.

The data shows a contrast between clients of ethnic minorities and white clients in their focus on trauma. Clients of ethnic minorities reportedly experience trauma with a more collective perspective, emphasising the familial implications of their actions and feelings. Conversely, white clients tend to focus more on the individual impact of

trauma, with family playing a supportive but secondary role. The findings suggest that this difference can be attributed to varying cultural norms regarding individualism and collectivism. In more individualistic cultures, personal autonomy and individual well-being are often prioritised, while in collectivist cultures, the well-being of the group or family can be more central.

Participant 5 highlights that clients of ethnic minorities may experience more rejection from their families, possibly due to not meeting the stringent expectations or norms of their cultural background. This rejection can exacerbate feelings of shame and loss of control. In contrast, data show white clients may also face familial devastation, their families tend to provide more supportive roles rather than focusing on unmet expectations. Participant 5's experience provides insight into the profound impact of cultural differences on how trauma is perceived and processed by clients.

An interesting observation was made by Participant 7 regarding the impact of cultural differences on clients' appraisals following PTSD. The data indicate that clients from African backgrounds find it difficult to articulate their intrusive thoughts and other PTSD symptoms, such as flashbacks or reliving the trauma. For example, her appraisal of a Somali client reads:

'Intrusive thoughts forced and tried to push them to experience this'. 'The force pushed, and it was a bad force'. (B4.18, participant 7, p404

The findings suggest that they were experiencing flashbacks and reliving the trauma and understood intrusive thoughts as coming to their mind against their will. They could not make sense of it. In comparison, it is noted that clients from the West were clearer about intrusive thoughts and flashbacks and did not attribute these thoughts to

any external force. Participant 7's lived experience indicates that language and cultural upbringing can play a key role in making sense of the trauma.

Considering evidence from Participant 7's lived experience, it provides an insight of the clients' self-appraisal questions such as 'will I be able to fit into this society?', 'in the white culture?', and 'will I be sent back?'. The data show how the clients internalised feelings of guilt and shame, encapsulating sentiments like 'I brought shame to the family and community,' 'We as a family and community feel ashamed,' and 'The stigma of shame attached to the family and community.' This illustrates how her interpretation of her lived experience is deeply intertwined with the clients' sense of belonging and the collective identity of their family and community. Considering the lived experiences and participants' interpretations and understandings, the data reveal how cultural differences significantly influence clients' appraisals across various cultural backgrounds.

7.5 Clients' Appraisal of their Traumas

The findings suggest that in the Asian culture, there is a tendency to believe in karma and fate. Desai and Pargament (2015) explore how religious and spiritual beliefs, including karma, influence the perception and processing of trauma. The study highlights the importance of understanding these beliefs in providing effective and culturally sensitive therapy to clients. If something bad happens, such as experiencing trauma and subsequent PTSD, appraisals are culturally driven, and data support this perception:

'*People with different beliefs feel that perhaps they have been punished for something that they have done in previous life, I was met to experience this'. From a religious*

perspective, client said 'whoever decided for me, I endured my life rather than changing my perception'. My life has been predestined'. (D6.1, participant 1, p379)

Participant 1's lived experience provides an insight into people with different beliefs. The data show that clients attributes their trauma to karma and fate. It provides an insight into how Participant 1 finds this perspective familiar and resonates with her own cultural beliefs. It offers an understanding of shared cultural perspectives that can foster empathy and a deeper connection with clients. The findings show how Participant 1 can relate to the client's beliefs and emotional responses. These findings provide a framework for making sense of suffering and misfortune, offering a coherent explanation that aligns with cultural and religious values. For the client who feels punished for past actions or believes their life is predestined, it is suggested that adaptive coping mechanisms are in place within their cultural context to cope with their traumas.

However, it illustrates how this cultural alignment might also introduce biases, potentially leading Participant 1 to overemphasize spiritual or fate-based explanations at the expense of exploring other psychological or situational factors contributing to the client's trauma. The data indicate that cultural differences significantly impact Participant 1's lived experience, interpretation, and understanding of clients' appraisals. This experience highlights that belief in karma and fate shapes how trauma is perceived and processed, influencing the participant and the client (Mayer, 2017).

The cultural differences in Participant 2's lived experience show how deeply ingrained beliefs can shape one's interpretation of trauma and mental health. In this case, participant 2's lived experience of their clients, the findings indicate that the trauma is

deeply influenced by their spiritual and religious background, which is a significant factor in how they perceive and seek help for their experiences.

'They felt that they were possessed by the devils, and they would seek counselling from the Church/Pasteur, with a view that they would be cured, failing to understand the concept of PTSD. The way I interpret this form of appraisal, is linked to spiritual and religious deep belief since childhood upbringing'. (G9.3, participant 2, p384)

The data suggest that the notion of being possessed by devils reflects a cultural and religious framework that prioritises spiritual explanations over psychological ones. This perspective is rooted in upbringing and cultural environment, where spiritual and religious interpretations are central to understanding personal distress. Consequently, through the lived experience of Participant 2 and her subsequent interpretation and understanding of the clients' appraisal, trauma is not seen through a psychological lens but rather through a spiritual one, which significantly affects their perception of the problem and potential solutions.

Reflecting on Participant 2's lived experience, the findings show that the clients seek help from the Church, or a Pastor highlights the cultural belief that spiritual or religious interventions are the primary means of addressing such issues. In their view, the trauma is something that can be cured through spiritual means rather than psychological treatment. This approach reflects a cultural reliance on religious authorities for healing, rather than a mental health professional who might approach the issue from a clinical standpoint.

In addition, Participant 2's interpretation and understanding the clients' appraisal indicates trauma is influenced by their cultural and religious beliefs. Participant 2's experience shows that the concept of PTSD, with its clinical and psychological

importance, may be foreign or less meaningful within the cultural context. It points out the difficulty of fully grasping the psychological dimensions of trauma or how it affects mental health, as the cultural framework emphasises spiritual explanations and remedies. Participant 2's lived experience provides insight into the clients' appraisal of trauma through a spiritual lens, meaning that they might not relate to or see the relevance of psychological therapies, which could lead to a less effective approach to managing their trauma.

Reflecting on Participant 2's lived experience, it shows that spiritual beliefs allow for more culturally sensitive approaches in therapy. It indicates that the professionals might need to integrate an awareness of these beliefs into their practice or collaborate with spiritual leaders to provide a holistic approach to care. Participant 2's experience of trauma provides insight into the profoundly influential aspect of the cultural and religious background, indicating the preference for spiritual healing over psychological interventions. It highlights the importance of culturally competent care that acknowledges and respects individual beliefs while offering effective support for trauma.

Participant 3's lived experience provides an insight into the perceive loss of autonomy and identity, frequently presenting with trauma and the theme of *"I am not in control."* The data suggest that there is a sense of control which is typically associated with individualistic cultures but is also noted among clients from collectivistic backgrounds:

"There is a difference in the appraisal of control in PTSD. 'Westerners feel that they should be able to control it whereas I find that Asian women I worked with, didn't have a lot of control over their life generally anyway – just an example of not having control

in their life perhaps'. It is not such a big thing for them when compared to a person /westerner woman, who has more control over their life generally. 'Something happened and they lost control', more of an impact on the western women, whereas Asian women do not have that level of control in their life generally anyway. I found that westerner women were more affected re: control in raped cases. In situation of rape in other cultures, I found the intensity was not that severe, probably of their upbringings or not treated so well in their life as the westerner women, or culturally a submissive role in their societies" (F8.1, F8.2, Participant 1, p380).

Participant 3's experiences highlight the client's emotional impact of cultural differences and the feelings of inadequacy that often accompany relocation and cultural shifts. The data reflect a complex interplay of identity, self-perception, and the struggle for acceptance in a new cultural environment. The data show sentiments such as, *"I am different," "I don't want to look or feel the same as the next person," and "I am not as good as the next person" (F8.7, participant 3, p. 389).*

This sentiment reveals a resistance to assimilation or losing one's unique cultural identity. The finding indicates a desire to maintain individuality and cultural heritage despite the pressures to conform.

The findings from Participant 6's lived experience indicate a universal lack of ability to plan lives, activities, and social interactions. Clients felt weak, unable to minimise physical or psychological harm, and often described themselves as withdrawn, silent, vague, and purposeless. They reported an inability to speak out or defend themselves, and a shift in self-perception, expressing thoughts such as, *"What control have I got? I feel powerless. I can't cope. It's a very difficult situation" (E7.16, participant 6, p. 401).*

In contrast to clients from war-torn countries, cultural differences significantly influence how individuals appraise themselves (Markus & Kitayama,1991). Issues of identity appraisal and community support are evident in the findings. The findings from the lived experience of Participant 7 show how clients from these regions express their self-appraisal:

"I am feeling so depressed; I don't understand—being in this country, I have been feeling low. I cannot do my work, cannot engage in activity, I am indoors, people speak to me, I hear voices telling me about sad things. We have lost our family, our country, our culture. Our identity, our connection" (B4.17, participant 7, p404).

Similarly, the data from Participant 7's lived experience show the individualistic approach of the client's self-appraisal as*: "I have lost my identity, my country, my connection" (D6.14, participant 7, p404).* Findings related to PTSD reveal a paradigm shift in the clients' lives across both Eastern and Western cultures. It is understood that the impact of trauma has *"changed their world view, the triad of the world itself" (A3.7, participant 4, p406).*

Data from the lived experience of Participant 8 indicate that clients struggle to cope, with stigma and shame becoming significant issues, leading to a sense of insecurity. For instance, clients self-appraise as *"I can't cope," and "I am not safe anymore, my life is coming to an end," reflecting an individualistic approach. Stigma and shame are attached to the individual self rather than the community or family, with a greater focus on the individual (E7.20, participant 8, p411).*

In contrast, people from Eastern, African, and Middle Eastern cultures are more concerned with how others view them, especially female clients. Lindholm (2007) explores various cultural identities and discusses how social perception and gender

roles vary across different cultures. The lived experience of Participant 2 indicates that while working with an African woman infected with HIV by her unfaithful husband. She expressed profound shame, stating: *"I should have been able to prevent that from happening, and people see me 'differently'; then I see myself differently, mentally weak" (C5.2, participant 2, p382).* It is understood that Participant 2's experience and understanding of the appraisal, reveals the impact of culture on the self, family, and the community, saying, *"We as a family/community feel shameful, and the 'stigma of shame' is attached to the family/community" (C5.2, participant 2, p 382).*

7.6 Therapists' Difficulties in Therapy

Considering the theme of therapists' difficulty in therapy, the findings reveal a critical challenge: clients struggle to grasp how psychological interventions, particularly those involving talking therapies like Cognitive Behavioural Therapy (CBT), can alleviate their distress.

'Trauma in India, I think its treated by medication, clients expect a cure! Our role is more of a psychological intervention. It is difficult for them to understand how talking can help, 'something in my body, how can talking help? It is difficult to verbalise what is happening at that time. It is difficult for the therapist to go and update the memory. – it is challenging with CBT' (G9.5, participant 2, p384).

Reflecting on the participant's interpretation and understanding of the clients' appraisal, it is evident that there are several key aspects of the challenges where physical symptoms are treated with medication. The data indicate that clients may expect a tangible, quick fix using medication for trauma, perceiving it primarily as a physical or medical issue rather than a psychological one. Participant 2's lived

experience shows that there may be a limited understanding or acceptance of psychological interventions such as Cognitive Behavioural Therapy (CBT). The concept of talking therapies might be less familiar or valued compared to physical treatments. It is observed that providing psychological interventions can be challenging when clients are sceptical about the effectiveness of these methods. The data indicate that clients might experience and express psychological distress through physical symptoms. They might struggle to see how talking can address what they perceive as a physical problem, i.e., "something in my body."

The findings from Participant 2's lived experience show that CBT involves cognitive restructuring, which requires clients to reflect on and verbalise their experiences to reframe their thoughts and memories. It is understood that this process can be difficult if clients are not accustomed to or comfortable with introspection and verbal expression. The participant's experience highlights the need for therapists to understand and navigate cultural differences to provide effective trauma treatment. The data indicate that adapting therapeutic approaches to align with clients' cultural beliefs and communication styles can enhance the therapeutic alliance and improve outcomes.

Findings reveal that the use of translators can be challenging, as trusting the translator to convey the message and terminology accurately can be problematic. The lived experience of Participant 4 illustrates this difficulty:

'I see therapists as being "blind" here; they don't know what the translator is conveying when working with clients from different cultural backgrounds' (D6.8, Participant 4, p. 392).

Conversely, findings show that therapists working with clients who had sufficient knowledge of English and were somewhat fluent did not need a translator. However, there was a danger of misinterpretation, and psychological terminology might not be understood (Olfson, 2014). Therapists found psychoeducation to be difficult with clients from different cultural backgrounds (Hays, 2016). The data reveal that there is a misconception of how the world is viewed by different cultures:

'I find working with clients from different cultural backgrounds difficult. I gain different insights as a clinician. It challenges my practice, working with clients from different cultural backgrounds whose first language is not English. Recounting their trauma and psychoeducation prove difficult to handle' (G9.15, Participant 4, p395).

'*I felt at that time that their understanding of what was happening to them was extremely important. Knowing what was happening to them had to be explained in such a way as to convey the message. I found psychoeducation challenging, and there were cultural implications to understand. Knowing what they were experiencing, making meaning for them, and understanding them were crucial' (B4.21, Participant 7, p405).*

'I experience difficulty in finding a language that I can share with my Asian clients. For me, this can be a significant barrier, a communication problem, necessitating help from a translator' (B4.24, Participant 8, p410).

Reflecting on the findings, it becomes apparent that therapists are experiencing difficulties in therapy. Psychoeducation involves the use of language and psychological terminologies, which may be difficult for clients from ethnic minorities to understand (Sue et al., 2012). The findings raise concerns about the difficulties encountered by therapists in therapy, posing challenges to the recovery and

psychological adjustment of clients from different cultural backgrounds. The data suggest that it is difficult for therapists to share the same language at a level that allows clients to understand these terminologies. It is understood from the data that interpreters are appropriate to support clients who cannot speak the language or have limited knowledge of it. The data show that the use of an interpreter can be problematic concerning psychoeducation, as the misinterpretation of terminology or concepts can delay psychological recovery. Pope & Vasquez (2016) discuss the importance of clear and accurate communication in psychoeducation. They point out that misunderstandings or misinterpretations of psychological concepts can lead to confusion and potentially hinder the therapeutic process.

7.7 Lack of Support: Facing Family and Community Rejection

Lack of support and rejection from family and community emerges as one of the main themes. It is crucial that clients undergoing therapy are supported by both their families and the community. Findings indicate that this lack of support and rejection can impact clients and delay recovery from PTSD. The lived experience of Participant 1, who had worked with Tamil refugees, indicates that the clients feel '*very broken, helpless, hopeless, and powerless, and described it with a Tamil expression meaning*, *out of your hand,'* which conveys a sense of weakness. It is understood that responsibility and self-control become problematic and difficult. The findings from Participant 1's lived experience indicate that the traumatised clients feel guilty and perceive themselves as a burden on their families – *"how does the family see them?" One client told me that their family thought they were a burden (A3.2, Participant 1, p378).*

Participant 1's lived experience offers insight into a client who, after being abused by a relative, was not supported by her family. The client reported the incident to her family, who told her that her duty was to the family. They did not believe her and rejected the opportunity to support her. Participant 1 highlights the impact of this lack of support on the individual, who developed low self-esteem, PTSD, and depression. She was deeply affected by her family's lack of support and was left feeling confused, asking herself questions such as, *'To whom should I tell? How do I frame this? People talk' (F8.2, Participant 1, p.380).*

Data show that in the Sri Lankan Tamil community, the traumatised individuals are seen as 'mad', 'an outcast', and they are ostracised. The impact extends to the family, with other members looking down on them. In that culture, mental health is understood and perceived differently, *'it is not how we understand it in this culture, it is understood very differently' (B4.2, Participant 1, p.378)*. Reflecting on the observation made by Participant 1, it is understood that the clients perceive mental health differently, and there is an expectation for the individual to stay in a hospital or an institution, being kept away from their family. Participant 1's lived experience suggests that clients in this group are concerned about not being part of the community or family; they feel mistrusted by community members and their families. They are isolated, and *'the focus is on losing a lot of things' (B4.2, Participant 1, p.378).*

This is more evident from the observation made by Participant 5. The findings suggest that clients from a Black African background experienced rejection more from family and loss of control, whereas for White clients, family can be devastated, but the focus was on the impact of the trauma on the individual, i.e., '*how the client will be affected, family plays a minor role, but can be supportive' (E7.11, Participant 5, p396).*

Similarly, lack of support and rejection is an issue within the Asian community. Considering Participant 5's lived experience, clients from the Indian ethnic group appraise themselves negatively following sexual assault, which severely impacts their lives, resulting in a lack of support and rejection from family and community members. Findings indicate that clients from the Indian ethnic group felt suicidal:

'I am not pure, I should not be living anymore, I would rather die than live, and I am alone' (G9.24, Participant 7, p407).

Considering Participant 8's lived experience, it is understood that clients avoided religious places, such as temples, because they felt impure. The data show that the clients are seen as 'not pure' and feel they should not be there. They felt isolated, something they valued was being taken away from them, separated from their family and community, leading to a lack of support and rejection. In comparison, data indicate that this happens in Western culture, i.e., isolation, separation, and alienation, but not with the same intensity as for clients from Eastern cultures. It is understood that clients within the British Asian community perceive their responsibilities as deeply embedded within the family, and separation from the family can lead to re-traumatisation, such as rejection or being disowned by the family. Ethnic minority families adopt a collectivist approach, hence *'the fear of humiliating the family' (B4.27, participant 8, p411).*

7.8 Findings from the Sub-themes

i) Language Barriers in Therapy

Participant 7's lived experience underscores the profound impact of cultural differences on therapy, particularly regarding language barriers. The data show that the language used in therapy can act as an obstacle for clients from diverse cultural

backgrounds. This issue persists even within the white community, where psychological jargon can hinder comprehension and delay recovery. For clients who do not understand English, translators are often brought in to facilitate communication and engagement in therapy (Sue & Sue, 2016). However, the data from Participant 7's lived experience, points out that relying on translators introduces its own set of challenges, potentially diminishing the effectiveness of treatment:

'Trusting the translator to convey the message and terminology correctly can be problematic' (D6.7, participant 4, p392).

The use of specific language and psychological terminologies in psychoeducation exemplifies this issue. The data from Participant 7 indicate how these terms can be challenging to understand, further complicating recovery: '*sometimes it is difficult for me to share the same language at a level where clients can understand these terminologies'* and *'you have your language, and I have mine*' *(G9.26, participant 7, p407).* This sentiment illustrates the struggle to convey complex concepts such as trauma and its effects through psychoeducation.

Participant 7's interpretation and understanding of her lived experience suggests that therapy involves the use of psychological terminologies such as intrusive thoughts, emotions, rumination, and many other jargon. Culturally, these terms do not exist in the client's language and vocabulary. The data reveal that clients from different cultural backgrounds are unable to express their cognitive appraisal of trauma. Participant 7's interpretation and understanding of her lived experience indicates that clients can't articulate intrusive thoughts or other symptoms such as flashbacks, reliving experiences, or rumination. Reflecting on Participant 7's lived experience, show that the clients have difficulty in therapy due to language barriers. It is understood that the

lack of understanding of these symptoms such as hearing voices and experiencing intrusive thoughts can delay recovery. Participant's experience and interpretation of her clients' appraisal suggest the symptoms of flashbacks and reliving the trauma are not fully understood by the clients. For example, the findings from Participant 7 indicate that Somalis experienced flashbacks and unwanted thoughts that came to them against their will: *'The force pushed, and it was a bad force' – 'this was their way of describing their traumas', 'They couldn't make sense of it' (B4.16, Participant 7, p404).*

ii) Alienation from Others and the World

Participant 2's lived experience indicates that clients from Western cultures feel alienated after being traumatised, experiencing a sense of being different, and avoiding social interactions. The findings show that there is a degree of alienation present in other cultures. Participant 2, who specialises in EMDR therapy, observed: *"I think it is their perception that causes them to keep away, feeling rather different rather than people treating them differently. I find that clients from other cultures often do feel that they are treated 'differently', and they feel 'alienated', leading them to withdraw or avoid meeting people" (F8.3/F8.4, Participant 2, p.384).*

Further findings from Participant 3 show that clients from Asian and African backgrounds have different perceptions regarding mental health services, feeling isolated and helpless. For example, "*Tamil people feel alienated within their own community, avoiding association with other members out of fear that messages about them could get back to their home country, potentially causing implications for them and their families. The presence of a translator can exacerbate this 'fear', as they worry about information being relayed back to their home country"* (G9.11,

Participant 3, p.389). The data indicate that this issue is less prevalent in Western culture, where the problem is more individualised. Reflecting on Participant 3's lived experience, alienation is common to both cultures, as they perceive the world as dangerous. Participant 3, who specialises in integrative therapy, observed that alienation and stigma are higher in collectivistic societies: *'Clients in this group avoid engaging in their community; they are isolated, and fear being judged' (F8.24, Participant 8, p412).*

Participant 3's data further suggest that young men feel '*alienated by adults, the system, and the world'*. As traumatised individuals, they felt undervalued in society, which exacerbated their trauma *(F8.28, Participant 8, p412).*

iii) Current PTSD Models Fail to Meet the Needs of Clients from non-Western Cultures

The findings show that models of PTSD do not meet the needs of clients from non-Western cultures:

"*From my understanding of eastern cultures, I am of opinion that the current models of PTSD are not appropriate for Asian and other non-western cultures. I find difficulty in using Ehlers and Clark model of PTSD – You look at the world before the trauma, then the way of seeing the world during and after the trauma and the benchmark you are not trying to get and see the world as from a westerner would. Clients from eastern cultures aim to get them back to their original viewpoint of the world, very completely different to someone view or different view from the westerners. It can be difficulty sometimes in challenging someone perceptions, particular if somebody has the view of the world after the trauma – "a dangerous place" (H10.2, Participant 2, p386).*

It is understood that the current model of PTSD, i.e., Ehlers and Clark's model, presents difficulties when applied to clients from ethnic minorities. Their views of the world are entirely different, making it challenging to address their perceptions following trauma. In contrast, the findings show that there are other framework or model that can be applied to the clients from ethnic minorities which can be beneficial to address their symptoms of PTSD. The data from Participant 7's lived experience illustrates the appropriateness of the Stone/Net model. It is understood that this model provides an insight into the understanding and interpretation of the concept of PTSD:

"*Through application of 'stone/net' I feel connected to the clients and used their narrative to develop a ground technique to understand and interpret the way they are feeling. For example, reflect on ground technique that I used in sessions – taken the African experience and narrative re: way of life – in Somalia, they walked for long distances, i.e., about 10 miles and connected with nature and beautiful places. This scenery was used as a ground-breaking technique to connect with the clients, aiding to connect culturally, their moods elevated, became alive, then I proceeded with safety plan, psychoeducation, goals, appraisals of trauma. I feel that this groundwork or structure and gradual build up technique comes from their culture and visual mapping of their surrounding at home. I feel that the application of western models of PTSD do not achieve the goals re: therapy" (H10.3. Participant 2, p386).*

iv) Lack of Understanding about Mental Health and PTSD

The findings suggest that there is a lack of understanding of mental health and PTSD:

"This is brought up by relatives of clients from Asian backgrounds regarding concepts and understanding of PTSD – they think that 'she is going mad.' I can see a lack of understanding of what PTSD is!" (H10.9, Participant 3, p390). It is understood that

education is crucial to raise their awareness and the terminologies which are not clear or well understood by people from ethnic minority backgrounds.

The data from Participant 3's lived experience suggest that relatives of clients from Asian backgrounds frequently perceive symptoms as signs of madness due to a lack of understanding of PTSD. The findings support the importance of education in raising awareness, as these clients often lack a psychological perspective, and the terminologies are not well understood by individuals from ethnic minority backgrounds. The data show that Tamil-speaking clients have difficulty comprehending even straightforward terms such as 'flashback,' which may not have a direct equivalent in Tamil. The findings provide an insight into the difficulty of understanding concepts like 'rumination' and 'negative thought', and the need to clarify these terms using examples and analogies related to physical trauma to explain psychological trauma.

Reflecting on Participant 4's understanding and interpretation of the clients' appraisal, it is evident that cultural differences play a significant role in shaping perceptions of mental illness and PTSD. For example, in Arab countries, there is no clear concept of PTSD, and it is not recognised as a condition (Jordans et al., 2013). Clients do not understand the concept of PTSD, making psychoeducation challenging – *'clients thinking irrevocable damage is not cured' (H10.15, participant 4, p394).* It is understood that mental health is not integrated into the culture. The data show that clients from Asian, African, and other Eastern cultures often perceive themselves as going *'mad', 'nobody is going to like me,' and they feel isolated (H10.23, participant 7, p386)*. Reflecting on Participant 4's lived experience, it becomes clear that clients'

lack of understanding of mental health and PTSD significantly impacts the effectiveness of treatment and delays recovery.

v) Lack of Control

The data from Participant 2's lived experience indicate that everyone she worked with felt they were out of control, unable to manage two aspects. Firstly, the environment – '*they were unable to control their reaction to it, resulting in heightened fear and anxiety*'. Secondly, '*they judged themselves harshly for not responding better in the situation, feeling a sense of inevitability and helplessness'*. It is understood that there is a difference in the perception of control in PTSD across cultures. The data suggest that Western women felt they should be able to maintain control, whereas Asian women generally had less control over their lives. Losing control was less significant for Asian women compared to Western women, who typically had more control over their lives. The impact of losing control was more profound on Western women, especially in cases of rape. The findings suggest that in other cultures, the intensity of such experiences was '*less severe, possibly due to different upbringings, less favourable treatment in their lives, or culturally submissive roles in their societies' (E7.3, participant 2, p 383), and '*probably *of their upbringings or not treated so well in their life as the westerner women, or culturally a submissive role in their societies' (E7.4, participant 2, p383).*

The data from Participant 3, specialised in CBT, indicate that people in the West are generally in control of their lives, accustomed to independence and having everything planned. When something disrupts their lives, it causes a complete system collapse, making control a significant challenge. In Eastern and African communities, control is

not as highly valued; instead, there is a greater concern for security and safety. From Participant 3's experience, refugees, dependent on government benefits and housing, feel isolated and out of control, lacking the support of their community

'*Being a refugee, the client depends on benefits and housing given by the Government. They feel a sense of isolation, for them, it is not having control and the community is not around them' (E7.6, participant 3, p388***).**

vi) Family Support for the Clients

The data from Participant 5, specialising in CBT and Integrative therapy, show that people of ethnic minorities place more emphasis on the family. It is understood that they experience *'shame, guilt, disobedience, and a lack of control'* because of not meeting family expectations *(E7.10, participant 5, p396).* The findings suggest that people of ethnic minorities are more likely to be rejected by their families and experience a loss of control. Conversely, for white clients, while the family can be devastated, the focus tends to be on the impact of the trauma on the individual. The data suggest that in Western culture, the emphasis is primarily on the client's personal experience, with the family playing a minor but potentially supportive role. Data from the participant indicate that in Asian and African cultures, traumatic experiences are often kept secret, *'swept under the carpet, unlike in Western society where there is more transparency and family support' (E7.12, participant 5, p397).*

The findings from Participant 8, who specialises in Counselling and CBT therapy, indicate that control within Asian families is strong and that the family plays a significant role in trauma. Based on Participant 8's experiences it is understood that clients aged 17 or 18 were often under pressure from their families and religious

leaders to conform. The data suggests that '*clients from both cultures feel the pressure, which confuses them and exacerbates their trauma. They struggle to control their lives or plan for themselves, leading to a lack of responsibility, helplessness, disempowerment, and silence' (E7.21, participant 8, p411).* In cases of sexual abuse, the findings indicate that the family often exerted control over younger generations in ethnic minorities. In comparison to Western cultures, it is understood that families tend to fall apart when the abuser is a close family member:

'both cultures feel a responsibility to protect younger siblings and their children. As they grow up, the environment remains dangerous, a reality evident in both cultures' (E7.21, participant 8, p411).

vii) Community Support for Trauma Victims

The data from Participant 3's lived experience indicate that clients from Asian and African cultures experienced significant resistance to being rehoused in what was considered beautiful and desirable areas in Derbyshire or Nottingham. Despite the favourable conditions of the new housing and surroundings, the clients expressed a reluctance to move.

'They don't want to go, and this is not about control, but about the community spirit' (F8.5, participant 3, p389)

It is understood that this reluctance was not rooted in a desire for control but rather in the importance of maintaining community spirit. For these individuals, the sense of community and cultural familiarity in their existing environments was of paramount

importance. Moving to a new, albeit objectively nicer, area with a different cultural backdrop did not hold the same value for them. Instead, it caused feelings of alienation. Being removed from their community environment led to feelings of displacement, loss of control, and additional trauma, which in turn delayed their recovery process. This indicates that, for these clients, the sense of belonging and community cohesion was critical to their well-being and stability.

The data suggest that cultural differences played a significant role in Participant 3's interpretation and understanding of the situation. It is recognised that while Western perspectives might prioritise improved living conditions and picturesque surroundings, clients from Asian and African backgrounds place a higher value on the communal and cultural aspects of their living environment. This understanding highlights the importance of cultural sensitivity and the need to consider the unique values and needs of different cultural groups when making decisions about rehousing and support.

Considering Participant 3's experiences, having worked in India during the devastating earthquake in Gujarat, where hundreds of people were killed instantly, highlights the community spirit in the rehabilitation process. It is understood that the collective cultural response of the community came together to support each other, sharing resources and skills, and transforming the streets into spaces for intervention and treatment. The findings provide insight into how folk stories specific to the region were narrated to survivors to boost morale, which proved to be helpful.

Reflecting on Participant 3's experiences, the findings suggest incorporating collective approaches to trauma care into the NICE guidelines for victims from diverse cultural backgrounds. It was noted that in the UK, trauma related to personal assault is often

treated differently due to various predisposing factors, which can make a collective approach less suitable.

The findings indicate that a lack of community support leads to negative perceptions and difficulties in coping with trauma. It is recognised that clients who are not connected to their community may feel lost, as mental health is not widely understood or accepted in many Asian, African, and other Eastern cultures. The data show that these individuals often perceive themselves as ‘mad’ and worry that ‘nobody is going to like me,’ resulting in feelings of isolation (*H10.5, participant 3, p389*).

Considering the lived experience of participant, it is understood that community support is crucial for the recovery of clients following trauma in PTSD. Without this support, clients from Asian and African cultures may struggle significantly in their recovery process.

viii) EMDR is Effective in Treating Clients from Different Cultural Backgrounds

The lived experiences of both participants highlight the significant impact of cultural differences on the effectiveness and accessibility of therapy. The data indicate that clients often perceived trauma processing as miraculous, despite not understanding the underlying mechanisms.

‘*The clients experienced and felt that processing the trauma was miraculous – they did not understand why, but it worked’ (G9.8, participant 2, p.385).*

This reaction suggests that EMDR's approach can transcend cultural and cognitive barriers, providing relief even when clients cannot intellectually grasp the process. The emphasis on the 'miraculous' nature of the therapy points to its profound and possibly

unexpected impact, which may be especially valuable in cultures where discussing trauma is less common or less acceptable.

Participant 4's lived experience provided insights into the practical challenges faced by clients from non-English speaking backgrounds. It is understood that EMDR is particularly effective for these clients because it relies on eye movements rather than the verbal recounting of trauma, which can be difficult for those with limited English proficiency. Participant 4's preference for EMDR over trauma-focused CBT underscores the importance of adapting therapeutic techniques to meet the linguistic and cultural needs of clients.

'I practise EMDR as well as CBT. It is easier for clients whose first language is not English or where translators take a Western point of view. EMDR gets people to focus on eye movements rather than recounting or narrating the trauma as in CBT. It is difficult for people with limited English proficiency to engage in therapy and recount their trauma. I personally work more with EMDR rather than trauma-focused CBT. The recovery rate is quicker with a limited number of sessions. For example, for clients who feel shame for being traumatised, it is easier to use a blink process protocol' (G9.14, participant 4, p.393).

The quicker recovery rate with EMDR, especially for clients who experience shame related to their trauma, illustrates how culturally sensitive approaches can facilitate more efficient and compassionate care. Both participants' experiences raise awareness of the necessity of culturally adaptable therapeutic practices. Considering their interpretation and understanding of the lived experiences, EMDR can bridge linguistic and cultural gaps, making therapy more inclusive and effective for diverse client populations. The emphasis on non-verbal processing techniques in EMDR appears to

offer a significant advantage in cross-cultural contexts, where language barriers and cultural perceptions of trauma can hinder more traditional, narrative-based therapies.

7.9 Stand -alone Themes, Results and Findings

Introduction

This section presents the results and findings of the stand-alone themes The themes explored include secondary trauma due to organisational misunderstanding, racial discrimination, cultural perceptions of mental health, community support, and the applicability of PTSD models across different cultures. The report highlights the necessity for culturally sensitive approaches within both organisational and therapeutic settings.

Findings

i) Secondary Traumas Due to Organisational Misunderstanding

One of the key findings is the occurrence of secondary trauma among individuals from Asian and African cultures due to a lack of understanding by organisations. It was observed that individuals from these backgrounds, when employed by organisations, are often expected to undertake roles with minimal preparation, support, or assistance. This lack of cultural understanding and inadequate support systems has led to instances of trauma, as evidenced by shocking documents from HR departments, detailing how these individuals have been traumatised in various ways within the organisational structure.

ii) Racial Discrimination, Verbal Abuse, and Personal Attacks

The findings identify a significant issue of racial discrimination, verbal abuse, and personal attacks experienced by ethnic minority individuals, particularly those of British Black, Asian, and other ethnic backgrounds. These individuals have been

traumatised by the way they have been treated, which has been reflected in therapeutic settings. The concept of trauma and its effects are not well understood within the context of racial discrimination, leading to an exacerbation of these traumatic experiences.

iii) Perception of Mental Health by the Community

The perception of mental health within some communities, particularly those from ethnic minority backgrounds, was found to differ significantly from Western views. In these communities, mental health is often associated with institutionalisation, where individuals are kept away from their families. In contrast, Western societies often attach stigma to the individual suffering from mental health issues, which further complicates the acceptance and treatment of mental health concerns within these communities.

iv) Similarities Regarding Alienation and Avoidance in Both Cultures

There are notable similarities in how alienation and avoidance manifest in both Western and non-Western cultures. In both cases, individuals tend to distance themselves from perceived dangers, leading to a sense of isolation. This shared experience of alienation suggests a commonality in the human response to trauma, regardless of cultural background.

v) Similarities in Appraisal from Both Cultures

The appraisal of the environment as dangerous and the protective nature of families was observed in both Western and non-Western cultures. In both contexts, families tend to shield their young from perceived threats, leading to a worldview that is cautious and defensive. This similarity highlights the universal aspect of familial protection in the face of environmental dangers.

vi) Trauma Impacting Clients, Family, and Community

The impact of trauma extends beyond the individual, affecting their family and community. The collective nature of trauma in non-Western cultures, where the suffering of one is felt by the many, contrasts with the more individualistic approach often seen in Western contexts. This difference necessitates a more communal approach to therapy in non-Western settings.

vii) Community Support for Both Western and Asian Cultures

A striking observation was the reluctance of clients, particularly those from Asian cultures, to move into more desirable housing in areas like Derbyshire or Nottingham. Despite the appeal of these locations, the strong sense of community spirit in their original environments made them resistant to relocation. This is not an issue of control but rather a reflection of the importance of community ties, which are deeply valued in these cultures.

viii) Therapist's Understanding of Family Support in White Society

Therapists working with clients from Western backgrounds observed that families tend to be more supportive and open, with a better understanding of the trauma affecting their loved ones. This support system helps the individual in their recovery process. In contrast, individuals from Asian and African cultures often internalise trauma, feeling it is something they must deal with on their own, with less support from the wider community or system. This highlights a cultural difference in how trauma is processed and addressed within families.

ix) The Stone/Net Framework Helping Clients from Ethnic minority Backgrounds

The application of the "Stone/Net" framework has proven effective in connecting with clients from Ethnic minority backgrounds. This approach involves using the clients' narratives and cultural experiences as a foundation for therapy. For example, drawing on the African experience of connecting with nature by walking long distances in Somalia was used as a ground-breaking technique to elevate the clients' moods and build a therapeutic connection. This culturally sensitive approach was instrumental in developing safety plans, providing psychoeducation, setting goals, and appraising trauma in a manner that resonated with the clients.

x) Psychodynamic Therapists' Views on Models of PTSD Across Cultures

There is a growing concern among psychodynamic therapists that current models of PTSD, while solid, may be inappropriate across different cultures. The lack of a cross-cultural understanding in these models limits their effectiveness for clients from diverse backgrounds. A deeper, more nuanced approach is needed to address the unique cultural contexts of trauma.

xi) Cultural Differences Impacting Referrals to NHS IAPT Services

The report notes that despite the solid foundation of models like the Ehlers and Clark model of PTSD, there is a noticeable under-referral of individuals from Asian and African communities to NHS IAPT (Improving Access to Psychological Therapies) services. This may be due to cultural differences, including a loss of faith in the system or a disconnect between the services offered and the cultural needs of these communities.

Conclusion

The findings highlight the critical importance of cultural sensitivity in both organisational and therapeutic contexts. There is a need for organisations to better understand and support individuals from diverse cultural backgrounds to prevent secondary trauma. In therapy, culturally tailored approaches, such as the Stone/Net framework, can significantly enhance the effectiveness of interventions. Additionally, there is a pressing need to reassess the applicability of PTSD models across cultures and address the barriers to accessing mental health services faced by ethnic minorities. By addressing these issues, a more inclusive and supportive environment can be created for all individuals, regardless of their cultural background.

Chapter 8

8.0 Introduction

The aim of this chapter is to discuss the results, their impact on practice, the strengths and limitations of the study, my reflexivity, and a summary of key points, followed by a conclusion. As a thematic analysis approach was used, the data were open to interpretation, and main themes, sub-themes, and single-stand themes were generated from the participants' lived experiences. In view of the results obtained, a variety of products were generated that will help disseminate the findings of this study.

8.1 Discussion and Interpretation of Findings

For the discussion, the research questions and the main themes related to the exploration of cultural differences impacting therapists' interpretation and understanding of clients' appraisals in PTSD are as follows:

1. To explore the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in PTSD.
2. To explore the impact of cultural differences on clients' appraisals in PTSD.

The following themes will be examined:

i) Cultural differences impacting therapists' interpretation and understanding of clients' appraisals in PTSD.

ii) Cultural differences impacting clients' appraisals of their trauma.

iii) Clients' appraisals of their trauma.

iv) Therapists' difficulties in therapy.

v) Lack of support, family, and community rejection.

Discussion and Interpretation of Fndings

The study suggests that there is sufficient evidence that cultural differences influence therapists' interpretations and understandings of clients' appraisals. The data highlight how these differences manifest across various therapeutic modalities. This acknowledgment is crucial as it emphasises the ubiquity of cultural factors in therapeutic settings, regardless of the specific therapeutic approach used. It is noted that therapists from different modalities experience cultural impacts uniquely. This points to the nuanced ways in which cultural context interacts with therapeutic practice. It is essential to recognise that different therapeutic approaches may have varying degrees of sensitivity and adaptability to cultural differences, which could influence outcomes for clients. The American Psychological Association (APA) (2017) provides guidelines on how cultural differences manifest across various therapeutic modalities and stresses the importance of understanding these differences for effective therapy.

The CBT therapist's interpretation, influenced by her Asian cultural background, highlights a collectivistic approach prevalent in the Sri Lankan community. This example illustrates how therapists' cultural backgrounds can shape their understanding of clients' experiences. The therapist perceives trauma as affecting the family unit rather than just the individual, which aligns with collectivistic values that prioritise group harmony and social cohesion over individualism. The therapist's insight into the Sri Lankan Tamil community reveals that mental health issues are stigmatised, with traumatised individuals being labelled as "mad," "outcasts," or "ostracised." This highlights how cultural perceptions of mental health can shape clients' experiences and the stigma they may face. Understanding these cultural nuances is crucial for therapists

to provide culturally competent care and to avoid misinterpretations that could exacerbate clients' distress (Sue & Sue, 2016). The example underscores the importance of cultural competence in therapy. Therapists must be aware of their own cultural biases and how these might affect their interpretations of clients' experiences. Therapists, like everyone else, are shaped by the cultural backgrounds in which they were raised. These backgrounds influence their beliefs, values, and perspectives on the world (Sue, 2019). Cultural biases often operate unconsciously, subtly influencing how therapists comprehend and interpret their clients' behaviours, thoughts, and emotions. If a therapist remains unaware of these biases, there is a risk of misinterpreting a client's experiences. According to the British Psychological Society (BPS), "therapists must be aware of their own cultural backgrounds and biases to avoid misinterpretation and ensure a more accurate understanding of their clients' experiences" (BPS, 2022).

For example, a behaviour that is normal within the client's culture might be mistakenly seen as a psychological issue simply because it does not align with the therapist's own cultural norms. This can lead to incorrect assessments and potentially harmful interventions. Several examples in the findings necessitated an understanding of the client's culture and appropriate therapeutic interventions. For instance, a profound religious belief that "Allah" determines one's future, the concept of being possessed by the "devil," and a lack of understanding of PTSD, as seen in the secondary traumas experienced by the Sri Lankan community traumatised by war in their country.

The study highlights the necessity of training in cultural competence, which can assist therapists in better understanding and respecting clients' cultural backgrounds, resulting in more effective and empathetic treatment. Comas-Díaz (2012) supports the practical application of cultural competence in clinical settings, providing examples of how therapists can integrate cultural awareness into their practice.

Reflecting on the participant's cultural background and the findings offers significant insights into her experiences. However, there is a notable risk of misinterpretation should the participant's cultural lens remain overly rigid. The findings, for instance, highlight the participant's mixed cultural background, which enables her to relate to clients more effectively. The participant suggests that a degree of self-disclosure could be beneficial in fostering rapport. Moreover, her experiences of travelling East have seemingly cultivated a mindset that enhances her understanding and effectiveness as a therapist.

It can be argued that therapists must balance their cultural understanding with openness to each client's unique experience, avoiding overgeneralisation based on cultural stereotypes. Sue & Sue (2016) emphasise the need for therapists to balance their cultural understanding with an openness to each client's unique experience. The data effectively highlight the significant role cultural differences play in therapists' interpretation and understanding of clients' appraisals in PTSD. Paniagua (2013) highlights how therapists' cultural backgrounds can shape their interpretations and interactions with clients. Hwang (2006) highlights how cultural values such as collectivism and family orientation influence both clients' experiences and therapists' approaches, supporting the statement that cultural differences impact therapeutic interpretations. By providing an example of a CBT therapist with an Asian cultural

background, it illustrates both the benefits and challenges of incorporating cultural awareness into therapeutic practice. In their study, Choi & Miller (2014) explore how Korean American families navigate cultural differences and the impact on mental health. It illustrates how cultural context influences both clients' experiences and therapists' interpretations, supporting the need for culturally competent care. The critical insights raise awareness for a continued emphasis on cultural competence in therapy to ensure that all clients receive respectful and effective care tailored to their cultural contexts. The findings, including the negative appraisals of ethnic minority women following sexual assaults, the impact of religious beliefs like Karma and faith, and the issues of control and loss of identity, underscore the need for therapists to engage in meticulous consideration and understanding. These factors highlight the imperative for therapists to approach their work with a nuanced awareness, recognising that superficial or one-dimensional interpretations may not adequately address the complexities of their clients' experiences.

Reflecting critically on the therapist's approach, it is evident that cultural differences play a significant role in how clients appraise their trauma. The therapist's interpretation and understanding of clients' trauma appraisal varied greatly when considering the influence of collectivist cultures, family dynamics, and the resultant negative impacts on individuals. Engelbrecht and Jobson (2016) argue that in collectivist cultures, trauma often leads to a loss or damage to an individual's role within their community, thereby devaluing them as group members. They highlight that this displacement and the accompanying feelings of exclusion can result in intensely poignant feelings of sadness. In such cultural contexts, if an individual is not an active and reciprocal member of their community, their self-worth is significantly diminished, leading to a compounded impact of the trauma. This underscores the

importance of cultural sensitivity in therapeutic settings, as the cultural context fundamentally shapes the client's experience and appraisal of trauma.

In relation to sexual assault and rape, the findings suggest that traumatised individuals in collectivistic cultures feel that there is no future for them to marry, particularly female clients, as they are viewed as ‘damaged’, ‘stigmatised’, and ‘subjects of gossip within the community’. These findings indicate that this situation is a serious concern for female members of the Asian community. Identity is an issue in both cultures. Participant 3, who worked with white British clients, understood from her own cultural perspective and interpreted her clients’ appraisals, perceiving them as changed individuals: no longer cheerful and having less control over their lives. Tsong and Ullman (2018) argue that women who are survivors of sexual assault are perceived as having less control and tend to engage in more self-blame behaviours. The findings suggest that women from Western societies tend to develop complex personalities, often perceiving their identities as damaged. The concept of identity is profoundly ingrained in Western culture. In contrast, the findings indicate that women who were victims of torture and working on a farm in Sri Lanka exhibited a diminished sense of identity due to the war.

Participant 2, who worked with both Western and Eastern cultures, observed differences in how clients were affected by their identity. She noted that Western individuals often focus on returning to their pre-trauma selves and see themselves as capable individuals. In contrast, Eastern individuals are more concerned with being accepted by their community. It can be argued that Westerners are more focused on actions needed to restore their sense of normalcy, while the study suggests they may perceive themselves as abnormal compared to their previous state (Hofstede, 2001).

Studies such as those by Erikson (1968) and Giddens (1991) discuss how Western individuals frequently grapple with identity issues, reflecting a high level of self-awareness and internal conflict. On the other hand, studies on post-conflict societies, such as those by Krog (1998) and Morrow (2009), show that victims of severe trauma and displacement often face identity disruptions that prioritise immediate survival and adaptation over personal introspection.

Considering appraisal, Participant 2 found that cultural differences were affecting her interpretation and understanding of how she should assess the negative thoughts of Muslim girls. She initially perceived these thoughts as excessively rigid, even considering them extreme from an Islamic perspective. After discussing these thoughts with the Imam, she learned that the thoughts were indeed seen as overly extreme within Islamic culture (Hussain & Cochrane, 2002). Her realisation was that her Muslim clients often used religious reasoning to validate their thoughts, but sometimes these thoughts were more extreme than what the religion would require (Crockett & Gearing, 2010). She recognised the need to be careful not to undermine someone's faith. Therefore, it is essential to consider how cultural differences impact the therapist's interpretation and understanding of clients' appraisals following PTSD (Kirmayer & Young, 1998). Being culturally aware, she insists that we need to broaden our approach to include diverse community perspectives, which might enhance our understanding of clients and improve the therapy we offer (Sue et al., 2012).

The analysis of Participant 3's experiences with Tamil refugees from Sri Lanka underscores the profound influence of cultural differences on the interpretation and understanding of trauma. Data from Participant 3 reveals that cultural contexts

significantly shape how individuals process and appraise their traumatic experiences (Hinton et al., 2013a). Participant 3's observations indicate that Tamil refugees, who have endured severe trauma from bombings and torture, utilize their cultural and religious frameworks to make sense of their suffering. Specifically, these individuals often interpret their experiences through Hindu philosophy, emphasizing concepts such as destiny and karma. For example, individuals might interpret their trauma as a form of divine or karmic retribution, believing that their suffering is predestined and that their faith serves as a form of appraisal, approached through a communal lens. This perspective implies that their comprehension of their suffering is deeply intertwined with their cultural beliefs about fate and destiny (Lai et al., 2021).

In analysing how these cultural beliefs impact trauma appraisal, Participant 3 noted that secondary appraisal, the process by which individuals evaluate the implications of their trauma, often occurs alongside or even during the traumatic events themselves. This is another example of how culture impacts on client's appraisal. For instance, the refugees might pre-emptively interpret their suffering as a predetermined outcome of their faith, '*This is the end, my faith, my karma—I see this'.* This form of pre-cognitive appraisal is reflective of a broader cultural framework where trauma is seen as an inevitable result of past actions or divine will.

This cultural lens presents significant challenges for therapists, particularly when addressing trauma in clients from diverse backgrounds. The notion of karma and faith can deeply influence how individuals perceive their trauma and their subsequent mental health. For instance, a Tibetan viewpoint, as described by Hussain and Bhushan (2010), posits that suffering is a consequence of collective bad karma from past lives: 'If we see from Buddhist point of view, then we Tibetans are suffering because of our

collective bad karmas which we had done. Otherwise, there are no reasons why we should suffer so much in our life. So, I accept whatever happens in my life as results of my past karmas. One cannot do anything about it' (Hussain and Bhushan, 2010: p. 528). This acceptance of suffering because of karma may lead to resignation and a lack of proactive coping strategies, complicating therapeutic interventions.

These findings suggest that therapists need an understanding of how cultural beliefs shape trauma appraisal to effectively support clients. The emphasis on faith and karma in some Asian cultures can profoundly affect how individuals approach recovery and psychological adjustment. For therapists unfamiliar with these cultural frameworks, addressing trauma may become particularly challenging, as conventional therapeutic approaches may not align with clients' cultural beliefs and coping mechanisms (Kuan, 2019). The broader literature supports the idea that trauma appraisal has significant implications for mental health and recovery. Research has shown that the way individuals interpret their trauma, including cultural and religious interpretations, can influence their recovery trajectory (e.g., Bryant & Guthrie, 2005; Ehlers & Steil, 1995; Foa & Riggs, 1995). Understanding these cultural dimensions is crucial for developing effective treatment plans and ensuring that interventions are culturally sensitive and responsive to clients' unique worldviews.

Participant 5's observations offer a nuanced perspective on how cultural differences influence the interpretation and understanding of clients' appraisals of trauma. Her data highlights significant variations in how traumatic experiences are processed and communicated across different cultural contexts. She notes that in Asian and African cultures, traumatic experiences are often concealed and not openly discussed, contrasting with the more transparent approach observed in Western societies. This

aligns with existing literature suggesting that cultural norms around stigma, shame, and familial reputation heavily influence the reporting and processing of trauma (Hsu, 2014; Kirmayer et al., 2011). In these cultures, the collective concern for maintaining family honour can overshadow individual suffering, leading to underreporting and a focus on family dynamics rather than individual trauma. While this observation is grounded in cultural theories, it's essential to acknowledge that such generalisations may oversimplify complex cultural practices (Sue et al., 2012) Not all individuals within these cultures will conform to these patterns, and there is significant variability within any cultural group.

Participant 5 emphasises that in Asian and African cultures, family dynamics play a crucial role in the interpretation of trauma. Concerns about shame and damaging family reputation often overshadow individual experiences (Chen & Mak, 2013; Mwaka et al., 2020). This observation underscores how cultural values can shift the focus from individual trauma to collective family concerns. The emphasis on family dynamics can indeed shape how trauma is internalised and communicated. However, it's important to consider the intersectionality within these cultures, such as differences based on socioeconomic status, urban versus rural settings, and generational gaps. These factors can influence how trauma is perceived and addressed (Gill et al., 2021). Participant 5's data suggest that in some cultures, victims of sexual abuse may face blame, which exacerbates their trauma by assigning responsibility to them (Chen & Mak, 2013; Mwaka et al., 2020). This victim-blaming attitude can undermine the individual's ability to cope with trauma and may result in them internalising feelings of guilt and helplessness.

Victim-blaming is a severe issue that not only affects the psychological well-being of survivors but also hinders their access to support and justice. While this observation highlights a critical issue, it's essential to approach it with sensitivity, recognizing that efforts are being made within these communities to address and challenge these harmful beliefs. Participant 5 observes that clients from these cultures may present with somatic symptoms such as headaches and back pain instead of directly discussing their traumatic experiences. This presentation might reflect cultural tendencies to express emotional distress through physical symptoms, a phenomenon documented in various cultural contexts (Jang et al., 2015; Lewis et al., 2019). Clients may also develop a negative self-view and feel helpless when confronting their trauma.

The somatization of trauma is a well-documented phenomenon in cross-cultural psychology (Hinton et al., 2016). It's crucial for practitioners to recognize and address somatic symptoms as potential manifestations of underlying psychological issues. Additionally, cultural competence in therapy involves understanding and validating these somatic expressions of distress while working to encourage more direct discussion of trauma when possible. Participant 5's insights highlight the need for culturally sensitive approaches in trauma therapy. Practitioners must be aware of cultural variations in the expression and processing of trauma and adapt their methods accordingly (Williams & Galli, 2021; Gone, 2016). This includes recognizing the impact of cultural norms on clients' self-perception, their willingness to discuss trauma, and their presentation of symptoms. McLeod and Miller (2020) show that willingness to discuss trauma is often mediated by cultural expectations. In some cultures, discussing trauma openly might be seen as a sign of weakness or might conflict with cultural values around privacy. Therapists must be aware of these barriers to create a safe and respectful therapeutic environment.

While cultural competence is vital, it's also important to avoid assuming that all individuals from a given cultural background will conform to generalised patterns. Research by Leong and Wagner (2018) found that even within cultural groups, there is considerable variation in how trauma is experienced and processed. An individualised approach that respects and incorporates the client's unique experiences, values, and needs will likely be more effective in addressing trauma. Participant 5's observations offer valuable insights into the cultural dimensions of trauma and its impact on clients' appraisals. Her data highlight the importance of integrating cultural awareness into therapeutic practice while remaining attuned to the individual variations within cultural groups.

Participant 7 observed that clients from both collectivistic and individualistic cultures experienced permanent changes, such as self-blame, feelings of being out of control, and weakened strength, all lasting for a long time. In Indian culture, she encountered clients who felt alienated within their own groups. She noted that in Pakistani culture, clients feared negative judgment from their community. Cultural differences have impacted individuals in varied ways. Compared to people from Sri Lanka, Afghanistan, and other war-torn countries, their appraisals began with their traumatic journeys, focusing on escaping rather than surrendering. Initially, the connection to PTSD or other anxiety and mental disorders seemed remote and insignificant; their priority was to escape danger. Considering the cultural background and war-like situations, it takes time to connect the trauma to their experiences and understand its impact on them (Karam et al., 2020).

Reflecting on this, it becomes clear that knowledge of cultural differences affecting the interpretation and understanding of clients' appraisals enhances therapy

effectiveness and psychological readjustment. Conversely, a lack of such knowledge can render therapy ineffective. The therapist's approach to clients' appraisals can have severe implications for clients' future self-esteem and ongoing mental health. For example, in Western cultures, the focus is often more individualistic, with clients' appraisals interpreted as 'not the same person' or 'not their fault.' In contrast, Asian clients might express appraisals like 'I should not be living anymore,' potentially indicating suicidal ideation linked to traumatic events such as rape. They might avoid religious places, feeling 'impure,' leading to isolation and separation anxiety (Root et al., 2015).

Similarly, Western clients also experience isolation, separation, and alienation following sexual assault (Dworkin et al., 2020). This illustrates how cultural differences impact therapists' interpretations and understandings of their clients' appraisals. If therapists do not understand these cultural differences, it can severely hinder psychological readjustment, delaying treatment and recovery. Research continually shows that PTSD is prevalent in many societies and cultures (Jobson, 2009). There is a need to improve our understanding of the role of culture in the development, maintenance, and treatment of the disorder (Foa et al., 2009).

In addition to these findings, the study reveals other results related to cultural differences and clients' appraisals, therapists' difficulties in therapy, family and community support, language barriers, alienation, control, models of PTSD, lack of understanding of mental health, and EMDR therapy. Cultural differences play an important role in the appraisal of trauma following PTSD (Stamm et al., 2000). Religion is part of the culture, and clients sometimes express their religious beliefs, impacting their appraisals. For instance, in Muslim culture, clients see God (Allah) as

their guide in life, influencing their thoughts, emotions, and decision-making (Lee et al., 2008). They may view their suffering as part of God's plan, which can significantly affect their coping mechanisms and treatment outcomes.

Religion is an important component in understanding and interpreting appraisals from clients of different cultural backgrounds. For example, Hu (2015) suggests that religion plays a larger role in post-traumatic coping for African Americans, and clinicians might consider assessing religious supports as a potential complement to the treatment plan for individuals who have experienced trauma. Thus, recognising the influence of religion and cultural differences is crucial for effective therapy and positive client outcomes.

In contrast, clients from Middle Eastern and Asian cultures often find themselves isolated within their own communities due to the tight-knit nature of these societies. They fear being shamed and feeling guilty and refuse to work with interpreters (Holliday & Lewis, 2019). The prospect of their trauma becoming known to their families back in their home countries leads to feelings of shame, dishonour, and ostracism. It can be argued that their cultural backgrounds and differences influence the way they appraise themselves and contribute to their avoidance of community interaction (Stamm et al., 2000). Coming from a collectivist culture, these clients fear stigmatisation and the loss of identity within their respective communities. For example, results indicated that clients did not want to be dishonoured, and they thought that people would know that something bad had happened to them.

The results show that cultural differences impact how clients appraise themselves. It can be argued that upbringing and cultural backgrounds influence clients' self-

appraisal following PTSD (Jobson and O'Kearney, 2009). In relation to African culture, clients may appraise themselves as being possessed and feel the need to be cured, seeking help from their local pastor rather than from a therapist (Slater et al., 2016). In Asian cultures, karma and faith play significant roles in influencing self-appraisal (Gilmoor et al., 2019).

Regarding change, control, alienation, and mental defeat, results indicate a limited cultural impact on clients' appraisals. Concerning physical trauma, clients from both cultures believe they might not fully recover or return to their previous state. This suggests that a loss of self-control and identity accompanies any trauma presentation. In terms of control, alienation, and mental defeat, the study demonstrates a universal lack of planning ability to manage life. Kirmayer et al. (2007) discusses how trauma affects individuals across different cultures. They found that, despite cultural variations, trauma consistently leads to feelings of helplessness, loss of control, and identity crises. This suggests that the psychological impact of trauma, such as mental defeat and alienation, transcends cultural boundaries (Kirmayer et al., 2007).

However, there are still discernible differences in appraisals influenced by individualistic and collectivist cultural impacts. For instance, alienation is more pronounced in Asian cultures compared to Western cultures (Berbardi and Jobson, 2019). Research by Nickerson et al. (2017) highlights that trauma survivors, regardless of cultural background, often experience a profound sense of alienation and a diminished sense of self-efficacy. Appraisals of control and mental defeat are approached more individualistically in Western cultures, whereas Eastern, African, and Middle Eastern clients are more concerned with how they are perceived by their communities.

The study highlights the challenges therapists face in therapy. Results show that language and cultural barriers, the use of interpreters, and a lack of understanding of mental health and PTSD affect therapy and psychoeducation. Cultural differences can hinder client engagement in therapy. From an Eastern perspective, clients may have different perceptions of their trauma and its impact. Misunderstandings may arise from the jargon and terminologies used by therapists (Martin et al., 2020). This can affect clients from diverse cultural backgrounds. Clients from Eastern and African cultures find it challenging to understand concepts such as flashbacks, intrusive thoughts, and the effectiveness of talking therapy. Asian clients frequently anticipate that their trauma will be addressed with medication rather than psychotherapy, whereas clients from African cultures often believe that consulting a local pastor will aid in overcoming their trauma. For instance, research has shown that Asian cultures generally favour pharmacological interventions due to a cultural emphasis on physical symptoms and somatisation (Ng, 1997). In African cultures, mental health problems are often viewed through a spiritual lens. As a result, visiting a local pastor or spiritual healer is commonly perceived as an effective way to address trauma. This preference is deeply rooted in the belief that spiritual guidance and community support play a crucial role in healing (Gureje & Lasebikan, 2006). Due to language and cultural barriers, psychoeducation, a vital aspect of PTSD treatment can become challenging for both clients and therapists. Additionally, therapists may struggle to tailor psychoeducational materials to be culturally relevant and sensitive (Sue & Sue, 2016).

In relation to the difficulties encountered by therapists, the study shows that the application of PTSD models presents problems associated with cultural differences. For example, the current models of PTSD do not address the cultural aspects of non-Western people; these models are Westernised and inappropriate (Engelbrecht and

Jobson, 2016). It is argued that models of PTSD are more suitable for clients from Western cultures. Hinton & Lewis-Fernández (2011) discuss the limitations of applying Western diagnostic criteria for PTSD to non-Western populations and emphasize the need for culturally sensitive approaches to diagnosis and treatment. While models of PTSD account for much of the phenomena observed in the disorder, it is of paramount importance to consider a cross-cultural and intercultural approach to understand how PTSD manifests in clients from non-Western backgrounds (Engelbrecht and Jobson, 2016).

According to Monson et al. (2004), the role of significant others is brought to light, and their role is to help the survivor in rebuilding their former and positive self. The data from this study show that family and community support are important in helping clients to overcome their trauma and achieve psychological readjustment. A lack of family and community support impacts clients and delays recovery (Kim & Park, 2006; Corrigan & Phelan, 2004, Ng, 1997). This is more common in Asian and African cultures compared to Western cultures. Responsibility and self-control become problematic, and clients see themselves as a burden to the family. In Sri Lankan culture, the traumatised individual is seen as ‘mad’ and an ‘outcast’. In the case of a Pakistani girl who was sexually abused, there was a lack of support from her family, which may be common in other Asian cultures. It can be argued that clients from Asian and African cultures place more weight on the family and feel shame, guilt, and a lack of control following rejection from the family and community. Guerra et al. (2018) argue that family support plays a crucial role in the psychological adjustment of individuals diagnosed with PTSD. In contrast, if clients are supported, then recovery could be quicker, and clients can be psychologically readjusted. Compared to Western cultures, family plays a minor but supportive role. In Asian cultures, the family exerts

pressure on traumatised clients. Findings show that clients from both cultures (East/West) feel pressure from their families, making them confused and worsening the trauma, thereby delaying recovery (Choi & Gressard, 2017).

Community support is crucial in helping clients recover from their trauma (Herman, 1997). Findings show that traumatised clients from Asian and African cultures who were rehoused in new environments, such as Derbyshire or Nottingham, experienced exacerbation of their trauma and delayed recovery. It can be argued that family and community interaction and personal relationships are crucial to recovery in the case of trauma. Woodward et al. (2015) state that the influence of family, friends, and other members of the community plays an important role in the readjustment of an individual recovering from trauma. Ehlers et al. (2000) find interpersonal support assists the trauma survivor in correcting negative beliefs about themselves and others. Brewin et al. (2000) have also found social support to be one of the more robust and consistent factors in clients' recovery from PTSD.

In summarising the key points of the results, it can be concluded that this study has identified key points regarding cultural differences impacting therapists' interpretation and understanding of clients' appraisals in PTSD. As the study is open to interpretation, it has highlighted other important issues, such as the impact of cultural differences on clients' appraisals of their trauma, difficulties experienced by therapists with reference to language and cultural barriers, control, alienation, models of PTSD, and family and community support.

8.2 Looking through the Lens of Interpretative, Constructivist, and Epistemological Approaches (*using a few examples from the findings*)

This analysis applies thematic analysis through the interpretative, constructivist, and epistemological approaches. The interpretative approach focuses on understanding the subjective meanings individuals attach to their experiences. The constructivist perspective emphasises the co-construction of knowledge between the researcher and participants. The epistemological stance considers the nature of knowledge itself, questioning how we come to know what we know. Together, these approaches provide a comprehensive framework for analysing findings within qualitative data, offering deep insights into the phenomena being explored and under investigation. From an interpretative perspective, the focus is on understanding the subjective meanings and experiences of individuals. This approach seeks to comprehend how the therapists themselves make sense of their clients' trauma, particularly in cases of sexual abuse. The findings of the therapists' interpretation, it is suggested that clients appraise themselves as being "out of control" and having "lost autonomy and identity," indicating a profound disruption in their self-concept. The interpretation that they "find something wrong in themselves, not their usual self" reflects an internalised sense of shame and guilt. Research supports this, as survivors of trauma, especially sexual abuse, often internalise the stigma and blame themselves, which is a common reaction (Herman, 1992).

The interpretative lens emphasises the clients' perception of losing their identity because of their trauma. This loss of identity is a subjective experience, shaped by the societal and cultural contexts that influence how therapists interpret their clients' trauma and its aftermath (Sue & Sue, 2016). The fear of shame as expressed by the therapist's interpretation suggests that the clients within their community and the

accompanying guilt suggests that their self-interpretation is deeply influenced by external societal norms and expectations. The constructivist perspective builds on the idea that reality is socially constructed, meaning that individuals' experiences and understandings are shaped by their interactions with the world around them (Berger & Luckmann,1966). From this perspective, the loss of identity is a subjective experience shaped by societal and cultural contexts, which play a significant role in how clients construct their identities and comprehend their trauma through the lens of social and cultural narratives.

The cover-up of the trauma, as indicated by the findings can be seen as a response to the social construction of shame and guilt. In many cultures, sexual abuse carries a significant stigma, leading survivors to conceal their experiences to avoid societal judgement. This concealment is not merely a personal choice but is constructed through the social pressures and norms that dictate what is considered acceptable behaviour. Research in this area indicates that societal attitudes towards sexual abuse can deeply affect how survivors process and disclose their experiences (Alcoff & Gray, 1993; Ullman, 2010). The constructivist perspective thus sheds light on how the clients' fear of shame and guilt is not just an internal feeling but a reflection of the societal values they have internalised.

Epistemologically, this analysis concerns the nature of knowledge and how clients come to know and understand their experiences of trauma. The findings suggest that clients come to know themselves as "out of control" and having "lost autonomy and identity," which implies a shift in their self-knowledge post-trauma. This change in self-perception can be understood through the epistemological process of self-reflection and self-assessment that occurs in response to trauma. According to Herman

(1992), trauma can challenge an individual's sense of control and coherence, compelling them to undergo a process of self-reflection and reassessment to make sense of their altered experience.

The epistemological perspective also considers how knowledge about trauma is constructed and validated. For instance, the belief that survivors of sexual abuse might see themselves as "in the wrong" can be linked to broader epistemic injustices, where certain voices and experiences, particularly those of survivors, are marginalised or discredited (Fricker, 2007). The internalisation of guilt and shame may arise from an epistemic environment where survivors' experiences are not fully recognised or validated by society. In contexts where survivors' experiences are not fully acknowledged or validated, they may internalize feelings of guilt and shame as a way of making sense of their suffering, often leading to a distorted self-perception and hindered recovery (Herman, 2015). Therefore, the clients' understanding of their identity loss is shaped by the limited or distorted knowledge available to them about trauma and its effects.

The findings reveal a perception of cultural differences in how trauma is processed and supported. It is suggested that people of ethnic minorities, particularly those from Asian and African backgrounds, may internalise trauma differently compared to white families, who are described as having more systemic support. This interpretation reflects a subjective view, rooted in personal or observed experiences, but it may not universally apply. Forbes and Kim (2017) argue that while systemic support may be more accessible to some groups, the internalization of trauma and the coping mechanisms can vary significantly based on cultural and socio-economic factors. In the study, the focus is on the lived experiences of the therapists and how they make

sense of their reality. The finding about ethnic minority families internalise trauma and being less supportive is an interpretation that could be influenced by the therapists' cultural background, their interactions with different communities, and their own experiences with trauma and support systems. It is crucial to consider that interpretations can vary significantly based on these factors. Therefore, while this perspective might resonate with some individuals, it could be perceived differently by others who have had diverse experiences.

Constructivism, which posits that knowledge and understanding are socially constructed rather than objectively discovered, would approach this analysis by considering how cultural narratives around trauma and support are formed and perpetuated. Gergen (1999) emphasises that knowledge is not an objective discovery but is constructed through social practices and discourses, aligning well with the constructivist view. The findings suggest that shame and embarrassment are more prevalent in collectivist cultures (often associated with ethnic minority communities) compared to individualist cultures (often associated with white communities). In collectivist cultures, which are often associated with ethnic minority communities, the self is viewed as deeply interconnected with family and community. Shame, therefore, is not merely a personal emotion but a collective experience that can extend to one's family and community. Research supports this cultural distinction. For instance, studies on cultural dimensions by Hofstede (2011) show that collectivist cultures place a high value on group cohesion and social harmony, making them more susceptible to collective emotions such as communal shame. In contrast, individualistic cultures emphasise personal achievement and individual responsibility, leading to a more individualised experience of shame and embarrassment (Markus & Kitayama, 1991).

These claims align with constructivist views that cultural contexts shape the way trauma is experienced and communicated.

From a constructivist standpoint, the perception that ethnic minority families are less understanding of trauma could stem from societal and cultural constructs that dictate how emotions like shame are managed. Neal et al. (2004) and Heine (2016) discuss how cultural frameworks, and societal norms dictate emotional responses and perceptions of mental health. This aligns with the idea that the perception of ethnic minority families' understanding of trauma could be influenced by societal constructs that affect emotional expression and coping mechanisms. In many collectivist cultures, the reputation of the family or community can take precedence over individual experiences, leading to a possible suppression of trauma-related discussions. However, this construct is not static and can evolve with changing social dynamics and increased awareness of mental health issues within these communities. According to Wong et al (2018), in many collectivist cultures, the emphasis on family and community reputation often leads to the suppression of individual experiences, particularly those related to trauma. This is due to the high value placed on maintaining social harmony and upholding communal honour, which can discourage open discussions about personal suffering or mental health issues. It’s also important to acknowledge that this narrative might reinforce stereotypes, potentially overlooking the diversity within ethnic minority communities and the nuanced ways they may address trauma.

From an epistemological stance, studies have shown that while there are cultural differences in how trauma is expressed and managed, there is also significant variability within cultures themselves. For instance, research has indicated that collectivist cultures may indeed place a higher value on family and community, which

can lead to both protective and suppressive responses to trauma. However, these findings do not necessarily mean that all ethnic minority families are less supportive or understanding; rather, the way support is offered may differ from Western, individualistic norms. Kirmayer and Minas (2000) discuss how cultural factors influence the expression and understanding of trauma and mental health. They highlight that while certain cultural norms and practices shape how trauma is experienced and managed, there is considerable variation in these experiences within any given cultural group.

From an epistemological standpoint, which concerns the nature and scope of knowledge, the claim invites scrutiny of how knowledge about shame and trauma is generated and validated across cultures. The assertion that shame is worse in people of ethnic minorities, could be seen as a form of cultural knowledge that has been developed within specific socio-historical contexts. However, this knowledge might be questioned if it relies on generalisations that overlook intra-cultural differences and the fluid nature of cultural identities. Branscombe and Doosje (2004) explore how social identities, and intergroup dynamics shape emotional experiences, including shame. They discuss the importance of considering intra-group variability and the influence of socio-historical contexts when examining how emotions like shame are experienced and expressed.

Moreover, epistemology prompts us to consider whose knowledge is being privileged in discussions of trauma and shame. The dominant psychological models that often inform trauma studies are rooted in Western epistemological frameworks, which may not fully capture the experiences of people from non-Western backgrounds. Scholars such as Spivak (1988) and Fanon (1967) have critiqued the Western-centric

epistemologies that marginalise non-Western ways of knowing and being. Therefore, it is essential to approach the topic with an awareness of the potential biases and limitations inherent in the knowledge systems used to understand trauma and its impact across cultures. From an interpretative perspective, this section highlights how individuals make sense of their life experiences through the lens of their cultural and religious backgrounds following trauma. The findings suggest that people draw upon their cultural norms, religious beliefs, and personal experiences to construct meaning around life events, particularly in the context of adversity or existential threats. The mention of life being "cut short" and taking more chances reflects a culturally influenced interpretation of the trauma experience as precarious and unpredictable, a view that may be more prevalent in certain Western cultures where individualism and the notion of seizing opportunities are emphasised.

The interpretative approach underscores that these meanings are not universal but are shaped by the individual's context. For instance, in certain Asian communities, the belief in life being "in your hand" or the idea of being "punished for something in a previous life" illustrates how different religious frameworks influence interpretations of life’s events. These interpretations guide actions and attitudes, such as whether a person chooses to endure life’s challenges or attempts to change their circumstances. This aligns with the interpretative approach's focus on understanding how people construct their reality based on their subjective experiences and cultural contexts (Schwandt, 2000).

From a constructivist perspective, the section demonstrates how individuals actively construct their reality through the interplay of personal experiences, cultural influences, and religious beliefs. The constructivist view posits that knowledge and

understanding are not passively absorbed but are actively created by individuals as they interact with the world around them (Guba & Lincoln, 1994). The idea that people might take more chances because "life could be cut short" is an example of how individuals construct their worldview based on their interpretation of life's unpredictability. This view is culturally constructed, particularly within Western societies where existential threats may lead to a heightened sense of urgency in life. This concept aligns with the theory of "terror management," which suggests that the awareness of mortality can drive individuals to pursue life more intensely, seeking to create meaning and achieve goals in the face of uncertainty (Pyszczynski, Greenberg, & Solomon, 1999).

Similarly, religious beliefs contribute to the construction of one's life narrative. For instance, the belief that one's life is predestined or that hardships are punishments for past actions suggests that individuals construct their reality based on religious doctrines, which provide a framework for understanding life's events. The constructivist perspective also acknowledges that these constructed realities can vary significantly between individuals and cultures, which is evident in the differing responses to life's challenges depending on one's religious background. Pargament (1997) discusses how religious beliefs play a crucial role in constructing one's life narrative, particularly through the lens of coping with challenges. Religious doctrines often provide individuals with frameworks for interpreting life events, thereby influencing the construction of reality and varying significantly across different religious backgrounds.

Knowledge about life's purpose and meaning is deeply intertwined with cultural and religious epistemologies, as these frameworks often provide foundational narratives

and values that shape individuals' understanding of existence and morality (Smith, 2009). For instance, the belief that life is "in your hand" versus the belief in predestination reflects different epistemological foundations, i.e., one rooted in individual agency and autonomy, the other in divine or cosmic determinism. These differing epistemological positions influence how people respond to life's uncertainties and challenges. Those who believe in personal agency may feel empowered to take risks and shape their own destinies, while those who subscribe to a deterministic or fatalistic worldview may see themselves as enduring rather than altering their circumstances. This aligns with the notion that epistemology is concerned with the sources and limits of knowledge—whether one believes knowledge is derived from personal experience, divine revelation, or cultural traditions (Crotty, 1998).

From an interpretative perspective, PTSD is socially constructed within different cultural contexts. From the findings, in the Sri Lankan Tamil community, mental health issues are interpreted not merely as individual failings but as collective problems that affect the entire family. The use of terms like 'mad' and 'outcast' reflects a cultural narrative where mental illness is highly stigmatised, leading to ostracism not only of the individual but also of their family. In Western cultures, the stigma associated with PTSD is often rooted in individualistic notions, where the disorder is perceived as a personal failure or weakness. This perspective aligns with the cultural ethos of autonomy and personal responsibility, leading individuals to internalize blame. In contrast, non-Western cultures tend to view trauma and its aftermath as a collective experience, which reduces personal stigma and emphasizes communal support" (Hinton & Good, 2016). The interpretative approach thus reveals the role of cultural narratives in shaping how trauma is understood and experienced. It suggests that in collectivist cultures, such as that of the Sri Lankan Tamils, the interpretation of

trauma issues is deeply embedded in social relationships and communal identity. The family's reputation and honour are at stake, leading to a more collective response to trauma crises. In contrast, the Western interpretation, influenced by individualism, often isolates the individual, focusing on personal blame and self-assessment. Markus and Kitayama (1991) state that in many collectivist cultures, such as those found in parts of Asia, Africa, and the Middle East, the family's reputation and honour are deeply intertwined with individual actions. As a result, trauma and crises often elicit a collective response, with the family and community rallying to protect and restore their collective honour. This stands in contrast to Western cultures, where individualism predominates. In such societies, the response to trauma often isolates the individual, with a focus on personal blame, self-assessment, and individual responsibility.

A constructivist perspective, which posits that knowledge and reality are constructed through social processes and interactions, can further illuminate the cultural differences in the appraisals of their traumas in the Sri Lankan Tamil community. Trauma, from this viewpoint, is not a fixed or objective reality but rather is shaped by cultural, social, and historical contexts (Bracken et al.,1995). The Sri Lankan Tamil community's understanding of mental health is constructed through communal norms and values, where the well-being of the individual is inextricably linked to that of the family and community. The construct of PTSD as something that brings shame upon the entire family reveals a socially constructed reality where the individual is less important than the collective. This phenomenon is particularly evident in collectivist cultures, where family reputation and social harmony are highly valued. Research has shown that in such societies, mental health issues are often stigmatized because they are perceived as a threat to the family's honour and social standing. For instance, studies on PTSD in collectivist cultures indicate that the condition is frequently viewed

not just as an individual ailment, but as a source of familial disgrace, leading to a suppression of symptoms and avoidance of treatment (Kim, 2010; Kleinman, 2006).

In Western societies, the construct of PTSD issues as a personal failing reflects a different social reality, i.e., one where individualism is paramount. The Western focus on self-blame and personal responsibility for PTSD can indeed be seen as a construct that emerges from a cultural emphasis on self-determination and independence. This emphasis is deeply rooted in Western individualism, where the self is often viewed as autonomous, and personal agency is highly valued. Consequently, psychological issues like PTSD are often seen as internal challenges that require personal reflection and individual therapy to address. This perspective aligns with Western therapeutic approaches that prioritize individualistic methods, such as cognitive-behavioural therapy, which focuses on changing an individual's thoughts and behaviours to manage symptoms of PTSD (Jobson, 2009).

In contrast, many non-Western or collectivist cultures view the self as interconnected with others and emphasize the importance of community and relational contexts in understanding and treating mental health issues. In these cultures, the focus may be less on individual blame and more on external factors such as social harmony and group dynamics. Consequently, PTSD treatment in collectivist cultures often involves community-based interventions that engage social support networks rather than focusing solely on the individual (Hinton & Lewis-Fernández, 2011). These cultural differences in the conceptualization of PTSD highlight the importance of culturally sensitive approaches to mental health that consider varying perspectives on responsibility, recovery, and the self.

Epistemology, the study of knowledge and how it is acquired, also offers valuable insights into the findings. The epistemological perspective questions the sources and validity of knowledge about PTSD in different cultures. In the Sri Lankan Tamil context, knowledge about mental health may be derived from traditional beliefs, religious teachings, and communal experiences. These sources of knowledge might not align with Western medical models, which are based on scientific research and clinical evidence. The statement that PTSD is "understood very differently" in the Tamil culture suggests an epistemological divergence, where different forms of knowledge and understanding are at play. In their study, Kirmayer and Young (1998) discuss how different cultures, including Tamil culture, may interpret and understand trauma and PTSD in ways that diverge from Western biomedical models. They emphasise that non-Western cultures often integrate spiritual, communal, and historical perspectives in their understanding of trauma, leading to different approaches to treatment and healing.

Moreover, the reference to African clients interpreting their trauma as possession by devils underscores the importance of spiritual and religious beliefs in shaping their understanding of mental health. This aligns with the broader anthropological literature, which posits that in many African cultures, mental health issues are often interpreted through a spiritual or religious lens. For example, traditional beliefs may view mental illness because of supernatural forces, leading individuals to seek help from religious figures rather than mental health professionals (Patel, 2001).

Western epistemology, which often privileges empirical and scientific knowledge, might pathologise the Tamil understanding of mental health as ‘backward’ or ‘incorrect’. However, from a relativistic epistemological stance, one could argue that

neither perspective is inherently superior; rather, they are different ways of knowing and understanding the world. The Tamil community's epistemology is deeply embedded in its cultural and social fabric, making it valid within its context, even if it diverges from Western models (Kirmayer and Young,1998). From an interpretative perspective, individuals from Asian and African backgrounds interpret their experiences of trauma within their cultural frameworks. The findings suggest that these clients focus significantly on external perceptions., i.e., how others in their community will perceive them, rather than on their own internal states or familial reactions. This observation is critical as it highlights the cultural dimension of trauma appraisal. In many non-Western cultures, the sense of self is deeply intertwined with community and collective identity, which can explain why individuals may be more concerned with how they are perceived by others rather than their internal emotional state (Markus & Kitayama,1991; Kirmayer & Young, 1998).

From a constructivist viewpoint, the findings can be seen as highlighting how cultural contexts construct and shape the experience and expression of trauma. Constructivism posits that reality is socially constructed, and therefore, the way individuals understand and respond to trauma is heavily influenced by their cultural environment (Bracken & Petty, 2016). The notion that African clients might view trauma as spiritual possession rather than a psychological issue suggests that their cultural upbringing has shaped a different construction of reality compared to the Western medical model of PTSD.

Similarly, the idea that Asian and African clients focus on how others perceive them could be interpreted as a reflection of the collectivist cultures in which they were raised. In collectivist societies, the self is often defined in relation to others, and maintaining social harmony and reputation is paramount (Markus & Kitayama, 1991).

This contrasts with the more individualistic perspective common in Western societies, where personal autonomy and internal feelings are given more importance.

Epistemologically, the findings raise questions about the nature of knowledge and understanding in relation to trauma and mental health. The different ways in which clients from various cultural backgrounds appraise and understand their trauma challenges the universality of Western psychological constructs like PTSD. The epistemological stance here suggests that knowledge of trauma is not universally applicable but is instead contingent on cultural and social contexts (Kirmayer, Guzder, & Rousseau, 2013). The statement that African clients seek counselling from religious leaders rather than understanding PTSD as a medical condition points to an epistemological divide. Western psychiatry, which is rooted in biomedical and psychological models, may not fully capture or be relevant to the experiences of those from different cultural backgrounds. This aligns with criticisms of the medicalisation of mental health, which argue that Western models of mental illness often fail to consider alternative epistemologies and healing practices (Kirmayer & Swartz, 2013).

From an interpretative perspective, these findings highlight the subjective meaning-making processes of the individual's experiencing trauma. The Somalian individuals describe their symptoms using language that reflects their cultural understanding, such as "a bad force" pushing intrusive thoughts into their minds. This contrasts with the more clinical language used in the host country, where terms like "intrusive thoughts" and "flashbacks" are common. The interpretative approach recognises that these individuals are not merely passive recipients of traumatic experiences; rather, they actively interpret and construct meaning based on their cultural and linguistic frameworks (Kirmayer, 2001).

Their appraisals, i.e., such as feeling depressed, hearing voices, or experiencing a sense of being overwhelmed, are embedded in their cultural narratives and cannot be fully understood without considering these contexts. This aligns with the hermeneutic approach, which emphasises understanding individuals' experiences within their broader cultural and social settings (Gadamer, 1975). The inability to articulate experiences using Western psychological terminology suggests a gap between their lived experiences and the available language for expressing these experiences.

From a constructivist perspective, the findings can be seen as an illustration of how knowledge and reality are socially constructed. The concept of PTSD, and the specific terminologies associated with it, are products of a particular cultural and medical paradigm, predominantly rooted in Western thought. For Somali individuals, whose cultural and linguistic backgrounds differ significantly, these concepts may not resonate or may be difficult to grasp (Kirmayer, 2001; Summerfield, 2001; Marsella & Yamada, 2000).

Constructivism posits that individuals construct their understanding of the world based on their experiences and interactions within their social and cultural environments (Vygotsky, 1978). In this case, the Somali individuals are constructing their reality of trauma through the lens of their cultural beliefs and language. The reference to "a bad force" pushing thoughts into their minds suggests a culturally constructed understanding of trauma that does not align neatly with Western psychological concepts. This divergence can lead to a sense of alienation or misunderstanding when these individuals encounter Western mental health systems, which rely on a different set of constructs and terminologies (Kirmayer, 2001).

The lack of direct translations for PTSD-related terminology further supports the constructivist view that language is a crucial tool in shaping our understanding of the world. The Somali individuals' reliance on interpreters who use English terms indicates a disjunction between their constructed reality and the medical discourse they are expected to engage with. This can create challenges in treatment and communication, as the cultural constructs of trauma may not be fully translatable into the Western medical model (Gerritsen et al, 2006).

Epistemologically, the findings raise questions about the nature and sources of knowledge, particularly in the context of trauma. The Western medical model of PTSD, with its specific terminology and diagnostic criteria, represents a form of knowledge that is treated as objective and universal within the context of Western psychiatry. However, the experiences of the Somali individuals suggest that this knowledge may not be universally applicable or accessible. Their descriptions of trauma, which do not align with the clinical language of PTSD, point to the existence of alternative epistemologies, i.e., ways of knowing that are rooted in different cultural and linguistic traditions (Hinton & Lewis-Fernández, 2011; Kirmayer & Young,1998).

The epistemological challenge here lies in the potential for cultural bias in the diagnosis and treatment of mental health conditions. If the Somali individuals' experiences are not recognised as valid because they do not fit into the Western conceptual framework of PTSD, their suffering may be misunderstood or overlooked. This echoes the critiques of epistemic injustice, where certain forms of knowledge or ways of knowing are marginalised or devalued because they do not conform to dominant paradigms (Fricker, 2007).

The Somali individuals' struggle to understand why they are experiencing symptoms such as hearing voices or having intrusive thoughts suggests a lack of epistemic resources within their cultural framework to make sense of these experiences. The reliance on interpreters who use English terminology indicates that these individuals are being forced to navigate between two epistemic systems, which may not fully align. This can lead to confusion, miscommunication, and potentially inadequate treatment (Lewis, 2008). The findings indicate that the application of PTSD models are inappropriate for clients from non-Western cultures. The imposition of Western PTSD models on non-Western individuals reflects a significant power dynamic that can lead to several problematic outcomes in therapy. This dynamic is rooted in the historical dominance of Western knowledge systems, which have often been presented as universal truths, marginalising other cultural understandings of trauma and mental health. From an epistemological stance, Western PTSD models are grounded in specific cultural, historical, and philosophical contexts. By applying these models universally, therapists may inadvertently dismiss or overlook the epistemological foundations of non-Western cultures. This imposition can perpetuate a form of epistemological imperialism, where Western ways of knowing are seen as superior, thus undermining the validity of indigenous knowledge systems and alternative approaches to trauma. There is a cultural misalignment (Bhui et al, 2007; Bracken, 2002; Marsella, 2005).

PTSD, as conceptualised in Western psychology, is based on particular understandings of the self, individualism, and the mind-body relationship. In collectivistic cultures, where the self is often understood in relation to the community and spirituality plays a central role, these Western models may not align with local understandings of trauma. The misalignment can lead to misdiagnosis, ineffective treatment, and a failure to

address the true nature of the individual's distress. Clients may be feeling disempowered and alienated (Hinton & Guy, 2018).

Imposing Western models on non-Western individuals can disempower them by invalidating their cultural narratives and coping mechanisms. When non-Western individuals are treated according to Western paradigms, they may feel alienated from their own cultural practices and less inclined to engage in treatment. This can lead to a loss of agency, where individuals are unable to make sense of their trauma within their own cultural framework. It can be argued that the imposition of Western PTSD models can inadvertently cause cultural harm. By pathologising normal cultural responses to trauma that do not fit Western criteria, therapists may stigmatise certain behaviours or beliefs, thereby contributing to cultural erosion. For example, practices like communal mourning or spiritual healing, which may be central to a culture's approach to trauma, might be disregarded or even discouraged (Kirmayer et al, 2007; Gone & Alcántara, 2007 & Sue, 2006).

It is argued that a more culturally sensitive approach requires therapists to engage with the cultural context of their clients, recognising that trauma is experienced and expressed differently across cultures (Gone, 2013). This approach involves respecting and incorporating local healing practices and understanding trauma within the framework of the individual's cultural and spiritual beliefs. By doing so, professionals can provide more effective and culturally congruent care, fostering healing in a way that honours the individual's cultural identity.

In summary, the interpretative perspective highlights the subjective experience of identity loss and internalised shame. The constructivist perspective reveals how these experiences are influenced by social and cultural narratives, leading to the concealment

of trauma. Finally, the epistemological perspective examines how survivors understand their trauma, often in contexts that marginalise or distort their experiences. Collectively, these perspectives provide a thorough understanding of how clients process and respond to trauma, particularly regarding their identity and self-concept. The findings reveal notable cultural differences in trauma understanding and experience between the Sri Lankan Tamil community and Western societies. Through an interpretative lens, it becomes clear how cultural narratives shape the meanings attached to trauma, resulting in varied social responses. The constructivist perspective shows that these differences represent socially constructed realities, reflecting broader cultural values and social structures. From an epistemological viewpoint, the findings question the universality of Western PTSD models and advocate for recognising and respecting alternative forms of knowledge.

For Somali individuals, the interpretative perspective underscores that their meaning-making processes are deeply embedded in their cultural and linguistic contexts, which differ significantly from those of the host country. The constructivist perspective highlights how they construct their trauma reality through culturally specific concepts that may not align with Western psychological constructs. Epistemologically, this situation raises important questions about the universality of mental health knowledge and the potential for cultural bias in diagnosis and treatment.

8.3 Implications for Clinical Practice

The findings of this study will have significant implications for clinical practice. This section will explore the impact of these findings on clinical settings. Cultural differences between therapists and clients can significantly affect the appraisal and interpretation of PTSD symptoms. Hinton and Lewis-Fernández (2011) state that cultural factors influence the way individuals express and interpret symptoms, and differences in cultural backgrounds between therapists and clients can lead to misunderstandings or misdiagnosis. Culture influences how individuals express and interpret emotional and psychological distress. Different cultures vary in their expression of distress and trauma. Western cultures may emphasise individual expression and verbal disclosure, while some non-Western cultures may prioritise emotional restraint and collective coping mechanisms (Kirmayer, 2001). For example, in some Asian cultures, the promotion of stoicism may discourage open discussions about trauma. This can lead to the underreporting or misinterpretation of PTSD symptoms, resulting in the avoidance of treatment or distorted therapy outcomes, which delays recovery (Chen et al., 2012). These cultural factors have critical implications for clinical therapy practice, highlighting the need for culturally sensitive approaches that encourage open communication and accurately assess trauma-related symptoms to provide effective treatment.

In the UK, the cultural perception of mental health can vary significantly among different communities, impacting the effectiveness of clinical therapy. For instance, within some South Asian communities, mental health issues are often stigmatised, with emotional distress frequently being somatised, i.e., expressed through physical symptoms rather than verbalising emotional difficulties. This cultural tendency can

lead to underreporting of mental health problems and miscommunication between patients and healthcare providers. Bhui et al. (2001) emphasise the need for culturally sensitive approaches in clinical therapy, including the importance of building trust and understanding cultural nuances in communication to ensure accurate assessment and effective treatment of trauma-related symptoms.

Cultural frameworks shape how individuals make sense of trauma. In Western contexts, PTSD is often framed within a medical or psychological model emphasising individual pathology. In contrast, other cultures may view trauma through spiritual or communal lenses (Jansen et al., 2015). For instance, Indigenous populations may interpret traumatic experiences as spiritual disruptions rather than solely psychological disturbances. Misalignment between a therapist's and a client's cultural frameworks can lead to misunderstandings and inadequate treatment plans (Gone, 2013).

Treatment plans that disregard a client's cultural background risk being not only ineffective but potentially harmful. For instance, therapeutic techniques that conflict with a client's cultural values or practices may result in the client disengaging from or rejecting the treatment altogether. This disengagement can lead to negative outcomes and client dissatisfaction, ultimately undermining the therapeutic process. In clinical practice, it is therefore imperative to acknowledge and address cultural differences to ensure that therapy is both effective and ethical. Research supports this approach, demonstrating that culturally sensitive therapy is associated with better client outcomes and greater client satisfaction (Sue et al., 2012).

Incorporating cultural competence into therapeutic practice also enhances the therapist-client relationship, fostering trust and communication, which are vital for successful therapy. Moreover, failing to consider cultural factors can inadvertently

reinforce feelings of alienation or marginalisation in clients, exacerbating their distress. As such, clinical practice in the UK should be informed by a thorough understanding of cultural diversity, with treatment plans tailored to the individual cultural contexts of clients. This approach not only aligns with ethical guidelines but is supported by evidence indicating that culturally tailored interventions lead to more positive therapeutic outcomes (Sue et al., 2012).

Cultural stigma surrounding mental health can affect how clients present their symptoms. In cultures where mental health issues are stigmatised, individuals might be less likely to seek help or disclose symptoms honestly. This can impact the accuracy of PTSD diagnosis and treatment, as clients may conceal symptoms due to fear of judgment or discrimination (Corrigan & Watson, 2002). For example, clients from African backgrounds failing to understand the concept of PTSD and fearing that they were possessed by the devils would seek help from the Church and Pasteur with a view that they would be cured.

Cultural differences can complicate the assessment and diagnosis of PTSD. Standard diagnostic tools may not be culturally sensitive, leading to potential misdiagnosis or underdiagnosis (Hinton et al., 2013). For example, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for PTSD may not fully capture culturally specific expressions of distress. Clinicians must be aware of these limitations and consider culturally adapted assessment tools or incorporate culturally informed interviewing techniques (Hollifield et al., 2007). Effective PTSD treatment requires culturally appropriate interventions. Therapists should be cautious when applying treatments developed in one cultural context to clients from another. For instance, Cognitive Behavioural Therapy (CBT), a common treatment for PTSD, may need

adaptation to fit the cultural beliefs and practices of the client (Hinton & Patel, 2017). Cultural adaptations might include integrating traditional healing practices or adjusting therapeutic techniques to be more culturally relevant (Barrera et al., 2014). In some cultures, traditional healing practices and beliefs are very important for mental health. Using these practices in PTSD treatment can make the therapy more suitable and effective for people from those cultures. For instance, adding community rituals, storytelling, or spiritual ceremonies to standard treatment methods can make the therapy more meaningful for patients (Kirmayer & Young, 1998).

The therapeutic alliance, crucial for effective therapy, can be impacted by cultural differences. Therapists' assumptions and biases about clients' cultural backgrounds can affect the trust and rapport between therapist and client (Sue et al., 2012). It is important for therapists to engage in cultural humility, acknowledge their own biases, and actively work to understand their clients' cultural perspectives. This study highlights the impact of cultural differences on the interpretation and understanding of clients' appraisals in PTSD, influencing the trust and rapport between therapist and client (Houghton et al., 2020).

In certain Asian cultures, mental health issues are frequently stigmatised, and seeking help may be viewed as a sign of weakness (Lin et al., 2017). This stigma can affect how individuals perceive and report PTSD symptoms. The expression of distress and trauma can vary widely across cultures. Symptoms of PTSD may be interpreted differently based on cultural frameworks. For example, in some cultures, symptoms like hypervigilance or intrusive thoughts may be seen as spiritual or supernatural causes rather than a mental health disorder (Al-Krena William & Graham, 2000). This

cultural interpretation can impact the client's perception of their symptoms and their openness to psychological interventions.

Clinicians must be aware of cultural variations in symptom presentation and interpretation to make accurate diagnoses. Standard diagnostic criteria may not fully capture the ways in which PTSD manifests in different cultural contexts. Clinicians should be cautious when using Western diagnostic tools and consider culturally adapted assessment instruments (Hinton & Good, 2009). Providing culturally competent intervention involves understanding and integrating cultural beliefs into the treatment process. This may include adapting therapeutic approaches to align with the client's cultural values and beliefs. For instance, integrating community-based support or incorporating culturally relevant practices into therapy can enhance engagement and effectiveness of treatment (Sue & Sue, 2016). Cognitive Behavioural Therapy (CBT) may need modifications to address cultural differences in cognition and expression of trauma (Hinton et al., 2013). Clinicians might also consider incorporating traditional healing practices or community resources that resonate with the client's cultural background.

Clinicians should be prepared to address cultural stigma associated with PTSD and mental health care. Building trust and demonstrating cultural sensitivity can help reduce stigma and encourage clients to engage in treatment. This might involve educating clients and their families about PTSD and the benefits of seeking professional help within a culturally sensitive framework (Wong et al., 2017). Cultural differences and language barriers present unique challenges in clinical settings, influencing both the therapeutic relationship and the efficacy of treatment. Cultural differences can affect the formation of trust and rapport between therapists and clients.

Research indicates that cultural mismatches may lead to misunderstandings and affect the therapeutic alliance. A study by Sue et al. (2012) highlights that cultural competence among therapists significantly impacts clients' perceptions of the therapy process and their willingness to engage in treatment. Clients may feel more comfortable with therapists who understand and respect their cultural context and values, which can support their recover (Garcia & Atkinson, 2017)

Language barriers can hinder effective communication between therapists and clients. According to the American Psychological Association (APA, 2016), miscommunication due to language differences can affect the clarity of the therapeutic process, leading to misunderstandings about the client's concerns and therapeutic goals. These barriers can diminish the effectiveness of therapy and impact client satisfaction. In situations where language barriers exist, interpreters are often used. However, the use of interpreters introduces additional complexities. A study by Cline and Lu (2008) found that the presence of an interpreter can alter the dynamics of the therapeutic relationship and potentially affect the confidentiality of the session. The choice of interpreter and their understanding of therapeutic concepts are crucial for maintaining the integrity of the therapy process. Therapeutic techniques that rely on language nuances can be particularly challenging when working through an interpreter. Treatment approach such as cognitive-behavioural therapy (CBT), which involve specific language-based strategies, may lose their effectiveness if not translated accurately. A study by Langer et al. (2014) highlights that language discrepancies can lead to variations in the interpretation of therapeutic techniques, potentially affecting outcomes.

For clients with language barriers, therapists should consider using trained interpreters who are familiar with therapeutic contexts. Additionally, developing language skills or providing services in multiple languages can help reduce the impact of language barriers. The application of psychoeducation to clients who are unable to understand the language can be challenging and frustrating for the therapist (Langer et al., 2014). The findings indicate that therapists face the challenge of overcoming language and cultural barriers in therapy across various modalities.

When clients struggle to comprehend the jargonistic language often used in therapy, it can result in significant clinical implications. These include disengagement from the therapeutic process and a diminished sense of confidence in the therapist's abilities. When clients do not fully understand the language or concepts being used, they may feel alienated or overwhelmed, leading to a lack of active participation in therapy sessions (McLeod, 2015). This disengagement can hinder the development of a strong therapeutic alliance, which is crucial for effective treatment outcomes. Furthermore, the client's uncertainty about the therapist's communication can erode trust, making it difficult for them to feel safe and understood within the therapeutic environment. Consequently, therapists must be mindful of the language they use, ensuring it is accessible and clear to support client engagement and foster a trusting, collaborative relationship (Stiles, 2020). It is suggested that protocols are reviewed and simplified to facilitate understanding of the language and improve the therapeutic alliance in therapy (McLeod, 2015; Wampold & Imel, 2015).

The findings from the study indicate that current PTSD models do not meet the needs of clients from non-Western cultures. Cultural differences, background, and related issues do not form part of the current models and their formulations (Hinton & Good,

2009). Reflecting on models of PTSD, further consideration should be given to developing models that include a cultural sphere (Jobson and O'Kearney, 2009).

Imposing a CBT model on clients without considering their cultural context can reflect and reinforce existing power dynamics between therapist and client. Therapists, often perceived as authority figures, may unintentionally perpetuate systemic oppression by disregarding the client's cultural background, thereby imposing a potentially harmful therapeutic framework (Sue & Sue, 2008). This dynamic mirrors broader societal power imbalances, where dominant cultural norms overshadow marginalised perspectives (Moodley & West, 2005). For traumatised clients, particularly those from marginalised groups, the pressure to conform to CBT may invalidate their cultural expressions of distress, leading to retraumatisation and reinforcing marginalisation (Fernando, 2010).

Clinically, applying CBT to clients who do not share its cultural foundations can lead to poor therapeutic outcomes, with clients feeling misunderstood or pressured to adopt a cognitive framework that does not resonate with their cultural belief. This may result in superficial adherence to CBT techniques, leading to short-term compliance but long-term dissatisfaction or relapse (Sue, 1998). Ethically, this raises concerns about informed consent and autonomy, as clients may not fully understand the nature of CBT or feel empowered to express discomfort, potentially compromising their participation in treatment planning (Sue & Sue, 2008).

To address these issues, culturally sensitive approaches are needed that respect and integrate the client's cultural background. This might involve adapting CBT techniques to include cultural narratives and values or considering alternative therapeutic modalities better aligned with the client's cultural backgrounds, such as

narrative therapy or culturally adapted psychodynamic approaches (Rathod et al., 2015). Practically, this requires therapists to develop cultural competence, reflect on their biases, and actively collaborate with clients to co-create a therapeutic approach that considers their cultural identity and experiences of distress (Pedersen, 1997). Such an approach not only enhances therapeutic efficacy but also promotes equity and respect within the therapeutic setting (Sue et al., 2009).

In addition to a culturally competent approach, family and community support play a crucial role in helping traumatised individuals recover and reclaim their lives. The study highlights the absence of such support, which can present a significant challenge for therapists, as various factors may be beyond their control. Nonetheless, incorporating family and community support into the treatment protocol is essential to ensure that traumatised individuals receive adequate assistance (Salvage, 2016; Hobfoll et al., 2007).

To address these challenges, therapists need ongoing training in cultural competence and language skills. Educational programmes should include components on cultural awareness, linguistic diversity, and strategies for working with interpreters. According to a review by Sue et al. (2012), incorporating cultural competence training into clinical education can enhance therapists' ability to navigate these complexities effectively. Therapists should employ culturally adapted interventions and continuously seek to understand their clients' cultural backgrounds. The integration of culturally relevant practices into therapy can improve engagement and treatment outcomes, as supported by Griner and Smith (2006).

8.4 Strengths and Limitations of the Study

The study is exploratory, making it well-suited for qualitative methods that allow for an in-depth understanding of complex phenomena such as cultural differences in PTSD interpretation. The research addresses a critical gap by exploring cultural differences in therapists' interpretations, which is essential for improving therapy for diverse populations. The research significantly strengthens the field of therapy for diverse populations by addressing a critical gap: the exploration of cultural differences in therapists' interpretations. This focus is essential for developing more effective and inclusive therapeutic practices across various therapeutic modalities, including Cognitive Behavioural Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), Psychodynamic Therapy, and Integrative Therapy (Sue & Sue, 2016). Research has shown that therapists' cultural competence, which includes their awareness, knowledge, and skills in working with clients from diverse backgrounds, directly impacts the therapeutic alliance and outcomes. A study by Sue et al. (2009) emphasises the importance of cultural competence in reducing disparities and improving the quality of mental health services for minority populations. The findings provide valuable insights that can inform therapists' training and professional development, potentially leading to more culturally competent therapy practices (Smith & Trimble, 2016). For example, the interpretation and understanding of the impact of religion and religious beliefs of clients' appraisals from the ethnic minorities, language barriers difficulty, the individualistic and collectivistic approach, all are relevant to therapists' training.

. This study highlights the importance of cultural understanding in the various modalities. Research supports the need for specialised training and supervision in

cultural sensitivity to improve therapists' abilities to navigate cultural differences effectively. Smith & Trimble (2016) discuss how research in multicultural psychology can inform therapists' training and professional development, leading to more culturally competent therapy practices. According to Constantine and Sue (2005), such training enhances therapists' competence in recognising and addressing cultural issues, which is critical for effective therapy with diverse populations.

The study identified five main themes, seven sub-themes, and nine emerging themes, indicating a rich and nuanced dataset. Manual analysis by the researcher allows for deep engagement with the data, which can be beneficial for identifying subtle and complex themes. Manual analysis enables researchers to engage deeply with their data, facilitating the identification of subtle cues and intricate patterns that automated methods might overlook (Patton, 2002). Continuous engagement and interpretation in qualitative research aid in developing themes that are not immediately obvious (Creswell, 2013). Manual analysis also promotes reflexivity, where researchers reflect on their biases and assumptions, enhancing their understanding and capturing complex themes (Tracy, 2010).

The sample size of eight participants is quite small, which limits the generalisability of the findings. However, it helps generate richer and deeper insights into the lived experiences of the participants. Smith et al. (2009) state that small sample sizes allow for a detailed and deeper analysis of participants' lived experiences. A larger sample could have provided more comprehensive data on the cultural differences impacting therapists' interpretations. Crouch and McKenzie (2006) point out that the small sample size typical of qualitative research makes generalisation to a wider population problematic. Mason (2010) reiterates that sample size in qualitative research is a

contentious issue, with a larger sample providing more robust data and greater generalisability.

Having a sample with seven women and just one man can introduce gender bias into the findings. Because the sample is mostly female, the results are likely to be dominated by women's experiences and opinions. The single male participant's views might be underrepresented or skewed due to this imbalance. This lack of male representation can make it difficult to apply the findings to both men and women. The results might mainly reflect women's experiences, possibly overlooking important differences between the genders. The gender imbalance in the sample is a real concern that could affect the accuracy and reliability of the study's findings, especially if gender differences are significant to the research. As this study is exploratory in nature, the research design for future studies will be improved to include equal representation of male and female participants, providing a more balanced perspective (Smith, 2023). The researcher’s subjective approach to interpreting the data is a limitation, as it can introduce personal biases and affect the objectivity of the findings. The findings are not generalisable to all therapists, clients, or therapy contexts due to the small and non-representative sample. The inability to recruit an equal number of male and female therapists and a larger sample size suggests potential constraints in the study design and its application.

Thematic analysis was used as the research methodology for the study. It is a robust method for identifying and analysing patterns within qualitative data, allowing for flexibility in examining complex and nuanced data (Braun & Clarke, 2006). Thematic analysis enabled the identification of multiple themes, sub-themes, and emerging themes, providing a detailed understanding of the cultural differences impacting

therapists' interpretations. The identification of numerous themes indicates that the data is rich and offers substantial insights into the research question.

Thematic analysis allows researchers to adapt the analysis to suit the research question, data set, and theoretical framework. This flexibility makes it suitable for exploring complex and nuanced data, such as cultural differences impacting therapists' interpretations. Braun and Clarke (2006) discuss how thematic analysis can serve as a method of adaptability for managing complex and nuanced data, including those involving cultural differences and interpretations.

By identifying multiple themes, sub-themes, and emerging themes, thematic analysis provides a comprehensive understanding of the data. This depth is crucial for capturing the intricacies of cultural differences and their effects on therapy. The method is effective in identifying recurring patterns within the data. This capability is particularly beneficial for understanding how common themes manifest across different cultural contexts and how they influence therapists' interpretations. When conducted rigorously, thematic analysis can be transparent and replicable. Researchers can follow a clear process, making it easier for others to understand and replicate the study (Braun and Clarke, 2006).

Thematic analysis can be subjective, with the identification and interpretation of themes heavily reliant on the researcher's perspective. This subjectivity can introduce bias, particularly in studies examining cultural differences where the researcher's cultural background might influence their interpretation (Willig, 2013). There is a risk of either over-interpreting data by seeing themes where there are none or under-interpreting by missing subtle themes. This risk can affect the validity of the findings, particularly in complex cultural contexts. The process of coding, identifying themes,

and analysing them is time-consuming and requires meticulous attention to detail. This time requirement can be a drawback when dealing with large datasets or when resources are limited (Creswell & Poth, 2018). Thematic analysis does not provide the quantitative rigor of other methods, potentially limiting the ability to generalise findings. While it offers depth, it may lack the breadth that quantitative methods provide.

The quality of thematic analysis largely depends on the researcher's skill and experience in qualitative research. Inexperienced researchers may struggle with the complexities of theme identification and analysis. To improve the design of the study, the use of multiple data sources, analysts, or methods should be considered to triangulate findings and mitigate the impact of individual researcher bias. Implementing inter-rater reliability checks, where multiple researchers independently code the data and compare their findings, can enhance reliability (Silverman, 2016; Braun and Clarke, 2006).

Researchers should be encouraged to reflect on their own cultural biases and perspectives throughout the analysis process to minimise subjective bias. Combining thematic analysis with quantitative methods or other qualitative approaches can provide a more holistic understanding of the data. Maintaining clear documentation of the coding process, theme development, and analysis decisions can enhance transparency and replicability (Creswell & Poth, 2018). While thematic analysis is a valuable method for exploring complex and nuanced qualitative data, attention to potential limitations and the implementation of strategies to address them can significantly enhance the robustness and credibility of the findings.

The subjective nature of the interpretation is a double-edged sword. While it allows for a deep and nuanced understanding, it also risks introducing the researcher's biases. The interpretation provides a contextual understanding of how cultural differences impact therapists' work, which is valuable for the field of therapy. The researcher acknowledges their subjective approach, which is commendable as it demonstrates an awareness of potential biases. The researcher's biases could influence the identification and interpretation of themes, potentially skewing the findings to reflect personal viewpoints. The study used two raters and a peer review as strategies to mitigate biases, thereby strengthening the credibility of the findings (Cooper & Hedges, 2009). Overall, the study provides valuable insights into the cultural differences impacting therapists' interpretation and understanding of clients' appraisal in PTSD. While the small sample size and potential biases are notable limitations, the thematic richness and relevance of the findings contribute meaningfully to the field of psychotherapy. Future research should aim for a larger, more balanced sample and employ strategies to mitigate researcher bias to enhance the generalisability and reliability of the findings.

8.5 Reflexivity Throughout my Journey

Reflecting on my study, I reach a point in my journey where I realize my readiness has been significantly shaped by my experiences in the Metanoia Programme and my role as a therapist. My eagerness to undertake this project became evident through the Review of Personal and Professional Learning (RPPL/DPY4421). This module provided a platform for me to reflect on my cultural experiences and learn from my role as a therapist. I made a firm commitment to undertake this project, drawing upon the knowledge gained from RPPL and my intensive literature review on cultural differences impacting cognitive appraisals of trauma survivors following PTSD, as well as my dissertation completed as part of my MSc course in Cognitive Psychotherapy. Reflecting on RPPL, I feel that this module was particularly meaningful as it encouraged me to focus on my goals and plan my research study.

The Research Challenges Module (DPY 4442) brought me back to research methodologies and proposal writing, creating a foundation that enabled me to choose an appropriate research design. The experience I gained through completing the Recognition and Accreditation of Learning (RAL 7) module reinforced my research knowledge and skills through reflection on my research studies at the master's level. Upon reflection, I feel that this module was instrumental in generating ideas related to research methodologies.

The Professional Knowledge (PK) Seminars have significantly impacted my learning and shaped my way of thinking. Dr. Andrew Reeves' study, "Research and Ethics: Limited by Our Own," shed light on my approach to ethics in my study, highlighting the importance of confidentiality, participant protection, and result publication. Reflecting on Professor Chris Evans' PK seminar, "Weaving Qualitative and

Quantitative Research Together: Distilling Evidence from Experience," I made a firm decision to choose the appropriate research methodology and methods for my study. Upon reflection, I believe this decision was crucial for facilitating the completion of my research.

Dr. Guy Harrison's PK seminar, "Auto-ethnography as Both Research Process and Product," influenced my thinking regarding research methodology. I recognize the invaluable roles of my Academic Advisor, Academic Consultant, and critical friend, whose support will be crucial during my study. In relation to my project, I struggled with reflexivity, meaning I had difficulty examining my beliefs, judgments, and practices during the research process and understanding how these might have influenced my research. To enhance my understanding, I attended Dr. Livholts' PK seminar, "Narrative Life Writing Genres as Tools for Academic and Professional Development."

In preparation for the seminar, I completed prearranged work, reflecting on my diary notes and reading the novellas provided via email. We explored various writing genres such as diaries, letters, memories, poetry, and photography, discussing how these promote analytical reflexivity and encourage critical, creative, and reflexive ways of working in research and practice. My expectation was to learn from the seminar and acquire the relevant knowledge and skills to improve my reflexivity, enabling me to examine the influence of my own beliefs, judgments, and practices on my research study. This seminar reinforced my abilities and empowered me with the relevant skills and knowledge to be reflective in my approach to my project. According to Dr. Livholt, writing is an act of translation and transformation, an embodied, material, and spatial activity through which researchers design and shape knowledge. Although I

struggled to relate my research to visual culture, such as photography, paintings, theatre, and film, I understood the importance of presenting research in different mediums and interacting with visual culture. Through discussions with peers, I learned that in research, the researcher is both the creator and storyteller of their work.

Dr. Livholt's seminar on "Narrative Life Writing Genres as a Tool for Academic and Professional Development" was interesting and informative. However, I found it challenging to relate this seminar to my study due to the complexity of the research methodology and the difficult concepts. My critical thinking skills have increased and developed throughout the program, but this is an ongoing, lifelong process. For example, this process has enhanced my ability to provide a critical discussion on the findings and its implication for clinical practice.

Dr. Thomas' seminar on using mental imagery to enhance reflexive and conceptual processes in research provides a framework for inclusive theory and practice. In preparation for this seminar, I read Dr. Thomas' paper on her work, which was informative and clarified her presentation. According to Dr. Thomas (2020), there is a "rapidly increasing interest in the way that mental imagery operates as a means of dialoguing with aspects of the self-outside conscious awareness." Mental imagery has been used as the main vehicle of the therapeutic process in clinical practice (Thomas 2010, 2011).

Her seminar was particularly interesting. She used the novel method of representing her research project as a specific mental image and kept a journal of how she interacted with this image during her research. Dr. Thomas used the image of a room as the focus for her creative reflective practice, visualizing the arrival of two figures: a fierce-looking samurai and an 11-year-old girl. Initially, there were difficulties, as the two

figures disappeared from her memory when she visualized the room. What worked better was to keep the samurai figure and introduce an alchemical apparatus, with a steady-burning flame. She interpreted the flame as representing the steady and continuous energy required for the completion of her research study.

I found this seminar to be meaningful and transformative. Reflecting on the existing application of mental imagery initiated transformative changes in how I approach my research. This reflection evoked unexpected feelings, such as a lack of motivation to continue my study. During the imagery exercise report from the seminar, I sketched an image of an empty room to illuminate my research process. After sharing my image with my peers and discussing mental imagery, I began using this technique to motivate myself, hoping that the empty room would gradually transform into a pleasant environment.

The initial stage of the empty room and my growing sense of low motivation indicated that there were no conceptual metaphors in place for this research activity (Thomas, 2013). A shift in my approach occurred when the representational image of myself appeared in this empty room. I understood that my mind had selected an appropriate metaphor: a complete room with pictures, books, and a table. I felt anxious and stressed due to fear of being infected by the Covid-19 virus and its implications for completing my study. This unprecedented time and frequent lockdowns created a sense of fear and uncertainty. The new experience of working at home and being restricted impacted my motivation and ability to continue my project. I asked myself, "How am I going to manage my project?" given the lack of face-to-face contact and the restrictions in place. Dr. Thomas' mental imagery technique has rekindled my interest in my studies. The seminar on the use of mental imagery was relevant and meaningful to my journey,

as it stimulated my passion to continue with my studies. It created an opportunity to engage with myself and improve my reflexivity in relation to my studies.

In addition to the mental imagery technique, as a practicing psychotherapist, I drew on my clinical experience and applied relevant cognitive behavioural therapy strategies to overcome my anxiety, fear, lack of motivation, and uncertainty, allowing me to complete my studies. Reflecting on the completion of my studies, I feel that analysing and engaging with the data created an environment where I acquired relevant knowledge and research skills to facilitate future work. The study influenced my way of thinking, encouraging an enquiring approach to explore cultural differences impacting other areas of psychotherapy, such as models of PTSD, language barriers, trauma appraisal, and its impact on treatment and recovery rates in PTSD. This study has heightened my awareness of being mindful of my own mental, emotional, and physical experiences as a clinician. I have realized that understanding my own experiences while working with patients is integral to understanding their diagnoses and the overall therapy process. I feel that my doctoral journey was enriched by expert knowledge, skills, and personal growth, and how these have impacted my ability to inform my practice.

8.6 Summary and Conclusion

The study was designed following an extensive literature search in the areas of cultural differences, interpretation, understanding, therapist and therapy across different modalities, and clients' appraisals in PTSD. It was an exploratory study, as no prior research was found on the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in PTSD. This qualitative study used thematic analysis as the research methodology, supported by the philosophies of epistemology, constructivism, and interpretivism. A purposive sample of eight participants was recruited, and data were collected using semi-structured interviews. Thematic analysis was employed to identify main themes, sub-themes, and emerging themes.

The findings show that cultural differences impact therapists' interpretation and understanding of clients' appraisals in PTSD and clients' appraisals of their trauma. Given the qualitative nature of the study, the data were open to interpretation, leading to the emergence of other relevant themes related to psychotherapy, such as therapists' difficulties in therapy, family and community support, language barriers, alienation, control, and models of PTSD. The critical discussion of the findings reveals that cultural differences are connected to these emerging themes, indicating a need for further research.

Reflecting on the findings, I believe the study's aims have been achieved. It explored the impact of cultural differences on therapists' interpretation and understanding of clients' appraisals in PTSD, generated knowledge relevant to the training and professional development of psychotherapists and other therapists involved in talking therapies. However, I cannot conclude that this study has significantly advanced our overall understanding of cultural differences impacting therapists' interpretation and

understanding of clients' appraisals in PTSD. As this study is exploratory, there is evidence to suggest that cultural differences in therapy warrant further research to improve recovery rates and psychological adjustment for individuals diagnosed with PTSD and other mental health disorders such as anxiety and depression. This study underscores the importance of cultural differences in therapy and adds to the overall picture of cultural differences in therapy. I hope my contribution will help fill the knowledge gap in this area of psychotherapy.

8.7 Products

I believe that my research will provide therapists with opportunity to understand the interpretation of clients' appraisals and its influence on improving clinical practice. For example, better recovery rate and positive psychological re-adjustment for clients following PTSD can be achieved. The research will generate new knowledge which will be disseminated to a wider audience in 4 different ways:

1) Metanoia Institute and Middlesex University – Research Forum & Research Announcements & Events - Presented my project to the Research Forum/Seminar on 13/5/2021.

Feedback: positive approach and interesting topic for exploration, to improve on critical review of literature/ to identify findings- more clearly. Impact on practice-relevant, appropriate research methodology used.

2) Presentation of my research at Kingston University – Faculty of Health, Social Care and Education on 27th May 2020

Dr Anne Oom, Director of Research at Kingston University invited me to present to Research group at Kingston University, Faculty of Health, Social Care and Education. Their feedback was positive with constructive advice to explore further aspects of cultural impact on treatment, education and other mental conditions such as anxiety, depression and stress.

3) A training package in the form of guidelines will be designed with the aim to inform therapists and raise awareness of cultural differences, impacting on interpretation and making sense of appraisals.

4) Preparation for presentation of research findings to BABCP conference usually in June or Annual conference in September 2022

5) Preparation to publish research findings in any of the following Journals: Behavioural and Cognitive Psychotherapy-BABCP, Journal of Psychology and Psychotherapy or International Journal of Psychology, Psychological therapy and Therapy Today.

Article i) The impact of cultural differences on therapists' interpretation and understanding of clients' appraisal in PTSD

Article ii) Impact of cultural differences on Language barrier in the treatment of PTSD

Article iii) What are the impact of cultural differences on clients' appraisal in PTSD.

Please see products i) to iv) in (appendix xii/p431).

(From introduction to products = 62833 words).

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Appendices:

Appendix i) – Covering letter and information for participants

An Invitation to participate in the research project titled:

Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study.

Date: …….

Dear …….,

I am conducting interviews as part of a research study to increase my understanding of how therapists interpret and make sense of clients' appraisals in PTSD and whether cultural differences play an important role in that process. As a qualified therapist working in cognitive behaviour therapy at Level 3 (High Intensity), you are in an ideal position to give me valuable first- hand information from your own perspective.

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

The interview takes around 50 to 60 minutes and is very informal. I am simply trying to capture your thoughts and perspectives on your interpretation and meaning of clients' appraisals. Your responses to the questions will be kept confidential. Each interview will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and write up of findings. There is no compensation for participating in this study. However, your participation will be a valuable addition to our research and findings could lead to greater understanding of clients' appraisals and could have an impact on recovery rate.

If you are willing to participate, please suggest a day and time that suits you and I'll do my best to be available. If you have any questions, please do not hesitate to ask.

Thanks!

G.S Ramkissoon

Interviewer/Researcher & Psychotherapist

Candidate on the Doctoral programme at Metanoia Institute & Middlesex University.

Course: Doctorate in Psychotherapy by Professional Studies

Information for participant

Metanoia Institute and Middlesex University

Doctorate in Psychotherapy by Professional Studies

Participant's information sheet and consent form

1. Study title:

Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study.

2. Invitation to take part:

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

3. What is the purpose of the study?

PTSD affects people worldwide and accumulating research indicates that it is a universal phenomenon (Jobson and O'Kearney, 2009; Figueira et al, 2007). There are several factors that impede post traumatic recovery and help to maintain symptoms and maintain the development of on-going PTSD. Cultural differences could be one of these factors. The aim of the study is to explore the influence of cultural differences impacting on therapists' interpretation and make sense of clients' appraisals in PTSD. The duration of the study might last between 15 to18 months.

4. Why have I been chosen?

You were chosen because you are involved in the assessment and treatment of clients with PTSD. You have been working as a practitioner in an IAPT Service to provide cognitive behavioural therapy to clients at level 3, i.e., face to face.

5. Do I have to take part?

It is entirely your decision to take part in the research. You are in an ideal position to give me valuable information at first-hand. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

Participants will be invited to take part in a semi-structured interview with the researcher. It will be an informal process and information will be collected in form of a narrative/or answer questions on how as a therapist you interpret and make sense of clients' appraisals and considering their thoughts, emotions, coping strategies and changes in their life.

7. What do I have to do?

If you decide to take part in the semi-structured interview, you will talk to the researcher on clients' appraisals, their emotions, thoughts and coping strategies.

8. What are the alternatives for diagnosis or treatment?

Alternative treatments are Behaviour therapy, psychodynamic therapy and medicine from the GP

9. What are the side effects of any intervention received when taking part?

There is no intervention involved in this study.

10. What are the possible disadvantages and risks of taking part?

The possible risks are that the participants can become distressed by narrating traumas of their clients. Participants will be given the telephone number of their supervisors for support.

11. What are the possible benefits of taking part?

The benefits are that the participants can have a better understanding of cognitive appraisal of traumas and will help them in the therapy sessions.

12. Will my taking part in this study be kept confidential?

All information that is collected about you during the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All data will be stored, analysed and reported in compliance with the Data Protection legislation of the DoH (2003, 2005), UK. Data will be stored for up to 12 months after the end of the study and then will be disposed safely and confidentially.

13. What will happen to the results of the research study?

i) The results of the research will be published as part of postgraduate dissertation.

ii) Participants will not be identified in any report/publication.
iii) An article in a form of research paper/report will be published in an academic psychotherapy journal.
iv) Participants will receive a copy of the report upon request.
v) Participants will be requested to give consent before the report is published in an academic journal or presented at a conference.

14. Who will review the Study?

Ethical approval by the Metanoia Research Ethics Committee.

15. Contact for further information

Participants can contact the following person for further information:

The Researcher on 07305931245

Email address: ved09@hotmail.co.uk

Researcher's Supervisor: Professor Simon du Plock

Email address: Simon.duPlock@metanoia.ac.uk

gsr@2019

Date: 20th October 2019

Appendix ii) Evidence from Raters and Participant (p 323 - p329).

Confirmation of Rater 1

Cultural Differences Impacting on Therapists' Interpretation and Understanding of Clients' Appraisals in Post-Traumatic Stress Disorder

Sharma G Ramkissoon
Post -graduate student

A dissertation submitted to UNIVERSITY in partial fulfilment of the requirements for the degree of Doctorate in Psychotherapy by Professional Studies.

A Joint Programme between the School of Health & Education, Middlesex University and Metanoia Institute

DPY 5360 Doctoral Project

Re-submit August 2024

Declaration

I solemnly declare that I acted as a rater for the transcribed data, coding, and recoding of the themes regarding the thesis titled "Cultural Differences Impacting Therapists' Interpretation and Understanding of Clients' Appraisals in Post-Traumatic Stress Disorder" to be submitted to Middlesex University in partial fulfillment of the requirements for the degree of Doctorate in Psychotherapy by Professional Studies.

Date: 31/08/2023

Signature: T. Rooney-Kaymakci

Name: Ms T. Rooney- Kaymacki

Title: Ex-Senior Lecturer
Social Sciences /Research
Faculty of Health and Education.
Kingston Hill Campus
River House
53-57 High Street
Kingston University
Kingston Upon Thames
KT1 1LQ

Confirmation of Rater 2

Cultural Differences Impacting on Therapists' Interpretation and Understanding of Clients' Appraisals in Post-Traumatic Stress Disorder

G S Ramkissoon
Post -graduate student

A dissertation submitted to UNIVERSITY in partial fulfilment of the requirements for the degree of Doctorate in Psychotherapy by Professional Studies.

A Joint Programme between the School of Health & Education, Middlesex University and Metanoia Institute

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Declaration

I solemnly declare that I acted as a rater for the transcribed data, coding, and recoding of the themes regarding the thesis titled "Cultural Differences Impacting Therapists' Interpretation and Understanding of Clients' Appraisals in Post-Traumatic Stress Disorder" to be submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctorate in Psychotherapy by Professional Studies.

Date: 31/08/2023

Signature:
Name: Ms Susan Strong

To:You
Dear Ram,

Thank you for this opportunity to view your original data, for your PhD submission, please may I make the following summarizing comments.

1. That I have independently identified themes, that may contribute to the internal validation of your data
2. I agree with the themes that you have identified, emerging from the data
3. We have discussed the themes and have jointly agreed with the themes identified

This is a very interesting original study that makes a valuable contribution towards an understanding of the "cultural differences impacting on Therapists' interpretation and understanding of clients' appraisals in post-traumatic stress disorder". In this UK context. Your study population provided a rich source of emerging evidence, within this sensitive and challenging area of clinical practice, new insights have clearly emerged and with your analysis, synthesis and evaluation of the data it a make a worthy contribution to both your own practice and the winder therapeutic community. I look forward to reading future publications of your insights and contributions

Please note that I have send the signed document of Rater 2 separately

May I take this opportunity to wish you every success for the future

Many thanks again for sharing your data with me towards the internal validation of your study

very kind regards,

Susan Strong

Meera Bahu Aug 4, 2024, 8:19 PM

Dear Ram,
Please see my feed back
I hope it makes sense. Please let me know if it's difficult to make sense.
I hope this is what was needed.
Kind Regards
meera.
--

Participant's Feedback on Thematic Analysis for IPA Study

Overall Feedback: The analysis conducted by the researcher aligns well with the content of the transcribed interviews. The themes identified appear to be a true representation of the data, capturing the nuances and complexities presented by the participants. Below are the detailed feedback points and examples of how the themes connect with the provided data.

Example Coding and Themes

1. **Theme: Impact of Cultural Differences on Clients' Appraisals**
Interview Segment (Participant 5, B4):

"I will say people that are Asian and African internalized the trauma a lot differently, e.g., they suffered from delusion from the trauma, but they believed that they were in control. Re: 'I am weak, and others see me as a weak person' - I get that sense from both clients, all clients focus on what other people will think about it."

"In the western culture clients that I saw in my practice, said 'how my family is going to see me, rather than the world will see me', whereas clients from Asian or African backgrounds, said 'how am I going to be perceived by people close to me'."

Theme Match: The researcher accurately identified the impact of cultural differences on clients' appraisals of themselves. This segment illustrates a clear difference in perception between Western clients and those from Asian or African backgrounds, with a focus on familial versus broader societal views.

2. Theme: Clients' Self-Appraisal Post-Trauma
Interview Segment (Participant 5, A3):

"As an integrative therapist and based on clients that I saw in the clinical practice, they appraised themselves negatively, for examples, lack a sense of control, self-esteem, confidence and negative self-talk."

"In the case of sexual abuse, quite often clients took the responsibility, meaning the way they were responsible, but not vulnerable, felt something done to them and they were not a victim."

"I did not notice too much of cultural differences when clients appraised themselves following a traumatic experience."

Theme Match: The researcher correctly captured the theme of negative self-appraisal post-trauma. This segment highlights common negative self-perceptions such as lack of control, self-esteem, and confidence, and also touches on the notion of responsibility and victimhood. The lack of significant cultural difference in this specific aspect is noted.

3. Theme: Mental Defeats and Decision-Making Post-Trauma
Interview Segment (Participant 5, C5):
"My interpretation and understanding of clients' appraisals in term of autonomous, there is a sense of self encompassing confidence, power, how much they are in control, I would ask and explore the meaning, ascribed different meaning to the words."

"With reference to clients, I provided therapy and in cases of sexual or physical abuse, I have seen in a lot of clients make them questioned whether they could and were capable of making good decision, they questioned a lot of their decisions, found it difficult to make decision in general in fear of being traumatized again, meaning vulnerable to sexual or physical abuse."

Theme Match: The researcher identified the struggle with decision-making and mental defeats accurately. This segment discusses clients' difficulties with confidence, decision-making, and fear of re-traumatization, reflecting a deeper level of vulnerability.

4. Theme: Loss of Identity Post-Trauma
Interview Segment (Participant 5, D6):

"The way I interpret and understand the clients is that they struggle with control, and they lack the ability to plan their life, go back to lack of sense of self."

"What is it about planning things? What are they finding difficult? What they want to be in control of, and is that realistic, can they be actually in control or outside of control?"

"I think that I do really try to understand where clients are coming from, and what things mean to them or how they perceive themselves and who they are?"

Theme Match: The researcher effectively captured the theme of identity loss. The segment highlights clients' struggles with control, planning, and self-perception, emphasizing the loss of a coherent sense of self.

Reflection on Data Interpretation:

Although some of the content of the data is difficult to interpret and understand the meaning behind it, the researcher has captured the themes accurately. For example, one participant reported that people from Asian and African backgrounds internalized trauma differently, sometimes experiencing delusions but believing they were in control. The statement "I am weak, and others see me as a weak person" was a common theme, with all clients focusing on others' perceptions. In Western culture, clients worried about their family's perception, whereas clients from Asian or African backgrounds were more concerned with how close acquaintances perceived them. Although this distinction is somewhat confusing, the researcher has accurately linked these themes with cultural differences, demonstrating an insightful understanding of the data.

Feedback Summary:

Alignment and Representation: The themes identified by the researcher accurately reflect the participants' experiences and perceptions as captured in the transcripts.

Cultural Sensitivity: The analysis appropriately considers cultural differences, particularly in how trauma is internalized and appraised by clients from diverse backgrounds.

Complexity and Nuances: The themes effectively capture the complexity and nuances of the clients' appraisals and experiences post-trauma.

Overall Reflection

Richness of Data: There are illustrative quotes and examples that enrich the themes and provide a deeper understanding of the participants' experiences. However, some content is confusing, making it difficult for the reader to understand. That said, this is the data from the participants, and in IPA, one cannot go back and clarify this with the participant, which is perhaps a disadvantage of the research method.

Contextualization: In your ongoing analysis, I believe that the themes will be linked more explicitly to existing literature or theories on cultural psychology to enhance the contextual understanding of the identified themes, providing a much richer understanding for the readers.

Overall, the thematic analysis is thorough and well-executed, with themes that are grounded in the transcribed data and reflective of the participants' lived experiences. The researcher's ability to link themes to cultural differences is particularly insightful, even when the content is complex and challenging to interpret.

Appendix iii)

Semi-structured interview questionnaire

Thank you for agreeing to take part in my research study.

Introduction:

I am conducting a semi-structured interview to explore your lived experiences as a therapist who has been involved in providing therapy to individuals who have been traumatised and

diagnosed with PTSD. The focus of the interview is on therapists' interpretation and understanding of clients' appraisals following traumatic event. As part of the semi-structured interview, Ehlers et al (1998, 2000) 10-page manual based on mental defeats, control strategies, alienation and permanent change will be used.

1. Please tell me about yourself and your experience as a therapist in your modality.
   Age range:
   Gender:
   Modality:
   Practice: Private: IAPT NHS:
   Years of experience:
2. Have you provided therapy to a wide range of clients from different backgrounds and ethnicity?
   Please give few examples:
A 3. How do you see clients appraised themselves after a trauma (PTSD?

B 4. Do you see any differences of how clients from different cultural backgrounds appraised themselves?
(For interviewer to explore in depth)
C 5. How do you see clients appraised themselves in relation to mental defeats after a trauma (PTSD)?
(*For interviewer – explore interpretations, understanding, lack of autonomy, threat to self, giving up mentally)*
D 6. What is your interpretation and understanding if a client says that they have lost their identity?
(For interviewer - lack of planning ability and inability to minimising physical or psychological harm).
E 7. Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control?
F 8. How do you see clients appraised themselves towards others and the world?
(For interviewer- alienation, interaction with others & engagement)
G 9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change?
(For interviewer- changes in their life being permanent, changes in themselves, personality and changes in life goals).
H 10. Do you think that the current PTSD models are appropriate for different cultural backgrounds?
   Please explain and give your reasons

Thank you for participating in my research. Your help/support is very much appreciated.

Appendix iv) Ethical Consideration and Stakeholders (p331 – p333)

Ethical Consideration: Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study.

Student number: 22397 **S. Ramkissoon**

Stakeholders	Expectations/Benefits	Concerns/Harms	Strategies to mitigate harm to an acceptable level
Participants. **(NHS IAPT services, Private practice & 3rd Sector Organisations**	Contributing toward the therapeutic intervention Helping them to understand the impact of cultural differences on the way therapists cognitively appraise clients' traumas I will support participants: Have a face-to-face meeting, identifying distress, discomfort, triggers and trauma, talk to them, reassured and collaborative discuss support needed and I will arrange/ contact appropriate Health care professionals to support participant (s).	Psychological traumatic issues could be brought to the surface/trigger of past trauma & increasing level of stress and distress caused by the narratives and lived experience(s) **Complaints re: research**	Psychoeducation /adequate explanation of the study (benefits, pros/cons) & offer choice of opting out if too traumatic for individuals and advise to seek help. Contact for help: i) To contact their General Practitioner for referral to Counselling Services ii) Self-referral to any of the following: • IAPT Croydon Tel no: 020 3228 4040 Email address: Croydon IAPT@ Slam.nhs.uk • Sutton & Merton IAPT Tel no: 0800 032 1411 • or 020 3515 4044 • Wandsworth IAPT Tel no: 020 3515 6264 • Lambeth IAPT Tel no: 0203 228 6747 To contact Professor Simon du Plock at Metanoia Institute - Email address: Simon.duPlock@metanoia.ac.uk Tel: 020 8579 2505
Researcher	To complete study, gaining new knowledge & skills/contribute to the profession, adding new knowledge & attempting to improve clinical therapeutic intervention in PTSD	Coping with traumatic experiences and effect /affect self, Stressful situations, pressure of work and commitment to complete study; pressure on	Effective planning and organization to reduce workload and relieve stress. Reasonable workload that can be manageable Setting short/long term goals to manage the complex nature of the study. Attend clinical supervision regularly and work in collaboration with Academic supervisor

		family /personal life	
Private Services	Improvement of clinical therapeutic intervention in CBT/better service provision for this client group/ cost effectiveness of the service /possibly better recovery rate and reduction in relapses in PTSD following treatment	Concern about reputation if study is not completed, Use of extra resources and time with reference to sessional allocated time per patient,	Complete Study as planned Discuss with supervisor and Clinical Lead for the likelihood of extra resources that may be required, seek confirmation and approval before commencing of study. Address any potential conflict before the study & create an environment where mutual discussion can take place/negotiation build up within the different parties/stake holders concerned
Researcher's Clinical Supervisor/ participants 'supervisors	Participation in research study, gaining new knowledge, skills and insight into the therapeutic intervention in PTSD/improvement in the supervisory skills	Stress due to extra work/supervision, Conflict of interest, Not interested in the study, Trigger psychological issues	Regular supervision at appropriate time and in agreement with supervisors, discuss any psychological issues, interest and workload dilemma with room to open negotiation/facilitating the research process, confident building measures
Researcher's peers & critical friends	Gaining insight into research study, new knowledge, skills and improvement in therapeutic intervention/better success rate in the treatment of PTSD	Lack of knowledge and understanding of concept with re: PTSD might cause upset, trigger of personal trauma	Discuss relevant issues, open for negotiation, mutual trust and support, exploring concepts collaboratively, seeking support/ advice from supervisor and Clinical Lead. Self- referral for psychological support/counselling. Contact for help: i) To contact their General Practitioner for referral to Counselling Services ii) Self-referral to any of the following:

			• IAPT Croydon Tel no: 020 3228 4040 Email address: Croydon IAPT@ Slam.nhs.uk • Sutton & Merton IAPT Tel no: 0800 032 1411 or 020 3515 4044 •Wandsworth IAPT Tel no: 020 3515 6264 • Lambeth IAPT Tel no: 0203 228 6747 I will support participants: Have a face-to-face meeting, identifying distress, discomfort, triggers and trauma, talk to them, reassured and collaborative discuss support needed and I will arrange/ make contact with appropriate Health care professionals to support participant (s).
3rd Sector/Voluntary Organisations	Involvement in research study, better reputation, gaining knowledge, insight and improvement in the treatment of patients with PTSD/ increasing partnership with other health care provider in Psychotherapy	Time consuming, reputation if study is not completed, trigger of past trauma for individual working in the organizations, requirement of more resources	Prior discussion of the study and possible factors that could impinge on the progress or hindrance to the study. Mutual trust and confident building measures. Seek supervisor support and collaborative discussion/negotiation with respective organisation

Appendix v) (p334 – p335)

Metanoia Institute and Middlesex University

Doctorate in Psychotherapy by Professional Studies

CONSENT FORM

Participant Identification Number:

Title of Project:

"Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder" – an exploratory study.

Name of Researcher: G S Ramkissoon

Please initial box

1. I confirm that I have read and understand the information sheet dated 29th October 2019 for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.

☐

3. Delete 3 and/or 4 if not applicable:

I understand that sections of any of my medical notes may be looked at by responsible individuals from [company name] or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.

☐

4. I understand that my interview will be taped and subsequently transcribed

☐

5. I agree to take part in the above study.

☐

6. I agree that this form that bears my name and signature may be seen by a

Designated auditor

☐

_____ _____ _____

Name of participant:

Date:

Signature:

_____ _____ _____

Name of person taking consent

Date:

Signature:

(if different from researcher)

S. Ramkissoon _____ _____

Researcher

Date:

Signature:

1 copy for participant; 1 copy for researcher

Appendix vi)

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research: *Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study*

IRAS Project ID (if available):

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the **HRA** to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at **Queries@hra.nhs.uk**.

For more information please visit the **Defining Research** table.

Follow this link to start again.

NOTE: If using Internet Explorer please use browser print function.

Appendix vii) Application for Ethical approval (p337- p353)

DETAILS OF APPLICANT AND RESEARCH SUPERVISOR

1.1. **Applicant's name:** Govinduth Sharma Ramkissoon

1.2. Email address: ved09@hotmail.co.uk

1.3. Telephone number: 02086572507 and mobile 07768145692

1.4. Research supervisor(s) name, qualifications and contact details:

Professor Simon du Plock CPsychol, ASFBPsS, FRSM
Email: Simon.duPlock@metanoia.ac.uk
Tel: 020 8579 2505

1.5 Institution/contact details (if applicable):

Metanoia Institute and Middlesex University
Tel: + 44 (0) 208 579 2505 & + 44 (0) 208 411 4509

1.6 Do you have any external funding for this project? Yes/No (please circle)
If yes, please provide brief details including the name of the funding body:
No

1.7. Project title:

Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study.

ETHICAL CONSIDERATIONS
Note: The items below cover all of those in the A/B categories of Middlesex University

	YES	NO	N/A
1. Will you describe the research procedures in advance to participants so that they are informed about what to expect? Please attach a copy of any recruitment letters and information sheet to be used.	yes		
2. Is the project based on voluntary participation?	yes		
3. Will you obtain written consent for participation?	yes		
4. If the research is observational, will you ask participants for their consent to being observed?			N/A
5. Will you tell participants that they may withdraw from the research at any time and for any reason and inform them of how they may withdraw?	yes		
6. Will you ensure that participants are not subtly induced, either to participate initially, or to remain in the project?	yes		
7. Will you give participants the option of omitting questions from interviews or questionnaires that they do not want to answer?	*yes*		
8. Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	*yes*		
9. Have you made provision for the safe keeping of written data or video/audio recordings?	*yes*		

10. Will you debrief participants at the end of their participation?	*yes*		
11. Have you ensured that your research is culture/belief/ social system sensitive and that every precaution has been taken to ensure the dignity, respect and safety of the participants?	*yes*		

If you have answered 'NO' to any of the questions listed in 1 to 12 above, then please provide further details on a separate page and attach it to this application.

	YES	NO	N/A
12. Is there a realistic risk of any participant experiencing either physical or psychological distress or discomfort? If YES, what will you tell them to do if they should experience any problems (e.g. who they can contact for help.) Contact for help: i) To contact their General Practitioner for referral to Counselling Services ii) Self-referral to any of the following: • IAPT Croydon Tel no: 020 3228 4040 Email address: Croydon IAPT@ Slam.nhs.uk • Sutton & Merton IAPT Tel no: 0800 032 1411 or 020 3515 4044 • Wandsworth IAPT Tel no: 020 3515 6264 • Lambeth IAPT Tel no: 0203 228 6747 **I will support participants**: Have a face-to-face meeting, identifying distress, discomfort, triggers and trauma, talk to them, reassured and collaborative discuss support needed and I will arrange/ make contact with appropriate Health care professionals to support participant (s).	Yes- There is a risk that participants might experience psychological distress/discomfort such as remembering their own trauma or feeling uncomfortable. For example, certain situations or narratives/ lived experience -which can act as a trigger/may cause distress such as reliving personal traumatic events. Will stop interview/ debrief/support and advise to seek help from GP or IAPT services.		
13. Is there an existing relationship between the researcher and any of the research participants? If YES, please describe the ethical implications and the safeguards in place to minimise risks.		No	
14. Your research does not involve offering inducement to participate (e.g. payment or other reward)? If YES, please describe the ethical implications and the safeguards in place to minimise risks.		No	
15. Will the project involve working with children under 16 years of age? If YES, please describe parental consent and safeguarding procedures.		No	

16. Will your project involve deliberately misleading participants in any way? If YES, please explain why this is necessary.		No	
17. Will you need to obtain ethical approval from any other organisation or source? If YES, please attach letter confirming their ethical approval.		No	
18. Are there any other ethical considerations in relation to your project that you wish to bring to the attention of the Research Ethics Committee that are not covered by the above? If YES, please describe on a separate sheet.	Yes/ Please see appendix iv)		

If you have answered 'YES' to any of the questions listed under 13 to 18 above, then please provide further details on a separate page and attach it to this application.

CANDIDATE DECLARATION

I have read the BACP and the BPS guidelines for ethical practices in research and have discussed this project with my research supervisor in the context of these guidelines. I confirm that I have also undertaken a risk assessment with my research supervisor:

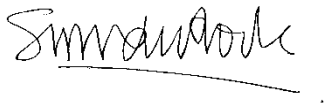
Signed:

Print name: G S Ramkissoon (Applicant) Date: 10/02/2019

RESEARCH SUPERVISOR DECLARATION

- As supervisor or principal investigator for this research study I understand that it is my responsibility to ensure that researchers/candidates under my supervision undertake a risk assessment to ensure that health and safety of themselves, participants and others is not jeopardised during this study.
- I confirm that I have seen and signed a risk assessment for this research study and to the best of my knowledge appropriate action has been taken to minimise any identified risks or hazards.
- I understand that, where applicable, it is my responsibility to ensure that the study is conducted in a manner that is consistent with the World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (see http://www.wma.net/e/policy/b3.htm).
- I confirm that I have reviewed all of the information submitted as part of this research ethics application.

- I agree to participate in committee's auditing procedures for research studies if requested.



Signed:

Print name: Professor Simon du Plock Date: 11.02.19
(Supervisor)

STATEMENT OF ETHICAL APPROVAL

This project has been considered by the Metanoia Research Ethics Committee and is now approved.

- Learning agreement approved/passed

Signed:…….....Print name…….....….
Date……...……
(On behalf of the Metanoia Research Ethics Committee)

Please note that the Metanoia Research Committee meets twice during each academic year. Submissions between these meetings are dealt with by chair's action in consultation with one other committee member. All applications are acknowledged in writing and considered at the bi-annual Metanoia Research Committee meeting.

B) Participant's information sheet and consent form

1. **Study title**:

Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study.

2. Invitation to take part:

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

3. What is the purpose of the study?

PTSD affects people worldwide and accumulating research indicates that it is a universal phenomenon (Jobson and O'Kearney, 2009; Figueira et al, 2007). There are several factors that impede post traumatic recovery and help to maintain

symptoms and maintain the development of on-going PTSD. Cultural differences could be one of these factors. The aim of the study is to explore the influence of cultural differences impacting on therapists' interpretation and make sense of clients' appraisals in PTSD. The duration of the study might last between 15 to18 months.

4. Why have I been chosen?

You were chosen because you are involved in the assessment and treatment of clients with PTSD. You have been working as a practitioner in an IAPT Service to provide cognitive behavioural therapy to clients at level 3, i.e., face to face.

5. Do I have to take part?

It is entirely your decision to take part in the research. You are in an ideal position to give me valuable information at first-hand. If you decide to take part, you are still free to withdraw at any time and without giving a reason

6. What will happen to me if I take part?

Participants will be invited to take part in a semi-structured interview with the researcher. It will be an informal process and information will be collected in form of a narrative/or answer questions on how as a therapist you interpret and make sense of clients' appraisals and taking into account their thoughts, emotions, coping strategies and changes in their life.

7. What do I have to do?

If you decide to take part in the semi-structured interview, you will talk to the researcher on clients' appraisals, their emotions, thoughts and coping strategies.

8. What are the alternatives for diagnosis or treatment?

Alternative treatments are Behaviour therapy, psychodynamic therapy and medicine from the GP

9. What are the side effects of any intervention received when taking part?

There is no intervention involved in this study.

10. What are the possible disadvantages and risks of taking part?

The possible risks are that the participants can become distressed by narrating traumas of their clients. Participants will be given the telephone number of their supervisors for support.

11. What are the possible benefits of taking part?

The benefits are that the participants can have a better understanding of cognitive appraisal of traumas and will help them in the therapy sessions.

12. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All data will be stored, analysed and reported in compliance with the Data Protection legislation of the DoH (2003, 2005), UK. Data will be stored for up to 12 months after the end of the study and then will be disposed safely and confidentially.

13. What will happen to the results of the research study?

i) The results of the research will be published as part of postgraduate dissertation.
ii) Participants will not be identified in any report/publication.
iii) An article in a form of research paper/report will be published in an academic psychotherapy journal.
iv) Participants will receive copy of the report upon request.
v) Participants will be requested to give consent before the report is published in an academic journal or presented at a conference.

14. Who will review the Study?

Ethical approval by the Metanoia Research Ethics Committee.

15. Contact for further information

Participants can contact the following person for further information:

The Researcher on 07768145692

Email address: ved09@hotmail.co.uk

Researcher's Supervisor: Professor Simon du Plock

Email address: Simon.duPlock@metanoia.ac.uk

17. Participants will be given the information sheet and a signed consent form to keep (B section above for information sheet and consent form below section 17)

18. Consent Form

CONSENT FORM

Participant Identification Number:

Title of Project:

"Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder" – an exploratory study.

Name of Researcher: G S Ramkissoon

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐

Delete 3 and/or 4 if not applicable:

3. I understand that sections of any of my medical notes may be looked at by responsible individuals from [company name] or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐

4. I understand that my interview will be taped and subsequently transcribed ☐

5. I agree to take part in the above study. ☐

6. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent (if different from researcher)	Date	Signature
S. Ramkissoon	_____	
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT

This proforma must be completed as part of the research ethics submission for all fieldwork. It is to be completed by the person carrying out the fieldwork (which in most cases is the candidate) in conjunction with the research supervisor.

FIELDWORK DETAILS

Name of person carrying out fieldwork (usually the candidate): G S Ramkissoon

Name of research supervisor: Professor Simon du Plock

Telephone numbers and name of next of kin who may be contacted in the event of an accident	**FIELDWORK NEXT OF KIN** **Name:** Mrs Sunita Ramkissoon **Phone:** 07984615958
Physical or psychological limitations to carrying out the proposed fieldwork	No physical or psychological limitations identified …to carry out semi-interviews…..……..
Any health problems (full details) which may be relevant to proposed fieldwork activity in case of emergencies.	Diagnosed with hypothyroidism but on medication. The condition will not be impacting on the work to be undertaken.
Locality (Country and Region)	Surrey and Outer London areas, England
Travel arrangements	Use own transport - travelling by car to private clinics.
NB: Comprehensive travel and health insurance must always be obtained for independent overseas fieldwork.	Has comprehensive car/health Insurance

Dates of travel and fieldwork

From April 2019 to March 2020
……..……..……..……..……

……..……..……..……..……

Hazard Identification and Risk Assessment - PLEASE READ VERY CAREFULLY

List the localities to be visited or specify routes to be followed **(Col. 1).** For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 2).**

Examples of Potential Hazards:
Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (Weil's disease, hepatitis, malaria, etc.), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc.), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use And repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

1. LOCALITY/ROUTE	2. POTENTIAL HAZARDS
	NONE **Will not be travelling in adverse weather conditions, e.g.,** **Flooding, snowing & strong wind** **Will not be travelling in polluted areas re: traffic**

Risk Minimisation/Control Measures PLEASE READ VERY CAREFULLY

For each hazard identified **(Col 2),** list the precautions/control measures in place or that will be taken **(Col 3)** to **"reduce the risk to acceptable levels",** and the safety equipment **(Col 5)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 3),** categorise the fieldwork risk for each location/route as negligible, low, moderate or high **(Col. 4).**
Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:
Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individual's fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted, and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

3. PRECAUTIONS/CONTROL MEASURES	4. RISK ASSESSMENT (Low, moderate, high)	5. SAFETY/EQUIPMENT
None	none	None or N/A

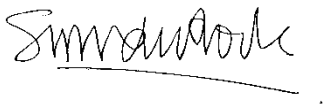
DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker (Candidate/Staff)

Date: 10/02/19

Signature of candidate's Research Supervisor



Date: 11.02.19

APPROVAL:

Approved by Programme Approval Panel

Middlesex University London

Doctorate in Psychotherapy by Professional Studies

METANOIA INSTITUTE

LA REVISIONS ASSESSMENT FORM

Revisions to DPY 4444 following PAP – Resubmission of Final LA

To be submitted to the Programme Approval Panel by:

1. Academic Adviser : Prof Simon du Plock
2. First and/or Second Assessor (if decided by the PAP): First Assessor

Date	10th September 2019	Date of Formative PAP Board	23rd November 2018
Candidate Name	Govinduth Ramkissoon	University No.	M00435051

Title of Proposed Project:
Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study.

Number of Credits: 40 Your name: Dr Nigel Copsey

Your role (e.g., academic adviser, first/second assessor): First Assessor

I agree that the above candidate has carried out the revisions given by the Programme Approval Panel.
I am recommending that the Learning Agreement now be Approved. (please attach a copy of the list of revisions given by the PAP.)

Although I am recommending that Govinduth should proceed to part two I think it is important that he is rigorous with his implementation of the IPA methodology. There is a suggestion in the document that he already assumes the outcome. This would be contrary to the phenomenological approach. I also think he needs to be clear in the criteria he uses for finding co researchers. He needs to ensure that he is open to interpret the findings whatever they might be.
Please sign

First Assessor Nigel Copsey. 24.9.19

Middlesex University London

Doctorate in Psychotherapy by Professional Studies METANOIA INSTITUTE

LA REVISIONS ASSESSMENT FORM

Revisions to DPY 4444 following PAP – Resubmission of Final LA

To be submitted to the Programme Approval Panel by:

1. Academic Adviser: Prof Simon du Plock

2. First and/or Second Assessor (if decided by the PAP): Second Assessor

Date	10th September 2019	Date of Formative PAP Board	23rd November 2018
Candidate Name	Govinduth Ramkissoon	University No.	M00435051

Title of Proposed Project:
Cultural differences impacting on therapists' interpretation and understanding clients' appraisals in post-traumatic stress disorder – an exploratory study.

Number of Credits: 40 Your name: Dr Alistair McBeath

Your role (e.g., academic adviser, first/second assessor): Second Assessor

I agree that the above candidate has carried out the revisions given by the Programme Approval Panel.
I am recommending that the Learning Agreement now be Approved. (Please attach a copy of the list of revisions given by the PAP.)

Short report

The candidate has addressed the main concerns that emerged from the Programme Approval Panel. For example, the proposed sample is smaller (8) and more diverse.

The candidate must ensure that the research has a strong and open phenomenological focus. At present there is a fundamental assumption being made that a hypothesised cultural factor (e.g., collectivist versus individualistic cultures) will be discernible in the way that therapists interpret existing PTSD assessments. This may turn out not to be the case.

Second Assessor 

FIELDWORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

X Safety knowledge and training?

X Awareness of cultural, social and political differences?

X Physical and psychological fitness and disease immunity, protection and awareness?

Personal clothing and safety equipment? N/A

Suitability of fieldworkers to proposed tasks. N/A

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

Visa, permits? N/A

X Legal access to sites and/or persons?

X Political or military sensitivity of the proposed topic, its method or location?

Weather conditions, tide times and ranges? N/A

Vaccinations and other health precautions? N/A

Civil unrest and terrorism? N/A

X Arrival times after journeys?

Safety equipment and protective clothing? N/A

X Financial and insurance implications?

Crime risk? N/A

X Health insurance arrangements?

X Emergency procedures?

X Transport use?

X Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments:

Once the risk assessment is completed and approval gained the **research supervisor** should retain this form and issue a copy of it to the fieldworker participating on the fieldwork. In addition, the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Middlesex University Sponsoring Organisation Letter

Date

School of Science and Technology

The
Burroughs
London
NW4 4BT

To .....

This is to confirm that Middlesex University has declared itself as a sponsoring organisation for research projects that involve NHS patients, staff and other resources as described in the *Research Governance Framework for Health and Social Care* (DoH 2000). Middlesex University confirms that it accepts the responsibility of Sponsor Organisation, and has structures in place, to ensure that:

- The research proposal respects the dignity, rights, safety and wellbeing of participants and the relationship with care professionals.
- The research proposal is worthwhile, of high scientific quality and represents good value for money.
- The research proposal has been approved by an appropriate research ethics committee.

**Appropriate arrangements are in place for registration of trials.*

- The principal investigator, and other key researchers, have the necessary expertise and experience and have access to the resources needed to conduct the proposed research successfully.
- The arrangements and resources proposed will allow the collection of high quality, accurate data and the systems and resources proposed are those required to allow appropriate data analysis and data protection.
- Intellectual property rights and their management are appropriately addressed in research contracts or terms of grant awards.
- Arrangements proposed for the work are consistent with the Department of Health research governance framework.
- Organisations and individuals involved in the research all agree the division of responsibilities between them.
- There is a clear written agreement identifying the organisation responsible for the ongoing management and monitoring of the study, whether this is the organisation employing the researchers, the sponsor, or another organisation.
- *Arrangements are in place for the sponsor and other stakeholder organisations to be alerted if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.

- An agreement has been reached about the provision of compensation in the event of non-negligent harm and any organisation, including the sponsor itself, offering such compensation has made the necessary financial arrangements.
- Arrangements are proposed for disseminating the findings.
- All scientific judgements made by the sponsor in relation to responsibilities set out here are based on independent and expert advice.
- Assistance is provided to any enquiry, audit or investigation related to the funded work.

** Working towards establishing the structures to achieve these indicators.*

I therefore confirm that Middlesex University will be the sponsor for the research being undertaken by ……. as part of her/his…….. Programme Interventions……..

Signed on behalf of Middlesex University

Chair, School of Science and Technology Research Committee

Appendix viii) Coding clean-up (p 354 -p 377)

Table 1: Transcribed interview data Participant 1	**Coding** Raters: GSR & TR & SS
A3.How do you see clients appraised themselves after a trauma or PTSD? Understanding clients' appraisals means how they see themselves after the trauma, and its impact on the individuals. From my experience as a therapist and working with Tamil refugees, the clients feel "very broken", helpless, hopeless and powerless, and said in an special expression Tamil "out of your hand", meaning not so strong. Responsibility and control of the self, become problematic and difficult. Being traumatised, there is guilt feeling and clients see them as being a burden on their family – "how the family see them?" One client told me that the family thought that they were a burden. B4.Do you see any differences of how clients from different cultural backgrounds appraised themselves? From my interpretation this is only in their mind and the negative way of thinking about their situation. In the Sri Lankan Tamil community, the traumatised individual is seen as being "mad", an "outcast", and they are ostracised. In such community the impact is on the family, i.e., other members look down on them. In that culture, they understand mental health and perceive mental health differently – " it is not how we understood it in this culture, understood it very differently". Their view of mental health is that people stay in hospital or institution, kept away from their family. In western society stigma is attached to the individual- "something wrong with them". It is more on an individual basis, appraised themselves as "I am to be blamed", " I am in danger", "I am guilty". They blamed themselves, appraised self as "weak, my fault", " I went outside and was attacked". Clients from eastern cultures appraised differently and the collectivistic approach became clear – "community/others see me as a weak person" . I believe that clients in this group are concerned of not being part of the community or family, they feel being mistrust by members and family. They are isolated and the focus is on losing a lot of things. C5.How do you see clients appraised themselves about mental defeats? A lot of people I worked with felt that "there is no future for them to get married, especially female clients", because they are seen as "damaged", "being raped", "everyone knows about it in the community", "it is their fault". Family feels that no one will be interested in their daughter or son because of what happened. This is a grave concern for female members of the Asian community, person is ostracised. Similarly, in the western culture, clients are equally concerned about their future, i.e., relationship, intimacy, and "I have to find a partner" rather than the family. D6. What are your interpretations and understanding if a client says that they have lost their identity? Identity is an issue in both cultures. I worked with white British clients and their identity affected, viewed themselves as a change person, no longer the happy going person. Some of them developed complex personalities, seeing their identity dented. The concept of identity is deeply embedded in the western society. In a small village in Sri Lanka, and working on the farm, and tortured as a result of war, identity is not deep as the layers of identity are not there. Impact of trauma on identity is less compared to individuals in the western society. E7. Do you see any differences of how clients from different cultural backgrounds appraised themselves to being in control of their lives ?	*A3.1 ~~-Therapist's experience of clients' trauma~~* *A3.1 Therapist's interpretation and understanding of clients's appraisal.* *A 3.2 Family rejection after a trauma* *A3.3 Clients' ~~negative~~ appraisals after a trauma* *B4.1 Perception of mental health by the community* *B4.2 Rejection by family/ community* *B4.3 Cultural differences ~~in~~ impacting on clients' appraisal* *B4.4 ~~Collective approach to appraisal - East~~* *B4.4 cultural differences impacting on clients' appraisal- East* *B4.5 ~~Individualistic approach~~ cultural differences impacting on clients' appraisal - West* *C5.1. ~~Therapist 's interpretation~~*/ Impact of cultural differences on understanding of clients' experiences of trauma & mental defeats *~~D6. 1 Negative appraisal of trauma~~* *~~D6.2 Cultural differences in appraisals identity & control—Replaced by D6.1~~* *E7.1 Religious belief influences appraisals in Asian culture*

As far as control is concerned, this depends on the individual. From Asian culture not being in control and powerless is related to religion and how religious they are. "Allah designed for me what I deserved", acceptance" of God 'Will as they think they are helpless. "It does not matter if someone else designs my future for me, I am going to do it, believe in God" – "I can't physically or emotionally go against God' will. I worked with clients from the eastern culture, and in the case of sexual assault, they see this as being "my fault", community members/family see this as "the way they are dressed, deserved to be punished, their fault". There is no such impact in the western society on the self. The focus is more on the individual, appraising themselves as "I am weak, taken advantage". Across the board clients develop a pattern of how they think about the self and how the world sees them. F8. How do you see clients appraised themselves towards others and the world? Alienation and avoidance are common form of appraisals across cultures. I have not noticed differences among cultures in relation to alienation and avoidance. I had seen clients who had been tortured, were afraid to go out, avoided seeing build, colours, objects in case these factors trigger a flashback and reliving the traumatic event. In the western society, individuals are not exposed by tortured, but avoidance can be problematic and presents as an ongoing issue. For fear of going out, white British clients avoid a particular place in London, they are on constantly alert – what is going to happen next? This is more related to the nature of the trauma rather than culture. I have seen non-white British clients in sessions with different types of traumas, i.e., childhood sexual abuse, domestic violent, road traffic accident – been westernised – they are the 1st generation, and they have the "foot in both camp", meaning their appraisal of the trauma can be both from an individualistic as well as a collectivistic approach. I provided therapy to an Asian girl from a Pakistani family, born here and was sexually abused by a relative. She reported the incident to her family and was told that her duty was to the family, and they did not believe her, and the family did not understand about her mental health issues related to PTSD. She was presented with low self-esteem, PTSD and depression. She was affected deeply as her family was not supportive. She was confused and came up with a few questions such as "to who I tell? How I frame this? people talk". She told me that she had support from her Asian and white friends who she trusted. G9. Following trauma (PTSD), how do you see clients appraised themselves concerning permanent change? I could see that she was not the same person, loss control, agency of self-absent, and she was broken. I see that permanent change in clients to be across the board and across cultures. She was powerless, weak and helpless, Fearing that her family would reject her and how they would see her, during her episode of nightmares, waking up screaming and her depression. She had the fear of re-living the traumatic experience, knowing that her family would not understand her situation and mental health issues. She could not make decision for her, and she avoided to go out, withdrawn and did not want to socialise with her friends because of shame, guilt and self-blame. Clients from African background I saw in sessions, provided a different perspective on their appraisal of the trauma following PTSD. They felt that they were possessed by the devils, and they would seek counselling from the Church/Pasteur, with a view that they would be cured, failing to understand the concept of PTSD. The way I interpret this form of appraisal, is linked to spiritual and religious deep belief since childhood upbringing. H10. Do you think that the current models of PTSD are appropriate for different cultural backgrounds? Please explain and give reasons When providing therapy to people of Asian and African origin, I feel that an understanding their cultures is important to ensure that recovery is achieved. It is in my opinion that the current models of PTSD do not address the cultural aspects of non-western people. I think that current models of PTSD are westernised and do not address cultural issues for clients from a non-western background. These	*E7.2. Appraisals are more individualised in the west.* *E7.3 Similarity re: alienation and avoidance in both cultures* *F8.1 ~~Therapist's interpretation~~/ Impact of cultural differences understanding of clients' experiences of trauma* *F8.2. Perception of therapist of non-white British clients and their experiences of trauma* *F8.3. Lack of family support in Asian culture.* *F8.4 Family rejection* *G9.1 ~~Therapist's understanding of~~ Impact of cultural differences impacting on clients' appraisal.* *G9.~~2 Therapist's interpretation of cultural impact and differences on clients from non-white backgrounds~~* *H.10 Models of* *~~PTSD are not suitable for non-white individuals~~.*

models work well with clients from western background and recovery rate are satisfactory.	

Table 2: Transcribed interview data Participant 2	**Coding** Raters: GSR & TR
A3. How do you see clients appraised themselves after a trauma (PTSD)? The common one where the women being raped, I worked with – there is a sense of blame and the responsibility that I should being able to stop it. Thought harder they internalised their own role in having the experience of trauma. In my experience, with reference to road traffic accident, clients find that they are out of control, powerless, weak, lot of people blame themselves. – not being able to prevent it. B4. Do you see any differences of how clients from different cultural backgrounds appraised themselves? I see that clients from different cultural backgrounds appraised themselves differently. A lot of people I worked with, i.e., from Asian culture, being tortured, detained in war situation, thinking themselves as being powerless, not so much weak unless the trauma is severe. They don't feel something that they are able to bear – related to civil war. I have worked with women who have been in domestic violence – they feel less essence of doing something about it in their culture. What others will think about me? Am I normal – usually how the women from the collectivistic culture appraised themselves? It is not their fault, and outside of family life, trauma is seen as being shameful to talk about thing and to seek help about it. Yes, very much of their standing in the community have been impacted. C5. How do you see clients appraised themselves in relation to mental defeats? People think that" I should be able to cope with it better – in the sense that you should be able to deal with it on your own, but I can't cope mentally, having to seek professional help". Eastern, African, and middle east people are more concerned of how other view them, particularly in the female clients. I worked with an African lady who was infected with HIV by her husband who was cheating and was in relationship with another woman. It was the most shameful for her that had happened to her – she told me "I should have been able to prevent that from happening, and people see me differently, then I see myself differently, mentally weak". D6. What is your interpretation and understanding if a client says that they have lost their identity? Working with both cultures, I can see a difference in the way their identity is affected. Western people have the very sense of their identity – my goal is to get back to the person I used to be before the trauma and to view themselves as an individual capable person. They feel very much that they don't after the trauma whereas people from the eastern cultures are more often about being accepted in the community. I think westerners is much more about what I need to do to get myself back to normal whereas I think, they view themselves as being abnormal compared to as they were. Sometime there is a belief the way I see myself, meaning important change that can affect me. Whereas in the eastern cultures is about how I am being perceived by others now having gone through the trauma. Reflecting on my background, my dad is Italian, and my mum is English, and I am from a mixed culture/background. I find part of me, can identify with the clients, sometimes this could be useful. I found that a little of self-disclosure could help to build that rapport – "understand their view of the world". I have travelled East; I understand eastern cultures. Have the mindset, try to empathise, get into the mind set of somebody in that position/culture – all these facilitate my understanding as a therapist. E7. Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? In PTSD the ability to maintain self-control is an issue. There is a lack of control to the self- this is across the board; I mean both cultures. Virtually everybody I worked with, they felt they were out of control, not being able to control two things. Firstly, the environment, they were unable to control their own reaction to it, meaning fear and anxiety high. Secondly, judging themselves for not being able to respond better in that situation, a sense of knowing that it was going to happen and unable to prevent it.	~~*A3.1Self -blame and out of control*~~ A3.5 Clients' appraisal if their trauma -self-blame and control *B4.5 Cultural* ~~*backgrounds*~~ *differences impacting on clients' appraisal* ~~*B4.2 Shame and low standing in Community*~~ B4.6 Therapists' interpretation/understanding of clients' appraisals *5.2 Clients'* ~~*appraised themselves as being unable to cope and mentally weak*~~ *Replaced by B5.2* ~~*C5.2 Shame and negative perception of self*~~ *D6.2 Therapist's interpretation and understanding of clients' appraisals* *D6.3 Cultural differences impacting on clients' appraisals* *E7.1 Lack of self-control is present in both cultures (East/West)* *E7.2 unable to control their environment, applicable to clients from West & East.* *E7.3 cultural differences impacting more on clients from Asian background.*

There is a difference in the appraisal of control in PTSD. Westerners feel that they should be able to control it whereas I find that Asian women I worked with, didn't have a lot of control over their life generally anyway – just an example of not having control in their life perhaps. It is not such a big thing for them when compared to a person /westerner woman, who has more control over their life generally. Something happened and they lost control, more of an impact on the western women, whereas Asian women do not have that level of control in their life generally anyway. I found that westerner women were more affected re: control in raped cases. In situation of rape in other cultures, I found the intensity was not that severe, probably of their upbringings or not treated so well in their life as the westerner women, or culturally a submissive role in their societies. F8. How do you see clients appraised themselves towards others and the world? Clients from the western cultures, feel alienated from others who I think people don't have the concept what the clients been through. It is a sense of being different because they are different, avoiding being with people. I think it is their perception that why they keep away, feeling rather different than people treated them differently. I find that clients from other cultures often do feel that they are treated differently, and they feel alienated, leading them to withdraw or avoid meeting people. G9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? Following trauma, I think that their perception changed, appraised themselves as "how others have treated them because of the trauma". In some communities, for example, clients from middle east experienced difficulties, often isolated themselves from their own culture because they told me of the tie-nit community, fearing that if they interact with members of their community, some one knows people back home, words can get round about them and their trauma, leading to shame and guilt. Similarly, they refused to work with interpreter from the same community. They don't want an interpreter from the same group, afraid that this interpreter might know someone back home, and words will get round about them and their trauma. They don't want to be dishonoured, and they think that people will know that "something bad had happened to them". So, in some ways they withdraw from the community because of that fear. I find that this is not an issue with westerners, no such things as a tie community. But I have noticed a difference in clients from the western cultures. Older generation see PTSD as shell shock, linked to World War II, Vietnam war etc. Younger generations are aware of the hurt, recognised the symptoms of PTSD. In the eastern cultures, I think there are different perception and understanding of mental health/PTSD. This is not in their everyday language- difficult for them to talk about flashbacks, explaining flashback is challenging, difficult for people from eastern cultures because it is not something in their vocabulary. People from Asian culture somatised their symptoms much more, difficult in CBT to separate the thoughts and feelings, because "it's all about what is happening to me". Trauma in India I think its treated by medication, clients expect a cure! Our role is more of a psychological intervention. It is difficult for them to understand how talking can help, "something in my body, how can talking help?" It is challenging for them to see the link between mind and body. If they understand the language, it is easier to use CBT as an intervention. Trauma can be processed – it is necessary to get a full picture to the trauma. If a person is not able to take themselves back, connect through that mind, it is difficult to verbalise what is happening at that time. It is difficult for the therapist to go and update the memory. – it is challenging with CBT, but EMDR is much more applicable to the clients because it is not so important to know what is happening – let the brain do the processing. Re: EMDR - What is in the eye movement, brain activity/processing is not essential. EMDR is a treatment that most cultures are sceptical - clients find that it is difficult to understand how this treatment helps – Having worked with clients where EMDR was used, the clients experienced and felt that processing the trauma was miraculous – does not understand why, but it works. In CBT I think that clients I provided therapy, had made positive changes. Seeing that their life is different, and they were more open to challenge themselves, took more chances because they thought that life could be cut short. This is experienced across cultures, possibly more in the western cultures. Depending on someone religion, they "feel that your life is in your hand and yours to decide what to do". People with different beliefs feel that "perhaps they have been punished for something that they have done	~~*F8.1 Alienation is present in both cultures*~~ ~~*F8.2 Avoid meeting other people*~~ ~~*F8.3 World is an unsafe place*~~. *G9.1 Change of their perception and alienation from the community due to something bad happened to them (Asian clients)* *G9.2 Community is not an issue in the west.* *G9.3* ~~*Therapist's*~~ *Impact of cultural differences on interpretation and understanding of clients' appraisals following trauma* *G9.4 Cultural differences impacting on clients' appraisals* *G9.5 Difficulty of therapist to understand Asian culture* *G9.6 EMDR is effective in the treatment of clients from different cultural backgrounds.* *G9.7 Clients from the west benefit more from CBT compared to Asian clients.* *G9.8 Therapist's understanding and interpretation of clients' appraisals in relation to permanent change.*

in previous life", "I was met to experience this". From a religious perspective, client said "whoever decided for me, I endured my life rather than changing my perception". "my life has been predestined". Physical changes in road traffic accidents occur and it can be tricky. Physical trauma is tricky – clients see/feel changes to their self, due to physical injuries – their appraisal: "I will not get back to my previous self, never 100%". During the process injuries healing, clients experienced psychological problems such as anxiety, feeling low in mood, anger, frustration, commented that "acceptance of what happened, I never be that person again". Changes can be very difficult to work with. In some cases, I Found that clients discovered a lot about themselves, they realised the qualities and characteristic they did not know and felt that they were being tested, before realised how resilient they were at that time. Following traumatic experiences, clients had a rigid view of how life could be or met to be. I have to continually put myself in the clients' position to think- well "what I think is not that important". Using Socratic questioning during sessions, I got to be in their awareness, if outside their sphere of acceptance or knowledge, then it was not something that they took on board. – this is my experience working with clients from non-western cultures. H10. Do you think that the current models of PTSD are appropriate for clients from different cultural backgrounds? From my understanding of eastern cultures, I am of opinion that the current models of PTSD are not appropriate for Asian and other non-western cultures. I find difficulty in using Ehlers and Clark model of PTSD – You look at the world before the trauma, then the way of seeing the world during and after the trauma and the benchmark you are not trying to get and see the world as from a westerner would. Clients from eastern cultures aim to get them back to their original viewpoint of the world, very completely different to someone view or different view from the westerners. It can be difficulty sometimes in challenging someone perceptions, particular if somebody has the view of the world after the trauma – "a dangerous place". I think models of PTSD need to be appropriate for different cultural backgrounds – replanning your life following PTSD treatment needs to be tailored and linked to the person's goals and reclaiming your life whoever you are but be careful not to introduce western values into what a person should be aiming for – the bulk of the treatment should focus on reprocessing the trauma, essentially adapted to any culture and processing and updating the memory. Westerners are more challenging in their approach, meaning pushing yourself, but easterners are more inclined to accept loss in life. Westerners' way is to strive for more. Re: appraisals- one would expect cognitive flexibility. For example, refer to a case I had seen and provided therapy re: PTSD – Muslim girls sees things too rigidly, even in Islamic culture will be seen as extremely. Discussed with the Imam re: these thoughts she was getting to get their perspective. They explained that these thoughts were too extreme by Islamic culture. Sometimes people can use religious thinking to prove a thought they are having., but sometimes these thoughts are more extreme than the religion necessitated. Has to be careful not to undermine somebody's religion. We need to expand the way we work to include members of the community which might help to understand the clients and provided better therapy.	*H10.1* *Models of PTSD do not meet the needs of clients from non-western cultures* *H10.2* ~~*Design a model to meet cultural needs of clients.*~~ *H10.3* ~~*Cultural knowledge is important in therapy*~~

Table 3: Transcribed interview data Participant 3	**Coding** Raters: GSR &TR
A3. How do you see clients appraised themselves after a trauma (PTSD)? In case of PTSD happened, this is a kind of universal theme. I could have seen this coming across cultures, it affects a large number of people in the same way. I work with Tamil refugees from Sri Lanka, affected by bombs and tortured during the war. I found that they have ways, i.e., Hindu philosophy, faith, and destiny to deal with their trauma – "we are destined, it is our faith – a kind of appraisal, using community approach. So, I find and sometime wonder, have seen asylum seeking population from those countries came here, stuck with their belief system, despite being in a new country and having escaped from a war-torn country. I don't know whether there has been any war recently in the western context for people to experience this phenomenon of being bombed, tortured or sexually assaulted - I wonder? B4. Do you see any differences of how clients from different cultural backgrounds appraised themselves? In my experience working with refugees, I find that secondary appraisal occurred while the trauma is happening, there is pre-cognitive appraisal, i.e., "this is the end, my faith, my karma – I see this happening when clients generalise on their fear and anxiety related to authority, police vehicle, blue light vehicles – meaning that I have to hide, reminding them of what was happening in their home country, the military regime, the tortures and bombing environment. Secondary appraisal keeps the trauma going, self-agency is weak, see these triggers as a threat. Clients lose autonomy and their identity, come with any trauma presentations – "I am not in control" is a common theme – "I feel the trauma, it is overwhelming me", "I can't have control", "I can't trust myself to make the right decision dependently", "I need somebody else to help me ". In single trauma event there is a lot of guilt, amount of responsibility is diminished – representative of white clients and their appraisals of their trauma. C5. How do you see clients appraised themselves in relation to mental defeats? I think large part of trauma and its presentation generally I feel depend on the cultural beliefs of the person. Tried to help them to recover from the trauma, or sometimes cultural beliefs exacerbate the trauma. Considering appraisal in eastern or western cultures, I think clients across the board come up with "I am traumatised", but I think people are different in term of kind of lifestyle. From my experience, clients feel that they can't cope, give up and unable to care for themselves, I am finished and mentally unable to keep fighting. I find people from eastern background are friendlier, their community is larger in context, fluid concept of family, not nuclear but extended. In a wider context the concept of family is different from the west, flexible way of living, see each other regularly, "come and go". It is not like the west, which is more focused in individualistic way of living. I don't know whether this is good or bad. I find that appraisal is straight forward, understood how trauma affecting the individual, help the person and have closure. D6. What is your interpretation and understanding if a client says that they have lost their identity? Looking on the bigger picture, clients appraised themselves as "it is not my fault, something I could have prevented". There is a bit of leeway here and there is support system in place. Shame is not an issue, and they can say it aloud. Whereas taken the eastern perspective, clients worried as what the neighbours	~~*A3.1 Destiny and faith impacting on Asian clients' appraisal*~~ ~~*A3.2 Belief system influencing Asian clients' appraisal*~~ *A3.6 Therapist's understanding and interpretation of clients' appraisals in relation to permanent change* ~~*B4.1 Pre-cognitive appraisal*~~ *B4.2* ~~*Impact of trauma on individuals from Asian culture following torture and bombing*~~ ~~*B4.3 Lose autonomy and identity*~~ *Replaced by B4.7 & B4.8* *C5.3 Cultural belief impacting on trauma* ~~*C5.2 Both Cultures are affected by trauma*~~ ~~*C5.3 Collectivistic approach*~~ *C5.4 Therapist's interpretation and understanding of clients' appraisal* *D6.4 Cultural differences in appraisal* ~~*D6.2 Stigma and identity*~~

will say, news travel, there is stigma, shame in the community, support system is not in place – could be a bad thing, " I have lost myself and my identity"	*Replaced by D6.5*
E7. Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? There is loss of control, lack of planning – in what sort of way? Generally, appraisal is different. Re: control issue -I think that people in the west are much in control of their life, use to be independent, having everything plan. The day something happened to them, there is complete change of the system – everything collapses – control is a big challenge for the individual. In eastern and African countries, autonomy or control is not a such big value – but a kind of a bigger picture is the community, think more of security and safety. How I see this community picture and link with trauma are the socio-economic factors. Being a refugee, the client depends on benefits and housing given by the Government. They feel a sense of isolation, for them, it is not having control and the community is not around them.	*E7.1 Lack of control from among individuals from the White community* *E7.2 Fear and loss of control* *E7.3 Be part of their own community*
F8. How do you see clients appraised themselves towards others and the world? I have noticed that clients who were rehoused in a nice place, nice surrounding of Derbyshire or Nottingham, beautiful houses – yet they don't want to go, and this is not about control, but about the community spirit. Taken this into account, trauma is exacerbated, and recovery is delayed. This causes a problem in relation to alienation. What they value most? Not the western background – feeling alienated not being in their community. The concept of collectivism emerges in situation like that, it can impact on the way clients appraised themselves following trauma. For example, "I can't have an intimate relationship", "I can't trust anyone". I think alienation is more in term of relocation and cultural shift and clients' appraisals include "I am different", "don't want to look feel the same as the next person", "I am not good as the next person".	*F8.1 Community support for both Caucasian and Asian culture* ~~*F8.2 Collectivism*~~ ~~*F8 .3: Collective data captured*~~ ~~*F8.4 Child's symptomatic*~~
G9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? Considering appraisals from clients that I have worked with, I find that cultural, geographical, socio-economic factors and language barrier impacted on the way they appraised themselves after a trauma. For example, they don't see them as equal to the local population or having the same opportunity than somebody else. In relation to permanent change re: goals and beliefs, I feel that no cultural answer to it. Depending on the impact of the trauma, life changing injuries required readjustment – I see no differences across the board.	*G9.1 Feeling inferior to local population*
H10. Do you think that the current models of PTSD are appropriate for clients from different cultural backgrounds? I have doubt whether the PTSD protocol is compatible and appropriate for clients from eastern/ African cultures. There is the community factor/collectivism which do not feature in the models of PTSD – I think. I worked in India when there was a mass disaster as the result of a violent earthquake in Gujarat where there were 100s and 100s people killed instantly. I was part of a rehabilitation team. I was impressed by the collective cultural kind of approach – community rally around and helping each other, sharing resources, skills and using street as the theatre for intervention and treatment. To boost their moral, folk stories specific to the region narrated to the survivors and were helpful. This collective kind of trauma approach and intervention was an eye opener for me. I made recommendation for as a NICE guideline for collective. (In this country) Here, kind of trauma related to personal assault is different because of the pre-disposing or precipitating factors, and it cannot be generalised or having a collective approach is inappropriate. One of my colleague Dr ---, advocated for a community approach re: trauma affecting individuals from different cultural backgrounds. He suggested community society and collective trauma work but was rejected. With	*H10.1 Models of PTSD are not appropriate for collectivistic cultures* *H10.2 Community approach to trauma and natural disaster* *H10.3 Cultural impact on trauma* *H10.4*

reference to Ehlers and Clark protocol, it depends on the nature oof trauma re: appropriate and effective. I have seen people respond well on a 1:1 across the board. I think that collective approach rather than 1:1 might be appropriate for clients of Asian background, I think. I find that clients from middle eastern background are not psychological minded, there are lots of somatising when it is a PTSD diagnosis – reported physical symptoms rather than psychological symptoms. They see medication as the answer to get cure, not necessary to challenge thoughts, explore emotions and behaviours. Talking therapy is a myth, not understanding the concept of mental illness. As I said before, models are appropriate to eastern, African and middle eastern clients. There are 2 strands of thinking – firstly, the collective trauma and secondly, the single approach. I can see that a collective approach is needed for Asian, African and Middle eastern clients. But there is not enough evidence in my opinion to say that another model is needed. Ether and Clark model would be used for this group of clients, to develop another model for clients from a non-white background that could be more effective, I don't know that. Re: negative appraisal on the trauma, an understanding of what the client means will depend on the skills of the clinician and a good psychoeducation needed for the client before starting on the processing of the trauma. For prognosis to be successful, a robust psychoeducation should be given to the clients. I see the understanding of the trauma and its impact on the clients is related to how aware is the client of this condition- their understanding of PTSD. This is brought up by relatives of clients from Asian background re: concepts/understanding of PTSD – they think that "She is going mad". I can see a lack of understanding what PTSD is! I think education is important to raise their awareness as they are not psychologically minded, and the terminologies are not clear and well understood by people of non-western background. Tamil speaking clients find difficulty to understand the simple terminology, for example, the term flashback might not be existed in the Tamil language- Tamil to explain this, don't happen. Rumination might be a difficult term to explain in Tamil. I speak their language and culturally, I feel that I need to clarify with examples, such as meaning of words, using and making reference to physical trauma to explain psychological trauma. So, an understanding of cultural background of clients is vital in therapy.	*Collective approach to trauma* *H10.5* *Lack of Mental Health understanding In middle eastern culture* *H10.6* *~~Clients from collectivistic culture Somatise symptoms of trauma~~* *H10.7* *~~Importance of psych-Education in session~~* *H10.8* *Lack of understanding of the concept of PTSD* *H10.9* *Language barrier in therapy*

Table 4: Transcribed interview Data - Participant 4	**Coding** Raters: GSR & TR
A3. How do you see clients appraised themselves after a trauma (PTSD) I guess diagnosing people with PTSD in step 3 starts with a triage assessment before coming up with a provisional diagnosis. Client is invited on to Level 3 for 1:1 CBT therapy and they are assessed, using Impact of Event Scale-Revised (IES-R) a diagnosis of PTSD made, follow by treatment plan. In term of appraisals, clients feel the impact and it affects their self. Before PTSD they were capable and in control. Following PTSD there is a paradigm shift in their life, can't cope, it has changed their world view, the triad of the world itself. B4. Do you see any differences of how clients from different cultural backgrounds appraised themselves? From my experience, people from eastern cultures reported shame around the family, not just for PTSD but for other presentations – they said that they felt unable and difficult to discuss it with family members, close friends and other members of the community. This is seen as being a sign of defective, so that actually presented another challenge for therapists, i.e., a negative belief about the condition. Re: eastern/collectivistic cultures, their approach is what others think about them, there is stigma attached to mental health, not fault of their own if they were attacked, raped, tortured because subsequent mental health problems manifest itself, shame associated with that reaction. Western individuals' appraisals are the same but can be different and it varies from person to person, can be some shame associated with some groups, for example, I have worked with this person within the military culture, and a lot of ex-soldiers find difficult to report mental health problems, because culture of need to be strong, but reporting a problem is seen as a sign of weakness. C5. How do you see clients appraised themselves in relation to mental defeats? Being mentally weak comes across people within the African Caribbean community, and this is documented, having witnessed friends and family members in the community be afraid of mental health service – "if you are involved in Mental health/have a mental health issue, there is the danger of being sectioned. It varies a lot and more on an individual basis, they see themselves traumatised and affected, the self is weak in the context of PTSD. Individuals from western cultures are high in functioning and psychological minded, present with least problems, attached to the presentation of PTSD, able to differentiate and perhaps more likely, i.e., this happens to me, it is not my fault and no shame associated with it. With reference to personal autonomy and a sense of agency, this depends on circumstances. I got referrals from the Tamil community, clients with trauma from their war-torn country, waiting approval from the Home Office to get permission to stay in England. This is a huge impact on the self, accelerated the symptoms of PTSD because they feel unsafe, insecure, and not a sense of agency, do not have control over the self, traumatised ruminating on at any moment they could be repatriated if their appeals were declined. This presents huge challenges to help them to process the PTSD because of the lack of control. D6. What is your interpretation and understanding if a client says that they have lost their identity? Communities vary in the lack of control -it depends on the socio-economic status of the client, there are multiple problems, irrespective of their ethnicities, e.g., housing problem, poverty and loss of identity. Multiple stress led to no sense of agency and difficulty to treat and challenging, delayed recovery. Language used in therapy can be a barrier for clients from different cultural backgrounds. Even for the white community, the use of psychological language can act as a barrier and delay recovery. Translators are involved in the therapy, and this can be challenging, trusting the translator to convey the message and terminology correctly can be problematic. I see therapists as being "blind" here, they don't know what the translator is putting across when working with the clients from different cultural backgrounds. On the other hand, working with clients who have sufficient knowledge of English and a bit fluent, don't need a translator, but there is a danger of misinterpreting and psychological terminology might not be understood, Psychoeducation proves to be difficult with clients from different cultural backgrounds. There is misconception of how the world	~~*A3.1 Impact of PTSD on the clients.*~~ *A3.7 clients' appraisal of their trauma* *A3.8 Therapist's interpretation//understanding of clients' appraisals* *B4. 9 Cultural differences impacting on clients' appraisals* *B4.10 Therapists' ~~awareness of cultural impact on~~ Interpretation/understanding of clients' appraisals* *B4.3 Therapist's Understanding of clients' appraisals* *C5.5 Cultural differences impacting on clients' appraisals* *C5.6 Therapist's interpretation and understanding of cultural differences impacting on clients' appraisals* *D6.6 Therapist's understanding of*

is viewed by different cultures. For example, clients from the Muslim religious faith believe that Allah God creates the world in a certain period, so appraisal such as the world is a dangerous place might be problematic, so I have to be sensitive to people's cultural belief and religions otherwise barriers will be set, leading to therapeutic alliance rupture. E7. Do you see any differences how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? Alternative there could be mistrust between therapist and client where they hold back, don't share problems or feelings - client might have thoughts such as "I don't trust this person "or "I don't believe what they are saying", and not being in control, making therapy difficult and leading to failure to achieve goals. F8. How do you see clients appraised themselves towards others and the world? They can feel alienated from the therapist. This can be seen across cultures and how they see the world and others, depends on the personal circumstances. For example, if they have poor mental health services or poor community services, they may feel alienated before coming to therapy which is a barrier that needs to be overcome before recovery can be achieved. I see client's vulnerability at the begin of therapy. Clients from within their community and from Asian and African backgrounds have different perceptions around mental health services, they feel isolated and helpless. For example, Tamil people are alienated within their own community, not associated with other members in the community, for the fear that the messages about them could get back to their own country and there could be implications for them and their families. Having a translator to act on their behalf can trigger the fear of information getting back to their own country. G9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? As for permanent change, following PTSD the person is not the same, can be completely affected the person confidence and self-esteem. In the case of violated rape, the person can't change this violation or gets this mental health out of their mind. This can change them permanently in a negative way. I guess, get back to my point, people who high functioning are quite educated, have a sense of agency, are more likely less affected, rather than stigmatised. I practise EMDR as well as CBT. It is easier for clients whose 1st language is not English or translator taken a western point of view, EMDR gets people to focus on eye movements rather than recounting or narrating the trauma as in CBT. It is difficult for people whose English language is limited, to engage in therapy, and recounting their trauma. I personally work more with EMDR rather than trauma focus CBT. The recovery rate is quickly with limited number of sessions. For example, clients who feel shame for being traumatised, it is easier to use a blink process protocol. I find working with clients from different cultural backgrounds, I get different insights as a clinician. It is challenging my practice, working with clients from different cultural backgrounds whose 1st language is not English, recounting their trauma and psychoeducation prove to be difficult to handle. H10. Do you think that current models of PTSD are appropriate for clients from different cultural backgrounds? I find models of PTSD are more appropriate for clients from western cultures, but these models are not suitable for eastern cultures as these models do not consider their cultural backgrounds into consideration. In relation to intrusive negative thoughts and how clients appraise themselves depend on their background. People coming from certain places might interpret these thoughts and nightmares as being struck by black magic or demons and they are being repossessed. In their own country, they might seek the help of the Witch Doctor. It is challenging to work with them and apply the westernised protocol, a huge misrepresentation the approach to deal with all these mental issues. Black African and Caribbean communities trust their Pasteur for counselling on mental health issues/problems as they are afraid of being stigmatised by the mental health services. I find that people from different cultures have different perception of mental illness and PTSD. For example, in Arab countries they have no clear concept of PTSD and they do not recognise PTSD. Clients do not understand	*clients' appraisals* *D6.7 Language barrier in therapy* *D6.8 therapist's ~~awareness of the~~ difficulty ~~to use translator.~~ Replaced by* *D6.9 Therapist's understanding ~~of client's religious belief~~ /interpretation of cultural differences impacting on clients' appraisals* *E7.1 Clients feel the lack of control in therapy and They don't trust no one.* *F8.1 Therapist's interpretation of clients' appraisals & awareness of their cultural impact.* *F8.2 ~~Tamil people feel alienated in their community~~* *G9.1 Therapist's understanding of clients' appraisals* *G9.2 Cultural differences in clients' appraisals* *G9.3 EMDR is effective in treating clients with PTSD* *G9.4*

the concept of PTSD and psychoeducation is difficult – “clients thinking irrevocable damage is not cured”. Accessing the IAPT services by clients from Asian and African cultures is poor. Men from the Asian community are reluctant to use IAPT services, feeling alienation as they see this process to be challenging. In case of sexual assaults Indian women present with somatic symptoms rather that psychological symptoms of the trauma. They are afraid of being rejected by their family and community.	*Therapist’s difficulty and lack of understanding of client’s culture.* H10.1 Models of PTSD suitable for western clients H10.2 Therapist’s understanding of clients’ appraisals and their cultures H10.3 ~~Lack of understanding of mental health in African, Asian and Arab cultures~~ H10.4 ~~Difficulty to access mental health services~~ ~~H10.5~~ ~~Somatising of trauma symptoms by Indian women~~

Table 5: Transcribed interview data for participant 5	Coding Raters: GSR & TR
A3. How do you see clients appraised themselves after a trauma (PTSD)? As an integrative therapist and based on clients that I saw in the clinical practice, they appraised themselves negatively, for examples, lack a sense of control, self-esteem, confidence and negative self-talk. In the case of sexual abuse, quite often clients took the responsibility, meaning the way they were responsible, but not vulnerable, felt something done to them and they were not a victim. I did not notice too much of cultural differences when clients appraised themselves following a traumatic experience.	~~*A3.1*~~ ~~*Integrative therapist's interpretation of clients' appraisals*~~ *A3.9* *Therapist's interpretation/understanding of clients' appraisals*
B4. Do you see any differences of how clients from different backgrounds appraised themselves? I will say people that are Asian and African internalised the trauma a lot differently, e.g., they suffered from delusion from the trauma, but they believed that they were in control. Re: "I am weak, and others see me as a weak person" - I get that sense from both clients, all clients focus on what other people will think about it. In the western culture clients that I saw in my practice, said "how my family is going to see me, rather than the world will see me", whereas clients from Asian or African backgrounds, said "how am I going to be perceived by people closed to me".	*B4.1* *Integrative therapist's understanding the impact of culture on clients' appraisals*
C5. How do you see clients appraised themselves in relation to mental defeats? My interpretation and understanding of clients' appraisals in term of autonomous, there is a sense of self encompassing confidence, power, how much they are in control, I would ask and explore the meaning, ascribed different meaning to the words. With reference to clients, I provided therapy and in cases of sexual or physical abuse, I have seen in a lot of clients make them questioned whether they could and were capable of making good decision, they questioned a lot of their decisions, found it difficult to make decision in general in fear of been traumatised again, meaning vulnerable to sexual or physical abuse. I find that clients had difficulty to take decision or organised/planned their life, depending on their level of confidence. A lot of people I saw in sessions reported that they found it hard to be kind to themselves because they felt that they did not deserve it and giving up mentally, meaning "I am a bad person"- for both cultures. I find that it is a lot heavier with people of colour when compared to white clients, meaning they are less traumatised. I find that family is much more important in the collectivistic culture.	*C5.7* *Integrative therapist's interpretation of clients' appraisals* *C5.8* *Cultural differences impacting on clients' appraisals* ~~*C5.3*~~ ~~*Mental defeat is experienced by both cultures, but more in people of colour*~~
D6. What is your interpretation and understanding if a client says that they have lost their identity? The way I interpret and understand the clients is that they struggle with control, and they lack the ability to plan their life, go back to lack of sense of self. What is it about planning things? What are they finding difficult? What they want to be in control of, and is that realistic, can they be actually in control or outside of control? I think that I do really try to understand where clients are coming from, and what things mean to them or how they perceive themselves and who they are? I want to have an idea of actually what they are thinking of themselves. I see that clients feel that others perceive them negatively, like they are helpless, "I should have done x, y, z. I see that there is not so much compassion or forgiveness, I see that clients have rules, i.e., "If…then…" I find the rules creates negative thoughts in the mind of the clients and they try to take responsibility for it. I get that sense of responsibility to give them that sense of control, identity and power over the situation, so that they are not helpless; give them a sense of responsibility. Give them the sense of self, meaning who they are as a person, their likes and dislikes, who they are?	*D6.10* *Therapist's interpretation and understanding of clients' appraisals* ~~*D6.2*~~ ~~*Integrative approach to clients' problems*~~ *Replaced by D6.11*
E7. Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? I have noticed differences and similarities of cultural background impacting on the way the clients appraised themselves and be in control. I see that in both cultures the family is important to them, but there are differences in the way clients see how the family reacts to them after the trauma. I find that people of colour put more	*E7.1*

weight on the family. They feel the shame, guilt, disobedience and lack of control as not following the family expectations. They feel that "I am done, what my family would expect more of me that I want to do". I hear that in my work with the clients. I find that clients are rejected more by family and losing control, common in people of colour whereas for the white clients, family can be devastated, but the main focus is on the impact of the trauma on the individual, i.e., how the client will be affected, family plays a minor role, but can be supportive. In Asian and African cultures, the traumatic experience is swept away under the carpet, "it remains a secret", but this is not so much in the western society, where it is more transparent and family supportive. My interpretation of clients' appraisals in Asian and African cultures leads me to this question: What people will think of the family and not what you are doing? The focus is on the family – shame and spoiling the family name. In relation to sexual abuse, their communities blame the women – "It is your fault" and this affects their ability to be in control of their lives. Clients complain of somatic symptoms such as headache, pain in the back rather than opening up and talk about their sexual abuse and its impact on them. Clients from this group have a negative opinion of themselves, feeling weak and out of control, especially when they experience flashbacks – they can't control this experience and are helpless.	*Cultural differences impacting on clients' appraisals* *E7.2* *Family is more important in the non-white society* *E7.3* *Family rejection is more common in non-white cultures.* *E7.4* *~~Transparency and family support in western society~~* *E7.5* *Asian And African clients somatise symptoms of PTSD* *E7.6* *Cultural differences impacting on appraisals*
F8. How do you see clients appraised themselves towards others and the world? I think it is quite similar in the clients from the western cultures. I understand that being weak, out of control and the impact on the clients are common appraisals in this group of clients. In my experience less of an impact on the family, less more vocal, more hidden than in white family. In people of colour impact on the family is heavier, brought shame to the family. For example, reflect on one of the situations of an Indian woman: she was sexually abused by her uncle at the age of 8 years old, she remembered that she went to tell her mother and her aunt, they told her to be quiet and she felt that she was not believed to tell the truth". She could not trust her mother and others around her, and she saw the world as an unsafe place. My interpretation of this situation is disturbing and heart breaking as she had to carry this trauma for a long time until she had therapy with me. I try to understand and make sense of this situation and ask myself the question – how the family sees this? Is it guilt or shame on the family! Is this why hush, hush and keep the secret among themselves or what others think about them? I know that I will not get a direct answer to these questions, just assume that it is a culture issue within the Asian community.	*F8.1* *Therapist's understanding of clients' appraisals* *F8.2* *Cultural differences impacting on client's appraisals* *F8.3* *Therapist's interpretation & understanding of trauma experienced by client.*
G9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? In my experience of therapeutic intervention with clients from western backgrounds, I find families are more supportive and open, have an understanding of the trauma affecting their loved one and how they have changed, not their usual self. I think that this is difference in people of colour, "they internalised the trauma" and "something that they have to deal on their own, whereas white people although internalised the trauma, there are more supported by the system. In the Asian and African cultures, I find that there is a lack of understanding of the nature of the trauma – people of colour family are less understanding and don't necessary want to understand, explore or hear about it. I think shame and embarrassment are considered worst in people of colour than white culture, more in collectivistic cultures, not only the person feels the shame, but the whole family/community – a permanent change of blame and shame, impacting on the self, rejection to the individual, family and community. In the white society, the person as an individual feels the shame, but may extend to the parents only. Permanent change such as being weak, personality change is more individualised.	*G9.1* *Therapist's understanding of family support in white society* *G9.2* *Cultural differences impacting on clients' appraisals* *G9.3* *Therapist's understanding of clients' permanent change* *G9.4* *Cultural differences impacting on clients' appraisals*
H10. Do you think that the current models of PTSD are appropriate for clients with different cultural backgrounds? I find the Models in general for PTSD do not address the needs of clients from non-western cultures. I do not think these models are appropriate. I think sometimes some symptoms of trauma are perceived differently by difference	*H10.1* *Models are not appropriate for non-white individuals* *H10.2*

cultures, for examples in African culture, it is considered to be delusion. I think for the western cultures PTSD is seen as a mental health issue whereas from an African perspective, it can be perceived to be more spiritual rather than something wrong with the person – need to see the Spiritual Doctor as the view is that it is not deemed to be normal. For example, in Vietnamese culture, if someone has mental problem such as symptoms of PTSD, they pray to their ancestors, offering foods, etc – they think that their ancestors are angry and that why they are not well mentally. In Arab countries I think the concept of PTSD is not well understood. Reflecting on one case I saw in my clinic- she was diagnosed with PTSD and referred for treatment. She had 12 sessions previously by a therapist from western background. Client told me that the treatment was not effective, and the therapist did not understand her or where she was coming, her problems were not addressed as she felt being an African, the therapist did not understand what she needed to get better. She related to me as a person of colour and considering her cultural background, I saw her for 12 sessions, goals achieved and discharged her. Reflecting on this case I think culture is important in therapy and I am of opinion that there is a gap in the education of therapists in general. Practising as an integrative therapist, I have observed people of colour often pick me because I am brown and can relate to me, and a different understanding, assume understand them better.	*Cultural differences impacting on clients' appraisals* *H10.3* *~~Therapist's lack of understanding of cultural differences impacting on clients' appraisals~~* *H10.4* *Clients' choice of therapist being of the same colour* *.*

Table 6: Transcribed interview data for participant 6	**Coding** Raters: GSR & TR
A3. How do you see clients appraised themselves after a trauma (PTSD)? Clients appraised themselves as being hopeless, their own agency being affected, meaning that they are not in control of themselves. They can't reconnect with assertiveness, feeling weak, worthless, and sometimes they have a degree of shame. I found that if they had been involved in "previous childhood trauma, neglect or sexual abuse, they have lost of "problematic psychological issues – what I mean by this the psychological recovery is delayed.	~~*A3.1*~~ *A3.10* *Psychodynamic* *Therapist's interpretation/understanding of clients' appraisals*
B4. Do you see any differences of how clients from different backgrounds appraised themselves? In my experience I have observed/ seen that clients with PTSD are not fully recovered, especially in the Asian and black communities. During my clinical practice, I observed that in non-western families, especially from collectivism culture, traumatised clients appraised themselves as less competitive and they did not have the same expectation as white individuals. Non-western client appraised themselves they lack support, seeing themselves as inferior, and (I think this may be due to cultural upbringing. I have noticed that people from Asian backgrounds tend to be subservient, tolerate and submissive, "against may be due I think to their cultural upbringing". As a therapist I that noticed in my practice that trauma made all these worst. From my experience, this was more common in Asian female clients, against may be link to their cultural upbringing whereas these characteristics are not present in the individualistic culture.	~~*B4.1*~~ *B4.13* *Psychodynamic therapist's understanding of cultural differences impacting on clients' appraisals* *B4.14* *Cultural differences impacting on clients' appraisals*
C5. How do you see clients appraised themselves in relation to mental defeats? I found people from Afro-Caribbean had a strict upbringing and they felt isolated, and alienated when exposed to trauma and clients from this community always appraised themselves as being badly treated and giving up -"life can treat you badly", whereas I observed not so much in the western cultures. From my experience working with Asian clients, I found that in Asian Pakistani culture, clients appraised themselves as being mentally "weak"	*C5.9* *Cultural differences impacting on clients' appraisals* *C5.10 therapist's understanding of cultural differences impacting on clients' appraisals*
D6. What is your interpretation and understanding if a client says that they have lost their identity? From my experience when clients appraised themselves as being out of control, lost autonomy and identity, I understand that "they find something wrong in themselves, not their usual self". In certain types of traumas, such as sexual abuse, they cover up the incident or the trauma event. I interpret this cover up as they fear of being shame in their community and guilt set in that they are in the wrong or have wrong themselves. They are no seen as their own self, lost their identity.	*D6.12* *Psychodynamic therapist's interpretation of clients' appraisals re: autonomy and identity*
E7. Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their life? Well, from my experience and having seen clients with PTSD, I found that they appraised themselves as having lost control over the situation as that why the trauma event took place. They blamed themselves for being weak, unable to defence themselves. They lack planning ability re: their life, activities and social life. They had a sense of being weak, lacked the ability to minimise physical and/or psychological harms. They had the feeling of being withdrawn, silent and vague, having no purpose in life. They could not speak out, felt weak and inability to defence themselves. They changed their belief of how they viewed themselves -"what control have I got, I feel powerless, I can't cope, very difficult situation.	*E7.1* *Psychodynamic therapist's interpretation of clients appraised their loss of control*
F8. How do you see clients appraised themselves towards others and the world? Working with clients coming to my practice, in sexual abuse cases, I found that the family took control of the situation in younger generation in non-western cultures	*F8.1*

whereas in Western cultures, I found that family felt apart, especially if the abuser was known to the family. I observed that families from both cultures protected their young children. As they grew up, they saw the environment as being dangerous, I understood that they saw the world as being dangerous in both cultures. From my personal experience, I found that refugees from non-western cultures, were more anxious, had the fear of real dangers, fear of being deported because of the trauma they experienced. I saw this as a double effect and they were traumatised deeply, for example, people of black colour felt more dangerous, traumatised by attitude and behaviour of the Police who they Thought of being hard on them, leading to further traumatisation. I had not seen any white westerners with the same problem. I felt that the white therapists in post had little training, which might contribute to lack of understanding of Police personal in post. From my understanding I interpret loss of control and planning strategies as a fear of unable to cope, the client is overwhelmed with anxieties of not being able to manage their life. The whole self is under threat, they avoid going out of the house, withdrawn and see staying at home to be a safe environment. I see this affect clients from different cultural backgrounds. From my experience, I can say that clients from collectivistic cultural backgrounds tend to be affected more if they have lost control and planning strategies. They appraise themselves as being unsafe, lack of security, fear, threat from others, uncertainty becomes an issue. They feel the shame and the guilt more that clients from other cultural backgrounds (western). They fear of being stigmatisation within their community family, feeling rejected and not accepted by the members of their community. From my experience, clients from both cultures did not trust others and they saw the world as a dangerous place, feeling isolated. Clients from collectivistic backgrounds felt that they were being discriminated, being judged by their community and did not engage with society. In the case of sexual abuse, I found that trusting others had a huge implication for clients from the Asian community. In my view this tends to an on-going lasting problem for them if they are not understood and have the appropriate therapy to address this issue. I can tell you the case of a 15-year-old Asian girl who was pregnant and had an abusive relationship with her father. She was traumatised and she did not tell anyone, did not trust herself, lived in fear for years until the age of 60-year-old when she saw me for therapy. I felt so sad about this individual. But then clients from Caucasian and African backgrounds went through a lot of physical abuse	*Therapist's understanding of clients' appraisals towards others and the world.* *F8.2* *Cultural differences impacting on clients' appraisals* *F8.3* *Psychodynamic therapist's interpretation of how clients feel about the loss of control.* *F8.4* *Cultural differences impacting on clients' appraisals re: fear, safety, and threat* *F8.5* *Similarities in appraisals from both cultures* *F8.6* *Psychodynamic therapist's understanding of clients' appraisals towards others and the world*
G9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? From my experience as a therapist, I can say that clients reported permanent change in their appraisals/ saw that there were behavioural changes. i.e., a broken person, more so reflecting that behaviour of Asian men/ they were retraumatised/ they were weak and evidence of lack of cultural support from the community/difficulty to cope with life- they did not understand what they brought into the room was very hard for me to comprehend/ could not share outside of my experience/ all these happened in both cultures. One example of a client from a Caucasian background – a 51-year-old was married for 51 years. She had trouble in the relationship, and she was traumatised by physical abuse from her husband. She could not carry on and she felt weak, and this was long lasting and resulted in a permanent change – saw herself as a different person with low self-esteem, weak and could not defence herself. Then things were different for clients from collectivistic cultures. My interpretation is that they lost faith in God, religion played a big part in their life. Personally, I see this behaviour being negative, clients often asked the question: How could God done that to me? Is God punishing me now. They ruminated over this issue until they became so much pre-occupied by this thought and started to affect the client much deeper. From my experience as a psychodynamic therapist, I can say that permanent change occurred in clients from both cultures -there were self-blame, the self out of control, strength weaker, all lasting for a long time. In Indian culture, I encountered clients who felt alienated in their own group for a long time. In the Pakistani culture, clients were frightened of being judged negatively by their community. Based on my clinical experiences cultural differences have made impacted on individuals in different ways.	*G9.1* *Psychodynamic therapist's interpretation of clients' experiences of permanent change* *G9.2* *Cultural differences impacting on clients' appraisals* *G9.3* *Psychodynamic therapist's Interpretation of client's religious belief and its impact on appraisals* *C9.4* *~~Psychodynamic therapist's understanding similarities in appraisals for both cultur~~es* *H10.1* *Psychodynamic therapist 's view on models of PTSD is*

H10. Do you think the current models of PTSD are appropriate for clients with different cultural backgrounds? I think that we need to have need a solid model crossed cultures to meet the need of the client. I think that the current model of PTSD is inappropriate across cultures due to the lack of deeper understanding of the clients by the community.	*inappropriate across cultures*

Table 7: Transcribed interview data Participant 7	**Coding** Raters: GSR & TR
A3 How do you see clients appraised themselves after a trauma (PTSD)? To make sense of appraisal in PTSD/Trauma, clients talk about an experience that had happened to them in an unfortunate situation – a kind of feel numb about their trauma when coming to the sessions. Seen people from different cultures and being in this country, I have come across clients who were traumatised by war trauma in their homeland – people from Sri Lanka, Afghanistan, and other torn war countries. Their appraisals begin at the start of the journey, escaping from war, all kind of terrible things that happened to them. They focus on the situation of how they flee, rather than surrender. To connect to PTSD or other anxiety and Mental disorder, they feel that they are not connected to their journey. It takes a bit of time to connect to the trauma and its impact on them. Why they are experiencing what they are experienced.	*A3.11* *Therapist's interpretation/understanding of clients' appraisals* ~~*A3.2*~~ ~~*Impact of war trauma on clients*~~ *A3.12 clients' appraisal of their trauma*
B4. Do you see any differences in how clients from different cultural backgrounds appraised themselves? Their appraisals: "I am feeling so depressed"," I don't understand"- "being in this country, I have been feeling low", "I cannot do my work", "cannot engage in activity"," I am indoor, people speaking to me, hearing voices, telling me about the sad things". Exploring more their appraisals, they said the traumatic experience came to their mind without their will. They told me "Intrusive thoughts forced and tried to push them to experience this". They can't articulate this as an intrusive thoughts or other symptoms such as flashbacks or reliving. It takes time for them to understand as to why this is happening to them, i.e., hearing voices, intrusive thoughts. From my experience and interpretation, they were experiencing flashbacks and reliving the trauma. For example, Somalian's experience flashbacks, intrusive thoughts coming to their mind against their wills. I can recall what they told me: "The force pushed, and it was a bad force" – how they saw their traumas". They could not make sense of it. Comparing to people of this country, they are clear about intrusive thoughts, flashbacks and attribute no external force to, these thoughts. I think language and cultural upbringing play a key role in making sense of the trauma. The PTSD terminologies are not common language for the African or Somalian people. They don't have direct translation for word for word, for example, in my experience most interpreters use the English terms for key words using to describe symptoms of PTSD. They told me that "there was nothing available in my language, these words were alien to me, not in my vocabulary". My understanding and the way I interpreted their appraisals led me to believe that they were thinking something happened to them and they were going mad, getting unwell. How to manage them? Knowing that PTSD concept does not exist and no concept of mental health in their country, I felt at that time that their understanding of what was happening to them, was extremely important. – knowing what was happening to them, had to explain in such a way to convey the message. I found psychoeducation challenging and there were cultural implications to understand and to know what they were experiencing, made meaning for them, understood them. From a western perspective, I can see things are different due to the common language used by the clients and the therapists. Sometimes, western way of interpretation makes sense – how they make sense of it? How we make sense of it? Find similarities and form that relationship and connection, create story of understanding for both of us – so the common language simplifies understanding.	*B4.15* *Therapist's understanding of Asian clients 'appraisals* *Replaced by B4.16* ~~*Concept of trauma is not well understood by non-white clients*~~ ~~*B4.3*~~ ~~*Clients' interpretation of how trauma affecting them*~~. *B4.18* *Cultural differences impacting on clients' appraisals* *B4.15* *Therapist's interpretation/ understanding of clients' appraisals* *B4.20* *Language barrier* *B4.21* *Therapist's difficulty with psychoeducation* ~~*B4.8*~~ ~~*Common language helps in therapy*~~ *Replaced by B4.17, B4.19, B4.22*
C5. How do you see clients appraised themselves about mental defeats? From my interpretation re: western cultures, I can see the clients have a sense of self, important to know where clients are coming from, talk about their independence in term of may be their work, relationship, and impact of trauma and its effects on them as individuals. Refugees have a different perspective due to different cultural backgrounds, and alien to a new society and depended on the Government. As a person, I see that they have lost their self-esteem, autonomy give up mentally. They have lost their culture, home, family, community and	*C5.12* *Cultural differences impacting on clients' appraisals* *C5.13* *Clients' appraisals of their trauma* *C5.11*

everything – autonomy linked with relationship and relating as a community, and as people connecting to their own individual kind of existence, collective kind of existence and community spirit. Clients felt very lost without the sense of community spirit. Whereas clients from individualistic background focus on individual, even in relationship progression – appraised themselves as "who am I in this world?", " I am unlovable", I am dislike", suffering from depersonalisation. Similarly, to the collectivistic approach, people with individualistic principles, find people to be important in their life.	*Therapist's understanding of clients' trauma and appraisals* ~~*C5.4*~~ ~~*Individual focus on appraisals*~~
D6. What are your interpretations and understanding if a client says that they have lost their identity? Depending on the nature of the trauma, trust becomes an issue – "I can't trust people" and in situation of sexual assault or personal attack, there is more fear dealing with people and when they are in a relationship in term of their existence, rather than their individual self. There is also the emphasis on pronouns "I" and "we". Community oriented individuals' appraisal of self includes "we", e.g., "We have lost our family, our country, our culture. Our identity, our connection". From an individualistic perspective, "I have lost my identity, my country, my connection".	*D6.13* *Therapist's interpretation/understanding of clients' appraisals* *D6.14* *Cultural differences impacting on appraisals and identity*
E7. Do you see any differences in how clients from different cultural backgrounds appraised themselves to being in control of their life? I can expand on this further - following a traumatic event, control of their life becomes difficult. I find that lack of control applied to both. Speaking about the lack of control, the pronoun "I" emerged in the appraisal of control – "I can't cope", overwhelming kind of self, uncertainty, difficult in that sense, coping might be related to work, carrier, relationship, feeling unsafe or lack of safety – "I am not safe anymore, my life coming to an end." – all attributed to the individualistic approach. Stigma and shame are attached to the individual self and not the community or family. It is more on individual focus.	*E7.1* *Trauma impacting on control* *E7.2 Therapist's understanding of clients' appraisals* *E7.3* *Individual focus on trauma & appraisal*
F8. How do you see clients appraised themselves towards others and the world? Looking through the lens of collectivism approach, clients appraised themselves as "Will I be able to fit in this society" "in the white culture" or "will I be sent back"., "will I be welcome". The focus is also on the family and community in relation to appraisal following trauma – "I brought shame to the family and community", ""we as a family /community feel shameful and "the stigma of shame attached to the family/community". In the sexual assault cases, clients might have the fear and anxiety related to their future – "I can't get married", "this is not part of my culture", "family/community expect me to get married, but I can't". This is not so much in the western culture; their problem is more individual – "I am having problem in my relationship". I see that for clients from both cultures, the world is dangerous. Stigma is higher in collectivistic society, clients in this group avoid engaging in their community, they are isolate, and fear of being judged.	*F8.1* *Clients' alienation towards others and the society/ their world* *F8.2* *Trauma impacting on clients, Family and community* *F8.3* *Cultural differences impacting on client" appraisals*
G9. Following trauma (in PTSD), how do you see clients appraised themselves concerning permanent changes? In my experience, both cultures experience permanent change, but in different ways. Clients from collectivistic culture, appraised their life change as " I have changed for ever", "Who I was, I am broken", "I am damaged" – how women from this group see their permanent change following sexual assault, this more so in Asian culture – " I can't get married", "I am not the same person"," others see that I am impure", family and community reject me". This has severe implications to their future life and ongoing low self-esteem. In the western culture, the focus is more on individualistic approach – "I am not the same person", "It is my fault". I have never come across this appraisal from clients in the western culture – "I am not pure". Asian clients might come up with appraisals such as "I should not be living anymore" – there is suicidal tendency associated with rape – a bit more intense in eastern culture – "I rather die, than living". Clients avoid religious places, temples, as they feel that there are impure. From their perspective, they are not "pure" and feel that they should not be there. They feel isolated, something they value, being taken away from them, separated from their family, community – "I am alone", leading to separation anxiety. It happens in the western culture – isolation, separation and alienation. But intensity is higher in the eastern culture. Re: models of PTSD, I think Ehlers and Clark model is appropriate to single trauma, narrative of the trauma. But it is problematic for multiple traumas and	*G9.1* *Permanent change common to both cultures* *G9.2* *Cultural differences impacting on clients' appraisals concerning permanent change* *C9.3* *Family And Community rejection in collectivistic cultures* *C9.4* ~~*Ehlers and Clark model appropriate for single trauma, but not for multiple traumas*~~ *C9.5*

where clients are depended on the family and community – cultural aspects are not addressed for this group. I feel that psychoeducation initially is important with refugees and other Asian or African clients to provide an understanding of PTSD and its impact on the individual. Psychoeducation involved the use of language, and psychological terminologies are quite difficult to understand. I think language could be a barrier to successful recovery. Sometimes it is difficult for me to share the same language at a level when clients could understand these terminologies. The use of interpreters is appropriate to support clients who can't speak the language or have limited knowledge of the spoken language. Clients commented "You have your language, and I have mind", "this is how you are experience it" – a kind of sharing through psychoeducation to explain PTSD and its impact on them. How they experience it? Tamil refugees revealed the fear and experience of PTSD in sessions by telling me that police syren with loud noise triggered the memories of the traumas – "I know why I am going into panic mode, reminding me of situations in my home country". I found the use of "stone/net" helpful to explain PTSD and its impact on the individual. H10. Do you think that the current model as of PTSD are appropriate for different cultural backgrounds? Through application of "stone/net" I feel connected to the clients and used their narrative to develop a ground technique to understand and interpret the way they are feeling. For example, reflect on ground technique that I used in sessions – taken the African experience and narrative re: way of life – "in Somalia, they walked for long distances, i.e., about 10 miles and connected with nature and beautiful places" . This scenery was used as a ground-breaking technique to connect with the clients, aiding to connect culturally, their moods elevated, became alive, then I proceeded with safety plan, psychoeducation, goals, appraisals of trauma. I feel that this groundwork or structure and gradual build up technique comes from their culture and visual mapping of their surrounding at home. I feel that the application of western models of PTSD do not achieve the goals re: therapy. Culturally groundwork technique is more beneficial in connecting with the clients from African background. I think creating models for Tamil community with reference to psychoeducation would be helpful and to relieve the problems of language barrier, Again the socioeconomic factors exacerbate the symptoms of PTSD. My interpretation of their appraisals: "No relationship with the community, no supportive network, being on their own lead to rumination and often suicidal – deprived group with no work, no income, can't work, vulnerable and what is the point of living". It is challenging to engage and work with them to achieve their goals. They overdose themselves, end up in hospital, difficult for them to cope with the trauma, not connected to the community. They feel lost as mental health is not part of the culture, Asian, African and other clients from eastern cultures consider themselves going "mad" - "nobody is going to like me" and they feel isolated. There is also the "dislocation factor", and as I see and understand their association with community network – throughout their journey, they had to endure element of dislocated and traumatised events – leaving their homeland, community support, arrived in a new environment and relocated to places like Derbyshire or other north town, which is totally alienated to them.	*Language is a barrier in therapy* *C9.6* *Therapist's difficulty to engage with clients from different cultural backgrounds.* *H10.1* *"Stone/net" framework helps clients from non-white backgrounds* *H10.2* *Cultural differences impacting on the understanding of trauma.* *H10.3* *Application of Western models of PTSD are not effective.* *H10.4* *Language is a barrier* *H10.5* *Therapist's interpretation of clients' appraisals and difficulties.* *H10.6* *Limited understanding of the concept of PTSD in the Asian and African cultures.* *H10.7* ~~*Mental defeat and alienation*~~ *H10.8* *Community support important*

Table 8: Transcribed interview data Participant 8	**Coding** Raters: GSR & TR
A3. How do you see clients appraised themselves after a trauma (in PTSD)? From my clinical experience as therapist, I find individuals from Asian and African cultures are less understood by organisation and this can lead to secondary trauma. For example, individuals from other countries who are employed by the organisation are expected to take on job with little preparation, help or support. I found shocking documents from HR on those individuals who were traumatised in various ways within the organisation. British black, Asian and people from other ethnicity are traumatised the way they have been treated, subjected to racial discrimination, verbal abuse and threatening personal attacks. Seeing these individuals in therapy, I understand that the concept of trauma and its effects were not well understood. Psychoeducation helped them to understand the nature of trauma and how it could have an impact on them. Being a white therapist and having worked with clients from different ethnicity, I believe that I am aware of their cultural needs of the clients in these group and how I should approach them in sessions or respond to a situation. I am of opinion that my white colleague therapists have limited understanding and lack awareness of cultural aspects from individuals of different cultural backgrounds. B4. Do you see any differences in how clients from different cultural backgrounds appraised themselves? I find that across-the-board clients have difficulties with the language and jargons used in therapy. This can be problematic in relation to psychoeducation, misinterpretation of a terminology or concept can delay psychological recovery. This is common to most ethnicity – Caucasian, African, Asian etc. I experience difficult to find a language that I can share with my Asian clients, for me this can be a big block, communication problem and seek help from translator. With reference to their appraisal of self, people feel defeated, helpless, hopeless and lack of their own agency. They struggle with the reconnection with the self-assertiveness and their own recovery. The issue of shame and guilt are common in non-white individuals – All these are originated from deeper shame of childhood traumas, e.g., sexual abuse, bullying and physical abuse. I find Asian culture is deeper rooted in shame when it comes to sexual abuse. I understand that clients within this group find their responsibility embedded in the family, and separation from the family can lead to re-traumatisation, for example, rejection or being disowned by the family. Non-western families adopt collectivism approach for traumatised clients who are less competitive and brought shame on the family. C5. How do you see clients appraised themselves about mental defeats? Their expectation as a non-west person and the lack of support, lead them to believe that they are inferior which is already rooted in their cultural upbringing of being subservient and tolerate, submissive and trauma made all these worst – giving up, defeated mentally- more common in Asian female clients. Organisation does not help people to be competitive and this is problematic for individuals who have experienced permanent changes such as lack of confidence, reinforced self-belief of being weak, could not achieve goals. D6. What are your interpretations and understanding if a client says that they have lost their identity? Using Socratic and thoughtful questioning, I found that cohesive control, violence relationship, caught in a controlling family, lack of independent as a teenage and other pressures from the family/ religious affect autonomy, identify in traumatised clients who had been sexually abused - common in both eastern/western cultures. I see control in the Asian family to be strong and family plays an important part in the nature of trauma.	*A3.13 Secondary traumas occur due to lack of understanding by the organisation~~.~~* *A3.14 Therapist's interpretation/understanding of clients' appraisals* *A3.15 Racial discrimination, verbal abuse and personal attacks traumatised non-white individuals.* *B4.23 Cultural differences impacting on clients' appraisals* *B4.24 Therapist's difficulty in therapy* *B4.25 Language barrier in therapy* *B4.26 Therapist's understanding of clients' appraisals* *B4.27 Family rejection* *~~C5.1~~ Replaced by C5.14 ~~Inferior and diving up mentally~~* *C5.15 Cultural differences impacting on clients' appraisals* *D6.15*

E7. Do you see any differences in how clients from different cultural backgrounds appraised themselves to being in control of their life? 17and 18 years old clients can be pressurised from the family, religious leaders – pressure to conform. Clients from both cultures feel the pressure, make them confused and make trauma worst. They can't control their life or planning for themselves, lack responsibility, helpless, disempowered, and silent. I find differences in the appraisals, for example, in sessions individuals from western background appraised themselves as "I am weak", "I went in the wrong direction" and clients from Asian background appraised themselves as "others see me as weak person", " not strong enough". In sexual abuse cases I find family is in control with reference to younger generation in non-western cultures. In Western cultures family falling apart and referring to abuser, could be close family member. Both cultures feel responsible to protect young siblings/ their children. As they grown up, environment is as dangerous, world is dangerous, evident in both cultures. F8. How do you see clients appraised themselves towards others and the world? Working with refugees, they have a high level of risks, adjustment of anxiety, and fear of being deported because of the trauma – it is a double effect/ they are traumatised deeply. Clients from black communities see their environment to be more dangerous – violent crimes and police are harder on them, authorities are not allied to them, affected them psychologically whereas white westerners are not exposure to this problem, not traumatised. From my understanding of appraisals from the Black /Asian clients, they feel that there is an element of racism and the way they are being treated. The Black/Asian Communities are not well understood by therapists/ language jargon for all population of Asian and black clients is problematic, and misinterpretation of cognitive appraisals lead to wrong diagnosis and treatment plan/ clients' appraisal – more like seeing them being shame, blame in their community. Another example, an Asian girl felt that she was not supported following her traumatic experience involved in a road traffic accident. "my teachers are not compassionate", "they don't understand my problems", "I am in constant pain" – affecting my study. My experience working with young men lead me to believe that they are alienated by adults, the system and the world. As a traumatised individual, they feel that they are not being valued in society, for example, traumatised individuals from LGBT community I saw in sessions, felt they were not being valued in society, making trauma worst. I see language problems with lower social class, impacting on understanding terminologies and concepts in therapy sessions, impacting on treatment and recovery, working class is marginalised, feeling shame, look down, inferiority complex – making trauma worst, also being re-traumatised when put into that situation, all these social barriers delay recovery. I see massive class differences, based on class background, ethnicity and clients being marginalised/ and felt being inferior, discriminates, not being recognised as an individual, or recognition of her trauma, and disbelief that she was not being supported. Client experienced shame being of a working-class community and from ethic background -not being valued within the system, lack of understanding/difficult to recover/frustrated – no time to work through that. G9. Following trauma (in PTSD), how do you see clients appraised themselves concerning permanent change? Another example, a young Asian woman saw domestic violence towards her mother and on another occasion saw someone committed suicidal and the cross imagery-link in both trauma/retraumatised and appraised her role in the 2 traumas.	*Therapist's interpretations and understanding of clients' appraisals* *D6.16 Cultural differences Impacting ~~of trauma~~ on clients' appraisal- autonomy and identity* *E7.1 Cultural differences impacting on clients' appraisals* *E7.2 Therapist's understanding of clients' appraisals re: control* *E7.3 ~~Protection of children by both cultures~~* *F8.1 ~~Alienation towards others and the world~~* *F8.2 ~~World is a dangerous place~~* *F8.3 Cultural differences impacting on clients' appraisals* *~~F8.4 Therapist's difficulty in engaging with clients from Black/Asian clients~~.* *F8.5 ~~Young men are alienated by adults, the system and the world.~~* *F8.6 ~~Not being valued by society makes trauma worst~~* *F8.7*

The way I interpret her appraisals – "feeling worthless, can achieve her goals, behaviour change, withdrawn and broken". Was challenging for me working with her. I saw one client from African background in therapy, and could not make sense of his problems/trauma related to? Egyptian God as he explained – I could not understand his problems as I felt then cultural understanding was an issue for me.	*Therapist's interpretation and understanding of clients' appraisals re: alienation*
I tried through my own cultural lens, but I could not get something, and the talk brought into the room was hard to understand, I was out of depth about what the client was saying. I had to refer him to another therapist. Another of my experience was with an Asian man, aged 23-year-old who was sexually abused at a younger age. He was broken and appraisal of his trauma was difficult as he could not understand the psychological impact and the nature of the traumatic event. I felt at that time that culture was a barrier, failing to understand where he was coming from and there was total therapeutic rupture, meaning he stopped coming to therapy, despite several messages sent to him. Reflecting on the two experiences, I feel that cultural knowledge is important in therapy.	*G9.1 Therapist's interpretation and understanding of client's permanent change* *G9.2 ~~Therapist's difficulty working with client from African background~~* *G9.3 ~~Therapist's lack of cultural understanding~~.* *G9.4 Therapist's difficulty and lack of understanding of client's culture* *G9.5 ~~Client's lack understanding of trauma~~* *G9.6 ~~Culture as a barrier~~*
H10. Do you think that the current models of PTSD are appropriate for different cultural backgrounds? With reference to models of PTSD, I think these are pretty solid across cultures and well understood in practice. Ehlers and Clark Model is the most popular one, and I think it suits all cultures. I have noticed that not so many people are being referred to NHS IAPT services, especially from the Asian and African communities. I wander whether cultures play a role when referral is concerned for ethnic minorities, i.e. loss faith in the system	*H10.1 ~~Models of PTSD are suitable across cultures~~* H10.2 ~~Poor referral from Ethnic minorities to IAPT services~~ H10.3 Cultural impacting on referral to IAPT services

Appendix (x) Final recoding of themes (*table 9 to 16= p 378 – p 413)*

Table 9: Transcribed interview data Participant 1

Q	Table 9: Transcribed interview data Participant 1	Re-Coding Raters GSR /TR/SS
A3	How do you see clients appraised themselves after a trauma or PTSD? response/ unit: Understanding clients' appraisals means how they see themselves after the trauma, and its impact on the individuals. From my experience as a therapist and working with Tamil refugees, the clients feel 'very broken', helpless, hopeless and powerless, and said in a special expression Tamil 'out of your hand', meaning not so strong. Responsibility and control of the self, become problematic and difficult. *Being traumatised, there is guilt feeling and clients see them as being a burden on their family – 'how the family see them?' One client told me that the family thought that they were a burden.*	A3.1 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals A 3.2 Family rejection after a trauma A3.3 Clients' appraisal of their trauma
B4	Do you see any differences of how clients from different cultural backgrounds appraised themselves? response/unit: From my interpretation this is only in their mind and the negative way of thinking about their situation. *In the Sri Lankan Tamil community, the traumatised individual is seen as being 'mad', an 'outcast', and they are ostracised. In such community the impact is on the family, i.e., other members look down on them. In that culture, they understand mental health and perceive mental health differently – 'it is not how we understood it in this culture, understood it very differently'. Their view of mental health is that people stay in hospital or institution, kept away from their family. In western society stigma is attached to the individual- 'something wrong with them'. It is more on an individual basis, appraised themselves as 'I am to be blamed', 'I am in danger', 'I am guilty'. They blamed themselves, appraised self as 'weak, my fault', 'I went outside and was attacked'. Clients from eastern cultures appraised differently and the collectivistic approach became clear – 'community/others see me as a weak person'*. I believe that clients in this group are concerned of not being part of the community or family, they feel being mistrust by members and family. They are isolated and the focus is on losing a lot of things.	B4.1 Perception of mental health by the community B4.2 Rejection by family & community B4.3 Cultural differences impacting on clients' Appraisal (east/west) B4.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
C5	How do you see clients appraised themselves about mental defeats? response/unit:	

	A lot of people I worked with felt that 'there is no future for them to get married, especially female clients', because they are seen as 'damaged', 'being raped', 'everyone knows about it in the community', 'it is their fault'. Family feels that no one will be interested in their daughter or son because of what happened. This is a grave concern for female members of the Asian community, person is ostracised. Similarly, in the western culture, clients are equally concerned about their future, i.e., relationship, intimacy, and 'I have to find a partner' rather than the family.	C5.1. Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
D6	What are your interpretations and understanding if a client says that they have lost their identity? response/unit: *Identity is an issue in both cultures. I worked with white British clients and their identity affected, viewed themselves as a change person, no longer the happy going person. Some of them developed complex personalities, seeing their identity dented. The concept of identity is deeply embedded in the western society. In a small village in Sri Lanka, and working on the farm, and tortured as a result of war, identity is not deep as the layers of identity are not there. Impact of trauma on identity is less compared to individuals in the western society.*	D6. 1 Clients' appraisal of their trauma
E7	Do you see any differences of how clients from different cultural backgrounds appraised themselves to being in control of their lives? response/unit: As far as control is concerned, this depends on the individual. From Asian culture not being in control and powerless is related to religion and how religious they are. 'Allah designed for me what I deserved', acceptance' of God 'Will as they think they are helpless. 'It does not matter if someone else designs my future for me, I am going to do it, believe in God' – 'I can't physically or emotionally go against God' will. I worked with clients from the eastern culture, and in the case of sexual assault, they see this as being 'my fault', community members/family see this as 'the way they are dressed, deserved to be punished, their fault'. There is no such impact in the western society on the self. The focus is more on the individual, appraising themselves as 'I am weak, taken advantage'. Across the board clients develop a pattern of how they think about the self and how the world sees them.	E7.1. Cultural differences impacting on clients' Appraisal – Asian/ Western cultures E7.2. Impact of cultural differences on therapists' interpretation and understanding of clients' Appraisal
F8	How do you see clients appraised themselves towards others and the world? response/unit	

	Alienation and avoidance are common form of appraisals across cultures. I have not noticed differences among cultures in relation to alienation and avoidance. I had seen clients who had been tortured, were afraid to go out, avoided seeing build, colours, objects in case these factors trigger a flashback and reliving the traumatic event. In the western society, individuals are not exposed by tortured, but avoidance can be problematic and presents as an ongoing issue. For fear of going out, white British clients avoid a particular place in London, they are on constantly alert – what is going to happen next? This is more related to the nature of the trauma rather than culture. *I have seen non-white British clients in sessions with different types of traumas, i.e., childhood sexual abuse, domestic violent, road traffic accident – been westernised – they are the 1st generation, and they have the 'foot in both camp', meaning their appraisal of the trauma can be both from an individualistic as well as a collectivistic approach.* I provided therapy to an Asian girl from a Pakistani family, born here and was sexually abused by a relative. She reported the incident to her family and was told that her duty was to the family, and they did not believe her, and the family did not understand about her mental health issues related to PTSD. She was presented with low self-esteem, PTSD and depression. She was affected deeply as her family was not supportive. She was confused and came up with a few questions such as 'to who I tell? How I frame this? people talk'. She told me that she had support from her Asian and white friends who she trusted.	F8.1 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal F8.2. Lack of family support and rejection in Asian culture.
G9	Following trauma (PTSD), how do you see clients appraised themselves concerning permanent change? response/unit: I could see that she was not the same person, loss control, agency of self-absent, and she was broken. I see that permanent change in clients to be across the board and across cultures. She was powerless, weak and helpless, Fearing that her family would reject her and how they would see her, during her episode of nightmares, waking up screaming and her depression. She had the fear of re-living the traumatic experience, knowing that her family would not understand her situation and mental health issues. She could not make decision for her, and she avoided to go out, withdrawn and did not want to socialise with her friends because of shame, guilt and self-blame. *Clients from African background I saw in sessions, provided a different perspective on their appraisal of the trauma following PTSD. They felt that they were possessed by the devils, and they would seek counselling from the Church/Pasteur, with a view that they would be cured, failing to understand the concept of PTSD. The way I interpret this form of appraisal,*	G9.1 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal G9.2 Clients' appraisal of their trauma

	is linked to spiritual and religious deep belief since childhood upbringing.	
H10	Do you think that the current models of PTSD are appropriate for different cultural backgrounds? Please explain and give reasons response/unit: When providing therapy to people of Asian and African origin, I feel that an understanding their cultures is important to ensure that recovery is achieved. It is in my opinion that the current models of PTSD do not address the cultural aspects of non-western people. I think that current models of PTSD are westernised and do not address cultural issues for clients from a non-western background. These models work well with clients from western background and recovery rate are satisfactory.	H.10.1 Models of PTSD are not suitable for individuals from the ethnic minority

Table 10: Transcribed interview data Participant 2

Q	Table 10: Transcribed interview data Participant 2	Re-coding Raters: GSR /TR/SS
A3	How do you see clients appraised themselves after a trauma (PTSD)? response/unit The common one where the women being raped, I worked with – there is a sense of blame and the responsibility that I should being able to stop it. Thought harder they internalised their own role in having the experience of trauma. In my experience, with reference to road traffic accident, clients find that they are out of control, powerless, weak, lot of people blame themselves. – not being able to prevent it.	A3.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal A3.5 Clients' appraisal of their trauma- self-blame & out of control
B4	Do you see any differences of how clients from different cultural backgrounds appraised themselves? response/unit I see that clients from different cultural backgrounds appraised themselves differently. A lot of people I worked with, i.e., from Asian culture, being tortured, detained in war situation, thinking themselves as being powerless, not so much weak unless the trauma is severe. They don't feel something that they are able to bear – related to civil war. *I have worked with women who have been in domestic violence – they feel less essence of doing something about it in their culture. What others will think about me? Am I normal – usually how the women from the collectivistic culture appraised themselves? It is not their fault, and outside of family life, trauma is seen as being shameful to talk about thing and to seek help about it. Yes, very much of their standing in the community have been impacted.*	B4.5 Cultural differences impacting on clients' appraisal B4.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
C5	How do you see clients appraised themselves in relation to mental defeats? response/unit People think that' I should be able to cope with it better – in the sense that you should be able to deal with it on your own, but I can't cope mentally, having to seek professional help'. Eastern, African, and middle east people are more concerned of how other view them, particularly in the female clients. I worked with an African lady who was infected with HIV by her husband who was cheating and was in relationship with another woman. It was the most shameful for her that had happened to her – she told me 'I should have been able to prevent that from happening, and people see me differently, then I see myself differently, mentally weak'.	C5.2 Clients' appraisal of their trauma -shame and negative perception of self

D6	What is your interpretation and understanding if a client says that they have lost their identity? response/unit *Working with both cultures, I can see a difference in the way their identity is affected. Western people have the very sense of their identity – my goal is to get back to the person I used to be before the trauma and to view themselves as an individual capable person. They feel very much that they don't after the trauma whereas people from the eastern cultures are more often about being accepted in the community. I think westerners is much more about what I need to do to get myself back to normal whereas I think, they view themselves as being abnormal compared to as they were. Sometime there is a belief the way I see myself, meaning important change that can affect me. Whereas in the eastern cultures is about how I am being perceived by others now having gone through the trauma.* Reflecting on my background, my dad is Italian, and my mum is English, and I am from a mixed culture/background. I find part of me, can identify with the clients, sometimes this could be useful. I found that a little of self-disclosure could help to build that rapport – 'understand their view of the world'. I have travelled East; I understand eastern cultures. Have the mindset, try to empathise, get into the mind set of somebody in that position/culture – all these facilitate my understanding as a therapist.	D6.2 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.3 Cultural differences impacting on clients' appraisal - identity.
E7	Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? response/unit In PTSD the ability to maintain self-control is an issue. There is a lack of control to the self- this is across the board; I mean both cultures. Virtually everybody I worked with, they felt they were out of control, not being able to control two things. Firstly, the environment, they were unable to control their own reaction to it, meaning fear and anxiety high. Secondly, judging themselves for not being able to respond better in that situation, a sense of knowing that it was going to happen and unable to prevent it. There is a difference in the appraisal of control in PTSD. Westerners feel that they should be able to control it whereas I find that Asian women I worked with, didn't have a lot of control over their life generally anyway – just an example of not having control in their life perhaps. It is not such a big thing for them when compared to a person /westerner woman, who has more control over their life generally. Something happened and they lost control, more of an impact on the western women, whereas Asian women do not have that level of control in their life generally anyway. I found that westerner women were more affected re: control in raped cases. In situation of rape in other cultures, I found the	E7.3 Lack of self-control is present in both cultures (East/West) E7.4 Lack of control to their environment, applicable to clients from West & East. E7.5 cultural differences impacting clients' appraisal

	intensity was not that severe, probably of their upbringings or not treated so well in their life as the westerner women, or culturally a submissive role in their societies.	
F8	How do you see clients appraised themselves towards others and the world? Response/unit Clients from the western cultures, feel alienated from others who I think people don't have the concept what the clients been through. It is a sense of being different because they are different, avoiding being with people. I think it is their perception that why they keep away, feeling rather different than people treated them differently. I find that clients from other cultures often do feel that they are treated differently, and they feel alienated, leading them to withdraw or avoid meeting people.	F8.3 Alienation is present in both cultures F8.4 Alienation towards others and the world is an unsafe place
G9	Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? Response/Unit Following trauma, I think that their perception changed, appraised themselves as 'how others have treated them because of the trauma'. *In some communities, for example, clients from middle east experienced difficulties, often isolated themselves from their own culture because they told me of the tie-nit community, fearing that if they interact with members of their community, some one knows people back home, words can get round about them and their trauma, leading to shame and guilt. Similarly, they refused to work with interpreter from the same community. They don't want an interpreter from the same group, afraid that this interpreter might know someone back home, and words will get round about them and their trauma. They don't want to be dishonoured, and they think that people will know that 'something bad had happened to them'. So, in some ways they withdraw from the community because of that fear. I find that this is not an issue with westerners, no such things as a tie community.* But I have noticed a difference in clients from the western cultures. Older generation see PTSD as shell shock, linked to World War II, Vietnam war etc. Younger generations are aware of the hurt, recognised the symptoms of PTSD. In the eastern cultures, I think there are different perception and understanding of mental health/PTSD. This is not in their everyday language- difficult for them to talk about flashbacks, explaining flashback is challenging, difficult for people from eastern cultures because it is not something in their vocabulary. People from Asian culture somatised their symptoms much more, difficult in CBT to separate the thoughts and feelings, because 'it's all about what is	G9.3 Cultural differences impacting on clients' appraisals G9.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.5 Cultural differences impacting on clients' appraisals G9.6 Difficulty of therapist to

	happening to me'. Trauma in India, I think its treated by medication, clients expect a cure! Our role is more of a psychological intervention. It is difficult for them to understand how talking can help, 'something in my body, how can talking help?' It is challenging for them to see the link between mind and body. If they understand the language, it is easier to use CBT as an intervention. Trauma can be processed – it is necessary to get a full picture to the trauma. If a person is not able to take themselves back, connect through that mind, it is difficult to verbalise what is happening at that time. It is difficult for the therapist to go and update the memory. – it is challenging with CBT, but EMDR is much more applicable to the clients because it is not so important to know what is happening – let the brain do the processing. Re: EMDR - What is in the eye movement, brain activity/processing is not essential. EMDR is a treatment that most cultures are sceptical - clients find that it is difficult to understand how this treatment helps – Having worked with clients where EMDR was used, the clients experienced and felt that processing the trauma was miraculous – does not understand why, but it works. In CBT I think that clients I provided therapy, had made positive changes. Seeing that their life is different, and they were more open to challenge themselves, took more chances because they thought that life could be cut short. This is experienced across cultures, possibly more in the western cultures. Depending on someone religion, they 'feel that your life is in your hand and yours to decide what to do'. People with different beliefs feel that 'perhaps they have been punished for something that they have done in previous life', 'I was met to experience this'. From a religious perspective, client said 'whoever decided for me, I endured my life rather than changing my perception'. 'my life has been predestined'. Physical changes in road traffic accidents occur and it can be tricky. Physical trauma is tricky – clients see/feel changes to their self, due to physical injuries – their appraisal: 'I will not get back to my previous self, never 100%'. During the process injuries healing, clients experienced psychological problems such as anxiety, feeling low in mood, anger, frustration, commented that 'acceptance of what happened, I never be that person again'. Changes can be very difficult to work with. In some cases, I Found that clients discovered a lot about themselves, they realised the qualities and characteristic they did not know and felt that they were being tested, before realised how resilient they were at that time. Following traumatic experiences, clients had a rigid view of how life could be or met to be. I have to continually put myself in the clients' position to think- well 'what I think is not that important'. Using Socratic	understand Asian culture G9.7 EMDR is effective in the treatment of clients from different cultural backgrounds. G9.8 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.9 Clients' appraisal of their trauma

	questioning during sessions, I got to be in their awareness, if outside their sphere of acceptance or knowledge, then it was not something that they took on board. – this is my experience working with clients from non-western cultures.	
H10	Do you think that the current models of PTSD are appropriate for clients from different cultural backgrounds? response/unit From my understanding of eastern cultures, I am of opinion that the current models of PTSD are not appropriate for Asian and other non-western cultures. I find difficulty in using Ehlers and Clark model of PTSD – You look at the world before the trauma, then the way of seeing the world during and after the trauma and the benchmark you are not trying to get and see the world as from a westerner would. Clients from eastern cultures aim to get them back to their original viewpoint of the world, very completely different to someone view or different view from the westerners. It can be difficulty sometimes in challenging someone perceptions, particular if somebody has the view of the world after the trauma – 'a dangerous place'. I think models of PTSD need to be appropriate for different cultural backgrounds – replanning your life following PTSD treatment needs to be tailored and linked to the person's goals and reclaiming your life whoever you are but be careful not to introduce western values into what a person should be aiming for – the bulk of the treatment should focus on reprocessing the trauma, essentially adapted to any culture and processing and updating the memory. Westerners are more challenging in their approach, meaning pushing yourself, but easterners are more inclined to accept loss in life. Westerners' way is to strive for more. *Re: appraisals- one would expect cognitive flexibility. For example, refer to a case I had seen and provided therapy re: PTSD – Muslim girls sees things too rigidly, even in Islamic culture will be seen as extremely. Discussed with the Imam re: these thoughts she was getting to get their perspective. They explained that these thoughts were too extreme by Islamic culture. Sometimes people can use religious thinking to prove a thought they are having., but sometimes these thoughts are more extreme than the religion necessitated. Has to be careful not to undermine somebody's religion. We need to expand the way we work to include members of the community which might help to understand the clients and provided better therapy.*	H10.2 Models of PTSD do not meet the needs of clients from non-western cultures H10.3 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals

Table 11: Transcribed interview data Participant 3

Q	Table 11: Transcribed interview data Participant 3	Re-coding Raters: GSR/TR/SS
A3	How do you see clients appraised themselves after a trauma (PTSD)? response/unit In case of PTSD happened, this is a kind of universal theme. I could have seen this coming across cultures, it affects many people in the same way. I work with Tamil refugees from Sri Lanka, affected by bombs and tortured during the war. I found that they have ways, i.e., Hindu philosophy, faith, and destiny to deal with their trauma – 'we are destined, it is our faith – a kind of appraisal, using community approach. So, I find and sometime wonder, have seen asylum seeking population from those countries came here, stuck with their belief system, despite being in a new country and having escaped from a war-torn country. I don't know whether there has been any war recently in the western context for people to experience this phenomenon of being bombed, tortured or sexually assaulted - I wonder?	A3.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
B4	Do you see any differences of how clients from different cultural backgrounds appraised themselves? response/unit In my experience working with refugees, I find that secondary appraisal occurred while the trauma is happening, there is pre-cognitive appraisal, i.e., 'this is the end, my faith, my karma – I see this happening when clients generalise on their fear and anxiety related to authority, police vehicle, blue light vehicles – meaning that I have to hide, reminding them of what was happening in their home country, the military regime, the tortures and bombing environment. Secondary appraisal keeps the trauma going, self-agency is weak, see these triggers as a threat. Clients lose autonomy and their identity, come with any trauma presentations – 'I am not in control' is a common theme – 'I feel the trauma, it is overwhelming me', 'I can't have control', 'I can't trust myself to make the right decision dependently', 'I need somebody else to help me '. In single trauma event there is a lot of guilt, amount of responsibility is diminished – representative of white clients and their appraisals of their trauma.	B4.7 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.8 Clients' appraisal of their trauma
C5	How do you see clients appraised themselves in relation to mental defeats? response/unit I think large part of trauma and its presentation generally I feel depend on the cultural beliefs of the person. Tried to help them to recover from the trauma, or sometimes cultural beliefs exacerbate the trauma. Considering appraisal in eastern or western cultures, I think clients	C5.3 Cultural differences impacting on clients' appraisal- collectivistic approach

	across the board come up with 'I am traumatised', but I think people are different in term of kind of lifestyle. From my experience, clients feel that they can't cope, give up and unable to care for themselves, I am finished and mentally unable to keep fighting. I find people from eastern background are friendlier, their community is larger in context, fluid concept of family, not nuclear but extended. In a wider context the concept of family is different from the west, flexible way of living, see each other regularly, 'come and go'. It is not like the west, which is more focused in individualistic way of living. I don't know whether this is good or bad. I find that appraisal is straight forward, understood how trauma affecting the individual, help the person and have closure.	C5.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
D6	What is your interpretation and understanding if a client says that they have lost their identity? response/unit Looking on the bigger picture, clients appraised themselves as 'it is not my fault, something I could have prevented'. There is a bit of leeway here and there is support system in place. Shame is not an issue, and they can say it aloud. Whereas taken the eastern perspective, clients worried as what the neighbours will say, news travel, there is stigma, shame in the community, support system is not in place – could be a bad thing, ' I have lost myself and my identity'	D6.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.5 Cultural differences impacting on clients' appraisal- Stigma and identity
E7	Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? Response/unit There is loss of control, lack of planning – in what sort of way? Generally, appraisal is different. Re: control issue -I think that people in the west are much in control of their life, use to be independent, having everything plan. The day something happened to them, there is complete change of the system – everything collapses – control is a big challenge for the individual. In eastern and African countries, autonomy or control is not a such big value – but a kind of a bigger picture is the community, think more of security and safety. How I see this community picture and link with trauma are the socio-economic factors. Being a refugee, the client depends on benefits and housing given by the Government. They feel a sense of isolation, for them, it is not having control and the community is not around them.	E7.6 Lack of control among individuals from the White community E7.7 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
F8	How do you see clients appraised themselves towards others and the world? response/ Unit I have noticed that clients who were rehoused in a nice place, nice surrounding of Derbyshire or Nottingham,	

	beautiful houses – yet they don't want to go, and this is not about control, but about the community spirit. Taken this into account, trauma is exacerbated, and recovery is delayed. This causes a problem in relation to alienation. What they value most? Not the western background – feeling alienated not being in their community. The concept of collectivism emerges in situation like that, it can impact on the way clients appraised themselves following trauma. For example, 'I can't have an intimate relationship', 'I can't trust anyone'. I think alienation is more in term of relocation and cultural shift and clients' appraisals include 'I am different', 'don't want to look feel the same as the next person', 'I am not good as the next person'.	F8.5 Community support for both Western and Asian cultures F8 .6: Cultural differences impacting on clients' appraisals F8.7 Clients' appraisal of their trauma
G9	Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? response/Unit Considering appraisals from clients that I have worked with, I find that cultural, geographical, socio-economic factors and language barrier impacted on the way they appraised themselves after a trauma. For example, they don't see them as equal to the local population or having the same opportunity than somebody else. In relation to permanent change re: goals and beliefs, I feel that no cultural answer to it. Depending on the impact of the trauma, life changing injuries required readjustment – I see no differences across the board.	G9.10 Cultural differences impacting on clients' appraisal G 9.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
H10	Do you think that the current models of PTSD are appropriate for clients from different cultural backgrounds? response/Unit I have doubt whether the PTSD protocol is compatible and appropriate for clients from eastern/ African cultures. There is the community factor/collectivism which do not feature in the models of PTSD – I think. I worked in India when there was a mass disaster as the result of a violent earthquake in Gujarat where there were 100s and 100s people killed instantly. I was part of a rehabilitation team. I was impressed by the collective cultural kind of approach – community rally around and helping each other, sharing resources, skills and using street as the theatre for intervention and treatment. To boost their moral, folk stories specific to the region narrated to the survivors and were helpful. This collective kind of trauma approach and intervention was an eye opener for me. I made recommendation for as a NICE guideline for collective. (In this country) Here, kind of trauma related to personal assault is different because of the pre-disposing or precipitating factors, and it cannot be generalised or having a collective approach is inappropriate. One of my colleague Dr ---, advocated for a community approach re:	H10.4 Models of PTSD are not appropriate for collectivistic cultures H10.5 Community approach to trauma and natural disaster H10.6 Cultural impact on clients' appraisal H10.7 Cultural differences impacting on clients' appraisal

	trauma affecting individuals from different cultural backgrounds. He suggested community society and collective trauma work but was rejected. With reference to Ehlers and Clark protocol, it depends on the nature oof trauma re: appropriate and effective. I have seen people respond well on a 1:1 across the board. I think that collective approach rather than 1:1 might be appropriate for clients of Asian background, I think. I find that clients from middle eastern background are not psychological minded, there are lots of somatising when it is a PTSD diagnosis – reported physical symptoms rather than psychological symptoms. They see medication as the answer to get cure, not necessary to challenge thoughts, explore emotions and behaviours. Talking therapy is a myth, not understanding the concept of mental illness. As I said before, models are appropriate to eastern, African and middle eastern clients. There are 2 strands of thinking – firstly, the collective trauma and secondly, the single approach. I can see that a collective approach is needed for Asian, African and Middle eastern clients. But there is not enough evidence in my opinion to say that another model is needed. Ether and Clark model would be used for this group of clients, to develop another model for clients from a non-white background that could be more effective, I don't know that. Re: negative appraisal on the trauma, an understanding of what the client means will depend on the skills of the clinician and a good psychoeducation needed for the client before starting on the processing of the trauma. For prognosis to be successful, a robust psychoeducation should be given to the clients. I see the understanding of the trauma and its impact on the clients is related to how aware is the client of this condition- their understanding of PTSD. This is brought up by relatives of clients from Asian background re: concepts/understanding of PTSD – they think that "She is going mad". I can see a lack of understanding what PTSD is! I think education is important to raise their awareness as they are not psychologically minded, and the terminologies are not clear and well understood by people of non-western background. Tamil speaking clients find difficulty to understand the simple terminology, for example, the term flashback might not be existed in the Tamil language- Tamil to explain this, don't happen. Rumination might be a difficult term to explain in Tamil. I speak their language and culturally, I feel that I need to clarify with examples, such as meaning of words, using and referring to physical trauma to explain psychological trauma. So, an understanding of cultural background of clients is vital in therapy.	H10.8 Lack of understanding of the concept mental health & PTSD H10.9 Language barrier in therapy H10.10 Lack of understanding of Mental Health In middle eastern culture H10.11 Importance of psychoeducation H10.12 Lack of understanding of PTSD by Asian culture

Table 11: Transcribed interview data Participant 4

Q	Table 12: Transcribed interview Data - Participant 4	Re-coding Raters: GSR / TR/SS
A3	How do you see clients appraised themselves after a trauma (PTSD) response/unit I guess diagnosing people with PTSD in step 3 starts with a triage assessment before coming up with a provisional diagnosis. Client is invited on to Level 3 for 1:1 CBT therapy and they are assessed, using Impact of Event Scale-Revised (IES-R) a diagnosis of PTSD made, follow by treatment plan. In term of appraisals, clients feel the impact and it affects their self. Before PTSD they were capable and in control. Following PTSD there is a paradigm shift in their life, can't cope, it has changed their world view, the triad of the world itself.	A3.7 Clients' appraisal of their trauma. A3.8 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
B4	B4. Do you see any differences of how clients from different cultural backgrounds appraised themselves? response/unit From my experience, people from eastern cultures reported shame around the family, not just for PTSD but for other presentations – they said that they felt unable and difficult to discuss it with family members, close friends and other members of the community. This is seen as being a sign of defective, so that actually presented another challenge for therapists, i.e., a negative belief about the condition. Re: eastern/collectivistic cultures, their approach is what others think about them, there is stigma attached to mental health, not fault of their own if they were attacked, raped, tortured because subsequent mental health problems manifest itself, shame associated with that reaction. Western individuals' appraisals are the same but can be different and it varies from person to person, can be some shame associated with some groups, for example, *I have worked with this person within the military culture, and a lot of ex-soldiers find difficult to report mental health problems, because culture of need to be strong, but reporting a problem is seen as a sign of weakness.*	B4.9 Cultural differences impacting on clients' appraisal B4.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
C5	How do you see clients appraised themselves in relation to mental defeats? response/unit Being mentally weak comes across people within the African Caribbean community, and this is documented, having witnessed friends and family members in the community be afraid of mental health service – '*if you are involved in Mental health/have a mental health issue, there is the danger of being sectioned'.* It varies a lot and more on an individual basis, they see themselves traumatised and affected, the self is weak in the context of PTSD. *Individuals from western cultures are high in functioning and psychological minded, present with least problems, attached to the presentation of PTSD, able to differentiate and perhaps more likely, i.e., this happens to me, it is not my fault and no shame*	C5.5 Cultural differences impacting on clients' appraisal C5.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals

	associated with it. With reference to personal autonomy and a sense of agency, this depends on circumstances. I got referrals from the Tamil community, clients with trauma from their war-torn country, waiting approval from the Home Office to get permission to stay in England. This is a huge impact on the self, accelerated the symptoms of PTSD because they feel unsafe, insecure, and not a sense of agency, do not have control over the self, traumatised ruminating on at any moment they could be repatriated if their appeals were declined. This presents huge challenges to help them to process the PTSD because of the lack of control.	
D6	What is your interpretation and understanding if a client says that they have lost their identity? response/unit Communities vary in the lack of control -it depends on the socio-economic status of the client, there are multiple problems, irrespective of their ethnicities, e.g., housing problem, poverty and loss of identity. Multiple stress led to no sense of agency and difficulty to treat and challenging, delayed recovery. Language used in therapy can be a barrier for clients from different cultural backgrounds. Even for the white community, the use of psychological language can act as a barrier and delay recovery. Translators are involved in the therapy, and this can be challenging, trusting the translator to convey the message and terminology correctly can be problematic. I see therapists as being 'blind' here, they don't know what the translator is putting across when working with the clients from different cultural backgrounds. On the other hand, working with clients who have sufficient knowledge of English and a bit fluent, don't need a translator, but there is a danger of misinterpreting and psychological terminology might not be understood, Psychoeducation proves to be difficult with clients from different cultural backgrounds. There is misconception of how the world is viewed by different cultures. For example, clients from the Muslim religious faith believe that Allah God creates the world in a certain period, so appraisal such as the world is a dangerous place might be problematic, so I have to be sensitive to people's cultural belief and religions otherwise barriers will be set, leading to therapeutic alliance rupture.	D6.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.7 Language barrier in therapy D6.8 therapist's difficulty in therapy D6.9 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
E7	E7. Do you see any differences how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? Response/unit Alternative there could be mistrust between therapist and client where they hold back, don't share problems or feelings - client might have thoughts such as 'I don't trust this person 'or 'I don't believe what they are saying', and not being in control, making therapy difficult and leading to failure to achieve goals.	E7.8 Clients feel the lack of control in therapy and they don't trust no one.
F8	F8. How do you see clients appraised themselves towards others and the world?	

	Response/unit They can feel alienated from the therapist. This can be seen across cultures and how they see the world and others, depends on the personal circumstances. For example, if they have poor mental health services or poor community services, they may feel alienated before coming to therapy which is a barrier that needs to be overcome before recovery can be achieved. I see client's vulnerability at the begin of therapy. *Clients from within their community and from Asian and African backgrounds have different perceptions around mental health services, they feel isolated and helpless. For example, Tamil people are alienated within their own community, not associated with other members in the community, for the fear that the messages about them could get back to their own country and there could be implications for them and their families. Having a translator to act on their behalf can trigger the fear of information getting back to their own country*	F8.8 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals F8.9 Alienation-Tamil people feel alienated in their community
G9	Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? Response/unit As for permanent change, following PTSD the person is not the same, can be completely affected the person confidence and self-esteem. In the case of violated rape, the person can't change this violation or gets this mental health out of their mind. This can change them permanently in a negative way. I guess, get back to my point, people who high functioning are quite educated, have a sense of agency, are more likely less affected, rather than stigmatised. I practise EMDR as well as CBT. It is easier for clients whose 1st language is not English or translator taken a western point of view, EMDR gets people to focus on eye movements rather than recounting or narrating the trauma as in CBT. It is difficult for people whose English language is limited, to engage in therapy, and recounting their trauma. I personally work more with EMDR rather than trauma focus CBT. The recovery rate is quickly with limited number of sessions. For example, clients who feel shame for being traumatised, it is easier to use a blink process protocol. I find working with clients from different cultural backgrounds, I get different insights as a clinician. It is challenging my practice, working with clients from different cultural backgrounds whose 1st language is not English, recounting their trauma and psychoeducation prove to be difficult to handle.	G9.12 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.13 Cultural differences impacting on clients' appraisal G9.14 EMDR is effective in treating clients with PTSD G9.15 Therapist's difficulty and lack of understanding of client's culture.
H10	Do you think that current models of PTSD are appropriate for clients from different cultural backgrounds? response/unit I find models of PTSD are more appropriate for clients from western cultures, but these models are not suitable for eastern cultures as these models do not consider their cultural backgrounds into consideration. In relation to intrusive negative thoughts and how clients appraise themselves depend on their background. People coming from certain places might interpret these thoughts and nightmares as being struck by black magic or	H10.13 Models of PTSD suitable for western clients H10.14

	demons and they are being repossessed. In their own country, they might seek the help of the Witch Doctor. It is challenging to work with them and apply the westernised protocol, a huge misrepresentation the approach to deal with all these mental issues. Black African and Caribbean communities trust their Pasteur for counselling on mental health issues/problems as they are afraid of being stigmatised by the mental health services. I find that people from different cultures have different perception of mental illness and PTSD. For example, in Arab countries they have no clear concept of PTSD and they do not recognise PTSD. Clients do not understand the concept of PTSD and psychoeducation is difficult – 'clients thinking irrevocable damage is not cured'. Accessing the IAPT services by clients from Asian and African cultures is poor. Men from the Asian community are reluctant to use IAPT services, feeling alienation as they see this process to be challenging. In case of sexual assaults Indian women present with somatic symptoms rather that psychological symptoms of the trauma. They are afraid of being rejected by their family and community.	Lack of understanding of mental health in African, Asian and Arab cultures H10.15 Cultural differences impacting on clients' appraisal

Table 12: Transcribed interview data Participant 5

Q	Table 13: Transcribed interview data Participant 5 (clean data)	Re-coding Raters: GSR / TR/SS
A3	How do you see clients appraised themselves after a trauma (PTSD)? response/unit As an integrative therapist and based on clients that I saw in the clinical practice, they appraised themselves negatively, for examples, lack a sense of control, self-esteem, confidence and negative self-talk. In the case of sexual abuse, quite often clients took the responsibility, meaning the way they were responsible, but not vulnerable, felt something done to them and they were not a victim. I did not notice too much of cultural differences when clients appraised themselves following a traumatic experience.	A3.9 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
B4	B4. Do you see any differences of how clients from different backgrounds appraised themselves? response/unit I will say people that are Asian and African internalised the trauma a lot differently, e.g., *they suffered from delusion from the trauma, but they believed that they were in control. Re: 'I am weak, and others see me as a weak person' - I get that sense from both clients, all clients focus on what other people will think about it. In the western culture clients that I saw in my practice, said 'how my family is going to see me, rather than the world will see me', whereas clients from Asian or African backgrounds, said 'how am I going to be perceived by people closed to me'.*	B4.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.12 Cultural differences impacting on clients' appraisal
C5	How do you see clients appraised themselves in relation to mental defeats? response/unit My interpretation and understanding of clients' appraisals in term of autonomous, there is a sense of self encompassing confidence, power, how much they are in control, I would ask and explore the meaning, ascribed different meaning to the words. With reference to clients, I provided therapy and in cases of sexual or physical abuse, I have seen in a lot of clients make them questioned whether they could and were capable of making good decision, they questioned a lot of their decisions, found it difficult to make decision in general in fear of been traumatised again, meaning vulnerable to sexual or physical abuse. I find that clients had difficulty to take decision or organised/planned their life, depending on their level of confidence. A lot of people I saw in sessions reported that they found it hard to be kind to themselves because they felt that they did not deserve it and giving up mentally, meaning 'I am a bad person'- for both cultures. I	C5.7 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals C5.8 Cultural differences impacting on clients' appraisals

	find that it is a lot heavier with people of colour when compared to white clients, meaning they are less traumatised. I find that family is much more important in the collectivistic culture.	
D6	D6. What is your interpretation and understanding if a client says that they have lost their identity? response/unit The way I interpret and understand the clients is that they struggle with control, and they lack the ability to plan their life, go back to lack of sense of self. What is it about planning things? What are they finding difficult? What they want to be in control of, and is that realistic, can they be actually in control or outside of control? I think that I do really try to understand where clients are coming from, and what things mean to them or how they perceive themselves and who they are? I want to have an idea of actually what they are thinking of themselves. I see that clients feel that others perceive them negatively, like they are helpless, 'I should have done x, y, z. I see that there is not so much compassion or forgiveness, I see that clients have rules, i.e., 'If…then…' I find the rules creates negative thoughts in the mind of the clients and they try to take responsibility for it. I get that sense of responsibility to give them that sense of control, identity and power over the situation, so that they are not helpless; give them a sense of responsibility. Give them the sense of self, meaning who they are as a person, their likes and dislikes, who they are?	D6.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
E7	Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their lives? response/unit I have noticed differences and similarities of cultural background impacting on the way the clients appraised themselves and be in control. I see that in both cultures the family is important to them, but there are differences in the way clients see how the family reacts to them after the trauma. I find that people of colour put more weight on the family. They feel the shame, guilt, disobedience and lack of control as not following the family expectations. They feel that 'I am done, what my family would expect more of me that I want to do'. I hear that in my work with the clients. I find that clients are rejected more by family and losing control, common in people of colour whereas for the white clients, family can be devastated, but the main focus is on the impact of the trauma on the individual, i.e., how the client will be affected, family plays a minor role, but can be supportive. In Asian and African cultures, the traumatic experience is swept away under the carpet, 'it remains a secret', but this is not so much in the western society, where it is more transparent and family supportive. My interpretation of clients' appraisals in Asian and African	E7.9 Cultural differences impacting on clients' appraisals E7.10 Family is more important in the ethnic minority group E7.11 Family rejection is more common in the ethnic minority group

	cultures leads me to this question: *What people will think of the family and not what you are doing? The focus is on the family – shame and spoiling the family name. In relation to sexual abuse, their communities blame the women – 'It is your fault' and this affects their ability to be in control of their lives.* Clients complain of somatic symptoms such as headache, pain in the back rather than opening up and talk about their sexual abuse and its impact on them. Clients from this group have a negative opinion of themselves, feeling weak and out of control, especially when they experience flashbacks – they can't control this experience and are helpless.	E7.12 Family support to Asian clients E7.13/E7.14 Cultural differences impacting on clients' appraisal E7.14 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
F8	How do you see clients appraised themselves towards others and the world? response/unit I think it is quite similar in the clients from the western cultures. I understand that being weak, out of control and the impact on the clients are common appraisals in this group of clients. In my experience less of an impact on the family, less more vocal, more hidden than in white family. In people of colour impact on the family is heavier, brought shame to the family. For example, reflect on one of the situations of an Indian woman: she was sexually abused by her uncle at the age of 8 years old, *she remembered that she went to tell her mother and her aunt, they told her to be quiet and she felt that she was not believed to tell the truth'. She could not trust her mother and others around her, and she saw the world as an unsafe place. My interpretation of this situation is disturbing and heart breaking as she had to carry this trauma for a long time until she had therapy with me.* I try to understand and make sense of this situation and ask myself the question – how the family sees this? Is it guilt or shame on the family! Is this why hush, hush and keep the secret among themselves or what others think about them? I know that I will not get a direct answer to these questions, just assume that it is a culture issue within the Asian community.	F8.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals F8.11 Cultural differences impacting on client's appraisals F8.12 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
G9	G9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change?	

	response/unit *In my experience of therapeutic intervention with clients from western backgrounds, I find families are more supportive and open, have an understanding of the trauma affecting their loved one and how they have changed, not their usual self. I think that this is difference in people of colour, 'they internalised the trauma' and 'something that they have to deal on their own, whereas white people although internalised the trauma, there are more supported by the system. In the Asian and African cultures, I find that there is a lack of understanding of the nature of the trauma – people of colour family are less understanding and don't necessary want to understand, explore or hear about it. I think shame and embarrassment are considered worst in people of colour than white culture,* more in collectivistic cultures, not only the person feels the shame, but the whole family/community – a permanent change of blame and shame, impacting on the self, rejection to the individual, family and community. In the white society, the person as an individual feels the shame, but may extend to the parents only. Permanent change such as being weak, personality change is more individualised.	G9.16 Therapist's understanding of family support in white society G9.17 Cultural differences impacting on clients' appraisal G9.18 Cultural differences impacting on clients' appraisal
H10	Do you think that the current models of PTSD are appropriate for clients with different cultural backgrounds? response/unit I find the Models in general for PTSD do not address the needs of clients from non-western cultures. I do not think these models are appropriate. I think sometimes some symptoms of trauma are perceived differently by difference cultures, for examples in African culture, it is considered to be delusion. I think for the western cultures PTSD is seen as a mental health issue whereas from an African perspective, it can be perceived to be more spiritual rather than something wrong with the person – need to see the Spiritual Doctor as the view is that it is not deemed to be normal. For example, in Vietnamese culture, if someone has mental problem such as symptoms of PTSD, they pray to their ancestors, offering foods, etc – they think that their ancestors are angry and that why they are not well mentally. In Arab countries I think the concept of PTSD is not well understood. Reflecting on one case I saw in my clinic- she was diagnosed with PTSD and referred for treatment. She had 12 sessions previously by a therapist from western background. Client told me that the treatment was not effective, and the therapist did not understand her or where she was coming, her problems were not addressed as she felt being an African, the therapist did not understand what she needed to get better. She related to me as a person of colour and considering her cultural background, I saw her for 12 sessions, goals achieved and discharged her. Reflecting on this case I think culture is important in therapy and I am of opinion that there is a gap in the education of therapists in general. Practising as an	H10.16 Models are not appropriate for ethnic minority group H10.17 Cultural differences impacting on clients' appraisals H10.18 Therapist's difficulty in therapy

	integrative therapist, I have observed people of colour often pick me because I am brown and can relate to me, and a different understanding, assume understand them better.	

Table 13: Transcribed interview data Participant 6

Q	Table 14: Transcribed interview data Participant 6	Re-coding Raters: GSR/TR/SS
A3	How do you see clients appraised themselves after a trauma (PTSD)? response/Unit Clients appraised themselves as being hopeless, their own agency being affected, meaning that they are not in control of themselves. They can't reconnect with assertiveness, feeling weak, worthless, and sometimes they have a degree of shame. I found that if they had been involved in 'previous childhood trauma, neglect or sexual abuse, they have lost of 'problematic psychological issues – what I mean by this the psychological recovery is delayed	A3.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
B4	Do you see any differences of how clients from different backgrounds appraised themselves? response/Unit In my experience I have observed/ seen that clients with PTSD are not fully recovered, especially in the Asian and black communities. During my clinical practice, I observed that in non-western families, especially from collectivism culture, traumatised clients appraised themselves as less competitive and they did not have the same expectation as white individuals. Non-western client appraised themselves they lack support, seeing themselves as inferior, and (I think this may be due to cultural upbringing. I have noticed that people from Asian backgrounds tend to be subservient, tolerate and submissive, 'against may be due I think to their cultural upbringing'. As a therapist I that noticed in my practice that trauma made all these worst. From my experience, this was more common in Asian female clients, against may be link to their cultural upbringing whereas these characteristics are not present in the individualistic culture.	B4.13 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.14 Cultural differences impacting on clients' appraisal
C5	How do you see clients appraised themselves in relation to mental defeats? response/Unit *I found people from Afro-Caribbean had a strict upbringing and they felt isolated, and alienated when exposed to trauma and clients from this community always appraised themselves as being badly treated and giving up -'life can treat you badly', whereas I observed not so much in the western cultures. From my experience working with Asian clients, I found that in Asian Pakistani culture, clients appraised themselves as being mentally 'weak'*	C5.9 Cultural differences impacting on clients' appraisal C5.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals

D6	D6. What is your interpretation and understanding if a client says that they have lost their identity? response/Unit From my experience when clients appraised themselves as being out of control, lost autonomy and identity, I understand that 'they find something wrong in themselves, not their usual self'. In certain types of traumas, such as sexual abuse, they cover up the incident or the trauma event. I interpret this cover up as they fear of being shame in their community and guilt set in that they are in the wrong or have wrong themselves. They are no seen as their own self, lost their identity.	D6.12 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
E7	Do you see any differences of how clients from different cultural backgrounds appraised themselves in relation to being in control of their life? response/Unit Well, from my experience and having seen clients with PTSD, I found that they appraised themselves as having lost control over the situation as that why the trauma event took place. They blamed themselves for being weak, unable to defence themselves. *They lack planning ability re: their life, activities and social life. They* had a sense of being weak, lacked the ability to minimise physical and/or psychological harms. They had the feeling of being withdrawn, silent and vague, having no purpose in life. They could not speak out, felt weak and inability to defence themselves. They changed their belief of how they viewed themselves -'what control have I got, I feel powerless, I can't cope, very difficult situation.	E7.15 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals E7.16 Clients' appraisal of their trauma
F8	F8. How do you see clients appraised themselves towards others and the world? response/Unit *Working with clients coming to my practice, in sexual abuse cases, I found that the family took control of the situation in younger generation in non-western cultures whereas in Western cultures, I found that family felt apart, especially if the abuser was known to the family. I observed that families from both cultures protected their young children. As they grew up, they saw the environment as being dangerous, I understood that they saw the world as being dangerous in both cultures. From my personal experience, I found that refugees from non-western cultures, were more anxious, had the fear of real dangers, fear of being deported because of the trauma they experienced. I saw this as a double effect and they were traumatised deeply, for example, people of black colour felt more dangerous, traumatised by attitude and behaviour of the Police who they*	F8.13 Cultural differences impacting on clients' appraisal F8.14 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals F8.15 Similarities in appraisal from both cultures

	Thought of being hard on them, leading to further traumatisation. I had not seen any white westerners with the same problem. I felt that the white therapists in post- had little training, which might contribute to lack of understanding of Police personal in post. From my understanding I interpret loss of control and planning strategies as a fear of unable to cope, the client is overwhelmed with anxieties of not being able to manage their life. The whole self is under threat, they avoid going out of the house, withdrawn and see staying at home to be a safe environment. I see this affect clients from different cultural backgrounds. From my experience, I can say that clients from collectivistic cultural backgrounds tend to be affected more if they have lost control and planning strategies. *They appraise themselves as being unsafe, lack of security, fear, threat from others, uncertainty becomes an issue. They feel the shame and the guilt more that clients from other cultural backgrounds (western). They fear of being stigmatisation within their community family, feeling rejected and not accepted by the members of their community*. *From my experience, clients from both cultures did not trust others and they saw the world as a dangerous place, feeling isolated. Clients from collectivistic backgrounds felt that they were being discriminated, being judged by their community and did not engage with society. In the case of sexual abuse, I found that trusting others had a huge implication for clients from the Asian community. In my view this tends to an on-going lasting problem for them if they are not understood and have the appropriate therapy to address this issue. I can tell you the case of a 15-year-old Asian girl who was pregnant and had an abusive relationship with her father. She was traumatised and she did not tell anyone, did not trust herself, lived in fear for years until the age of 60-year-old when she saw me for therapy. I felt so sad about this individual. But then clients from Caucasian and African backgrounds went through a lot of* physical abuse	F8.16 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals F8.17 Clients' appraisal of their trauma F8.18 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
G9	G9. Following trauma (PTSD), how do you see clients appraised themselves in relation to permanent change? response/Unit From my experience as a therapist, I can say that clients reported permanent change in their appraisals/ saw that there were behavioural changes. i.e., a broken person, more so reflecting that behaviour of Asian men/ they were retraumatised/ they were weak and evidence of lack of cultural support from the community/difficulty to cope with life- they did not understand what they brought into the room was very hard for me to comprehend/ could not share outside of my experience/ all these happened in both cultures. One example of a client from a Caucasian	G9.19 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals

	background – *a 51-year-old was married for 51 years. She had trouble in the relationship, and she was traumatised by physical abuse from her husband. She could not carry on and she felt weak, and this was long lasting and resulted in a permanent change – saw herself as a different person with low self-esteem, weak and could not defence herself. Then things were different for clients from collectivistic cultures. My interpretation is that they lost faith in God, religion played a big part in their life. Personally, I see this behaviour being negative, clients often asked the question: How could God done that to me? Is God punishing me now. They ruminated over this issue until they became so much pre-occupied by this thought and started to affect the client much deeper. From my experience as a psychodynamic therapist, I can say that permanent change occurred in clients from both cultures -there were self-blame, the self out of control, strength weaker, all lasting for a long time. In Indian culture, I encountered clients who felt alienated in their own group for a long time. In the Pakistani culture, clients were frightened of being judged negatively by their community. Based on my clinical experiences cultural differences have made impacted on individuals in different ways.*	G9.20 Cultural differences impacting on clients' appraisal G9.21 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals
H10	H10. Do you think the current models of PTSD are appropriate for clients with different cultural backgrounds? response/Unit I think that we need to have need a solid model crossed cultures to meet the need of the client. I think that the current model of PTSD is inappropriate across cultures due to the lack of deeper understanding of the clients by the community.	H10.19 Psychodynamic therapist 's view on models of PTSD is inappropriate across cultures

Table15: Transcribed interview data Participant 7

Q	Table 15: Transcribed interview data Participant 7	Re-coding Raters: GSR /TR/SS
A3	How do you see clients appraised themselves after a trauma (PTSD)? response/Unit To make sense of appraisal in PTSD/Trauma, clients talk about an experience that had happened to them in an unfortunate situation – a kind of feel numb about their trauma when coming to the sessions. Seen people from different cultures and being in this country, I have come across clients who were traumatised by war trauma in their homeland – *people from Sri Lanka, Afghanistan, and other torn war countries. Their appraisals begin at the start of the journey, escaping from war, all kind of terrible things that happened to them. They focus on the situation of how they flee, rather than surrender. To connect to PTSD or other anxiety and Mental disorder, they feel that they are not connected to their journey. It takes a bit of time to connect to the trauma and its impact on them. Why they are experiencing what they are experienced.*	A3.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal A3.12 Clients' appraisal of their trauma
B4	B4. Do you see any differences in how clients from different cultural backgrounds appraised themselves? response/Unit Their appraisals: 'I am feeling so depressed',' I don't understand'- 'being in this country, I have been feeling low', 'I cannot do my work', 'cannot engage in activity',' I am indoor, people speaking to me, hearing voices, telling me about the sad things'. Exploring more their appraisals, they said the traumatic experience came to their mind without their will. They told me 'Intrusive thoughts forced and tried to push them to experience this'. They can't articulate this as an intrusive thoughts or other symptoms such as flashbacks or reliving. It takes time for them to understand as to why this is happening to them, i.e., hearing voices, intrusive thoughts. From my experience and interpretation, they were experiencing flashbacks and reliving the trauma. For example, Somalian's experience flashbacks, intrusive thoughts coming to their mind against their wills. I can recall what they told me: 'The force pushed, and it was a bad force' – how they saw their traumas'. They could not make sense of it. *Comparing to people of this country, they are clear about intrusive thoughts, flashbacks and attribute no external force to, these thoughts. I think language and cultural upbringing play a key role in making sense of the trauma. The PTSD terminologies are not common language for the African or Somalian people. They don't have direct*	B4.15 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal B4.16 Language barrier Concept of trauma is not well understood by non-white clients B4.17 Clients' appraisal of their trauma B4.18 Cultural differences impacting on clients' appraisal B4.19 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal

	translation for word for word, for example, in my experience most interpreters use the English terms for key words using to describe symptoms of PTSD. They told me that 'there was nothing available in my language, these words were alien to me, not in my vocabulary'. My understanding and the way I interpreted their appraisals led me to believe that they were thinking something happened to them and they were going mad, getting unwell. How to manage them? Knowing that PTSD concept does not exist and no concept of mental health in their country, I felt at that time that their understanding of what was happening to them, was extremely important. – knowing what was happening to them, had to explain in such a way to convey the message. I found psychoeducation challenging and there were cultural implications to understand and to know what they were experiencing, made meaning for them, understood them. From a western perspective, I can see things are different due to the common language used by the clients and the therapists. Sometimes, western way of interpretation makes sense – how they make sense of it? How we make sense of it? Find similarities and form that relationship and connection, create story of understanding for both of us – so the common language simplifies understanding.	B4.20 Language barrier in therapy B4.21 Therapist's difficulty in therapy B4.22 Language barrier-Common language helps in therapy
C5	How do you see clients appraised themselves about mental defeats? response/Unit From my interpretation re: western cultures, I can see the clients have a sense of self, important to know where clients are coming from, talk about their independence in term of may be their work, relationship, and impact of trauma and its effects on them as individuals. *Refugees have a different perspective due to different cultural backgrounds, and alien to a new society and depended on the Government. As a person, I see that they have lost their self-esteem, autonomy give up mentally. They have lost their culture, home, family, community and everything – autonomy linked with relationship and relating as a community, and as people connecting to their own individual kind of existence, collective kind of existence and community spirit.* Clients felt very lost without the sense of community spirit. *Whereas clients from individualistic background focus on individual, even in relationship progression – appraised themselves as 'who am I in this world?', ' I am unlovable', I am dislike', suffering from depersonalisation. Similarly, to the collectivistic approach, people with individualistic principles, find people to be important in their life*.	C5.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal C5.12 Cultural differences impacting on clients' appraisal C5.13 Clients' appraisal of their trauma

D6	What are your interpretations and understanding if a client says that they have lost their identity? response/Unit Depending on the nature of the trauma, trust becomes an issue – 'I can't trust people' and in situation of sexual assault or personal attack, there is more fear dealing with people and when they are in a relationship in term of their existence, rather than their individual self. There is also the emphasis on pronouns 'I' and 'we'. Community oriented individuals' appraisal of self includes 'we', e.g., 'We have lost our family, our country, our culture. Our identity, our connection'. From an individualistic perspective, 'I have lost my identity, my country, my connection'.	D6.13 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.14 Clients' appraisal of their trauma
E7	Do you see any differences in how clients from different cultural backgrounds appraised themselves to being in control of their life? response/Unit I can expand on this further - following a traumatic event, control of their life becomes difficult. I find that lack of control applied to both. Speaking about the lack of control, the pronoun 'I' emerged in the appraisal of control – 'I can't cope', overwhelming kind of self, uncertainty, difficult in that sense, coping might be related to work, carrier, relationship, feeling unsafe or lack of safety – 'I am not safe anymore, my life coming to an end.' – all attributed to the individualistic approach. Stigma and shame are attached to the individual self and not the community or family. It is more on individual focus.	E7.17 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals E7.18 Clients' appraisal of their trauma
F8	How do you see clients appraised themselves towards others and the world? response/Unit *Looking through the lens of collectivism approach, clients appraised themselves as 'Will I be able to fit in this society' 'in the white culture' or 'will I be sent back'., 'will I be welcome'. The focus is also on the family and community in relation to appraisal following trauma – 'I brought shame to the family and community', ''we as a family /community feel shameful and 'the stigma of shame attached to the family/community'.* In the *sexual assault cases, clients might have the fear and anxiety related to their future – 'I can't get married', 'this is not part of my culture', 'family/community expect me to get married, but I can't'. This is not so much in the western culture; their problem is more individual – 'I am having problem in my relationship'. I see that for clients from both cultures, the world is dangerous. Stigma is higher in collectivistic society, clients in this group avoid engaging*	F8.19 Trauma impacting on clients, Family and community F8.20 Clients' appraisal of their trauma F8.21 Cultural differences impacting on clients' appraisal F8.22 Clients' alienation towards others and the society/ their world

	in their community, they are isolate, and fear of being judged.	
G9	Following trauma (in PTSD), how do you see clients appraised themselves concerning permanent changes? response/Unit In my experience, both cultures experience permanent change, but in different ways. *Clients from collectivistic culture, appraised their life change as ' I have changed for ever', 'Who I was, I am broken', 'I am damaged' – how women from this group see their permanent change following sexual assault, this more so in Asian culture – ' I can't get married', 'I am not the same person',' others see that I am impure', family and community reject me'.* This has severe implications to their future life and ongoing low *self-esteem. In the western culture, the focus is more on individualistic approach – 'I am not the same person', 'It is my fault'. I have never come across this appraisal from clients in the western culture – 'I am not pure'. Asian clients might come up with appraisals such as 'I should not be living anymore' – there is suicidal tendency associated with rape – a bit more intense in eastern culture – 'I rather die, than living*'. *Clients avoid religious places, temples, as they feel that there are impure. From their perspective, they are not 'pure' and feel that they should not be there. They feel isolated, something they value, being taken away from them, separated from their family, community – 'I am alone', leading to separation anxiety. It happens in the western culture – isolation, separation and alienation.* But intensity is higher in the eastern culture. Re: models of PTSD, I think Ehlers and Clark model is appropriate to single trauma, narrative of the trauma. But it is problematic for multiple traumas and where clients are depended on the family and community – cultural aspects are not addressed for this group. I feel that psychoeducation initially is important with refugees and other Asian or African clients to provide an understanding of PTSD and its impact on the individual. Psychoeducation involved the use of language, and psychological terminologies are quite difficult to understand. I think language could be a barrier to successful recovery. Sometimes it is difficult for me to share the same language at a level when clients could understand these terminologies. The use of interpreters is appropriate to support clients who can't speak the language or have limited knowledge of the spoken language. Clients commented 'You have your language, and I have mind', 'this is how you are experience it' – a kind of sharing through psychoeducation to explain PTSD and its impact on them. How they experience it? Tamil refugees revealed the fear and experience of PTSD in	G9.22 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal G9.23 Clients' appraisal of their trauma G9.24 Family and Community rejection in collectivistic cultures G9.25 Ehlers and Clark model appropriate for single trauma, but not for multiple traumas G9.26 Language is a barrier in therapy G9.27 Therapist's difficulty to engage with clients from different cultural backgrounds.

	sessions by telling me that police syren with loud noise triggered the memories of the traumas – 'I know why I am going into panic mode, reminding me of situations in my home country'. I found the use of 'stone/net' helpful to explain PTSD and its impact on the individual.	
H10	H10. Do you think that the current model as of PTSD are appropriate for different cultural backgrounds? response/Unit Through application of 'stone/net' I feel connected to the clients and used their narrative to develop a ground technique to understand and interpret the way they are feeling. For example, reflect on ground technique that I used in sessions – taken the African experience and narrative re: way of life – 'in Somalia, they walked for long distances, i.e., about 10 miles and connected with nature and beautiful places' . This scenery was used as a ground-breaking technique to connect with the clients, aiding to connect culturally, their moods elevated, became alive, then I proceeded with safety plan, psychoeducation, goals, appraisals of trauma. I feel that this groundwork or structure and gradual build up technique comes from their culture and visual mapping of their surrounding at home. I feel that the application of western models of PTSD do not achieve the goals re: therapy. *Culturally groundwork technique is more beneficial in connecting with the clients from African background. I think creating models for Tamil community with reference to psychoeducation would be helpful and to relieve the problems of language barrier*, Again the socioeconomic factors exacerbate the symptoms of PTSD. *My interpretation of their appraisals: 'No relationship with the community, no supportive network, being on their own lead to rumination and often suicidal – deprived group with no work, no income, can't work, vulnerable and what is the point of living'.* It is challenging to engage and work with them to achieve their goals. They overdose themselves, end up in hospital, difficult for them to cope with the trauma, not connected to the community. They feel lost as mental health is not part of the culture, Asian, African and other clients from eastern cultures consider themselves going 'mad' - 'nobody is going to like me' and they feel isolated. There is also the 'dislocation factor', and as I see and understand their association with community network – throughout their journey, they had to endure element of dislocated and traumatised events – leaving their	H10.20 'Stone/net' framework helps clients from non-white backgrounds H10.21 Cultural differences impacting on clients' appraisal H10.22 Application of Western models of PTSD are not effective. H10.23 Lack of understanding of the concept of PTSD in the Asian and African cultures. H10.24 Language is a barrier H10.25 Community support is important to trauma victims

	homeland, community support, arrived in a new environment and relocated to places like Derbyshire or another north town, which is totally alienated to them.	

Table 146: Transcribed interview data Participant 8

Q	Table 16: Transcribed interview data Participant 8	Re-coding Raters: GSR /TR/SS
A3	How do you see clients appraised themselves after a trauma (in PTSD)? response/Unit From my clinical experience as therapist, I find individuals from Asian and African cultures are less understood by organisation and this can lead to secondary trauma. For example, individuals from other countries who are employed by the organisation are expected to take on job with little preparation, help or support. I found shocking documents from HR on those individuals who were traumatised in various ways within the organisation. British black, Asian and people from other ethnicity are traumatised the way they have been treated, subjected to racial discrimination, verbal abuse and threatening personal attacks. Seeing these individuals in therapy, I understand that the concept of trauma and its effects were not well understood. Psychoeducation helped them to understand the nature of trauma and how it could have an impact on them. Being a white therapist and having worked with clients from different ethnicity, I believe that I am aware of their cultural needs of the clients in these group and how I should approach them in sessions or respond to a situation. I am of opinion that my white colleague therapists have limited understanding and lack awareness of cultural aspects from individuals of different cultural backgrounds.	A3.13 Secondary traumas occur due to lack of understanding by the organisation. A3.14 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals A3.15 Racial discrimination, verbal abuse and personal attacks traumatised non-white individuals.
B4	B4. Do you see any differences in how clients from different cultural backgrounds appraised themselves? response/Unit I find that across-the-board clients have difficulties with the language and jargons used in therapy. This can be problematic in relation to psychoeducation, misinterpretation of a terminology or concept can delay psychological recovery. This is common to most ethnicity – Caucasian, African, Asian etc. I experience difficult to find a language that I can share with my Asian clients, for me this can be a big block, communication problem and seek help from translator. With reference to their appraisal of self, people feel defeated, helpless, hopeless and lack of their own agency. They struggle with the reconnection with the self-assertiveness and their own recovery. The issue of shame and guilt are common in non-white individuals – All these are originated from deeper shame of childhood traumas, e.g., sexual abuse, bullying and physical abuse. I find Asian culture is deeper rooted in shame when it comes to sexual abuse.	B4.23 Cultural differences impacting on clients' appraisals B4.24 Therapist's difficulty in therapy B4.25 Language barrier in therapy B4.26 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals

	I understand that clients within this group find their responsibility embedded in the family, and separation from the family can lead to re-traumatisation, for example, rejection or being disowned by the family. Non-western families adopt collectivism approach for traumatised clients who are less competitive and brought shame on the family.	B4.27 Rejection by family and community
C5	C5. How do you see clients appraised themselves about mental defeats? response/Unit Their expectation as a non-west person and the lack of support, lead them to believe that they are inferior which is already rooted in their cultural upbringing of being subservient and tolerate, submissive and trauma made all these worst – giving up, defeated mentally- more common in Asian female clients. Organisation does not help people to be competitive and this is problematic for individuals who have experienced permanent changes such as lack of confidence, reinforced self-belief of being weak, could not achieve goals	C5.14 Clients' appraisal of their trauma C5.15 Cultural differences impacting on clients' appraisal
D6	D6. What are your interpretations and understanding if a client says that they have lost their identity? response/Unit Using Socratic and thoughtful questioning, I found that cohesive control, violence relationship, caught in a controlling family, lack of independent as a teenage and other pressures from the family/ religious affect autonomy, identify in traumatised clients who had been sexually abused - common in both eastern/western cultures.	D6.15 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.16 Cultural differences Impacting on clients' appraisal
E7	E7. Do you see any differences in how clients from different cultural backgrounds appraised themselves to being in control of their life? response/Unit I see control in the Asian family to be strong and family plays an important part in trauma. 17and 18 years old clients can be pressurised from the family, religious leaders – pressure to conform. Clients from both cultures feel the pressure, make them confused and make trauma worst. They can't control their life or planning for themselves, lack responsibility, helpless, disempowered, and silent. *I find differences in the appraisals, for example, in sessions individuals from western background appraised themselves as 'I am weak', 'I went in the wrong direction' and clients from Asian background appraised themselves as 'others see me as weak person',* ' not strong enough'. *In sexual abuse cases I find family is in control with reference to younger generation in non-western cultures.*	E7.19 Cultural differences impacting on clients' appraisals E7.20 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals E7.21 Family support and protection to

	In Western cultures family falling apart and referring to abuser, could be close family member. Both cultures feel responsible to protect young siblings/ their children. As they grown up, environment is as dangerous, world is dangerous, evident in both cultures	children by both cultures
F8	F8. How do you see clients appraised themselves towards others and the world? response/Unit Working with refugees, they have a high level of risks, adjustment of anxiety, and fear of being deported because of the trauma – it is a double effect/ they are traumatised deeply. Clients from black communities see their environment to be more dangerous – violent crimes and police are harder on them, authorities are not allied to them, affected them psychologically whereas white westerners are not exposure to this problem, not traumatised. From my understanding of appraisals from the Black /Asian clients, they feel that there is an element of racism and the way they are being treated. The Black/Asian Communities are not well understood by therapists/ language jargon for all population of Asian and black clients is problematic, and misinterpretation of cognitive appraisals lead to wrong diagnosis and treatment plan/ clients' appraisal – more like seeing them being shame, blame in their community. Another example, an Asian girl felt that she was not supported following her traumatic experience involved in a road traffic accident. 'my teachers are not compassionate', 'they don't understand my problems', 'I am in constant pain' – affecting my study. My experience working with young men lead me to believe that they are alienated by adults, the system and the world. As a traumatised individual, they feel that they are not being valued in society, for example, traumatised individuals from LGBT community I saw in sessions, felt they were not being valued in society, making trauma worst. I see language problems with lower social class, impacting on understanding terminologies and concepts in therapy sessions, impacting on treatment and recovery, working class is marginalised, feeling shame, look down, inferiority complex – making trauma worst, also being re-traumatised when put into that situation, all these social barriers delay recovery. I see massive class differences, based on class background, ethnicity and clients being marginalised/ and felt being inferior, discriminates, not being recognised as an individual, or recognition of her trauma, and disbelief that she was not being supported. Client experienced shame being of a working-class community and from ethic background -not being valued within the system, lack of understanding/difficult to recover/frustrated – no time to work through that.	F8.23 Alienation towards others and the world F8.24 Alienation-World is a dangerous place F8.25 Cultural differences impacting on clients' appraisals F8.26 Therapist's difficulty in engaging with clients from Black/Asian clients. F8.27 Young men are alienated by adults, the system and the world. F8.28 Alienation-Not being valued by society makes trauma worst F8.29 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals

G9	Following trauma (in PTSD), how do you see clients appraised themselves concerning permanent change? response/Unit *Another example, a young Asian woman saw domestic violence towards her mother and on another occasion saw someone committed suicidal and the cross imagery-link in both trauma/retraumatised and appraised her role in the 2 traumas. The way I interpret her appraisals – 'feeling worthless, can achieve her goals, behaviour change, withdrawn and broken'. Was challenging for me working with her.* *I saw one client from African background in therapy, and could not make sense of his problems/trauma related to? Egyptian God as he explained – I could not understand his problems as I felt then cultural understanding was an issue for me.* *I tried through my own cultural lens, but I could not get something, and the talk brought into the room was hard to understand, I was out of depth about what the client was saying. I had to refer him to another therapist. Another of my experience was with an Asian man, aged 23-year-old who was sexually abused at a younger age.* *He was broken and appraisal of his trauma was difficult as he could not understand the psychological impact and the nature of the traumatic event. I felt at that time that culture was a barrier, failing to understand where he was coming from and there was total therapeutic rupture, meaning he stopped coming to therapy, despite several messages sent to him. Reflecting on the two experiences, I feel that cultural knowledge is important in therapy*.	G9.28 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.29 Therapist's difficulty working with client from African background G9.30 Therapist's difficulty and lack of understanding of client's culture trauma
H10	Do you think that the current models of PTSD are appropriate for different cultural backgrounds? response/Unit With reference to models of PTSD, I think these are pretty solid across cultures and well understood in practice. Ehlers and Clark Model is the most popular one, and I think it suits all cultures. I have noticed that not so many people are being referred to NHS IAPT services, especially from the Asian and African communities. I wander whether cultures play a role when referral is concerned for ethnic minorities, i.e. loss faith in the system	H10.26 Cultural differences impacting on referral to NHS IAPT services

Appendix X – Emerging codes and thematic framework (table 17 -24= p 414 – p 427)

Table 17- Developing a thematic framework – emerging themes for question A3 (How do you see that clients appraised themselves after a trauma or PTSD

Question Number	Coding number and Emerging Themes	Participant
A3	A3.1 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals A 3.2 Family rejection after a trauma A3.3 Clients' appraisal of their trauma	Participant 1 (P1)
	A3.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals A3.5 Clients' appraisal of their trauma - Self -blame and out of control	Participant 2 (P2)
	A3.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 3 (P3)
	A3.7 Clients' appraisal of their trauma A3.8 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 4 (P4)
	A3.9 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 5 (P5)
	A3.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 6 (P6)
	A3.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals A3.12 Clients' appraisal of their trauma	Participant 7 (P7)
	A3.13 Secondary traumas occur due to lack of understanding by the organisation. A3.14 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals A3.15 Racial discrimination, verbal abuse and personal attacks traumatised non-white individuals	Participant 8 (P8)

Emerging themes from question A3	Coding number	Frequency
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	A3.1; A3.4; A3.6; A3.8; A3.9; A3.10; A3.11; A.14	8
Clients' appraisal of their trauma	A3.3; A3.5; A3.7; A3.12	4
Family rejection after trauma (code number	A3.2	1
Secondary traumas occur due to lack of understanding by the organisation	A3.13	1

Racial discrimination, verbal abuse and personal attacks traumatised non-white individuals	A3.15	1

Table 18: Developing a thematic framework – emerging themes for question B4 (Do you see any differences in how clients from different cultural backgrounds appraised themselves?)

Question Number	Coding number and Emerging Themes	Participant
B4	B4.1 Perception of mental health by the community B4.2 Rejection by family and community B4.3 Cultural differences impacting on clients' appraisal (east/west) B4.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 1 (P1)
	B4.5 Cultural differences impacting on clients' appraisal B4.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 2 (P2)
	B4.7 Client's appraisal of their trauma B4.8 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 3 (P3)
	B4. 9 Cultural differences impacting on clients' appraisal B4.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 4 (P4)
	B4.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.12 Cultural differences impacting on clients' appraisal	Participant 5 (P5)
	B4.13 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.14 Cultural differences impacting on clients' appraisal	Participant 6 (P6)
	B4.15 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.16 Language barrier -concept of trauma is not well understood by non-white clients B4.17 Clients' appraisal of their trauma B4.18 Cultural differences impacting on clients' appraisal B4.19 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.20 Language barrier in therapy B4.21 Therapist's difficulty in therapy B4.22 Language barrier -common language helps in therapy	Participant 7 (P7)
	B4.23 Cultural differences impacting on clients 'appraisal B4.24 Therapist's difficulty in therapy B4.25 Language barrier in therapy B4.26 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals B4.27 Rejection by family and community	Participant 8 (P8)

Emerging themes from question B4	Coding number	Frequency
Cultural differences impacting on clients' appraisal	B4.3; B4.5; B 4.9; B4.12; B4.14, B4.18; B4.23)	7
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	B4.4; B4.6; B4.8; B4.10; B4.11; B4.13; B4.15; B4.19; B4.26	9

Language barrier in therapy	B4.16; B4.20; B4.22; B4.25	4
Rejection by family and community	B4.2; B4.27	2
Therapist's difficulty in therapy	B4.21; B4.24	2
Clients' appraisal of their trauma	B4.7; B4.17	2
Perception of mental health by the community	B4.1	1

Table 19: Developing a thematic framework – emerging themes for question C5 (How do you see clients appraised themselves about mental defects?)

Question Number	Coding number and Emerging Themes	Participant
C5	C5.1 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 1 (P1)
	C5.2 Clients' appraisals of their trauma - shame and negative perception of self	Participant 2 (P2)
	C5.3 Cultural differences impacting on clients' appraisal - collectivistic approach C5.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 3 (P3)
	C5.5 Cultural differences impacting on clients' appraisal C5.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 4 (P4)
	C5.7 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals C5.8 Cultural differences impacting on clients' appraisal	Participant 5 (P5)
	C5.9 Cultural differences impacting on clients' appraisal C5.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 6 (P6)
	C5.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals C5.12 Cultural differences impacting on clients' appraisal C5.13 Clients' appraisals of their trauma	Participant 7 (P7)
	C5.14 Clients' appraisal of their trauma C5.15 Cultural differences impacting on clients' appraisal	Participant 8 (P8)

Emerging themes from question C5	Coding number	Frequency
Cultural differences impacting on clients' appraisal	C5.3; C5.5; C5.8; C5.9; C5.12; C5.15	6
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	C5.1; C5.4; C5.6; C5.7; C5.11	5
Clients' appraisal of their trauma	C5.2; C5.13; C5.14	3

Table 20: Developing a thematic framework – emerging themes for question D6 (What are your interpretations and understanding if a client says that they have lost their identity?)

Question Number	Coding number and Emerging Themes	Participant
D6	D6. 1 Clients' appraisal of their trauma	Participant 1 (P1)
	D6.2 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.3 Cultural differences impacting clients' appraisal - on identity.	Participant 2 (P2)
	D6.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.5 Cultural differences impacting on clients' appraisal - stigma and identity	Participant 3 (P3)
	D6.6 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.7 Language barrier in therapy D6.8 Therapist's difficulty in therapy D6.9 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 4 (P4)
	D6.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 5 (P5)
	D6.12 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 6 (P6)
	D6.13 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.14 Clients' appraisal of their trauma	Participant 7 (P7)
	D6.15 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals D6.16 Cultural differences impacting on clients' appraisal - autonomy and identity	Participant 8 (P8)

Emerging Themes from question D6	Coding number	Frequency
Cultural differences impacting on clients' appraisal	D6.3; D6.5; D6.16	3
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	D6.2; D6.4; D6.6; D6.9; D6.10; D6.11; D6.12; D6.13); D6.15	9
Clients' appraisal of their trauma	D6.1; D6.14	2
Language barrier in therapy	D6.7	1
Therapist's difficulty in therapy	D6.8	1

Table 21: Developing a thematic framework – emerging themes for question E7 (Do you see any differences in how clients from different cultural backgrounds appraised themselves as being in control of their life?)

Question Number	Coding number and Emerging Themes	Participant
E7	E7.1 Cultural differences impacting on clients' appraisal (Asian & Western cultures) E7.2 Similarity re: alienation and avoidance in both cultures	Participant 1 (P1)
	E7.3 Lack of self-control is present in both cultures (East/West) E7.4 Lack of control to their environment, applicable to clients from West & East. E7.5 cultural differences impacting clients' appraisal	Participant 2 (P2)
	E7.6 Lack of control among individuals from the White community E7.7 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	Participant 3 (P3)
	E7.8 Clients feel the lack of control in therapy, and they don't trust no one.	Participant 4 (P4)
	E7.9 Cultural differences impacting on clients' appraisal E7.10 Family support is more important in the non-white society E7.11 Lack of family support and rejection is more common in non-white cultures. E7.12 Family support to Asian clients E7.13 Cultural differences impacting on clients' appraisal E7.14 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	Participant 5 (P5)
	E7.15 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal E7.16 Clients' appraisal of their trauma	Participant 6 (P6)
	E7.17 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal E7.18 Clients' appraisal of their trauma	Participant 7 (P7)
	E7.19 Cultural differences impacting on clients' appraisal E7.20 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal E7.21 Family support and protection to children by both cultures	Participant 8 (P8)

Emerging Themes from question E7	Coding number	Frequency
Cultural differences impacting on clients' appraisals	E7.1; E7.5; E7.9; E7.13; E7.19	5
Lack of control	E7.3; E7.4; E7.6; E7.11	4
Family support to clients	E7.10; E7.12; E7.21	3
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	E7.7; E7.14; E7.15; E7.17; E7.20	5
Clients' appraisal to their trauma	E7.16; E7.18	2

Similarity re: alienation and avoidance in both cultures	E7.2	1
Lack of family support and rejection is more common in non-white cultures	E7.11	1

Table 22: Developing a thematic framework – emerging themes for question F8 (How do you see that clients appraised themselves towards others and the world?)

Question Number	Coding number and Emerging Themes	Participant
F8	F8.1 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal F8.2. Lack of family support and rejection in Asian culture.	Participant 1 (P1)
	F8.3 Alienation is present in both cultures F8.4 Alienation towards others & world is an unsafe place.	Participant 2 (P2)
	F8.5 Community support for both Western and Asian cultures F8.6 Cultural differences impacting on clients' appraisal F8.7 Clients' appraisal of their trauma	Participant 3 (P3)
	F8.8 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal F8.9 Alienation -Tamil people feel alienated in their community	Participant 4 (P4)
	F8.10 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal F8.11 Cultural differences impacting on client's appraisal F8.12 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	Participant 5 (P5)
	F8.13 Cultural differences impacting on clients' appraisal F8.14 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal F8.15 Similarities in appraisals from both cultures F8.16 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal F8.17 Clients' appraisal of their trauma	Participant 6 (P6)
	F8.18 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal F8.19 Trauma impacting on clients, Family and community F8.20 Clients' appraisal of their trauma F8.21 Cultural differences impacting on client' appraisal F8.22 Clients' alienation towards others and the society/ their world	Participant 7 (P7)
	F8.23 Alienation towards others and the world F8.24 Alienation - the world is a dangerous place F8.25 Cultural differences impacting on clients' appraisal F8.26 Therapist's difficulty engaging with clients from Black/Asian clients in therapy. F8.27 Young men are alienated by adults, the system and the world. F8.28 Alienation is not being valued by society makes trauma worst F8.29 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	Participant 8 (P8)

Emerging Themes from question F8	Coding number	Frequency

Alienation towards others and the world	F8.3; F8.4; F8.9; F8.22; F8.23; F8.24; F8.27; F8.28	8
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	F8.1; F8.8; F8.10; F8.12; F8.14; F8.16; F8.18; F8.29	8
Cultural differences impacting on clients' appraisal	F8.6; F8.11; F8.13; F8.21; F8.25	5
Clients' appraisal of their trauma	F8.7; F8.17; F8;20	3
Lack of Family and rejection	F8.2	1
Therapist's difficulty engaging with clients from Black/Asian clients in therapy	F8.26	1
Similarities in appraisals from both cultures	F8.15	1
Trauma impacting on clients, Family and community	F8.19	1
Community support for both Western and Asian cultures	F8.5	1

Table 23: Developing a thematic framework – emerging themes for G9 (Following trauma (in PTSD), how do you see clients appraised themselves concerning permanent change?)

Question Number	Coding number and Emerging Themes	Participant
G9	G9.1 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.2 Clients' appraisal of their trauma	Participant 1 (P1)
	G9.3 Cultural differences impacting on clients' appraisal G9.4 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.5 Cultural differences impacting on clients' appraisal G9.6 Difficulty of therapist to understand Asian culture G9.7 EMDR is effective in the treatment of clients from different cultural backgrounds. G9.8 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.9 Clients' appraisal of their trauma	Participant 2 (P2)
	G9.10 Cultural differences impacting on clients' appraisal G9.11 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 3 (P3)
	G9.12 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.13 Cultural differences impacting on clients' appraisal G9.14 EMDR is effective in treating clients with PTSD G9.15 Therapist's difficulty and lack of understanding of client's culture.	Participant 4 (P4)
	G9.16 Therapist's understanding of family support in white society G9.17 Cultural differences impacting on clients' appraisal G9.18 Cultural differences impacting on clients' appraisals	Participant 5 (P5)
	G9.19 Psychodynamic therapist's interpretation & understanding of cultural differences impacting on clients' appraisal G9.20 Cultural differences impacting on clients' appraisal G9.21 Psychodynamic therapist's interpretation & understanding of cultural differences impacting on clients' appraisal	Participant 6 (P6)
	G9.22 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.23 Family and Community rejection in collectivistic cultures G9.24 Ehlers and Clark model appropriate for single trauma, but not for multiple traumas G9.25 Language is a barrier in therapy G9.26 Therapist's difficulty to engage with clients from different cultural backgrounds.	Participant 7 (P7)
	G9.27 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals G9.28 Therapist's difficulty working with client from African background	Participant 8 (P8)

	G9.29 Therapist's difficulty and lack of understanding of client's culture	

Emerging Themes from question G9	Coding number	Frequency
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	G9.1; G9.4 G9.8; G9.11; G9.12; G9.19; G9.21; G9.22; G9.27	9
Cultural differences impacting on clients' appraisal	G9.3; G9.5; G9.10; G9.13; G9.17; G9.18; G9.20	7
Therapist's difficulty and lack of understanding of client's culture	G9.6; G9.15; G9.26; G9.28; G9.29	5
Clients' appraisal of their trauma	G9.2; G9.9	2
EMDR is effective in the treatment of clients from different cultural backgrounds	G9.7; G9.14	2
Language is a barrier in therapy	G9.25	1
Family and Community rejection in collectivistic cultures	G9.23	1
Ehlers and Clark model appropriate for single trauma, but not for multiple traumas	G9.24	1
Therapist's understanding of family support in white society	G9.16	1

Table 24: Developing a thematic framework –emerging themes for question H10 (Do you think that the current models of PTSD are appropriate for different cultural backgrounds?)

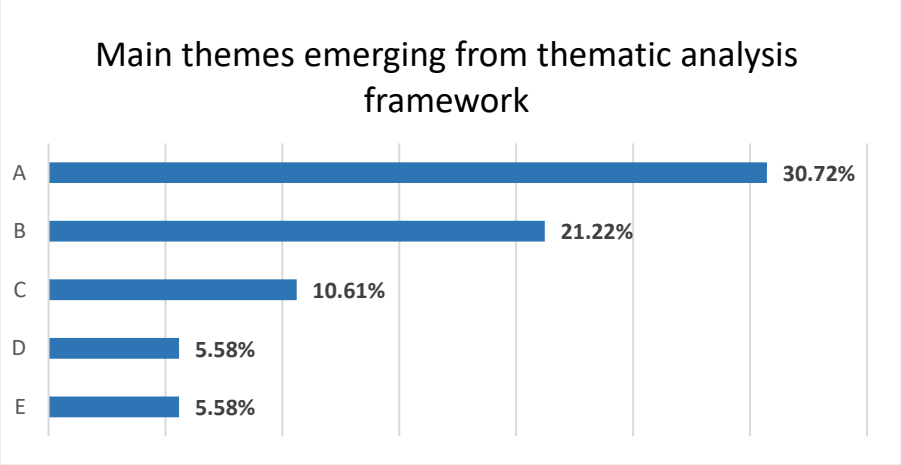
Question Number	Coding number and Emerging Themes	Participant
H10	H.10.1 Models of PTSD are not suitable for non-white individuals.	Participant 1 (P1)
	H10.2 Models of PTSD do not meet the needs of clients from non-western cultures H10.3 Impact of cultural differences on therapists' interpretation and understanding of clients' appraisals	Participant 2 (P2)
	H10.4 Models of PTSD are not appropriate for collectivistic cultures H10.5 Community approach and support to trauma victims and natural disaster H10.6 Cultural differences impacting on clients' appraisal H10.7 Lack of Mental Health understanding in middle eastern culture H10.8 Cultural differences impacting on clients 'appraisal H10.9 Lack of understanding of the concept of mental health & PTSD H10.10 Language barrier in therapy H10.11 Importance of psychoeducation H10.12 Lack of understanding of PTSD by Asian clients	Participant 3 (P3)
	H10.13 Models of PTSD suitable for western clients but not for Asian or African clients. H10.14 Lack of understanding of mental health in African, Asian and Arab cultures H10.15 Cultural differences impacting on clients' appraisal	Participant 4 (P4)
	H10.16 Models are not appropriate for non-white individuals H10.17 Cultural differences impacting on clients' appraisal H10.18 Therapist's difficulty in therapy	Participant 5 (P5)
	H10.19 Psychodynamic therapist 's view on models of PTSD is inappropriate across cultures	Participant 6 (P6)
	H10.20 'Stone/net' framework helps clients from non-white backgrounds H10.21 Cultural differences impacting on clients' appraisal H10.22 Application of Western models of PTSD are not effective. H10.23 Lack understanding of the concept of PTSD in the Asian and African cultures. H10.24 Language is a barrier H10.25 Community support is important to trauma victims	Participant 7 (P7)
	H10.26 Cultural differences impacting on referral to NHS IAPT Services	Participant 8 (P8)

Emerging Themes from question H10	Coding number	Frequency

Models of PTSD do not meet the needs of clients from non-western cultures	H10.1; H10.2; H10.4; H10.13; H10.16; H10.22	6
Cultural differences impacting on clients' appraisal	H10.6; H10.8; H10.15; H10.17; 10.21	5
Lack of understanding of mental health	H10.7; H10.9; H10.12; H10.14; H10.23	5
Community support to trauma victims	H10.5; H10.25	2
Language is a barrier	H10.10; H10.24	2
Impact of cultural differences on therapists' interpretation and understanding of clients' appraisal	H10.3	1
Therapist's difficulty in therapy	H10.18	1
'Stone/net' framework helps clients from non-white backgrounds	H10.20	1
Psychodynamic therapist 's view on models of PTSD is inappropriate across cultures	H10.19	1
Cultural differences impacting on referral to NHS IAPT Services	H10.26	1
Importance of psychoeducation	H10.11	1

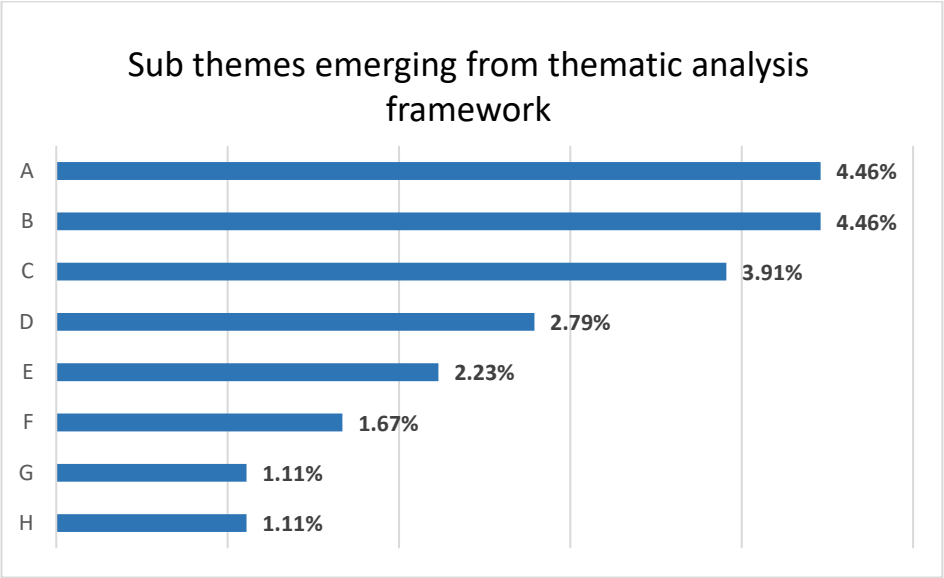
Appendix xi ***(tables 25 a, b, c = p 428 – p 430)***

Table 25 (a) Results of main themes emerging from thematic analysis



Key	Main themes	Frequency	Percentage
A	Therapists' interpretation and understanding of cultural differences impacting on clients' appraisal	55	30.72%
B	Cultural differences impacting on clients' appraisal	38	21.22%
C	Clients' appraisal of their trauma	19	10.61%
D	Therapists' difficulty in therapy	10	5.58%
E	Lack of support, family and community rejection	10	5.58%

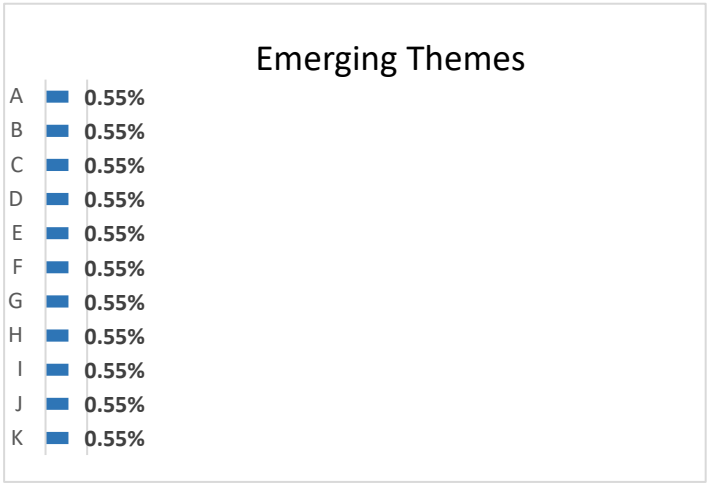
Table 25 (b) Results of sub-themes emerging from thematic analysis



Key	Sub-themes	Frequency	Percentage
A	Language barrier in therapy	8	4.46%
B	Alienation towards others and the world	8	4.46%
C	Models of PTSD do not meet the needs of clients from non-western cultures	7	3.91%
D	Lack of understanding of mental health/PTSD	5	2.79%
E	Lack of control	4	2.23%
F	Family support to clients	3	1.67%
G	Community support to trauma victims	2	1.11%
H	EMDR is effective in the treatment of clients from different cultural backgrounds	2	1.11%

Table 25 (c) Results of single stand-alone themes emerging from thematic analysis

Single (stand-alone) themes



Key	Single stand-alone themes	Frequency	Percentage
A	Secondary traumas occur due to lack of understanding by the organisation	1	0.55%
B	Racial discrimination, verbal abuse, personal attacks and traumatised non-white individuals	1	0.55%
C	Perception of mental health by the community	1	0.55%
D	Similarity re: alienation and avoidance in both cultures	1	0.55%
E	Similarity in appraisal from both cultures	1	0.55%
F	Trauma impacting on clients, family and community	1	0.55%
G	Community support for both Western and Asian cultures	1	0.55%
H	Therapist's understanding of family support in white society	1	0.55%
I	Stone/net' framework helps clients from non-white backgrounds	1	0.55%
J	Psychodynamic therapist's view on models of PTSD – is inappropriate across cultures	1	0.55%
K	Cultural differences impacting on referrals to NHS IAPT Services	1	0.55%

Appendix xii *(p 431 – p 433)*

Appendix xii	**Information on each product**
Product: Presentation of research findings-workshop Audience: Colleagues, mental health practitioners, PhD and Doctorate students Aims: i) To present of research methodology and findings ii)To generate an active discussion to gain further feedback on my research iii)To exchange ideas, and gain support from the participants	
Content: To examine the research background, literature review, and key factors leading to the study, several aspects will be addressed. This includes discussing cultural differences and their impact on therapists' appraisals and interpretations. Additionally, I will explore therapeutic treatments, recovery rates, and the challenges faced in overcoming these difficulties. The discussion will also cover the importance of receiving constructive feedback and the potential for publication.	
Product ii Training package designed Audience: Therapists from different modalities Students (mental health, therapists, undergraduate) Timeline: Following the completion of the study and gaining a Doctorate. Aim: i) To disseminate research findings to the participants ii) To design training package and run workshop. iii) To improve clinical practice, making therapists to be cultural competency	
Enhanced Cultural Competency: The package integrates cultural therapy principles, helping users understand and address the diverse backgrounds of clients. For example, it teaches therapists how to adapt their approaches to be sensitive to different cultural norms and values, ensuring more personalized and effective care. It fosters a culture of ongoing learning and knowledge sharing. Therapists and students are encouraged to stay updated with the latest research and practices, which improves their therapeutic techniques and effectiveness. For instance, it might include workshops or resources on emerging therapeutic methods or new research findings.	

Product iii) Presentation of research findings to BABCP conference	Audience: Psychologists &Therapists from different modalities providing treatment to individuals with PTSD and other psychological issues/diagnosis

Timeline: Following successful completion of Doctorate study

Aims:

1. Present key points related to my research process, e.g., background, purpose, methodology, research design & challenges.

2. Disseminate my research findings to the audience.

3. Invite questions re: my study from the audience.

Impact on clinical practice: The awareness of cultural influence upon therapists and its impact on recovery rate. Addressing the gap of knowledge in the field of psychotherapy, especially in PTSD. To encourage therapists to reflect on their practice and consider change of practice/improvement in relation to individuals with PTSD.

Product iv) Publication of Study and its findings in a peer review journal.	Audience: Psychologists & Therapists from different modalities, well- being therapists, mental health nurses, students from different backgrounds studying psychology, nursing, cognitive behaviour therapy & social research

Timeline: Following successful completion of Doctorate study.

Aims:

1. Disseminate knowledge gained and findings from the study.

2. Contribute to the body of knowledge re: cultural influences, cognitive appraisal, therapists' lived experience and post-traumatic stress disorder.

Impact:

1. Raise awareness of cultural influences in cognitive appraisal and PTSD.

2. Generate interest for further research in this area, e.g., explore other cultural diversities, Cognitive appraisals and PTSD.

Consent & Publication:

Consent will be sought before any work is published and participants will be given a copy of published work.