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Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)

St Cross College

University of Oxford

August 2024

Word Counts

Systematic Review of the Literature (SRL) **7601 Words**

Cultural Differences in the Symptomatology and Expression of Social Anxiety in East Asians and Southeast Asians and Implications for Clinical Practice: A Systematic Review.

Service Improvement Project (SIP) **5500 Words**

The Oxford DClinPsy 'mind-to-mind' mentoring scheme: Experience of benefits and barriers

Theory Driven Research Project (TDRP) **5500 Words**

A Novel Migration-Map Intervention for People from Diverse Ethnic Communities: A Multiple Baseline Single Case Experimental Study

Executive Summary **990 words**

Reflective Narrative **994 Words**

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Abstracts

Systematic Review of the Literature

Cultural Differences in the Symptomatology and Expression of Social Anxiety in East Asians and Southeast Asians and Implications for Clinical Practice: A Systematic Review.

Purpose: The majority of current research on Social Anxiety Disorder (SAD) has been carried out with Western populations. Since social anxiety is closely connected to social standards and performance expectations which can differ between cultures, this Systematic Review investigated cultural differences in the presentations of SAD amongst East Asian and Southeast Asians, focused upon symptoms, appraisal and cognitions.

Methods: A systematic search of five databases (PsychINFO, EMBASE, MEDLINE, Scopus and CINAHL) was conducted, and studies which reported information about SAD symptoms, appraisals or cognitions within the above group were included in the review, and the quality of each paper was assessed. Data relating to SAD symptoms in East Asians and Southeast Asians was summarised using Narrative Synthesis.

Results: 20 papers met inclusion criteria and were included in this review. Our findings suggest that there are some key cognitive differences in SAD amongst East Asians/Southeast Asians which centre around the allocentric fear of causing offence to others rather than oneself. Of particular note, individuals within this group expressed a fear of embarrassment or causing offence to closely related people, as opposed to complete strangers. This fear appears to be related to the emphasis on cognitions relating to 'maintaining family image' and avoiding 'face loss concerns'. Some studies also revealed that EA/ SEA individuals experience higher level of anxiety in social situations, and fear of embarrassment can lead to severe physiological symptoms such as loss of movement and memory loss. The presentation

of SAD amongst this group shared similarities with the Western individuals, in terms of types of feared social situations, affective and behavioural reactions.

Conclusions: There are key differences in culturally salient beliefs and cognitions in SAD amongst East Asians/Southeast Asians relating to the allocentric fear of causing offence to other people, and the inherent focus on ensuring cognitions relating to 'maintaining family image' are upheld. The severity of emotional and physiological symptoms experiences in social situations is also an important difference to highlight. These findings are important for clinicians to consider when assessing and treating SAD amongst this client group. Clinical implications are discussed in this paper.

Service Improvement Project

The Oxford DClinPsy 'mind-to-mind' mentoring scheme: Experience of benefits and barriers

Purpose: There is an underrepresentation of individuals from Diverse Ethnic Communities (DEC) in clinical psychology. Individuals from DEC face barriers in their journeys towards becoming a clinical psychologist, including a lack of support from those in the profession. The Mind-to-Mind mentoring scheme is a positive initiative action to support aspiring psychologists with their individual pathways into the profession. This project aimed to evaluate the first year of the scheme and offer recommendations of how mentees needs can be better met.

Methods: Feedback data collected by the service was analysed descriptively. Focus group discussions were carried out with four mentees, four trainee mentors and four qualified mentors to explore their experiences of the scheme. Open ended data from feedback forms and focus group discussions were analysed using inductive thematic analysis.

Results: Analysis of feedback captured via evaluation forms showed that overall mentors and mentees were satisfied with the different aspects of the mentoring scheme, with some recommendations for the trainee question and answer session, format of workshops and the mentor resource pack. Thematic analysis of the focus group discussions revealed three key themes for mentees: 'the journey of personal and professional development', 'keeping me at the centre' and 'barriers to meaningful support'. The following themes developed from trainee mentors focus group discussions: 'creating a meaningful space', 'navigating the role of a mentor', 'scheme structure' and 'reciprocal benefits'. Data from qualified mentors revealed four key themes: 'desire to make a difference', 'working with mentees to provide meaningful support', 'navigating the role of a mentor' and 'scheme structure'.

Discussion: Recommendations relating to the structure and delivery of the Mind-to-Mind mentoring scheme are offered. These include defining mentors and mentees role further, reducing formality around supervision contracts and reviewing communication of written information.

Theory Driven Research Project

A Novel Migration-Map Intervention for People from Diverse Ethnic Communities: A Multiple Baseline Single Case Experimental Study

Background: Disconnection from Ethnic Identity (EI) is a common experience reported by individuals from Diverse Ethnic Communities (DEC) after migration and has been linked with mental health problems, including depression. A brief migration-map intervention was developed for individuals from DEC experiencing low-mood and disconnection from EI. A multiple baseline single case experimental study was designed to investigate its acceptability, and its impact on exploration, resolution and affirmation associated with EI.

Methods: Nine participants from DEC who experienced disconnection with EI and low-mood symptoms were randomised to a baseline group of five, six or seven weeks, followed by a three-week intervention and single follow-up session. Participants completed a weekly measure of ethnic identity (exploration, resolution, affirmation) and low-mood. Acculturation (heritage and mainstream orientation) and self-esteem were assessed pre- and post-intervention. Acceptability of the intervention was assessed through participant ratings and thematic analysis of qualitative feedback.

Results: The migration-map intervention was rated as acceptable and highly valuable. Outcomes of EI development improved between baseline and intervention phases, however improvements as a result of the migration-map intervention could only be concluded for the exploration component of EI. Small improvements were observed in low-mood symptoms. Descriptive analysis showed a substantial increase in group heritage scores, but only a small increase for group mainstream and self-esteem scores.

Conclusion: The migration-map appears to be an acceptable and promising culturally sensitive intervention for improving exploration associated with EI development. Further

work with larger samples is required to explore how resolution and affirmation can be supported.

Systematic Review of the Literature

Cultural Differences in the Symptomatology and Expression of Social Anxiety in East Asians and Southeast Asians and Implications for Clinical Practice: A Systematic Review.

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March 2024

Internal Supervisors: Dr Victoria Roberts and Dr Angie Jenkin

Word count: 7601

Proposed Journal: The Cognitive Behavioural Therapist

Abstract

Purpose: The majority of current research on Social Anxiety Disorder (SAD) has been carried out with Western populations. Since social anxiety is closely connected to social standards and performance expectations which can differ between cultures, this Systematic Review investigated cultural differences in the presentations of SAD amongst East Asian and Southeast Asians, focused upon symptoms, appraisal and cognitions.

Methods: A systematic search of five databases (PsychINFO, EMBASE, MEDLINE, Scopus and CINAHL) was conducted, and studies which reported information about SAD symptoms, appraisals or cognitions within the above group were included in the review, and the quality of each paper was assessed. Data relating to SAD symptoms in East Asians and Southeast Asians was summarised using Narrative Synthesis.

Results: 20 papers met inclusion criteria and were included in this review. Our findings suggest that there are some key cognitive differences in SAD amongst East Asians/Southeast Asians centred around the allocentric fear of causing offence to others rather than oneself. Of particular note, individuals within this group expressed a fear of embarrassment or causing offence to closely related people, as opposed to complete strangers. This fear appears to be related to the emphasis on cognitions relating to 'maintaining family image' and avoiding 'face loss concerns'. Some studies also revealed that EA/ SEA individuals experience higher level of anxiety in social situations, and fear of embarrassment can lead to severe physiological symptoms such as loss of movement and memory loss. The presentation of SAD amongst this group shared similarities with the Western individuals, in terms of types of feared social situations, affective and behavioural reactions.

Conclusions: There are key differences in culturally salient beliefs and cognitions in SAD amongst East Asians/Southeast Asians relating to the allocentric fear of causing offence to

other people, and the inherent focus on ensuring cognitions relating to ‘maintaining family image’ are upheld. The severity of emotional and physiological symptom experiences in social situations is also an important difference to highlight. These findings are important for clinicians to consider when assessing and treating SAD amongst this client group. Clinical implications are discussed in this paper.

Introduction

Social Anxiety Disorder (SAD) refers to the experience of persistent fear of social or performance situations in which an individual's behaviour can be scrutinised by others (NICE, 2013). Common feared situations include conversations with strangers, public speaking, social gatherings, eating in public, job interviews or dating. Individuals with SAD fear they will act in a way that will lead to embarrassment and humiliation, therefore the feared situations are often avoided or accompanied by intense anxiety (NICE, 2013). Frequent concerns reported by people with SAD include a fear of making mistakes or having long silences in conversations, spilling food, stuttering, blushing, sweating, shaking, or coming across awkward and boring (Schneier & Goldmark, 2015). Individuals with SAD experience significant distress that is out of proportion to the situation, often leading to impairment in occupational functioning, social activities, and relationships (Lee et al., 2006).

SAD is one of the most common mental health disorders with lifetime prevalence rates estimated at around 13% in the United States (US, Kessler et al., 2005) and 7% in the United Kingdom (UK, Pilling et al., 2013). It typically starts during early adolescent years, with the average age of onset reported at thirteen years and is more common amongst females (Kessler et al., 2005; Merikangas et al., 2010). SAD is an unremitting condition that can continue into adulthood in the absence of treatment, and has comorbidity with depression, posttraumatic stress disorder, substance misuse and other anxiety disorders (Wittchen & Fehm, 2003).

Research informing our understanding of SAD comes from a combination of epidemiological studies on prevalence rates and risk factors (Kessler et al., 2005; McLean et al., 2011; Merikangas et al., 2010), neurobiological research (see Mathew et al., 2001 for a review) and empirical research on the cognitive behavioural mechanisms of the disorder (see Norton &

Abbott, 2016 for a review). This research has made a significant contribution to the identification of SAD (e.g., Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2013) and the development of effective treatment strategies (Clark & Wells, 1995; Rapee & Heimberg, 1997). There is a growing body of literature (Hofmann et al., 2010; Jankowska, 2019; Yoshinaga et al., 2013) questioning the applicability of extant research for culturally diverse groups, due to majority of this research being carried out with European and North American populations (Yoshinaga et al., 2013). This paper will use the terms 'West' and 'Western' to refer to Europe and North America.

Intriguingly, there is evidence of a disparity in lifetime prevalence rates of Social Anxiety (SA) symptoms and SAD between western and eastern countries (Hofmann et al., 2010). Asian countries such as China, Japan and South Korea have reported prevalence rates of 4.1% (Guo et al., 2016), 1.4% (Ishikawa et al., 2015) and 0.2% (Cho et al., 2007), which is significantly lower than the 13% rate reported by the United States (Kessler et al., 2012). Interestingly, two independent meta-analyses (Woody et al., 2015; Krieg & Xu, 2015) demonstrated the reverse, where individuals of Asian descent endorsed higher levels of self-reported SA compared to European individuals, although the effect size was small (d= 0.36 – 0.47).The discrepancy between self-reported symptoms (Krieg & Xu, 2015; Woody et al., 2015) and the prevalence rates of SAD in epidemiological studies (Hofmann et al., 2010; Kessler et al., 2012), may be explained by a lack of consideration of cultural variations in symptoms, in favour of Western conceptualisations of SAD (Lewis-Fernández et al., 2011).

Role of culture

Culture is a complex concept, encompassing knowledge, beliefs, values and customs that shape individuals' social behaviour (Tylor, 1976). Literature has highlighted the role of culture in shaping the trajectory of anxiety disorders (Hofmann et al., 2010). SAD is closely

connected to social standards and performance expectations which differ between cultures and depend on how individuals conceptualise themselves as the object of social threat (Hofmann et al., 2010). Existing attempts to characterise differences in SAD between Asia and the west have been understood in terms of self-construals, referring to how people perceive their relationship (level of connectedness) with others, and the notion of collectivism (Markus & Kitayama, 1991). However, efforts to characterise cultural differences in SAD have yet to be comprehensively synthesised.

East Asian and South-east Asian (EA/SEA) countries embody a 'collectivist' orientation, in which harmony within a group has higher value than individual gains, thoughts and feelings. Collectivist cultures have stringent rules governing social behaviour, deviation from which can impact the whole group (Rose & Kitayama, 1991), due to an 'interdependent' self-construal where individuals are intricately connected to their social group. Conversely, western cultures, promote an 'independent' self-construal, where individuals are autonomous, therefore emotions such as embarrassment due to social deviation are individually, not collectively, experienced (Kleinknecht et al., 1997).

Taijin-Kyofusho (TKS) is under the DSM-5 as a culturally specific form of SAD amongst Japanese people (APA, 2013). The specificity of TKS centres around an excessive fear of causing offence to others due to physical characteristics such as blushing, eye contact or body odour (Lim, 2013). The focus on offending others, highlights the importance of considering cultural influences on the trajectory of SA in EA/SEA populations (Yoshinaga et al., 2013). Please refer to appendix A for diagnostic criteria of TKS.

Cognitive Behavioural Therapy (CBT) for SAD is an evidence-based psychological therapy recommended by the National Institute for Health and Care Excellence guidelines (NICE, 2014). In the Cognitive-Behavioural model (Clark & Wells, 1995; Heimberg et al.,

2010), SAD develops when individuals form core beliefs from earlier life experiences that set (high) standards for social behaviour. Social-evaluative situations activate negative core beliefs about meeting these high standards and are thus perceived as threatening. This leads to changes in affective, attentional, behavioural, and cognitive processing.

Subsequently, individuals may adopt Safety-Seeking Behaviours (SSBs) to control or avoid the feared situations, and engage in self-focussed attention, both of which maintain negative self-beliefs. The theoretical orientations underlying CBT models have been developed from research with western populations, and therefore predominantly reflect western cultural views (Yoshinaga, et al, 2013). This raises questions about the compatibility of the model in non-western cultures, including culturally specific expressions of SAD found in EA/SEA populations, such as the allocentric fear of offending others and how this relates to the affective and behavioural aspects of SAD in CBT. Further research into the unique features of SAD across cultures will have clinical implications for the appropriate identification of SAD, and support the implementation of culturally sensitive treatment (Jankowska, 2019).

Rationale for current review

While previous reviews have attempted to synthesise the literature on cultural differences in SA (Hoffman & Hinton, 2014; Krieg & Xu, 2015; Woody, et al, 2015), there are several concerns around the methodology. Hoffman & Hinton (2014) did not implement systematic search criteria or systematic study selection, with the authors selectively reviewing studies they considered of interest, leading to potential bias (Mallett et al., 2012). The two meta-analyses (Krieg & Xu, 2015; Woody et al., 2015) did not use quality appraisal to assess selected papers. Both meta-analyses quantitatively compared the frequency of SA symptoms in Asian samples with European samples, excluding key research such as Sakurai et al.

(2005) and Tarumi et al. (2004) which focussed solely on symptomatology of SA in Asian populations and qualitative papers exploring first-person Asian perspectives and conceptualisations of SAD (Fan & Chang, 2015). Whilst these reviews yield important findings about the robustness of the difference in SA symptoms between Asian samples and European samples and their contributing factors, they provide limited detail about cultural variation in the expression of SAD symptoms.

This narrative review adopts a systematic approach to synthesising the literature on cultural differences in the symptoms, appraisals, and cognitions of SAD in collectivist cultures, updating and extending previous reviews. Research on SA symptoms amongst collectivist cultures have largely focussed on individuals from Asia. This review focuses specifically on EA/SEAs due to their shared cultural roots in Confucian traditions. These are core principles developed from the teachings of philosopher Confucius, which emphasise the importance of righteous behaviour, moral integrity and social cohesion, which have had a significant influence on shaping expectations about social and interpersonal relations (Slote & Vos, 1998). As the literature has highlighted low rates of SAD diagnosis amongst Asians and higher levels of self-report symptoms (Krieg & Xu, 2015; Woody et al., 2015), this review will focus on self-reported symptoms of social anxiety as well as diagnoses. For the purpose of this review the term 'SAD' will be used to refer to the two areas.

Research question:

What is the presentation of SAD in East Asian and Southeast Asian groups, in terms of their symptoms, appraisals and cognitions?

Method

Search strategy

This review followed the Preferred Reporting for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). The review was registered on Prospero in May 2023 (registration number: CRD42023413957).

The search was conducted in August 2023 and updated in July 2024 on five databases: PsychINFO, EMBASE, MEDLINE, Scopus and CINAHL (see appendix B for search terms. MeSH terms were used to combine keywords relating to SAD, culture and ethnicity. Terms were searched in the title, abstract and key words. A secondary search on Google Scholar, examination of reference lists and emails to key authors aimed to ensure a thorough and comprehensive search was completed.

Table 1.

Inclusion and exclusion criteria for systematic review

Inclusion criteria	Exclusion criteria
Studies including participants from EA/SEA ethnic backgrounds. This includes research carried out with individuals from the following ethnic backgrounds: Chinese, Japanese, Mongolic, North Korean, South Korean, Taiwanese (East Asia) and Bruneian, Burmese, Cambodian, Indonesian, Lao, Malaysian, Filipino, Singaporean, Thai and Vietnamese (Southeast Asia).	All studies in which the participant sample consisted of non EA/SEA populations. This involves studies that only included individuals from the following ethnic backgrounds: White, Hispanic, South Asian, Central Asian, Western Asian, Middle Eastern, North African, Sub-Saharan African.
Studies that measured SA in either clinical or non-clinical samples using validated measures or included participants with a diagnosis of SAD.	Studies that did not specify the ethnic breakdown of EA/SEA sample.

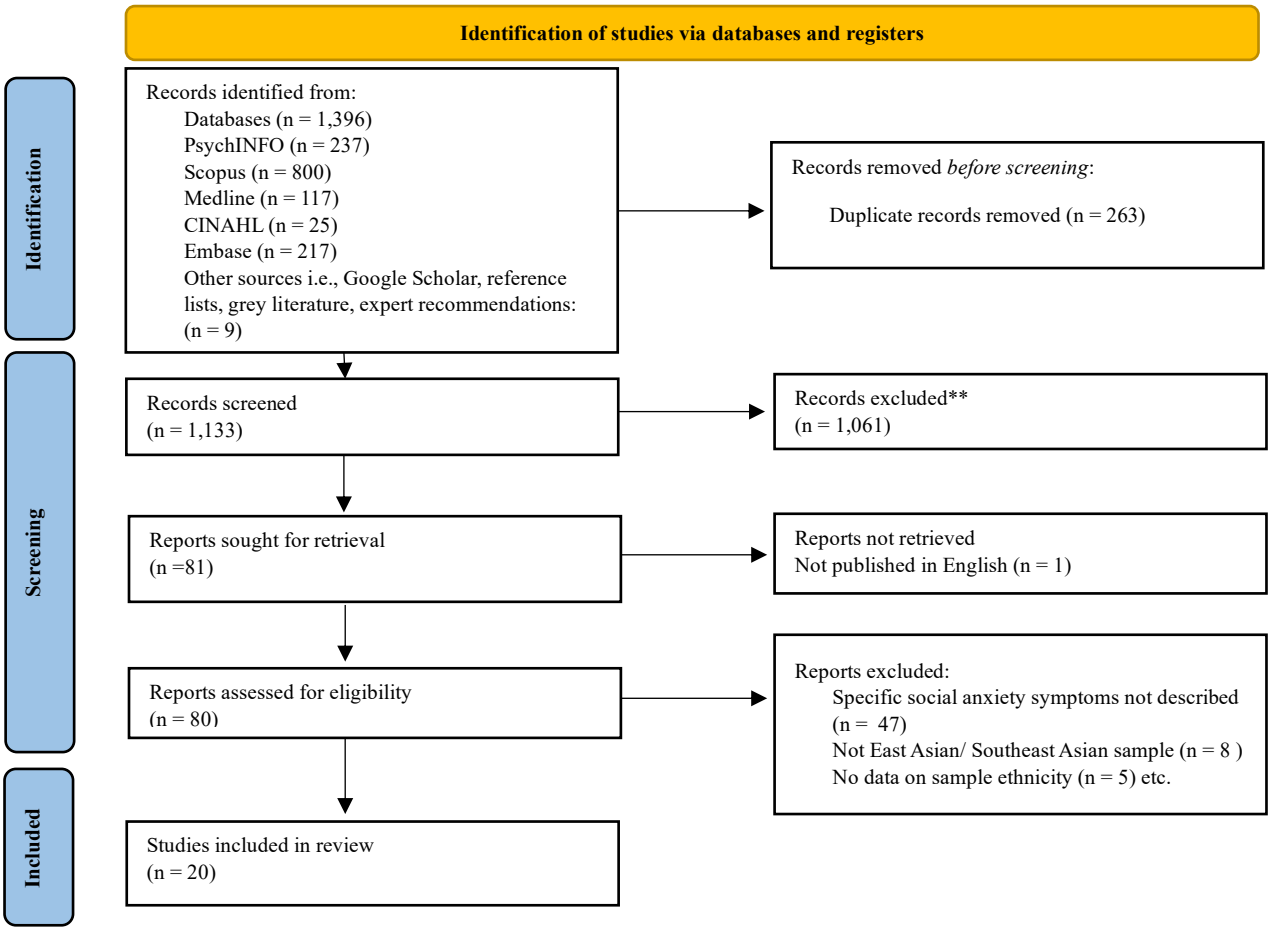
Studies which investigate, or comment upon the symptoms, appraisals, or cognitions of people with SAD or SA symptoms in the above group.	Studies that only measured the prevalence of SA symptoms in EA/SEA samples. These studies only provided a global score on social anxiety measures and were not relevant to our research question which wanted to understand what the differences are in terms of social anxiety symptomatology in EA/SEA.
Quantitative or qualitative methodology.	
Published in English language or able to be translated into English.	
Peer reviewed published papers and grey literature i.e., Thesis	

Study selection

A PRISMA flowchart illustrates the study selection process (Figure 1). The initial search yielded 1,396 papers from the five databases. To ensure a thorough review of literature, a search of other sources (Google Scholar, backward and forward citation tracking, expert recommendations and grey literature) was employed which resulted in a further nine papers being identified. Records were transferred to EndNote for screening and the removal of duplicates, which retained 1, 133 papers. Title and abstracts were screened against the eligibility criteria by the lead researcher. An independent rater screened 25% of papers and inter-rater reliability was examined using Cohen's Kappa. Any differences were discussed and resolved before proceeding to full text extraction (κ =.85), in line with Cochrane guidelines. Full texts were initially read by the first author to ensure papers met the eligibility criteria, 25% of these were also screened by the second rater (κ =.86). This process resulted in 20 relevant articles for this review. An updated search yielded 25 studies, but none met criteria for the current review.

Figure 1.

PRISMA flowchart illustrating study selection process



Data Extraction and Synthesis

Data extraction was completed via a standardised excel spreadsheet to ensure reliability and consistency. The following data was extracted (a) study aims (b) study location (c) participant characteristics (as reported, e.g. ethnicity, age, gender), sample size, (d) study design, (e) method of measuring SAD symptoms, or ascertaining diagnosis of SAD, (f) nature of social anxiety, in terms of symptoms, appraisals and cognitions.

This systematic review included diverse methodologies; findings were therefore synthesised using a narrative synthesis following the guidance of Popay et al (2006). Due to a higher proportion of quantitative studies, a qualitative synthesis and analysis was deemed unsuitable.

Quality Assessment

The Standard Quality Assessment Criteria tool (Kmet et al ., 2004) was selected due to its suitability for appraising the quality of research that have different research designs i.e., quantitative, qualitative and mixed methods. The quantitative tool consists of a 14-item checklist examining key areas of research, such as the appropriateness of design, data analysis, sampling strategy and accuracy of conclusions. The 10-item checklist was used to assess the quality of qualitative and mixed-methods studies. Items were scored between 0-2 (0 = does not meet criteria, 2 = fully meets the criteria). A summary score was computed for each paper (see table 2). The lead author assessed the quality of each study, and 25% were independently assessed by a second reviewer (LM). Cohen's K was computed to determine adequate interrater reliability (K> 0.81).

Results

Study characteristics

Research Aims and Design

Included studies varied in terms of research methodologies, including quantitative (n= 15), qualitative (n = 2) and mixed methods (n =3) (see Table 2). All, but one (Arai et al., 2022) of the quantitative studies were of cross-sectional design, and used survey data, experience sampling methodologies and laboratory experimental design to assess SAD symptoms. Qualitative and mixed-method studies used interviews and focus groups. One study was a thesis (Watanabe, 2015).

The majority of studies aimed to describe the nature of SAD symptoms in their samples. Some studies assessed SAD symptoms in EA/SEA samples, whilst the majority (12/20) focussed on comparing SAD symptoms in the above group with western samples. Four studies examined the validity and factor-structure of SAD scales amongst EA/SEA populations (Fan & Chang, 2015; Sakurai et al., 2005; Tarumi et al., 2004; Wong et al., 2019). One study was interventional, evaluating false safety behaviour elimination therapy for Japanese people (Arai et al., 2022). For this study and Krieg and Xu's (2018) study, secondary data was analysed.

Diagnostic Criteria and Measures

Nine studies used diagnostic criteria to assess SAD. Seven studies used the Diagnostic and Statistical Manual of Mental Disorders- IV (Arai et al., 2022; Choy et al., 2008; Luan et al., 2022; Sakurai et al., 2005; Suh et al., 2020; Wong et al., 2019; Yoshinaga et al., 2013; Zhu et al., 2014). Two studies used the Mini International Neuropsychiatric Interview (Arai, et al, 2022; Tarumi, et al, 2004). Clinical measures of SAD were used in all 20 studies, with the Liebowitz Social Anxiety Scale (Liebowitz, 2013) used in five. The Social Interaction Anxiety Scale (Mattick & Clarke, 2012) was used in 12 studies, The Social Phobia Scale (Mattick & Clarke, 2012) used in nine, and the Social Phobia and Anxiety Inventory (Turner et al., 1989) used in one study. Other measures used included: Taijin Kyofusho Scale (Kleinknecht et al., 1997), Social Anxiety- Distress to others scale (Rector et al., 2006) , Subtle Avoidance Frequency (Cuming et al., 2009) and Fear of Negative Evaluation Scale (Watson & Friend, 1969).

Sample

The 20 studies contributed to an overall sample of 4755 individuals, with sample sizes ranging from six (Arai et al., 2022) to 909 participants (Heinrichs et al., 2006) across studies. Majority of the overall sample were female, and one study included data about participants who were 'unidentified' (Norasakkunkit et al., 2012).

Study locations included EA/SEA countries (8/20), USA (4/20), some in both EA/SEA and North America (6/20), Europe (3/20) and Australia (2/20).

The number of studies relative to each ethnic background was as follows: Chinese (10/20), Japanese (12/20), Korean (9/20), Taiwanese (1/20), Vietnamese (2/20), Cambodian (1/20), Singaporean (1/20). Due to inconsistencies in reporting the proportion of individuals from each ethnic origin across EA/SEA, it was not possible to calculate participants ethnicity across the sample. All studies included EA/SEA participants, two studies also included a small proportion of South Asian participants, and were thus retained in the review (Lee et al., 2006; Okazaki et al., 2002).

Nine studies assessed individuals with a SAD diagnosis, and the remainder (11/20) used community samples to assess self-reported symptoms of SAD.

Table 2.

Study characteristics.

Study ID and Author(s)	Aims	Study design	Recruitment context	Diagnostic criteria	Study measures
1. Arai, et al (2022)	To examine the acceptability and efficacy of false safety behaviour elimination therapy in non-Western populations.	Pilot, single arm-controlled study	Cognitive behavioural therapy centre	Mini International Neuropsychiatric Interview DSM-IV	Liebowitz Social Anxiety Scale Beck Depression Inventory Sheehan Disability scale Frequency of safety behaviour using Subtle avoidance frequency examination.
2. Choy, et al (2008)	To assess the relationship between Taijin Kyofusho symptoms and SAD features in US and Korean patients with DSM-IV SAD.	Quantitative, Cross-sectional survey	Anxiety Disorders clinic	DSM-IV	Taijin Kyofusho Questionnaire Social Phobia Scale Beck Depression Inventory Sheehan Disability Scale Liebowitz Social Anxiety Scale Social Interaction Anxiety Scale
3. Essau, et al (2012)	To examine the frequency of social anxiety symptoms and their association with self-construal and perceived social norms.	Quantitative, Cross-sectional survey	Community	NR	The Social Interaction Anxiety Scale The Self-Construal Scale Social behaviour vignettes
4. Fan and Chang (2015)	(i)To explore the meaning and manifestation of social anxiety (ii) to examine whether the newly identified dimensions converge with existing constructs of social anxiety.	Mixed methods Interviews, focus groups and cross sectional survey.	Community/ university students	NR	The Social Interaction Anxiety Scale The Social Phobia Scale
5. Heinrichs, et, al (2006)	To investigate individuals personal and perceived cultural norms and their relationship to social anxiety and fear of blushing.	Quantitative Cross-sectional survey	Community/ university students	NR	Social behaviour vignettes Social Interaction Anxiety Scale Blushing questionnaire
6. Krieg & Xu (2018)	To test how cultural differences in self construal explain cultural differences in threat appraisal and social anxiety in sequential testing of mediation.	Quantitative, Cross-sectional survey	Community/ university students	NR	Social Phobia Scale Social Interaction Anxiety Scale Singelis self-construal scale

Study ID and Author(s)	Aims	Study design	Recruitment context	Diagnostic criteria	Study measures
7. Lau, et al (2009)	To explore the relationship between ethnicity, emotion recognition, concerns about interpersonal attunement and symptoms of social anxiety in European American and Asian American college students.	Quantitative, Cross-sectional survey	Community/ college students	NR	Individualism collectivism scale Social Anxiety Scale for Adolescents Neuroticism subscale from Big Five inventory Sensitivity to others subscale from Revised Self-monitoring subscale
8. Lau, et al (2014)	To examine the extent to which interdependent values moderate the association between emotion recognition ability and specific dimensions of social anxiety.	Quantitative, experimental laboratory task	Community/ university students	NR	Social Anxiety Scale Adolescents Parenting Styles ad Dimensions Questionnaire The Loss of Face Scale The Revised Self-Monitoring Scale
9. Lee, et al (2006)	To examine the frequency, intensity, and the naturalistic contexts in which Asian American students experience and report social anxiety in their daily lives compared to the experiences of European American's.	Cross sectional, diary study using experience sampling methodology	Community/ university students	NR	Social Phobia Anxiety Inventory The revised NEO personality Inventory Daily records of social anxiety
10. Luan, et al (2022)	To explore the anxiety experience of college students with social anxiety disorder.	Qualitative Semi-structured interviews	College students	DSM-IV	Social Interaction Anxiety Scale
11. Norasakkunkit, et al (2012)	To examine the relationship of self- construal and holistic cognition with social anxiety and Taijin Kyofusho symptoms.	Quantitative, Cross-sectional laboratory design	Community/ university students	NR	Taijin Kyofusho Scale The Social Interaction Anxiety Scale The Social Phobia Scale Self-Construal Scale Frame line test- holistic/ analytical attention
12. Okazaki, et al (2002)	To examine whether the Asian American – White American difference in social anxiety extends to nonverbal behaviour and anxiety related emotions during social performance task.	Quantitative, cross-sectional, laboratory experimental study	University students	NR	The Suinn-Lew Asian Self-Identity and Acculturation Scale The Social Phobia and Anxiety Inventory Emotion ratings before and after social performance task Behavioural coding (gaze avoidance, prolonged silences, fidgeting, negative affect, anxiety and appropriateness of behaviour)

Study ID and Author(s)	Aims	Study design	Recruitment context	Diagnostic criteria	Study measures
13. Sakurai, et al (2005)	To assess the symptoms of SAD among Japanese patients with SAD.	Cross-sectional survey	University hospital	DSM-IV	Social Interaction Anxiety Scale Social Phobia Scale Fear questionnaire Fear of negative evaluation scale
14. Suh et al., (2020)	To explore the prevalence and content of spontaneous recurrent images (SRis) in individuals with SAD in Korea.	Mixed methods Cross-sectional questionnaires, Semi-structured interview	University treatment centre	DSM-IV	Social Phobia Scale Social Interaction Anxiety Scale Singelis self-construal scale
15. Tarumi, et al (2004)	To clarify the concept of Taijin Kyofusho symptoms and delineate the characteristics of the offensive type Taijin Kyofusho through assessing patterns of fear.	Quantitative, cross-sectional survey	University students	Mini International Neuropsychiatric Interview	Taijin Kyofusho Scale Liebowitz Social Anxiety Scale
16. Watanabe (2015)	To explore the understanding, experiences, and interpretation of Taijin Kyofusho among Japanese and Euro-Canadian individuals.	Mixed methods, cross-sectional survey, Interviews	University students	NR	The Taijin Kyofusho questionnaire The Taijin Kyofusho Scale The Social Interaction Anxiety Scale The Self-construal Scale
17. Wong, et, al (2019)	To examine the measurement equivalence of the SIAS and SPS across individuals with SAD from a Japanese and Australian cultural context.	Quantitative, Cross-sectional, survey	Cognitive behavioural therapy trial	DSM-IV	Social Interaction Anxiety Scale Social Phobia Scale
18. Yoshinaga, et al (2020)	To explore the processes involved in post event processing from the perspectives of individuals with a SAD diagnosis.	Qualitative Semi-structured interviews	Community	SCID-I	Liebowitz Social Anxiety Scale
19. Yu, et al (2019)	To investigate the relationship between interpretation bias and social anxiety in Chinese adolescents.	Cross-sectional survey, between groups	School students	NR	Social Anxiety Scale for Adolescents Short Mood and Feelings Questionnaire Adolescents interpretation and Belief questionnaire
20. Zhu et al., (2014)	To explore the cultural variation in social anxiety symptom presentations between Chinese and Euro-Canadian patients.	Quantitative, Cross-sectional, survey	Psychiatric outpatients	DSM-IV	The Social Interaction Anxiety Scale Social Anxiety- Distress to others

Quality assessment of studies

The overall quality of the quantitative studies ranged from fair to high quality. Eight papers were rated as 'high' quality (>80%), seven papers were rated as 'good' quality and two papers were rated as 'fair'. Quality of the two qualitative studies was high. Strengths included the reporting of a clear rationale/ aim, a clear theoretical framework underpinning the study, clear data analysis procedures and the use of verification procedures to establish credibility of the reported themes (Luan et al., 2022; Yoshinaga et al., 2020). Mixed methods papers (Watanabe, 2015; Fan & Chang, 2015) that involved qualitative elements were of a lower quality compared to the solely qualitative papers. Limitations included the lack of clarity in reporting methods of data collection and analysis. Reflexivity was not mentioned in any of the studies.

Clarity of reporting

All but three studies (Fan & Chang, 2015; Lau et al., 2009; Tarumi et al., 2004) had clear research questions and objectives, and the study population under investigation was specified. The majority of the papers had identifiable research designs that were appropriate to answer the research question, bar-four papers in which the study design was not clearly described but gross inappropriateness was not evident (Choy et al., 2008; Norasakkunkit et al., 2012; Tarumi et al., 2004; Zhu et al., 2014). Qualitative papers and mixed method papers with qualitative aspects described study context, however only two papers referenced a theoretical framework underpinning the research (Suh et al., 2020; Yoshinaga et al., 2020).

The majority of the studies reported demographic information, including, age, sex, and ethnicity. Lau et al., (2009, 2014) failed to report participant age, limiting generalisability of findings. Norasakkunkit et al., (2012) reported the sex of some participants as 'unidentified' with no clarity on whether this was due to missing information, non-disclosure,

or nonbinary identities. For ethnicity, some studies did not report the specific backgrounds of participants from the 'Asian' sample. One study failed to report the ethnicity of participants, but following email correspondence, the author confirmed participant's ethnicity (Yoshinaga et al., 2020). Most studies sufficiently described participant characteristics using reproducible criteria, bar-five (Heinrichs et al., 2006; Lau et al., 2014; Lee et al., 2006; Sakurai et al., 2005; Tarumi et al., 2004).

Outcome measures and study variables

All studies described outcome measures assessing SAD in appropriate detail, and most used validated measures in participants' native language. One study used the Japanese version of the SIAS and SPS but failed to report whether other measures (Fear questionnaire and Fear of negative evaluation) were administered in English or Japanese (Sakurai et al., 2005). These two outcome measures were excluded in one of the testing sites with no justification provided, which may have led to measurement bias and limited reliability of findings. The Social Anxiety-Distress to Others Scale and the Taijin Kyofusho Questionnaire were unvalidated measures used in two studies (Choy et al., 2008; Zhu et al., 2014) which may have impacted generalisability of results due to potential measurement bias.

One study assessed participant's view on the appropriateness of social behaviour vignettes in line with their personal and cultural norms, however the personal norm scale yielded a unsatisfactory Cronbach's alpha (a= .40) and the authors failed to address this, questioning the reliability of the scale (Heinrichs et al., 2006). Another limitation of this study was the inconsistency of back-translating measures for all country groups due to a lack of funding, which increases risk of measurement not being accurate or equivalent across the groups. Best practice guidance suggests the use of two independent translators for forward and backward translation to enhance the accuracy of the translation (Tsang et al., 2017). In

line with this, Essau et al., (2012) used the same vignettes in their study without any reference to translation methods. One paper used the Liebowitz Social Anxiety Scale for Children and Adolescents (Masia-warner et al., 2003) which is validated for use in children and adolescents (aged 7- 18 years), however the sample included 'young adults' in college, therefore it is possible that the measure may not have been developmentally appropriate for the sample (Lau et al., 2009).

Sample selection

Inclusion and exclusion criteria were only partially described in most quantitative studies (12/20) and mixed methods studies (2/20). Some studies used clear inclusion and exclusion criteria to recruit participants, often including a DSM-IV diagnosis of SAD and exclusion of comorbid conditions (Arai et al., 2022; Choy et al., 2008; Luan et al., 2022; Suh et al., 2020; Tarumi et al., 2004; Wong et al., 2019; Yoshinaga et al., 2020; Yu et al., 2019). Studies that scored lower on 'method of subject selection' were due to lack of clarity on target population, use of 'convenience sampling', or lack of information on sampling strategy which may introduce subject bias. Whilst it is important to assess SAD symptoms amongst the community to whom western diagnostic criteria may not apply, studies method of subject selection strategy could have been strengthened by recruiting individuals who self-identified as having SAD.

Power, analysis, and results

Of studies not using a single group survey design, none reported a priori power calculations to determine an adequate sample size for the study. Six studies acknowledged the low sample size as a limitation of their findings (Fan & Chang, 2015; Lee et al., 2006; Okazaki et al., 2002; Sakurai et al., 2005; Watanabe et al.,; Yu et al., 2019). Of the four studies that used a factor analysis, two reported a low sample size to item ratio (Fan &

Chang, 2015; Sakurai et al., 2005), and the other two studies were identified as having a low - fair sample size (Tarumi et al., 2004; Wong et al., 2019). It is recommended to consider the ratio of sample size to number of scale items to determine an adequate sample size for a prior consideration of power for factor analysis, however there is no consensus in the literature regarding a specific ratio as this varies depending on the research context. A general rule of thumb has been followed traditionally of 5:1 ratio for exploratory factor analysis and 10:1 for confirmatory factor analysis (Kyriazos, 2018). Adequate sample size and statistical power is vital to reduce bias by ensuring true relationships are observed in the dataset.

All but three studies (Choy et al., 2008; Tarumi et al., 2004; Zhu et al., 2014) reported appropriate statistical analysis and results in detail. Controlling for confounding factors when comparing two groups is important, but was not considered in some studies, especially studies using a convenience sample of 'volunteers', which can impact the internal validity of findings. Conclusions were accurately supported by the results in all but four studies (Essau et al., 2012; Lau et al., 2014; Sakurai et al., 2005; Suh et al., 2020).

Table 3.

Study characteristics, key findings relevant to review and quality ratings. Kmet quality ratings represent the summary score and percentage (appendix C). For each included study, a summary score was calculated using the following groupings: below 50% (low quality), 50 – 65% (fair quality), 66-80% (good quality) and above 80% (high quality).

Study	**Country**	**Sample size**	**Population characteristics**			**Key characteristics of Social Anxiety**		**Culturally relevant factors associated with social anxiety**	**Kmet quality rating**
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Arai, et al (2022)	Japan	6	28.30 (11.6)	6 M	Japanese	**Fears and cognitions** Eye contact would offend people and the discomfort would lead to them attacking him 'Others thinking he dislikes them' 'Others will think I am strange' Fear of spilling drink in public and this will bring shame to family	**Physical symptoms** Hands/ body shaking **Safety behaviours** Wearing earphones and listening to music, pretending to sleep on public transport, folding arms tight, rehearsing before speaking, speaking less, avoidance of crowds, avoiding work during daytime.		75% Good quality
Choy, et al (2008)	(i) Korea (ii) US	(i) 64 (ii) 181	(i) 29.4 (8.4) (II) 32.6 (9.6)	I) 47 M, 17 F (II) 105 M, 76 F	Korean	**Fears** 75 % of the US patients reported moderate to-severe fear of one of the offensive subtype of TKS (intestinal gas, stiff facial expression, staring at other's body parts, body odour, and physical appearance). Koreans: fear of offending others due to body odour (28%), inappropriate staring (20%), stiff facial expression (44%), intestinal gas (24%), physical appearance (16%), sweating (20%), body trembling (28%), eye contact (28%), blushing (24%), and voice trembling (24%).	**Physical symptoms** stiff facial expression, body odour, inappropriate staring, intestinal gas, physical appearance).		68% Good quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Essau, et al (2012)	(i)UK (ii) Hong Kong	886 (i)Hong Kong (435) (ii) UK (451)	21.1 (1.8)	(i) 199 M, 236 F (ii) 157 M, 294 F	422 Chinese 13 Singaporean, Korean	**Cognitive appraisals** Greater acceptance of socially avoidant behaviour amongst Hong Kong participants than UK participants.		Hong Kong group scored higher on SA symptoms and interdependent self-construal than UK group. Independent self-construal negatively correlated with SA for both groups. Interdependent self-construal was not associated with SA in both groups. Cultural norms were slightly negatively correlated with SA for only Hong Kong group.	81% High quality
Heinrichs, et, al (2006)	Japan, Korea, The Netherlands, USA, Australia, Canada, Germany	909 Collectivist countries (394) Individualistic countries (515)	(i)19.5 (1.3) (ii)20.3 (1.0)	(i) 98 M, 296 F (ii) 160 M, 355 F	126 Japanese 159 Korean	**Fears** Individuals from collectivist countries scored higher on social anxiety measures and were more fearful of blushing in social situations, compared to individuals from individualistic countries. **Cognitive appraisals** Acceptance of attention-avoiding behaviours on a personal and cultural norm level was associated with higher social anxiety and a fear of blushing.		Collectivist countries were more accepting of socially avoidant behaviour (reflecting withdrawal and modesty) relative to individualistic countries who were accepting of behaviours reflecting self- promotion and attention seeking. Collectivist and individualistic groups did not differ in their personal views- both held negative views of attention seeking behaviour.	72% Good quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Krieg & Xu (2018)	US	559 (i) 310 Asian Americans (ii)249 European Americans	(i)20.08 (3.10) (ii)21.14 (5.01)	(i)20.08 (3.10) (ii)21.14 (5.01)	80 Japanese 50 Chinese 53 Korean 127 mixed Asian heritage	**Feared social situations** Interaction: Waving back to someone who was waving at someone else, being criticised by customers at job, being flirted with, trying to confront someone without hurting them, telling a joke and nobody finds it funny, not making good eye-contact. Performative: saying the wrong answer, sharing ideas for group project, participating in a singing contest, giving a speech. Ethnicity specific: only Asian in the store, being yelled at by parents.	**Maintenance factors** Asian Americans reported greater threat appraisal in social situations. Suggesting, Asians may find social situations more likely to occur and have worse consequences compared to European Americans.	Asian American sample reported higher social anxiety and lower independent and higher interdependent self-construal, as well as greater threat appraisal in social situations. Threat appraisal and self-construal had an integrative role in explaining cultural differences in social anxiety between both groups. The way in which participants viewed themselves (self-construal) influenced how threatening social situations were perceived and SA symptoms.	86% High quality
Lau, et al (2009)	US	319 (i)Asian American (116) (i)East Asian (148)	Not reported	(i)39 M, 77 F (ii) 41M, 107 F	83 East Asian (Chinese, Korean, Japanese) 33 South East Asian (Vietnamese, Cambodian, Laotian).	**Fears** Asian Americans were more likely to endorse face loss concerns and prevent negative attention from others. Loss of face concerns mediated the relationship between ethnicity and social anxiety between Asian Americans and European Americans.			81% High quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Lau, et al (2014)	Not reported	264 i) Asian American (116) (ii)European American (148)	Not reported	82 M, 182 F	Chinese Korean Japanese Vietnamese	**Fears** No ethnic differences between European Americans and Asian Americans on fear of negative evaluation.	**Emotions** Asian Americans scored significantly higher on distress in new situations than European Americans. No ethnic difference between general social inhibition (avoidance).	Asian Americans: significant interaction between self-reported emotion perception and collectivism in prediction of Distress in new situations and general social inhibition. European Americans: No significant interaction between Self-reported emotion perception and collectivism on social anxiety indices: fear of negative evaluation and social inhibition. Only marginal interaction for distress in new situations. Self-reported emotion competence had a significant negative association with distress in new situations in participants with high collectivism scores/ positive association when participants scored lower on collectivism. Objective emotion perception was negatively correlated with general inhibition only when participants scored high on collectivism.	68% Good quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Lee, et al (2006)	US	i)Asian 45 (ii)European 41	20.00 (1.52)	i) 26 F, 19 M ii)22 F, 16 M	13 Korean 9 Chinese 7 Taiwanese 5 Vietnamese 4 Filipino 1 Bangladeshi 1 Cambodian	**Fears** Frequency of situations of social anxiety was similar across Asian Americans (M 12.11, SD 7.56) and European Americans (14.18, SD 12.27). Events involving social evaluation included relationship and romantic contexts and classroom events, dates, meetings, and parties.	**Emotion** Asian Americans reported more intense negative emotion than European Americans across their recorded anxiety-arousing events in their daily lives.		77% Good quality
Norasakkunkit, et al (2012)	Japan, US	267 (i) Japanese (142) (ii) American (125)	(i)20.00 (1.51) (ii)19.90 (3.72)	(i) 42 M, 97 F, 3 unidentified (ii)36 M, 88 F, 1 unidentified	Japanese	**Fears, beliefs, cognitive appraisals** Americans scored higher on social phobia measures whereas Japanese participants scored higher on TKS measures (other focussed anxiety).		Social anxiety symptoms were associated with decreased levels of holistic cognition (self-focussed attention) whereas TKS were associated with increased levels of holistic cognition. Holistic cognition may be an important cognitive feature underlying the two types of social anxiety and their associated fears. Independent self-construal was associated with decreased levels of holistic cognition. Levels of interdependent self-construal were not associated with holistic cognition. Independent self-construal was found to be more strongly associated with the self-focused component of social anxiety while interdependent self-construal was only associated with the other-focused component of social anxiety	82% High quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Km et quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Okazaki, et al (2002)	US	80 (i) Asian Americans (40) (ii) White America	(i) 19.2 (1.2) (ii)20.2 (2.3)	(i) 20M, 20F (i) 19M, 21F	16 Chinese 9 Korean 4 Japanese 2 Indian 4 ‘other		**Emotions** Asian Americans reported higher levels of anxious emotions than White Americans during the social performance task. No significant difference between behavioural indexes (fidgeting, gaze avoidance, silences, anxiety) between both groups. The mean was slightly higher for gaze avoidance for Asian Americans compared to White Americans.		85% Good quality

		ns (40)			Asian’		
Sakurai, et al (2005)	Japan	149	29.6 (10)	74 M, 75 F	Japanese	**Fears** ‘fears of being observed by others’- mostly consisted of SPS items i.e., ‘ I would find it difficult to drink something in a group of people’. ‘conversation fears’- also mostly consisted of SIAS items i.e., ‘ I become tense if I have to talk about myself or about myself feelings’ ‘relationship fears’- did not involve interaction but being friends with someone. ‘fears of talking to people’ was distinct from ‘fears of mixing with people’.	65% Good quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Tarumi, et al (2004)	Japan	111	18.5 (1.45)	71 M, 40 F	Japanese	**Fears** Factor analysis of TKS scores revealed five factors: (1) anxieties that participant's appearance may offend others, (2)eye-to-eye confrontations or facial expressions may offend others, (3) fears about displaying a blushing face or trembling voice in interpersonal situations, (4) being scrutinised by others, (5) offending others by their unpleasant body odour, breaking wind, gaze. Individuals with high scores on TKS scale, had lower scores on the LSAS-J.			55% Fair quality
Wong, et, al (2019)	(i) Japan and (ii) Australia	(i) 295 (ii) 201	(i) 31.53 (9.43) (ii)33.34 (10.99)	(i) 166 F, 129 M (ii) 111 F, 90 M	Japanese	**Fears** Factor models for the SIAS and SPS were not measurement equivalent across Japanese and Australian individuals with SAD. No difference between both groups in levels of fear of overt evaluation and social interaction anxiety. Japanese participants reported lower levels of fear of attracting attention compared to Australian participants.			85% High quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Quantitative papers									
Yu, et al (2019)	China	251	16.69 (1.53)	155 F, 107 M	Chinese	**Cognitive appraisals** Participants in the high social anxiety group reported a higher level of negative interpretations and were not significantly associated with lower positive interpretations in social situations. They were also more likely to believe the negative interpretations during ambiguous social situations with depression symptoms being controlled for.	**Maintenance factors** **The high social anxiety group endorsed interpretation bias only in social situations and not in non-social situations**		81% High quality
(Zhu et al., 2014) 07/05/2025 10:37:00	(i) China and (II)Canada	179 (i) 175 (II) 104	(I) 31 (11) (ii) 36 (10)	(I) 80 M, 95 F (II) 44 M, 60 F	Chinese	**Fears** Fear of causing distress to others was observed for both Chinese and Euro-Canadian patients and related to social anxiety. The relationship was stronger for the Chinese group, highlighting the prevalence of fears relating to causing distress to others in Chinese individuals with social anxiety.			59% Fair quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Mixed Method and Qualitative papers									
Fan and Chang (2015)	China	61 A) 25 interviews B)36 focus groups	(i)21.00 (1.98) (ii) 22.33 (2.43)	(i) 18 M, 7 F (ii) 27 M, 9 F	Chinese	**Fears** 'other concerned': 'I am afraid of making others uncomfortable if I do not know them well'; 'I am afraid my inappropriate behaviours may cause stress in my friends' Maintaining own and family image: 'I am afraid of being seen as a person with no proper upbringing'; 'I am worried that I could not always maintain a good image'; 'I am afraid of losing my friends if I behave in a wrong way'; 'I am afraid of being misunderstood as a loner'	**Physical symptoms** 'I feel that I need to take a deep breath when I am with others' 'I stutter when I make a public speech'		Quantitative 80% Good quality Qualitative 50% Fair quality
Luan, et al (2022)	China	7	18.34 (1.02)	3 M 4 F	Chinese	**Fears** related to other people laughing, looking like a fool, making mistakes during speeches. **Cognitions** 'others will criticise me if I make mistakes' (p7), 'is my speech reading alright, or how do I sound? (p4).	**Maintenance factors** Avoidance – of public speaking in lectures. Self-consciousness- participants feeling self-conscious and detailed monitoring of own performance. Safety behaviours- looking at the wall whilst performing, rehearsing what to say. Post event processing- 'after the end I still think about how well I did'		85% High quality

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Mixed Method and Qualitative papers									
Suh et al., (2020)	Korea	64	27.00 (7.42)	23 M, 41 F	Korean	**Fears** relating to physical symptoms of anxiety being visible to others, looking like a 'looser/ fool' and embarrassing self.	**Maintenance factors** Negative self-images (17 images), with the self as the main subject of images) Physical symptoms (11 images), twitching cheeks, avoiding eye contact, voice is shaking, voice is weird. Negative view of self (6 images), looking embarrassed, intimidated, foolish Negative image of other people (9 images), evaluating them negatively and staring eyes.		Quantitative: 80% high quality Qualitative: 65% Fair quality
Watanabe (2015)	Japan and Canada	(I) 12 Japanese (i) 9 Euro-Canadian	(i)18.67 (.65) (II) 22.00 (4.00)	(i) 7 M, 5 F (ii) 9 F	Japanese	**Fears** Patterns of fear relating to causing discomfort to others increased with close friends or family. Japanese participant shared her fears of blushing Infront of family members and causing them discomfort but would not worry about making strangers uncomfortable. Fears of causing discomfort to others was higher in one-to-one situation, as large audiences would not be offended. TKS symptoms were observed in Euro Canadian participants.	**Physical symptoms** Embarrassment was associated with severe physiological symptoms amongst Japanese participants i.e., losing memory, blacking out, loss of movement and speech. Euro-Canadian participants noted common physical symptoms of sweating.		Quantitative: 90 % High Qualitative: 75%

Study	Country	Sample size	Population characteristics			Key characteristics of Social Anxiety		Culturally relevant factors associated with social anxiety	Kmet quality rating
			Age: M (SD) years	Gender: M/F	Ethnicity	Fears, beliefs, and cognitive appraisals	Physical symptoms or emotions Maintenance factors		
Mixed Method and Qualitative papers									
Yoshinaga, et al (2020)	Japan	21	39.2 (9.2)	5 M, 16 F.	Japanese	**Beliefs** Positive beliefs relating to PEP as a means to improve performance in social situations 'reviewing is a good opportunity to look at my choice of words' (p8). 'I feel certain that I am really weird and stupid' (p3).	**Maintenance factors** Internal focus of attention and post event processing: 'After all, I can't do anything except look back on the event by myself' (p20). 'I just dwell on my negative feelings and how much I was shaking at that time (p3) Safety behaviours: Rehearsing what to say during conversations. Controlling hands from shaking		85% High quality

Key Findings

Fears, beliefs, and cognitive appraisals

Feared social situations

Thirteen studies contributed to our understanding of, social situations related fears, beliefs and cognitive appraisals. The majority of situations that provoked anxiety in EA/SEAs were similar to situations feared in the West, including: social interactions with partners, friends and peers (Krieg & Xu, 2015; Lee et al., 2006; Sakurai et al., 2005), performative situations such as a speech, speaking in group settings, meetings or parties (Krieg & Xu, 2015; Lee et al., 2006), or taking part in a singing contest (Krieg & Xu, 2015). The exception was situations in which friendship with others or being around other people, elicited anxiety for Japanese patients, even when talking or interaction was not involved (Krieg & Xu, 2015; Sakurai et al., 2005).

Beliefs and cognitive appraisal

The literature described participants' fears and cognitions related to negative evaluation from others. Common themes of negative beliefs included: making mistakes during conversations (Fan & Chang, 2015; Krieg & Xu, 2015; Luan et al., 2022), 'behaving in a wrong way' (Fan & Chang, 2015) and physical symptoms such as trembling, stuttering or blushing being visible to others (Heinrichs et al., 2006; Suh et al., 2020; Tarumi et al., 2004). In line with our understanding of SAD, there was a theme of social situations being appraised as threatening and having disastrous consequences. The following situations accompanied by negative cognitive appraisals were described in studies: 'being laughed at' (Fan & Chang, 2015; Luan et al., 2022), 'being criticised' (Fan & Chang, 2015; Krieg & Xu, 2018; Suh et al., 2020), 'being singled out to deal with difficulties' (Fan & Chang, 2015) and others thinking they are 'weird', 'stupid', a 'fool', a 'loser' (Arai et al., 2022; Fan & Chang, 2015;

Luan et al., 2022; Suh et al., 2020; Yoshinaga et al., 2020). Lau et al., (2009) revealed that Asian Americans reported more 'face loss' concerns compared to European Americans, and this mediated the relationship between ethnicity and SAD.

In one study, semi-structured interviews with Chinese individuals revealed a fear of their behaviours impacting their family's image as well as their own, which is not a construct evident in western measures of SAD (SIAS/ SPS), highlighting a culturally specific fear of SAD amongst individuals of Chinese heritage (Fan & Chang, 2015). It is important to note, that the majority of studies contributing to our understanding of SAD related fears and cognitions used qualitative methods of data collection, two of which were high quality (Luan et al., 2022; Suh et al., 2020), whereas other studies were rated as 'fair' quality due to lack of clarity of data analytic methods and use of verification methods to assess credibility of findings (Fan & Chang, 2015; Suh et al., 2020).

Threat appraisal, defined as a bias of processing threat signals in social situations in terms of their anticipated consequence and likelihood of occurrence, was investigated by Krieg and Xu (2018) in a mediation analysis. Asian Americans reported greater threat appraisal of social situations, compared to European Americans. Independent and interdependent self-construal mediated the difference in threat appraisal between both samples, highlighting that an interdependent self-construal may lead to cognitive processes that influence how social and evaluative cues are perceived and the likelihood of worse consequences occurring (Clark & Wells, 1996; Heimberg, et al, 2010).

Allocentric focus of fear

Amongst five studies (Choy et al., 2008; Fan & Chang, 2015; Tarumi et al., 2004; Zhu et al., 2014), there was a theme of SAD being experienced 'allocentrically' in which fears involved causing discomfort to others. These 'other-focussed' cognitions are characteristics

of TKS, where individuals are fearful of causing offence to others due to their perceived physical and somatic 'defects'. However, three studies also found the presence of TKS symptoms and the allocentric focus of fear in American samples, questioning the cultural specificity of the disorder (Choy et al., 2008; Zhu et al., 2014, Watanabe, 2015). The proportion of fear was highest for a stiff facial expression, followed by body odour, intestinal gas, eye contact, body/ voice trembling and blushing (Choy et al., 2008). The fear of embarrassing oneself, characteristic of SAD, and the allocentric fear of causing offence to others are distinct constructs, however studies have not yet assessed the underlying cognitions that separate these constructs. It is also important to note that both of these studies used measures (SA-DOS and TKSQ) that are not yet validated and were therefore rated fair to good quality.

Watanabe (2015) assessed the validity of the TKSQ using mixed methods research design, reporting clarity of the items as a significant source of error amongst Euro-Canadian samples, impacting the validity of the scale in assessing TKS symptoms in cross cultural studies. The cognitive interviewing method used to evaluate the survey questions, revealed different interpretations of the questions amongst Japanese participants, suggesting interesting findings relating to patterns of TKS fears. The severity of the fear of causing discomfort to others was influenced by the closeness of the relative and the size of the audience. In contrast to our understanding of SAD, Japanese participants were fearful of blushing causing distress to family members and did not have these fears about strangers. Another participant shared fears of disrespecting someone in one-to-one situations as opposed to large audiences (Watanabe, 2015). This may be due to the strong focus of maintaining one's family image in Asian culture, therefore these situations may have higher stakes amongst people they know, as demonstrated by Fan and Chang (2015) who found cognitions related to 'maintaining family image' in Chinese people. Similarly, Norasakkunkit

et al., (2012) found that Japanese participants scored higher on TKS measure whereas European Americans scored higher on western measures of SAD. Independent self-construal had a strong association with the self-focussed component of SAD, whereas interdependent self-construal was only associated with 'other-focused' SA (as measured by the TKS scale), suggesting a link between self-orientation with one's social group and the other focussed fears in Japanese individuals, although the study design and analysis precludes a causal relationship to be inferred.

Social anxiety related emotions and physical symptoms

Six studies described SAD related emotions and physical sensations. Common physical symptoms included: stuttering, breathing heavily (Fan & Chang, 2015), blushing, trembling voice and sweating (Choy et al., 2008; Fan & Chang, 2015; Heinrichs et al., 2006). Interestingly, in one study Japanese participants described embarrassment eliciting severe physiological symptoms, including: memory loss, blacking out, loss of movement and speech (Watanabe, 2015). These symptoms highlight the severity of anxiety caused by embarrassment in social situations. Lee et al's., (2006) study similarly described a higher level of intense negative emotions amongst Asian Americans compared to European Americans across diary recorded events of SA.

Okazaki et al., (2002a) investigated expressions of SAD during a social-performance task where individuals were asked to give a speech to a research confederate and found that Asian American's reported higher level of anxious and negative emotions compared to European Americans. Analysis of behavioural symptoms (fidgeting, gaze avoidance, silences and appropriateness of behaviour) showed no difference between both groups, which might suggest that Asian Americans may supress their emotions in social situations due to their cultural norms focussed on maintaining harmony amongst others.

Social anxiety maintenance factors

Whilst the literature showed differences in the cognitive features of SAD in EA/SEA groups, the behavioural features and other maintenance factors were similar to features found in the West. A study investigating interpretation bias amongst Chinese adolescents found that participants in the high SA group had more negative interpretations and beliefs in social situations compared to non-social situations (Yu et al., 2019). The negative appraisal of environmental cues in social situations is a causal and maintenance factor of SAD in cognitive models (Clark & Wells, 1995), and appears to be a relevant characteristic of SAD in the East. Furthermore, one study found 47% prevalence of Spontaneous Recurrent Images (SRIs) in Korean individuals with SAD. The content of these images involved other people as well as the participants themselves, which might be linked to TKS fear of causing discomfort to others (Suh et al., 2020).

Studies also referenced avoidance and SSB's employed by participants to 'protect' themselves from embarrassment and enhance their social performance. These included: rehearsing what to say, avoiding eye-contact, controlling hands from shaking, folding arms tight, talking less, staying on the edge of a group and letting others guide conversation (Arai et al., 2022; Luan et al., 2022; Yoshinaga et al., 2020). Two studies mentioned Post Event Processing (PEP), which was considered as the 'only safe and useful way to improve' performance (Luan et al., 2022; Yoshinaga et al., 2020). Participants referred to an internal focus of attention in social situations and increased tendency to review past social performance, which increased anxiety by triggering memories of past situations, however they felt it was offensive to ask other people for feedback. Excessive self-focus and internal focus of attention reduces attention to important social cues in the environment, and are important maintaining factors of SAD, according to the cognitive model (Clark & Wells,

1995). Majority of the maintenance factors in the cognitive model of SAD appear to be relevant to EA/SEA, however, this is only according to a small number of studies (n= 5).

Cultural differences in social norms and social anxiety

Heinrichs et al (2006) assessed personal and cultural norms and the relationship with SAD and a fear of blushing. Individuals from collectivist countries were more accepting of socially avoidant behaviour that reflected withdrawal and modesty, compared to individuals from individualistic countries. This difference was only found for domains of cultural norms rather than personal norms, suggesting that individuals from collectivist countries residing in Western countries may experience a clash between cultural norms and personal norms. Individuals from collectivist countries, also reported higher levels of SA symptoms and a fear of blushing compared to the individualistic group. However, it is important to note the limitations of this study relating to an unsatisfactory Cronbach's alpha of the 'personal norm scale' and the lack of backtranslation of measures: findings should be interpreted with caution due to possible measurement bias. Essau et al., (2012) similarly found that individuals from Hong Kong were more accepting of socially avoidant behaviour compared to individuals from the UK. Therefore, cultural differences in social norms might explain the differences in SAD found between individuals of EA/SEA heritage and western samples.

Discussion

This systematic review aimed to synthesise the literature on the presentation of SAD in EA/SEA populations, to understand whether there are cross cultural differences in symptomatology. Previous research has shown a higher prevalence of self-reported SA in individuals of Asian heritage compared to Western samples (Krieg & Xu, 2015; Woody et al., 2015), and our research aimed to unpack cultural variations in symptom presentation in terms of fears, beliefs, cognitive appraisals, and other maintenance factors relevant to SAD in the

West. Due to a limited number of studies in this area, inclusion criteria were broad, including community samples who had completed measures of SA and diverse study designs.

Across the 20 studies in this review, quality ratings varied from fair to high quality. The two qualitative papers in this review were of high quality and provided rich data in relation to the research aims. Mixed-method research varied in their quality. Quantitative aspects were rated good to high quality, whereas qualitative components lacked clarity on data analysis, use of verification procedures and reflexivity.

The results are consistent with previous literature which has identified cross cultural differences in the presentation of SAD between individuals of Asian heritage and the West. The presentation of SAD in East and West is not mutually exclusive, as they share similar features, in terms of type of social situations perceived as threatening, as well as affective and behavioural responses. The divergence appears to be at the cognitive level, informed by five studies revealing an allocentric focus of fear, in which cognitions focus on causing offence to others due to their behaviour, a perceived defect in their body, or their physical sensations such as a stiff facial expression, gaze, body odour or the release of intestinal gas (Choy et al., 2008; Fan & Chang, 2015; Tarumi et al., 2004; Zhu et al., 2014). It is important to note, two (Choy et al., 2008; Tarumi et al., 2004) of these studies were rated as 'fair' quality; therefore, we can only confidently infer this difference from three studies.

Furthermore, these fears appear more prominent in situations with a close relative and a small audience as opposed to strangers and large groups (Watanabe, 2015). Studies reveal the importance of maintaining an image of oneself and one's family (Fan & Chang, 2015), which might explain why other-focussed fears appear more relevant amongst close relatives, as these situations may represent higher stakes for their family image. In line with this, in one study 'face loss concerns' mediated the difference in SA between Asian

Americans and European Americans (Lau et al., 2009). Two studies also revealed the presence of other people were amongst feared social situations in this group, even without performative or interactional events (Fan & Chang, 2015; Krieg & Xu, 2018).

The cognitive model of SAD (Clark & Wells, 1995) suggests that standards for social performance are influenced by beliefs formed from early life experiences, and are maintained by various cognitive and behavioural factors, such as: fear of negative evaluation, negative self-appraisal, self-focussed attention, interpretation bias, PEP and SSB's. Our studies revealed interpretation bias, internal focussed of attention, PEP and SSB's were all relevant factors in SAD presentation in EA/SEA, however these were only informed by five studies, and neither of these studies included participants with the other-focussed manifestation of SAD. It is therefore unclear whether similar processes drive and maintain TKS.

The aim of our review was to explore the symptom presentation of SAD in EA/SEA populations, and therefore our eligibility criteria centred around studies that would specifically report this information. Although it was beyond the scope of our review to investigate the underlying mechanisms of SA differences between EA/SEAs, five of our selected studies provided important insights on these factors. The extraction and inclusion of this data was valuable for contextualising the observed symptoms differences, and the fact that majority of the studies did not report or comment upon these, highlights the need for future research to be conducted in this area. It is hypothesised that cultural differences in self-construal, particularly an interdependent self-construal may heighten threat appraisal and SA concerns. Socialisation towards an interdependent self-construal in the East emphasises the importance of maintaining harmony with their social group, and self-worth is closely tied to being connected to and 'fitting in'(Okazaki, 1997). This may imply a heightened sensitivity to others' emotional responses (Markus & Kitayama, 1991). Interdependent self- construal was a mediator of threat appraisal between Asian Americans and European Americans (Krieg

& Xu, 2018), and significantly associated with other-focussed component of SA (Norasakkunkit et al., 2012).

Clinical implications

Our findings herein have clinical implications for the assessment and treatment of SAD amongst EA/SEA client groups. Culturally sensitive assessment of SAD in this client group may require clinicians to familiarise themselves with culturally-salient fears and cognitions related to an allocentric focus of fear and TKS symptoms and approach these with curiosity, sensitivity, and a non-judgmental position. It is important for services to educate their practitioners about cultural differences in SAD, specifically TKS, to enhance assessment and treatment outcomes. There is a lack of psychometrically validated measures to assess allocentric fears in SAD and TKS. To the authors knowledge, the TKS scale is the only validated measure of TKS (Kleinkecht et al., 1997) in Japanese and Korean individuals, and might not be sensitive amongst all EA/SEAs.

Furthermore, since social standards of performance are closely tied to cultural norms and values, it is important for clinicians to keep this in mind when using 'Socratic questioning' or evaluating the rationality of cognitions in CBT. This should also be incorporated into the development of behavioural experiments and other treatment strategies in treatment, to ensure individuals are not tested against their cultural norms, or encouraged to carry out behaviours that might have high stakes for their family's image. An interdependent self-construal amongst this client group may impact the therapeutic relationship between client and therapist, due to high levels of sensitivity to others which may lead to a reluctance to express thoughts or provide honest treatment feedback. It is important for clinicians to thoroughly evaluate therapeutic progress in therapy, providing opportunities for clients to express concerns. In addition,, it may be helpful to include family members

when planning and carrying out behavioural experiments to ensure clients' fears about their specific audience are tested. A culturally sensitive approach to treatment may facilitate the therapeutic relationship between client and clinician, and lead to better therapy outcomes (Beck, 2016).

Limitations and future research

This literature review restricted eligibility of studies published in English, therefore research in other languages which may increase the breadth of our understanding of cultural differences in the presentation of SAD in EA/SEA populations could have been missed. Searches of grey literature provided access to papers that were not accessible through databases and key authors were emailed to maximise the scope of our sample of papers, yet only one author responded.

The target population of our review was carefully considered to ensure data was synthesised from a homogenous group of collectivist culture, however there is linguistic and economic diversity amongst EA/SEA. It was noted that the majority of the research was carried out in China, Japan and Korea, possibly due to these countries having a more established research infrastructure, which limits the generalisability of our findings. Nearly half of the research studies were carried out in America, comparing EA/SEA samples to European Americans, therefore migration status might have influenced our findings. However, it was difficult to focus on this without the main scope of this review being compromised.

Finally, due to a lack of studies in this area our inclusion criteria was broad and included studies of 'convenience samples' of university students without self-identification of SA concerns, limiting generalisability of our findings to clinical samples. This could also be an advantage of the review, including findings from individuals who might not meet Western

criteria for diagnosis or clinically significant SA using cut-offs on measures developed in Western samples.

There is a need for future research to focus on understanding first-person perspectives of SAD or TKS using qualitative methods to further unpack the phenomenology of SAD in EA/SEA populations, focussing specifically on cognitive aspects as this was a key finding in our review, but our findings were constrained by the 'fair' quality of two studies. Furthermore, since other-focussed anxiety is a significant finding in this review, there is a need for future research to focus on developing and validating measures to assess this and SAD as existing measures are not sensitive to capture the experiences of this client group.

As discussed above only five of our studies provided important insights into the culturally relevant mechanisms underlying the difference in symptom presentation within EA/SEA populations. The main scope of our review was to understand the differences in the symptom presentation of SAD and therefore studies solely reporting on these cultural factors were excluded from our review. The lack of exploration of these culturally relevant factors for the observed cross-cultural difference in SAD symptomology is certainly a limitation of the literature, however it does not detract from the main aims of this review. Our paper highlights the need for further research to specifically investigate the underlying mechanisms of this observed difference in SAD for EA/SEA populations to bridge this gap in literature and to enhance our understanding in developing culturally sensitive and effective interventions.

Conclusion

In conclusion, this systematic review provides a detailed synthesis on the contents of fears, cognitive appraisals and emotional and behavioural symptoms in EA/SEA and highlights some of the similarities in symptoms as well as the nuances in cognitions related to

other-focussed anxiety. It is vital for clinicians treating SAD amongst this client group to take a culturally sensitive approach to assessment and treatment, reflecting on their own assumptions about standards of social performance and the dominant Western understanding of SAD. Clinicians should familiarise themselves with culturally salient fears and cognitions and incorporate client's norms and values into the treatment pathway.

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Service Improvement Project

The Oxford DClinPsy 'mind-to-mind' mentoring scheme: Experience of benefits and barriers

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Oxford Institute for Clinical Psychology Training and Research

University of Oxford

June 2023

Internal Supervisors: Dr Reena Vohora and Dr Libby Barnardo

Word Count: 5500

Published in Journal: Clinical Psychology Forum. This journal publishes research and evaluation papers on issues relevant to Clinical Psychology.

Abstract

Purpose: There is an underrepresentation of individuals from Diverse Ethnic Communities (DEC) in clinical psychology. Individuals from DEC face barriers in their journeys towards becoming a clinical psychologist, including lack of support from those in the profession. The Mind-to-Mind mentoring scheme is a positive initiative action to support aspiring psychologists with their individual pathways into the profession. This project aimed to evaluate the first year of the scheme and offer recommendations of how mentees needs can be better met.

Methods: Feedback data collected by the service was analysed descriptively. Focus group discussions were carried out with four mentees, four trainee mentors and four qualified mentors to explore their experiences of the scheme. Open-ended data from feedback forms and focus group discussions were analysed using inductive thematic analysis.

Results: Analysis of feedback captured via evaluation forms showed that mentors and mentees were satisfied with the different aspects of the mentoring scheme, with some recommendations for the trainee question and answer session, format of workshops and mentor resource packs. Thematic analysis of the focus group discussions revealed three key themes for mentees: 'the journey of personal and professional development', 'keeping me at the centre' and 'barriers to meaningful support'. The following themes developed from trainee mentors focus group discussions: 'creating a meaningful space', 'navigating the role of a mentor', 'scheme structure' and 'reciprocal benefits'. Data from qualified mentors revealed four key themes: 'desire to make a difference', 'working with mentees to provide meaningful support', 'navigating the role of a mentor' and 'scheme structure'.

Discussion: Recommendations relating to the structure and delivery of the scheme are offered. These include defining mentors and mentees role further, reducing formality around

the supervision contract, reviewing communication of written information and providing clearer guidance on sessions.

Introduction

Despite attempts to address the lack of representational diversity in clinical psychology, the profession remains dominated by individuals from a White background (Newnes, 2021). Diversity in the workforce is vital for the NHS to deliver culturally responsive services (Kline, 2014). There are ongoing discussions regarding appropriate terminology to describe ethnic groups, in this paper we use the term 'Diverse Ethnic Communities' (DEC) to refer to all individuals who do not identify as White British. The term 'minoritised' is excluded as it perpetuates disempowerment and 'whiteness' as the norm, despite this group making up 80% of world's population (Campbell-Stephens, 2021).

Diversity and clinical psychology

There are significant differences in success rates of clinical psychology training applications, when comparing applicants from DEC with White applicants. Figures reflect a lower acceptance rate for people from DEC (17%) compared to their White counterparts (82%) in 2020. Data from the 2023 entry showed slight improvement, with individuals from DEC having a 22.8% acceptance rate compared to 75.5% acceptance rate of their White counterparts (Clearing House for Postgraduate Courses in Clinical Psychology., 2020, 2023). Widening access initiatives (Scior et al., 2016) and the Division of Clinical Psychology Inclusion strategy (BPS; 2015), may have helped to improve figures slightly, but a difference in success rates remains.

Literature has highlighted the barriers people from DEC experience which may contribute to the acceptance rate gap for Clinical Psychology Training Programmes (CPTP). Scior et al (2007) investigated success rate of individuals from DEC applying to the University College London CPTP and found that DEC candidates were less likely to meet the selection criteria compared to White candidates. Applicants from Black and

Asian ethnic groups had a lack of relevant work experience, lower A-level points, degree classifications and reference scores compared to White applicants. Assistant Psychologist (AP) posts are the preferable route into the profession, however they are underpaid and not economically sustainable for those with financial struggles (Ahsan, 2020). Scior et al (2017) analysed applications from Leeds Clearing House and found that educational history had an impact on application outcomes, with factors such as attendance at comprehensive schools and a degree classification of 2:1 or lower leading to rejections pre-interview stage.

Individuals from DEC experience socioeconomic disadvantages and lower levels of attainment compared to their White counterparts (Troyna & Carrington, 1990) resulting in a disadvantage for meeting the criteria for CPTP. The aforementioned study by Scior et al (2007) did not analyse within group differences between ethnic groups, it is important to recognise that there is significant diversity within Black and Asian ethnic groups due to factors such as socioeconomic status and geographical variations, therefore academic attainment can vary even within ethnic groups. Intersectionality Theory (Crenshaw, 1989) stipulates that an individual's experience can be shaped by discrimination relating to the interconnection of multiple social categorisations. Englefield's (2023) narrative review highlighted the interplay of various factors (class, culture, education, gender and socioeconomic status) causing barriers for aspiring psychologists from DEC, although it is important to note that findings were derived from four papers due to little research in this area.

Papers highlight the lack of ethnic representation in the profession as a challenge for people from DEC, giving rise to feelings of insecurity, feeling 'othered' and devalued (Kinouani et al., 2016; Wallace & Dawood, 2018) .The Cultural Contracts Theory (Jackson, 2002) highlights the importance of identity development through social

interaction with others, which may contribute to the struggles of negotiating an identity within a profession lacking visible diversity.

Service context

With the aim of increasing access to the profession, Health Education England (HEE, 2021, appendix F) provided CPTPs in England with funding to implement a mentoring programme for individuals from DEC.

The Mind-to-Mind Mentoring Scheme (MMMS) developed by Dr Reena Vohora (Mentoring lead), contributes to improving equity of access in clinical psychology, by providing 35 aspiring psychologists from DEC support with individual pathways into the profession. The MMMS's first round was completed in October 2022, with a second round beginning in November 2022. Criteria for mentees were to have obtained or be on track for a 2:1 for their undergraduate degree and to be living, studying or working within the Thames Valley Region. The MMMS delivered both one-to-one mentoring sessions and reflective workshops. The mentoring lead was keen to evaluate the current model to identify areas of development for the second round of the scheme. The researcher carried out scoping interviews with the mentoring lead and APs to understand the development process of the scheme (see appendix G).

Aims and research questions:

I. What is the experience of mentees receiving support from their mentoring sessions and reflective workshops, what has worked well and what can be improved?

II. What is the experience of mentors delivering to support to mentees from DEC? How well have they been able to address their needs, what has worked well and what can be improved?

III. Are there any areas that have been difficult for mentors and mentees to explore and/or discuss?

Method

Design and Participants

The study used a cross-sectional, mixed-methods design across two phases to obtain an understanding of the experiences of mentors and mentees.

Phase 1: Mentors and Mentees completed feedback forms to provide feedback about their experiences of the mentoring scheme, including individual sessions and workshops.

Phase 2: This phase involved a qualitative design, using focus group discussions. The sample consisted of four female mentees from DEC aged 18-25 years), four female trainee mentors (aged between 25-34 years) and four qualified mentors (female n= 2, male n= 2), aged between 35- 40+ years. The trainee mentor sample self-identified as White British (n= 3) and of Pakistani ethnicity (n= 1). The qualified mentors self-identified themselves as White British (n=2), White other (n=1) and Mixed ethnicity (n=1).

Procedure

Phase 1: The mentoring team collected feedback of mentors and mentees experiences of the MMMS.

Phase 2: Participant information sheets were distributed to mentees and mentors via email (appendix, H1). The researcher contacted participants to schedule a time for focus group discussions and obtained written consent and demographic data through Qualtrics

(appendix H2). The focus group questions were co-developed with both supervisors (RV and LB) and a scoping interview with one mentor and mentee assessed the utility of the questions (appendix H3). Three separate focus group discussions took place with mentees, qualified mentors and trainee mentors via Microsoft Teams. The focus group discussions were audio-recorded and lasted between 45 – 60 minutes. They were transcribed verbatim and anonymised.

Ethical approval

The study was reviewed and approved by the OXICPTR Audit committee (appendix H4). Participants' anonymity was maintained using unique identification codes.

Credibility checks

Both supervisors reviewed samples of transcripts during coding and theme development process. This led to changes in structure and content of themes to ensure the analysis followed an inductive process. A reflective diary was used throughout the research process to keep track of the primary researcher's experiences.

Analysis

Phase 1: Feedback was interpreted descriptively. Inductive thematic analysis was conducted on data elicited by open-ended questions on the feedback forms. This followed Braun & Clarke's, (2006) six phase approach to coding and theme development. Appendix I outlines the thematic analysis process.

Phase 2: Braun & Clarke, (2006) thematic analysis was used to analyse the transcribed focus group discussions (appendix I). Data from the focus groups was analysed separately to capture the experiences of each group.

Results

Phase 1: Analysis of feedback forms data

Thirty-five mentee spaces were initially offered, however due to personal circumstances, two mentees dropped out . Thirty-three triads (of mentee, qualified mentor and trainee mentor) continued in the scheme.

Mentees

The mentoring team collected feedback data for mentees at five time points. Refer to appendix J for a summary of each feedback time point, satisfaction data from workshops and Thematic Analysis results from open-ended questions on feedback forms.

Mentors

Feedback data for mentors was collected at five time points. Appendix J contains a summary of feedback data from each time point and resulting themes from Thematic Analysis of open-ended questions on feedback forms.

Phase 3: Themes from focus group discussions

(i) Mentees

Table 3

Summary of themes and subthemes from focus group discussions with mentees (M).

Themes	Subthemes
1) The journey of personal and professional development	Opening up conversations
	'Finding my tribe'
	Reflections and 'digging deeper'
	Guidance with the next steps

2) Keeping 'me' at the centre	Feeling empowered Needing a 'safe space' Relationships with mentors
3) Barriers to meaningful support	Gaps leading to a sense of disconnection 'Choosing what to talk about in sessions' Desire for 'deeper conversations' to be initiated by mentors Desire for face-to-face contact

Note: See appendix K for full analysis

Theme 1. The journey of personal and professional development

Opening up conversations

Mentees expressed their desire to use the mentoring scheme to open up conversations about diversity in relation to clinical psychology; *"to talk about … the barriers that are specific to people of colour and in open forum as opposed to kind of like the elephant in the room" (M3)*. Mentees reported that; *"in usual day-to-day situations you don't really have these discussions" (M1)*.

'Finding my tribe'

Mentees described difficulties meeting people from DEC within the field and expressed a desire to use this space to find a sense of belonging by connecting with similar others: *"with schemes like that, we like pull these minorities out and group them together. This is where we can … find the tribe that we belong" (M2)*.

Reflections and 'digging deeper'

Mentees enjoyed the scheme's application process as it facilitated personal reflection, *"I never really thought about my ethnicity and how it affects my career before seeing this programme" (M1).*

Guidance with the next steps

Mentees wanted to use the scheme to seek guidance with next steps in their journeys. This involved support with doctorate applications, *"they were immensely helpful reading the personal statement, re-drafting… really giving me pointers on what to say" (M4)*.

Theme 2. Keeping 'me' at the centre

Feeling empowered

Mentees emphasised the importance of having control over their mentoring sessions, *"they set up meetings which was kind of revolved around the questions I had" (M1)*. Having their voice heard, and opinions valued, fostered a sense of empowerment, *"power dynamic wasn't too different. I felt like my opinions were valued on the same level and… he gave me a lot of autonomy to decide erm what how to spend the time" (M2).*

Needing a 'safe space'

Mentees mentioned the importance of having a 'safe space' in sessions to be able to speak honestly about their personal journeys. This involved feeling safe enough to have conversations about race, ethnicity and power. Having an empathic mentor strengthened trust in their relationship which made these conversations possible, *"how like warm she was made*

it really open to then continue to have conversations about race" (M3). Difficulties arose with having mentors from a White background, *"I felt awkward to talk about ethnicity …and they haven't really tried to bring it up either" (M1).*

Relationships with mentors

Mentees made a distinction between their relationships with the trainee mentors and qualified mentors, ***"****I found it easier to talk about race with the trainee as opposed to the qualified… due to my own experience of White supervisors I found her very much like work supervisor" (M3).* Mentees felt more comfortable with mentors when they established a personal connection not resembling a supervisor-supervisee relationship.

Theme 3. Barriers to meaningful support

Gaps leading to a sense of disconnection

Mentees expressed difficulties relating to the infrequency of meeting, *"I really struggled with the whole only four times a year thing" (M3)*, as this impacted building rapport with mentors*, "to build like a really meaningful rapport with someone you wouldn't see them only four times… maybe that was also why there would be that disconnect" (M3)*. Gaps in sessions were also caused by a lack of contact from mentors, contributing to feelings of disengagement.

Choosing what to talk about in sessions

The limited session time required mentees to make difficult decisions about how to use the time, *"the way the scheme is structured you can't have them conversations in depth" (M3). "It was quite stressful I guess choosing and picking what to talk about" (M4).*

Desire for deeper conversations to be initiated by mentors

Mentees reflected on the importance of having a space for 'deeper conversations' about their identity which was not fulfilled by their individual mentoring sessions, *"I didn't end up having conversation about race and ethnicity … I don't feel like it fulfilled that for me" (M1).* The confidence to initiate these conversations differed between mentees depending on their stages, although there was a consensus that mentors could have created more space for these discussions. Mentees valued when conversations were initiated by mentors, *"I felt more comfortable bringing up some of these things because they bought it up first and that was really important to create a safe space" (M4).*

Desire for face-to-face contact

Mentees experienced difficulties connecting with mentors and other mentees due to the scheme being delivered online. All mentees expressed desire for face-to-face contact*, "there could be more exercises to be done face-to-face, especially to try and strengthen that relationship" (M1).* Mentees spoke about the importance of having opportunities for networking which could allow people to achieve a sense of belonging with their group, *"it might give you a chance to find your tribe" (M3).*

(ii) Trainee Mentors

Table 4

Summary of themes and subthemes from focus group discussions with Trainee Mentors (TM)

Themes	Subthemes
1) Creating a meaningful space	Wanting to improve the experience of aspiring psychologists
	'Making it individualised'
	Considering positioning in a culturally sensitive way
	Building personal connections
	Practical support
2) Navigating the role of a mentor	'Am I the right person'
	'Not wanting to let mentee down'
	Confusion and role compensation
	Giving advice vs. sharing own perspective
	Frustration at systems of power
3) Scheme structure	Addressing fears at the outset
	Paperwork and time pressures
	Contact with the mentoring team
4) Reciprocal benefits	Satisfaction from 'doing something different'
	Deep conversations and reflection
	Building supervisory skills

Note: See appendix K for full analysis

Theme 1. Creating a meaningful space

Wanting to improve the experience of aspiring psychologists

Mentors acknowledged the lack of diversity in the profession and wanted to contribute towards change, *"I needed to focus a little bit more on… improving the experiences for people coming into training" (TM3)*.

"Making it individualised"

Mentors expressed the importance of prioritising mentees' needs and offering individualised support to make the mentoring sessions meaningful, *"I was really mindful of making it a meaningful space in terms of what they wanted for their time and I think that can be really individual" (TM3).*

Considering positioning in a culturally sensitive way

Mentors aimed to create a safe space where mentees felt comfortable opening up about their identities and journeys in clinical psychology. This involved naming ethnic differences, *"I am a White British person, so I was like reiterating at the start like this is a space where you can talk about that".* For some mentors, it was important to discuss differences relating to positions of privilege*, "I actually came from quite a position of privilege … what helped was just having that initial conversations … and just naming it" (TM2).*

Building personal connections

Mentors established personal connections with mentees to strengthen the relationship. For some this involved socialising*, "it was helpful that we met in a very informal way … that made it a lot easier for her" (TM1)* and for others, *"we sort of thought about family stories …So that was quite interesting to get a sense of their position and it opens up discussions" (TM3).*

Practical support

Mentors offered practical support depending on the mentee's needs which included advice about careers, personal statements and alternative routes into the profession. This also involved discussion of different pathways, *"my mentee is international student …so there was … practical stuff about like visas I had to … look up" (TM1).*

Theme 2. Navigating the role of a mentor

'Am I the right person?'

Mentors had doubts about whether they were the right person to provide support, *"I just wasn't sure err if I'm the right person to offer that kind of mentoring" (TM2).* Mentors from White backgrounds worried about not having lived experience of the barriers and inadvertently reducing mentees experiences of stress during their journey.

'Not wanting to let mentee down'

Mentors had concerns about managing mentoring commitments alongside their training workload, and worried about letting mentees down: *"can I offer time for this person in a way that they'll see helpful" (TM2).*

Confusion and role compensation

Some mentors dedicated more time to their role due to the absence of qualified mentors, *"I overcompensated and met her a lot at first" (TM2).* For one mentor this involved taking her mentee *"under the wing" (TM1)* and feeling responsible for socialising, resulting in role confusion: "*am I not doing enough by not offering to like us to meet at coffee… but then that wasn't the role" (TM1).*

Giving advice vs. sharing own perspective

Mentors expressed difficulties finding balance with offering advice and sharing their perspectives, whilst being mindful of power imbalances in their relationship, *"you're not wanting to put too much your perspective … how do you help her to problem solve but not takeover" (TM4).*

Frustration at systems of power

Mentors had to manage frustrations at systems of power at being unable to change structural barriers, *"my mentee had gone to visit the admissions … and said please can you change the A levels… she said no… I wanted to call up the office person myself and be like excuse me, but then knowing that's really not going to make a difference." (TM4).*

Theme 3. Scheme structure

Addressing fears at the outset

Mentors reflected on the introductory workshop which addressed fears and provided solutions for them, *"it's helpful to normalise a lot of you are going in with the same sort of hopes and concerns and sort of addressing that in the room and what we could do about that" (TM3).*

Paperwork and time pressures

Mentors acknowledged difficulties going through the detailed mentor pack for guidance on sessions due to time pressures, *"it was like a lot of paperwork to read through (TM2).* Mentors suggested having*, "bit more focused information…I mean like err more digestible"* (TM1).

Contact with the mentoring team

Mentors expressed the need for more contact from the mentoring team, *"it felt disconnected. It might have been nice to have potentially a few more check ins" (TM4).*

Theme 4. Reciprocal benefits

Satisfaction from 'doing something different'

Mentors shared positive experiences of mentoring which contributed to feelings of satisfaction from doing something different, *"I think it was just sort of refreshing as like a different activity during the course… I've talked to someone who needs support" (TM1).*

Deep conversations and reflection

Mentors were introduced to different experiences of people's journeys, increasing self-reflexivity when working with people from different backgrounds; *"it also increased my self-reflexivity…. how to just check in with yourself all the time about how different people's experiences and not making assumptions" (TM3).*

Building supervisory skills

The role allowed mentors to strengthen supervisory skills, *"I learned a lot from how she decided to use the programme and how she structured the sessions" (TM4).*

(iii) Qualified Mentors

Tables 5

Summary of themes and subthemes from focus group discussions with Qualified Mentors (QM).

Themes	Subthemes
1) Desire to 'make a difference'	Acknowledging the need for wider representation
	Sharing personal experiences of difference
	'A sense of empowerment'
2) Working with mentees to provide meaningful support	Coming to a collaborative agreement
	Being led by the needs of mentees
	Facilitating connections
3) Navigating the role of a mentor	Am I the right person to help?
	Consideration of power and privilege
	Working together to clarify aims and hopes
	Re-connecting with the journey towards clinical psychology
4) Scheme structure	Appropriateness of contracting
	Uncertainty about roles and responsibilities
	Guidance on endings

Note: See appendix K for full analysis

Theme 1. Desire to 'make a difference'.

Acknowledging the need for wider representation

Mentors described their reasons for taking part in the mentoring scheme which stemmed from a recognition of representational issues in the profession*, "inspiration for me really was part of the broader conversations we're having in the Trust about … the representational issues in the profession" (QM1).*

Sharing personal experiences of difference

Mentors shared personal experiences of negotiating feelings of difference in the field of psychology, "*my route to clinical psychology has been ermm different to my peers just because I didn't train in this country …but just having that sense of also being different …I thought might be useful also for someone else to hear" (QM2).*

'A sense of empowerment'

Mentors considered an important part of their role to empower mentees, supporting them to thrive in their journeys; *"a sense of empowerment that's how I see a lot of this work … helping people see that they have much of the knowledge and skills they need already" (QM3).*

Theme 2. Working with mentees to provide meaningful support

Coming to a collaborative agreement

Establishing a collaborative agreement with mentees was useful to clarify goals for sessions, *"our own confidentiality agreement, how we want these meetings to be, that we made joint*

decisions the three of us that we wanted to stay as a group and discuss different options" (QM2).

Being led by the needs of mentees

Mentors worked together with their mentee to provide individualised support*, "our mentee was sort of trying to work out what they wanted to do …. we ended up talking about different options" (QM2).* These ranged from support with doctorate applications, mock interviews, reflective conversations and different routes into psychology.

Facilitating connections

Mentors supported with building connections with others in the profession, *"mentee was about to do this placement … I know the head of Psychology for that Trust … would you like me to introduce you under the umbrella of this scheme (QM1).*

Theme 3. Navigating the role of a mentor

Am I the right person to help?

Qualified mentors had fears about whether they were the right person to offer support*, "I'm exactly the opposite from people that are looking for support … am I even the right person to do this" (QM2).*

Consideration of power and privilege

Mentors considered issues relating to power and privilege to reduce the power imbalance in their relationship, "*I don't want to be the qualified psychologist in the room" (QM2).*

Working together to clarify aims and hopes

Mentors placed high importance on wanting to meet mentees' needs, which involved offering practical support, discussing intersectionality and other areas of difference, *"it's important to create the space where they could talk about them but actually we need to stay close to what is useful" (QM1).*

Re-connecting with the journey towards clinical psychology

The mentoring role reconnected mentors with the 'complex' journey towards clinical psychology, *"it really falls home for me quite how challenging it is to get into Clinical psychology (QM3).*

Theme 4. Scheme structure

Appropriateness of contracting

Mentors expressed a range of views reagrding the supervision contract provided by the mentoring team. For some mentors, it was thought to be "too formal' and could potentially cause a power imbalance in the relationship. Other mentors found the contract useful for clarifying aims and goals for the mentorship.

Uncertainty about roles and responsibilities

Some mentors expressed concerns about mentees' lack of understanding of their role, *" my mentee seemed to come with very little expectation or prep" (QM4).*

Guidance on endings

Mentors expressed the need for clearer guidance on how to end sessions, *"We had a similar dilemma about ending or not ending or whether to carry on informally … none of the three seem to be clear on it" (QM1).*

Discussion

This project evaluated the MMMS to gather recommendations to strengthen the second round of the scheme. Results from analysing feedback forms suggest that overall, mentees were satisfied with the workshops. Mentors rated their expectations of workshops as met or partially met, only two mentors rated their expectations as 'not

met' for the introductory workshop. The feedback for mentor packs were overall rated as expectations met, with the exception of two responses for expectations not met.

Thematic analysis showed that mentees valued the MMMS as it allowed them to progress their journeys of personal and professional development through facilitating conversations, personal reflections and career pathways. Research shows that individuals from DEC have fewer opportunities to access guidance from individuals in the profession (Scior et al., 2007), therefore the MMMS was successful in meeting its aims of providing career support. It was promising to observe the mentee's gains being congruent with mentor's goals, which featured in the themes of 'desire to make a difference' and 'wanting to improve the experience of aspiring psychologists'.

Mentees were most satisfied with sessions that fostered a sense of empowerment and when mentors created a safe space to speak about their identities. Intersectionality Theory proposes that social identities can overlap and create different modes of discrimination and privilege. The opportunity to share aspects of their identities in relation to their journeys in clinical psychology may have fostered a sense of empowerment for mentees in their relationship with mentors. It was encouraging to see the alignment of mentee's experiences of 'feeling empowered' with TM's aspirations of 'creating a meaningful space' and QM's desire to 'make a difference' by fostering a 'sense of empowerment'.

Difficulties arose for mentees who had a mentor from a White background as mentees felt uncomfortable raising conversations about ethnicity. Research shows that ethnic similarity between a mentor and mentee leads to more positive mentoring relationships (Kelch-Oliver, et al, 2013). This can be explained by social psychology theories such as the 'homophily' principle (Lazarsfield & Merton, 1954), which

proposes that people connect more with those similar to them. Mentees may have felt more comfortable speaking about their ethnicity to mentors from DEC, and whilst this was the aim, the pool of mentors from DEC was too small to allow this for all triads.

Mentors emphasised the importance of 'being led by mentees needs', however this could have potentially led to important conversations relating to the identity and personal experience of mentees being missed. There was a consensus within the mentee group of wanting mentors to have been more proactive in naming important issues and providing a space to explore their identity and experiences. Potential implications of missing conversations about mentees identity could have left mentees feeling invalidated, perpetuating the longstanding culture of silence around this topic, as well as a power imbalance. Indeed, Kinouani et al. (2016) found that aspiring psychologists from DEC felt pressured to conceal their identities in interviews due to a fear of rejection, marginalisation and stigmatisation.

Further barriers to receiving meaningful support included gaps in sessions causing a sense of disconnection, prioritising what to talk about in sessions, a desire for deeper conversations to be initiated by mentors and face-to-face contact. Mentees expressed the need for face-to-face opportunities to network with individuals from DEC and find their "tribe" in the profession. Social Identity Theory (Tajfel, 1982) proposes that group membership provides a sense of social identity: a sense of belonging to the social world, which is an important source of self-esteem. Supporting mentees to find their "tribe" in the field may increase a sense of belonging and allow them to develop their identities through interaction with similar others, in line with the Cultural Contracts Theory (Jackson, 2002).

Similar themes emerged from the analysis of trainee and qualified mentors focus group discussions. Both emphasised the importance of creating a meaningful space for mentees by being led by their individual needs, considering positioning in a culturally sensitive way and facilitating connections. Trainee and qualified mentors sometimes felt unconfident about being the 'right person' to support mentees, due to not having experienced barriers specific to people from DEC. Trainee mentors experienced difficulties managing emotions at systems of power when their mentees experienced structural barriers to applying to CPTP. The analysis highlighted strengths of the scheme structure, including the introductory workshop for clarifying expectations of roles and addressing mentors' fears. Mentors requested more focussed information in the mentor resource pack and more guidance from the team.

Strengths and limitations

A strength of this study is the mixed-methods design, increasing the breadth of data collected. Triangulation provided a comprehensive evaluation of mentees and mentors experiences of the scheme. There is a lack of research on the mentoring needs of aspiring psychologists from DEC, therefore this study makes a valuable contribution to this area.

Limitations of this study include the use of pre-collected feedback form data which was limited by low response rates, lack of detail on feedback responses, inconsistency in questions asked and the timepoints the data was collected for mentee and mentor groups, For future evaluation of the scheme, it is recommended having standardised feedback questions for mutual aspects (i.e., satisfaction, communication, relationship experience and outcomes) to enhance the comparability of data between groups. This could follow the approach of George et al., (2024) study, who administered

pre/post surveys consisting of standardised questions relating to mentees' confidence and knowledge of applying to CPTP and mentoring goals. Subsequent evaluation of the MMMS could be enriched by having measurable metrics before and after the mentoring scheme as these outcomes would be valuable for dissemination to stakeholders.

In hindsight, framework analysis (Ritchie & Spencer, 1994) could have offered a more structured analytic approach for analysing data from focus group discussions and feedback forms. Since this approach uses a goal-driven framework to guide data analysis, it facilitates a thorough inspection of data, reducing the chances of subjective interpretations and increasing scientific rigour (Parkinson et al., 2016). This analytic approach may have aided in drawing connections between datasets.

Finally, interest in focus group discussions was low, despite numerous emails being sent out. This round of the MMMS took place remotely, due to restrictions on social distancing following the Covid-19 pandemic, which limited face-to-face recruitment and data collection. Thus, only four individuals participated in each focus group. These findings cannot be generalised to all mentees' experiences, which is important given the majority female sample and the underrepresentation of males in CPTPs. Further research should gather the voices of male aspiring psychologists from DEC to understand how they can be supported.

Recommendations

The researcher met with the mentoring team to discuss service recommendations (see appendix L for all recommendations).

Summary

1. Clearly define the role of mentors and mentees and provide this information in an accessible format.

2. Review how ‘contracting’ is presented to mentors and mentees and how this can be achieved less formally, i.e. conversation about ‘things to consider’ instead of a formal contract.

3. Provide a ‘frequently asked questions’ document with answers to common questions i.e. ‘what to do if I don’t feel like I’m getting the most from my sessions?’

4. Offer face-to-face opportunities for networking and consider having two ‘social representatives’ to arrange events.

5. Encourage mentors to initiate conversations relating to identity.

Conclusion

It is hoped that the recommendations suggested will support the MMMS to develop their current model to better meet the needs of mentees from DEC and work towards reducing the barriers individuals from DEC face. Ongoing evaluation of the MMMS will take place.

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Theory Driven Research Project

A Novel Migration-Map Intervention for People from Diverse Ethnic Communities: A Multiple Baseline Single Case Experimental Study

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August 2024

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Word count: 5500

Proposed Journal: The Cognitive Behaviour Therapist

Abstract

Background: Disconnection from Ethnic Identity (EI) is a common experience reported by individuals from Diverse Ethnic Communities (DEC) after migration and has been linked with mental health problems, including depression. A brief migration-map intervention was developed for individuals from DEC experiencing low-mood and disconnection from EI. A multiple baseline single case experimental study was designed to investigate its acceptability, and its impact on exploration, resolution and affirmation associated with EI.

Methods: Nine participants from DEC who experienced disconnection with EI and low-mood symptoms were randomised to a baseline group of five, six or seven weeks, followed by a three-week intervention and single follow-up session. Participants completed a weekly measure of EI (exploration, resolution, affirmation) and low-mood. Acculturation (heritage and mainstream orientation) and self-esteem were assessed pre- and post-intervention. Acceptability of the intervention was assessed through participant ratings and thematic analysis of qualitative feedback.

Results: The migration-map intervention was rated as acceptable and highly valuable. Outcomes of EI development improved between baseline and intervention phases, however improvements as a result of the migration-map intervention could only be concluded for the exploration component of EI. Small improvements were observed in low-mood symptoms. Descriptive analysis showed a substantial increase in group heritage scores, but only a small increase for group mainstream and self-esteem scores.

Conclusion: The migration-map appears to be an acceptable and promising culturally sensitive intervention for improving exploration associated with EI development. Further

work with larger samples is required to explore how resolution and affirmation can be supported.

Introduction

Migration is the voluntary or involuntary movement of individuals, from one geographical location to another (Bhugra, 2004). Migration, throughout history, has expanded ethnic diversity worldwide. A significant proportion (26%) of individuals in the United Kingdom identify with a 'minority ethnic background'(Office for National Statistics, 2021). This paper uses the term 'Diverse Ethnic Communities', to refer to all individuals not identifying as White British (The Law Society, 2024). There has been a shift from acronyms such as BAME (Black Asian Minority Ethnic) as they are criticised for excluding other ethnic groups in the UK (Aspinall, 2020). The term 'minoritised' is excluded to eradicate subordination and 'whiteness' as the norm, as this group makes up 80% of world's population (Campbell-Stephens, 2020). We focus on ethnicity, as opposed to race, as it is a concept inclusive of various dimensions, including shared cultural experiences, traditions, ancestry and language (Law Society, 2024).

Identity Transformation in Migration Processes

Ethnic Identity (EI) is a multifaceted component of one's social identity and is understood by a sense of belonging to one's ethnic group membership. This can be defined by various dimensions, including but not limited to cultural heritage, values, and ethnic behaviours i.e., traditions, language and cuisine (Phinney & Ong, 2007). EI is dynamic and can evolve over time depending on personal and contextual circumstances.

Migration is a significant life change that can lead to the uprooting of important cultural meaning systems linked to one's social identity (Bhugra, 2004). Leaving behind cultural connections and balancing the values of a host culture with culture of origin (acculturation; Sam & Berry, 2010) cause 'ambiguous loss' and disconnection with EI (Falicov, 2004). The level of acceptance migrants experience from host counties can impact

connection towards one's EI. Individuals whose ethnic status is poorly represented geopolitically and experience racial discrimination may internalise feelings of marginalisation, distancing themselves from their EI, or reaffirming their EI as a coping resource in the face of threat (Phinney, 1998).

Research has shown that compared to native populations, migrant groups are more vulnerable to developing mental health difficulties, like anxiety and depression (see Bas-Sarmiento et al., 2017 for a review). Various factors (i.e., racial discrimination, social exclusion and unemployment) can cause stressful living conditions and identity conflict for migrants. Through the navigation of acculturative stress individuals may experience isolation and hopelessness, which are symptoms of depression. Clinical depression refers to the presence of at least five symptoms of low-mood, anhedonia, loss of appetite, insomnia or excessive sleeping, worthlessness, fatigue, loss of concentration and suicidal thoughts – over a two-week period, causing significant impairment (American Psychiatric Association, 2013). Low-mood is a subjective emotional state that is a symptom of depression characterised by lower levels of mood disturbance that might not meet criteria for a depressive disorder (Vöhringer et al., 2013).

Theoretical Background: Ethnic Identity

The majority of work examining EI is based on Social Identity Theory (SIT; Tajfel, 1982) and Erikson's (1968) theory of Ego Identity Formation (EIFT, Phinney, 1989; Umana-Taylor et al., 2004). According to SIT (Tajfel, 1982) identity develops from a sense of belonging to a particular group and affective processes accompanying this membership. Self-esteem is closely tied to group membership, with positive group evaluations leading to higher self-esteem (Phinney & Chavira, 1992; Tajfel, 1982; Umaña-Taylor et al., 2002). EI is an

important aspect of social identity that becomes salient during the acculturation process. A recent meta-analysis showed increased social identification as a protective mechanism against anxiety and depression within migrant populations (Brance et al., 2023).

EIFT (Erikson,1968) highlights individual's universal need to explore important identity domains, to conclude who they are and want to become. *Exploration* and *resolution* through which individuals achieve clarity about an identity component amongst their broader self-concept, are critical domains of identity development. In line with the EIFT, Phinney, (1989) theorised an 'achieved' EI is attained after individuals have explored their values, goals and beliefs about their ethnicity (exploration) and commitment (resolution) to their ethnic group membership (Phinney, 1989). Greater exploration and resolution of EI has been associated with psychosocial benefits including, higher self-esteem and reduced depressive symptoms (Gonzales-Backen et al., 2016; Phinney & Kohatsu, 1997; Umaña-Taylor, 2016).

Marcia (1994) used the SIT and EIFT to operationalise EI development into categories: diffuse, foreclosed, moratorium and achieved (figure 1). Umana-Taylor et al (2004), extended this typology by incorporating the affective features of SIT, including feeling towards ethnicity (affirmation) as an additional dimension of assessing EI. Together, Erikson's (1968) EIFT and Umana-Taylor et al (2004)'s typology provide a comprehensive understanding of EI development, taking into account ethnic group membership, process and degree of identification, and feelings related to EI.

Figure 1.

Stages of Ethnic Identity Development (Kelly et al., 2020, Marcia, 1994; Umana-Taylor et al., 2004).

		Resolution	
		High	Low
Exploration	High	Achieved + or -	Moratorium + or -
	Low	Foreclosed + or -	Diffuse + or -

Note: This figure has been developed from Kelly et al's (2020) paper and Marcia (1994) and Umana-Taylor et al's (2004) work. Affirmation, or feelings related to ethnic identity can be characterised by positive (+) or negative (-).

Clinical Psychology: Current Practice

Migration processes represent an important area for Clinical Psychology, given their influence on EI and psychological well-being. Mental health services struggle to deliver treatment meeting the needs of diverse populations (Andrews & Boyle, 2008). Cognitive Behavioural Therapy (CBT) is a widely implemented treatment for anxiety and depression, however it is challenged for not considering diverse cultural factors (Hays, 2019). Reported barriers regarding delivery and content of psychological therapies for individuals from DEC include inadequate cultural sensitivity and competence, experiences of cultural dissonance and neglect of cultural identity (Faheem, 2023; Jameel et al., 2022; Phillips & Andriopoulou, 2022; Prajapati & Liebling, 2022).

The literature highlights a need to tackle the acceptability issues individuals from DEC face with psychological therapies. There have been moves towards developing the cultural responsiveness of CBT. For example Beck, (2016) emphasised the importance of incorporating cultural factors in assessment, including mapping out family systems and

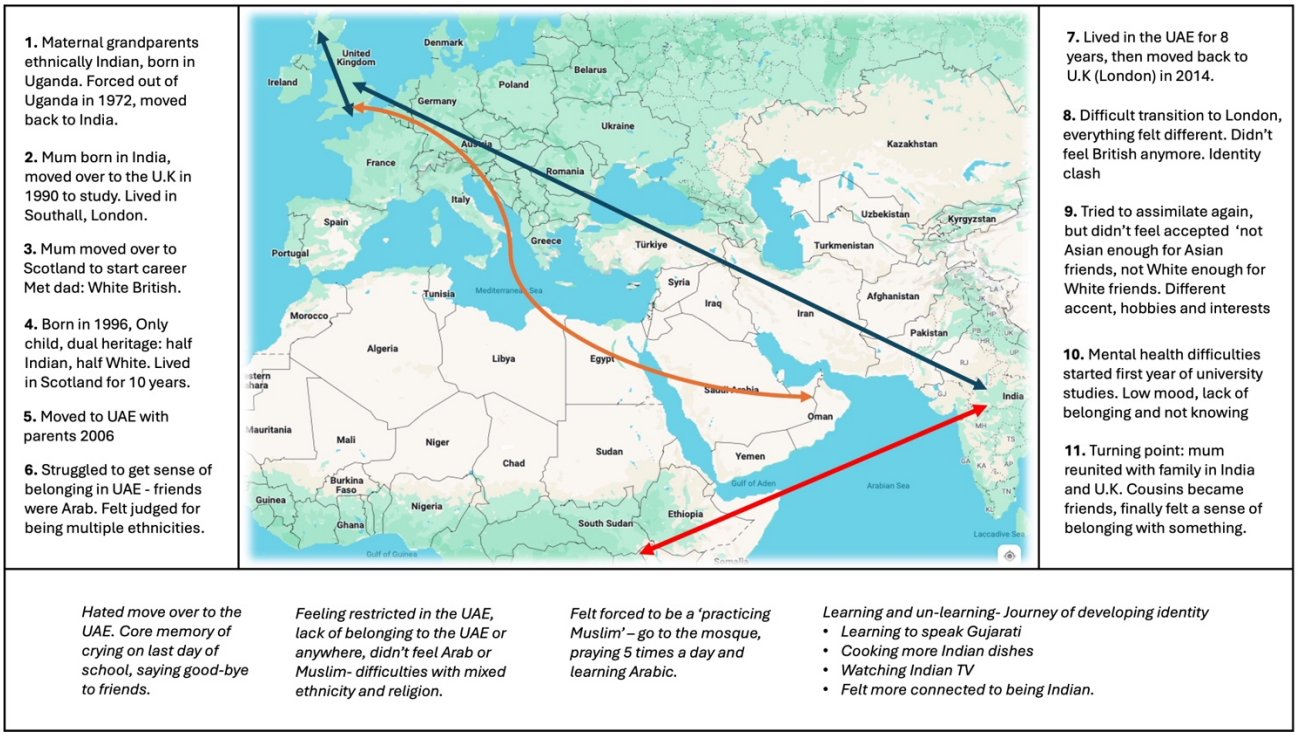
considering migration narratives within these. Visual tools, such as cultural genograms have been developed to facilitate understanding of family systems and cultural factors, and how they relate to presenting difficulties (Falicov, 1995; Hardy & Laszloffy, 1995), however to the author's knowledge they have not yet been evaluated and little is known about their effectiveness.

Migration Maps

The migration-map (Figure 2) is proposed as a new tool for an in-depth exploration of an individual's migration experience, depicting a visual representation of the migration journey via a geographical map. The migration-map tool was invented by Alasdair Churchard as part of a NHS Black History Month event, followed by further development of the concept and its potential application in clinical services. The migration-map's features differ from cultural genograms by visualising the journey(s), labelling emotional shifts and contextual factors tied with the journey(s). The migration-map can capture multiple migration events and represent their multifaceted connections, alongside the personal and emotional growth tied with the move(s). It is hypothesised that the visual and geographical features of the map would allow for deeper reflection of the migration process which could be reduced to a single symbol in a genogram. Research shows the need for culturally sensitive tools that allow therapists to explore people's cultural factors in therapy (Faheem, 2023; Naz et al., 2019), therefore the migration-map intervention was developed to fill this gap.

Figure 2.

Migration map example



Aims

The main purpose of this study was to conduct a case series to examine the acceptability and feasibility of the migration-map intervention for people from DEC with some clinical need (mild to severe low-mood symptoms). Guidance from the Medical Research Council (Skivington et al., 2021) suggests the use of case-series design during initial stages of developing complex interventions. The migration-map intervention had not been through prior piloting phases.

Primary aims:

1. The acceptability of the migration-map intervention.
2. The impact of the intervention on people's stages of EI development, specifically around exploration, resolution and affirmation associated with their ethnic identities.

A secondary aim of this study was to explore whether the migration-map intervention has

an impact on low-mood symptoms, level of self-esteem and acculturation.

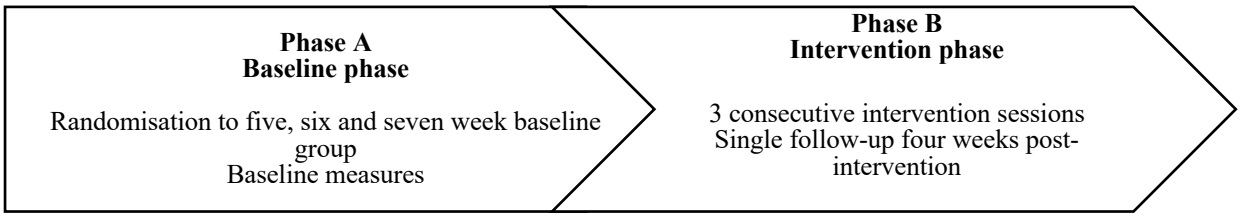
Method

Design

A multiple baseline Single Case Experimental Design (SCED) with two phases was employed (figure 3).

Figure 3

Overview of Study Phases



Participants

Participants from DECs who felt disconnected from their EI and experiencing low-mood, were invited to participate in this study (Table 1). Participants were recruited through advertisements on social media, DEC mentoring groups, the British Association for Behavioural and Cognitive Therapies (BABCP) research website and in-person approaches.

Table 1.

Eligibility criteria for study

Inclusion	Exclusion
Adults aged >18 years.	Intellectual disability or cognitive impairment.
Self-identification as belonging to DEC, defined as, all ethnic groups except the White British group, including individuals from minoritised White ethnic groups such as	Lack of capacity to consent.

Gypsy, Roma and Irish Traveller groups (The Law Society, 2024).	
Detachment or disconnection from ethnic identity (scoring below 19.5 on exploration and/ or 9.5 on resolution subscale of EIS;(Umana-Taylor et al., 2004).	Individuals who have not migrated or have at least one grandparent who is a migrant.
Meeting criteria for at least mild low-mood (scoring 5 or above on PHQ-8; Kroenke et al., 2009; Kroenke & Spitzer, 2002).	Suicidal intent, defined as: having intent to act on thoughts to harm oneself and identified plans/ preparations to do so.
	Diagnosis of severe mental illness and/ or those under step four mental health services.

Measures

Participants completed measures (Table two) via a Qualtrics survey pseudonymously during baseline and intervention phases.

Table 2

Summary of Measures

Measure	Characteristics
Ethnic Identity Scale (EIS, Umana-Taylor et al., 2004).	This is a 17-item scale measuring the degree of ethnic identity development across three dimensions: the degree to which individuals have explored their ethnicity (exploration; 7 items), the degree to which individuals have gained clarity on what their ethnicity means to them (resolution; 4 items) and the affect associated with this (affirmation; 6 items). The questionnaire asks participants to identify their ethnicity and answer questions in relation to this (i.e., "I have participated in activities that have exposed me to my ethnicity"). Items were rated on a 4-point likert scale from 1 (does not describe me at all) to 4 (describes me very well). Negatively worded items were reverse coded and a total score was computed by totalling the responses of items from each of their respective subscales. Higher scores indicated higher levels of exploration, resolution and affirmation associated with one's ethnic identity.

	The EIS is a widely used measure of ethnic identity and has demonstrated good validity and reliability across ethnically diverse samples (α=.84-.89, Umana-Taylor et al., 2004).
Patient Health Questionnaire-8 (PHQ-8; Kroenke et al., 2009)	This was used to measure symptoms of low-mood. The PHQ is a commonly used instrument to measure severity of depressive symptoms in adults, and the version used in this study (PHQ-8) assessed depression on eight of the nine DSM-IV dimensions, excluding suicidality. The questionnaire consists of 8 questions measuring the frequency of symptoms over the past two weeks. Sample items include: "little interest or pleasure in doing things" and "feeling down, depressed or hopeless". Items are rated on a 4-point Likert scale from 0 (not at all) to 3 (nearly every day). A total score was used, with higher scores indicating higher depressive symptomatology. Scores range from 0 – 24, and cut points of 5, 10, 15 and 20 represent mild, moderate, moderately severe and severe depression. Validation studies of the PHQ have suggested using the same scoring thresholds of the PHQ-9 for the PHQ-8 (Kroenke et al., 2009; Kroenke & Spitzer, 2002)
Measure	Characteristics
Self-esteem Scale (SES, Rosenberg, 1979)	Self-esteem was measured using Self-Esteem Scale, which is the standard measure of self-esteem in psychological research. The questionnaire consists of 10 items which are rated on a 4-point Likert scale, scores range from 0 (strongly disagree) – 3 (strongly agree). Sample items include the following: "on the whole I am satisfied with myself" and "I feel I do not have much to be proud of". Negatively worded items are reverse coded. Scores range from 0 – 30, and scores below 15 suggest low self-esteem. This scale has demonstrated moderate internal consistency across ethnically diverse samples (α=.79 - .85).
Vancouver Index of Acculturation (VIA, Ryder et al., 2011)	This is a 20-item scale measuring orientations towards heritage and mainstream groups, in relation to important dimensions of the acculturation process. Examples of these include values, social relationships and adherence to traditions. The questionnaire consists of 10 questions each for measuring heritage dimensions and mainstream dimensions. Items are rated on a 9-point Likert scale from strongly agree (1) to strongly disagree (9). Sample items for each dimension are: 'I

	am interested in having friends from my heritage culture' and 'I am comfortable interacting with British people'. The means of each respective subscales are considered for scoring, with higher scores indicating a positive orientation to the specific group. The VIA is a widely used measure of bi-dimensional acculturation process and has demonstrated good validity and reliability (Huynh et al., 2009; Ryder et al., 2011).
Acceptability	Acceptability of intervention was assessed through three domains: attendance and drop-out rates of the intervention, satisfaction ratings and open-ended questions about the intervention. The metrics for acceptability were shaped by acceptability measures used in previous case-series interventional studies (Sivarajah et al., 2024), guidance from the MRC (Medical Research Council, 2000) and consultation with expert by experience representatives (see below). This measure was collected as part of the 'end of intervention survey' and aimed to gain a rich understanding of participant's evaluation of the intervention. The measure included questions about general experience of the intervention, acceptability, satisfaction, usefulness, value, take-home messages, impact, as well as suggestions for improvement. The measure was co-developed with expert by experience representatives and incorporated elements of The Change Interview (Elliot et al., 2001). The 'end of intervention survey' was completed anonymously by participants.

Note: See appendix N for copies of all measures.

Intervention

The migration-map intervention (table 3, appendix O) was developed for this project using cultural genogram frameworks (Falicov, 1995; Hardy & Laszloffy, 1995) and Umaña-Taylor & Douglass' (2017) EI intervention. The intervention offers individuals an opportunity to explore their migration histories, identify changes that distanced them from their EI, take steps to re-connect with their ethnicity (exploration) and re-frame their relationship with their EI (affirmation and resolution). It is expected that the intervention will bring people closer to their EI, reflected by an increase in exploration, affirmation and resolution (Umaña-Taylor &

Douglass, 2017). Two clinicians were consulted to refine the intervention, and a technology officer from the University of Oxford provided practical guidance on producing the migration-map. The intervention was delivered by the first author, via MS Teams. Regular supervision took place to discuss the intervention sessions.

Table 3

Overview of the Migration-Map Intervention

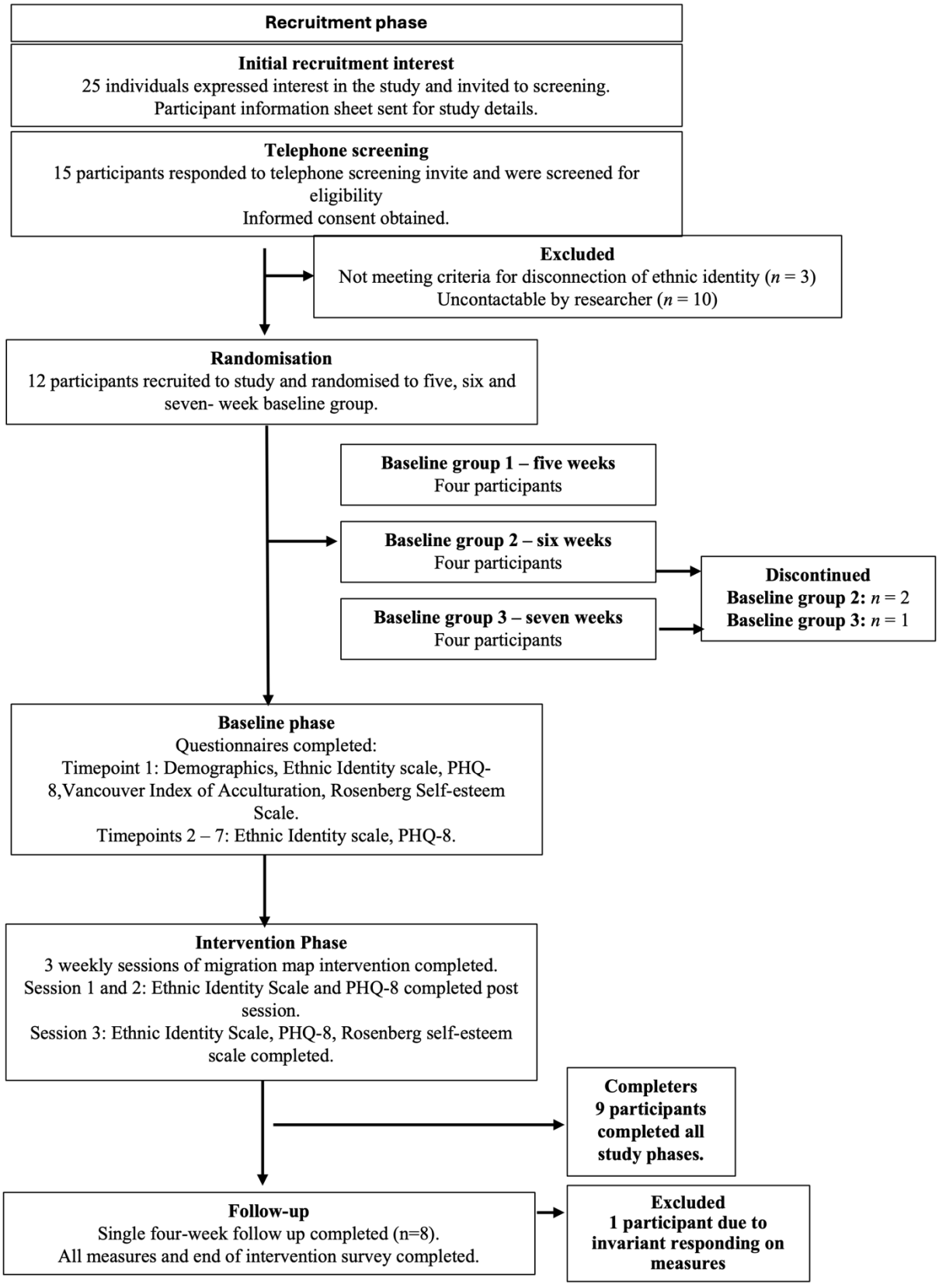
Session	Aims and session elements
Session one	Assessment and engagement session Opening - Discussion of rationale of intervention and structure of sessions - Introduce the migration-map as a tool to help process migration journey and impact on ethnic identity - Self- disclosure about personal rationale and interest in this area - Ask clients to briefly introduce themselves, their or their family's migration history, cultural/ ethnic identity, and what interested them in this research. Setting context for intervention - Asking clients to share their thoughts about migration in general, what associations or emotions this brings up for clients - Open up conversation about how migration is spoken about within their family. - Have you ever thought about your relationship with your ethnic identity prior to this intervention? Elicit information about migration patterns - Family's history of migration - When did they migrate, where did they migrate to and from and who did they migrate with - Reasons behind migration - Experience of migration (stressors/ losses associated with migration) - General impact on individual or family relationships - Relationship between migration, ethnic identity and mental health - Validate difficult experiences or emotions Goal setting - What would you like to achieve from this intervention, and what would that look like? - If you felt more connected with your ethnic identity, what would that look like? Homework - To continue thinking about goals or how they could work towards their goals.

Session	Aims and session elements
Session two	Migration-map - Check in and homework review Preparing geographical map, drawing arrows from country of origin to locations migrated to. Use of different colours to depict individual's migration journey and family's migration. Plotting text boxes around the map with key information about migration journey and the below areas: - Context of migration: was the migration planned/ unplanned, what was happening in the home country when leaving, was the migration welcomed/ supported by family members or did people differ in their views - Experience of migration (associated stressors, losses, bullying, discrimination) - Acculturation to 'majority culture' - Impact on individual (sense of belonging, global identity, mental health) - Impact on ethnic identity (when did you start to feel disconnected with your ethnic identity, in what ways did you feel distanced i.e., food, cultural practices, religion, language etc) - Aspects of cultural identity that you feel aligned to/ less aligned to, or embrace/ reject (pride and shame issues) - Consider global identity if relevant (gender, age, social class, religion, occupation) and how this has been shaped by family/ cultural beliefs/ attitudes. - Strengths of migration or familial/ personal advancements - Connections with 'country of origin'/ family members - Validate and normalise difficult experiences/ emotions
Session three	'Putting it all together' - Continuation of migration-map if not complete - Reflection on mapping out migration journey and considering identity - What has this intervention made you think about, what emotions has it brought up? - Have you faced any barriers with this intervention? - Have you noticed what areas you would like to feel more connected to in terms of your ethnic identity? - Have you noticed any difference in how you are feeling since the start of the intervention? - Have you started exploring aspects of your ethnic identity? - What steps can you take to re-connect with your ethnic identity (consider language, having conversations with family, celebrating cultural events, watching films or listening to podcasts etc) - Do you anticipate any difficulties with this (problem solve) - Has this intervention been valuable? Why or why not? - Take home messages

Procedure

The procedure is outlined in Figure 3. Expression of interest from participants was followed by an information sheet (appendix P), written consent (appendix Q) and telephone screening call (appendix R). Once 12 participants were recruited, randomisation to a five-, six- and seven-week baseline group took place via a random number generator (Appendix S). Participants created unique identifier codes which were used to collect all outcome data. The three intervention sessions were offered over three consecutive weeks, with a single four-week follow up. Participants received a £15.00 gift voucher following completion of the intervention and follow up.

Figure 3.
Overview of recruitment and participation



Data Analysis

Acceptability of the intervention was assessed through inspection of descriptive data and qualitative feedback. EIS and PHQ-8 data was graphed in Excel and the SCDA shiny web app (De et al, 2020), to assess intervention effects. Visual inspection within phases and between phases was carried out by the researcher and supervisors, using the What Works Clearinghouse (WWC; Kratochwill et al., 2010) protocol for Visual Analysis (VA). Tau-U was used as a robust statistical method for assessing data nonoverlap between phases. An online calculator (Vannest et al., 2016) was used to calculate the Tau-U statistic for baseline vs intervention comparison. The visual and statistical analysis was carried out using a systematic data analysis table (appendix T).

Self-esteem and acculturation data was analysed through descriptive statistics. Qualitative data was analysed using principles of Thematic Analysis (TA; Braun & Clarke, 2021). See appendix U for data analysis details for all outcomes.

Ethics

Ethical approval was for this study was obtained by the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC, reference R88676/ RE002, appendix V).

Involvement of Experts by Experience

Three people from DEC with lived experience of migration were recruited from the National Institute for Health and Care Research Centre to develop the intervention, study materials and provide general feedback on the study. Individuals took part in a focus group where they were presented with a draft intervention protocol and migration map example which led to discussions about the structure, delivery and content of the intervention. No changes were suggested for the intervention. The discussion led to some changes to the ‘end of intervention survey’.

Results

Acceptability

25 people expressed interest to participate, of which 15 responded to telephone screening invitations. 12 participants were recruited, and nine completed the intervention (Figure 3). As seen in table four, majority of the participants were female, aged 25 – 34 and first-generation migrants. Participant nine's data was excluded due to response bias, whereby the participant rated the same response for all items on questionnaires.

Overall, adherence was 'good'. Three participants withdrew prior to completing baseline measures, due to changes in personal circumstances (n=1) and being uncontactable. After baseline phase, retention was high with no dropouts during intervention phase. Eight participants attended all sessions and one (participant nine) missed the final session which was rescheduled. The eight participants engaged well with the intervention and completed homework in line with their goals. See appendix W for attendance and engagement report.

Most participants rated being 'very satisfied', 'satisfied' or 'somewhat satisfied' and two participants were 'neither satisfied nor dissatisfied' with the intervention. Most participants felt the migration-map intervention met their expectations (3,totally- 3, moderately), and two participants were 'unsure'. Most participants felt confident in recommending the intervention to others, except one participant (See appendix X for survey results).

Table 4

Participant Demographics and Screening Information

Participant	Age	Gender (self-identified)	Ethnicity	Religion	Ethnic identity typology	Mood	Migration generation	Reason for migration
1	25 - 34	Female	Mixed- Arab and East European	Islam	Foreclosed positive	Moderate	First	Career
2	25 - 34	Non-binary	Indian	Hinduism	Diffuse negative	Mild	First	Education and 'possible expatriation'
3	25 - 34	Female	Pakistani	Islam	Diffuse Positive	Mild	First	Parent's career
4	25 - 34	Female	White- other	Not religious	Diffuse negative	Mild	First	Education and career
5	25 - 34	Female	Chinese	Christianity	Diffuse negative	Moderate	First	Education
6	25 - 34	Female	Mixed – White and Chinese	Not disclosed	Diffuse negative	Moderate	First	Change of government
7	45 - 54	Female	Latina	Not religious	Foreclosed positive	Moderate	First	Husband's career
8	25 - 34	Female	Filipino	Christianity	Diffuse positive	Mild	Second	Employment
9	15 - 24	Female	Mixed- Asian and Caribbean	Christianity	Foreclosed- negative	Severe	Second	'better life'
Withdrawn								
10	25 - 34	Female	Indian	Not disclosed	Diffuse positive	Moderate	Third	Employment
11	15 - 24	Female	Indian	Not disclosed	Diffuse positive	Mild	Second	Not disclosed
12	35 - 44	Male	Bangladeshi	Islam	Foreclosed positive	Mild	Second	Better opportunity

Note. Ethnic identity typology is as follows: Foreclosed (low exploration, high resolution), Moratorium (high exploration, low resolution), Diffuse (low exploration, low resolution) and Achieved (high exploration, high resolution). Positive (high affirmation) and Negative (low affirmation). PHQ-8 symptoms of low-mood are characterised as follows: Minimal (scores 1-4), Mild (score of 5 -9), Moderate (score of 10 – 14), Moderately severe (scores 15- 19) and severe (20 – 27)

Ethnic Identity Development

The VA is presented in Figure 4 and Table 5a, and the statistical analysis in Table 5b. Refer to appendix Y for detailed description of results.

Exploration

VA revealed changing baseline trends for three participants (A, G, F), and Tau-U analysis showed this was significant for participants G and F, therefore baseline corrections were applied.

Comparisons across participants showed a similar process of change in exploration scores from baseline to intervention phase, with the exception of two participants (A, B). There is evidence of gradual change in level, with an increasing trend in the intervention phase, consistent across most participants. However, two participants (A, B) showed a decrease in level and participant G's trend was stable. The change in data pattern was significant for four participants and was replicated across three baseline conditions, indicating a functional relationship between the intervention and changes in exploration.

Resolution

Baseline trends were increasing for two participants (A, G) and decreasing for participant H, however none required baseline corrections. Accordingly, there was variability in the baseline phase for participants A and G, and little variability for participants B, C and H.

Overall, for the intervention phase most participants showed a gradual change in level, however for three participants this increase was small (B, C, E), and for two participants there was a slight decrease in level (A, G). Most participants showed an

increasing trend from baseline to intervention phase, except participant G. As seen in Table 5b, no significant improvements in resolution were observed for any participants.

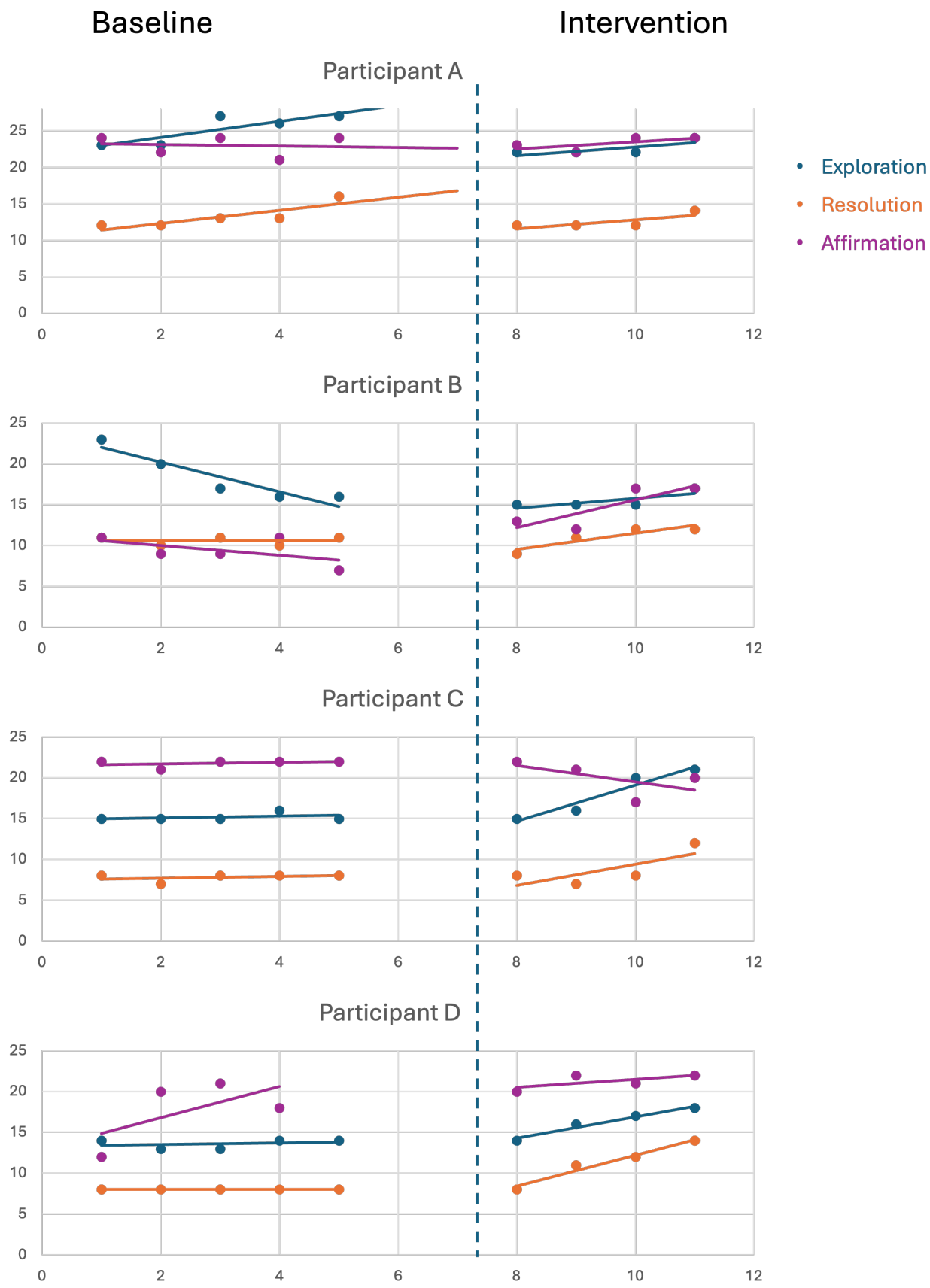
Affirmation

VA revealed increasing affirmation trends for two participants (D, G), however these did not require baseline corrections. There was some variability within the baseline phase for participants D and G.

Comparisons across most participants showed gradual increases in level from baseline to intervention phase, except participant C who showed a small decrease. From baseline to intervention phase, change in level was substantial for some participants (B, D) but small for others (A, E, F, G). Most participants showed increasing trends in the intervention phase, except two participants (C, E) who showed decreasing trends. Improvements in affirmation were significant for three participants (B, D, F), however these were only replicated across two baseline conditions.

Figure 4

Visual plots with trend lines for ethnic identity development outcomes



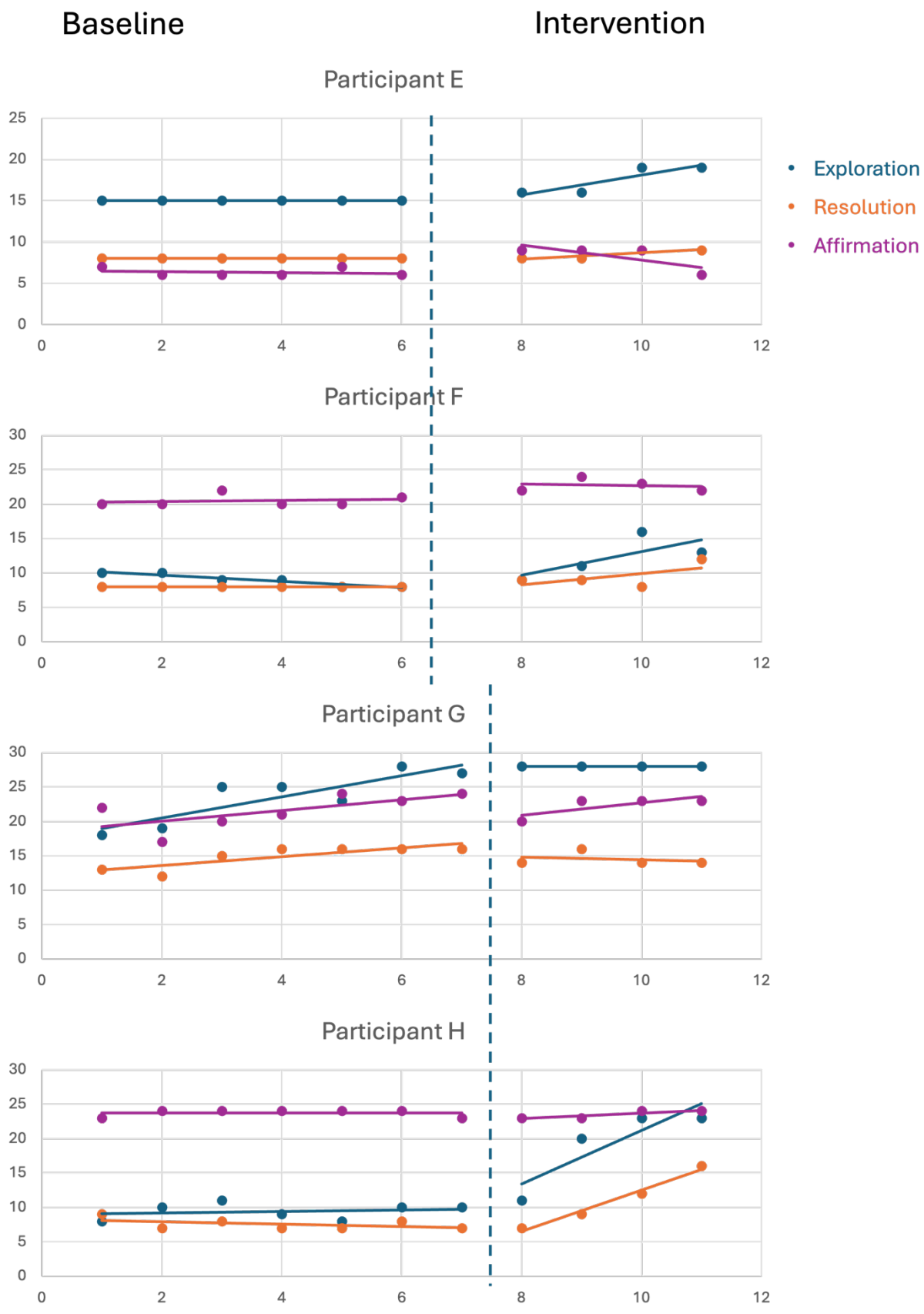

Baseline
Intervention
Participant E
Participant F
Participant G
Participant H
Exploration
Resolution
Affirmation

Table 5

A. Mean and Standard Deviation for Baseline and Intervention Phases for Ethnic Identity Development Outcomes

Participant	Exploration Mean (SD)		Resolution Mean (SD)		Affirmation Mean (SD)	
	Baseline	Intervention	Baseline	Intervention	Baseline	Intervention
A (B1)	25.2 (2.06)	22.5 (1.00)	13.2 (1.64)	12.5 (1)	23 (1.41)	23.25 (0.96)
B (B1)	17.8 (2.05)	15.5 (1.00)	10.6 (0.55)	11(1.42)	9.4 (1.67)	14.75 (2.63)
C (B1)	15.2 (0.45)	18 (2.94)	7.8 (0.45)	8.75 (2.22)	21.8 (0.45)	20 (2.16)
D (B1)	13.6 (0.55)	16.25 (1.71)	8 (0)	11.25 (2.5)	18.2 (3.63)	22 (0.82)
E (B2)	15 (0)	17.5 (1.73)	8 (0)	8.5 (0.58)	6.3 (0.52)	8.25 (1.5)
F (B2)	9 (0.90)	12.25 (2.99)	8 (0)	9.5 (1.73)	20.5 (0.84)	22.75 (0.96)
G (B3)	23.57 (3.83)	28 (0)	14.86 (1.68)	14.5 (1.00)	21.57 (2.51)	22.25 (1.5)
H (B3)	9.43 (1.14)	19.25 (5.68)	7.57 (0.79)	11 (3.92)	23.71(0.49)	23.5 (0.58)

Note: Higher mean scores indicate higher exploration, resolution and affirmation scores. \
Cut off for respective subscales: Exploration = 19.5, Resolution = 9.5, Affirmation = 20.5

B. Tau-U analysis of Baseline trend and Intervention Comparison for the Ethnic Identity Development Outcomes.

Participant	Exploration		Resolution		Affirmation	
	Baseline Trend (Tau-U)	**Baseline vs Intervention (Tau-U)**	**Baseline Trend (Tau-U)**	**Baseline vs Intervention (Tau-U)**	**Baseline Trend (Tau-U)**	**Baseline vs Intervention (Tau-U)**
A (B1)	0.6000	-0.8000	0.8	-0.3	-0.1	0.05
B (B1)	-0.8000	-0.7500	0	0.35	1-0.4	1*
C (B1)	0.2000	0.6500	0.2	0.15	-0.650.2	-0.65
D (B1)	0.2000	0.8500*	0	0.75	0.950.3	0.95*
E (B2)_	0	1*	0	0.5	-0.133	0.67
F (B2)	-0.8*+	1.25*	0	0.75	0.2	0.92*
G (B3)	0.67*+	0.36	0.619	-0.214	0.57	0.07
H (B3)	0.14	0.96*	-0.29	0.6071	0	-0.21

Note: B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3
*Significant change ($p \leq 0.05$)
+Baseline correction applied

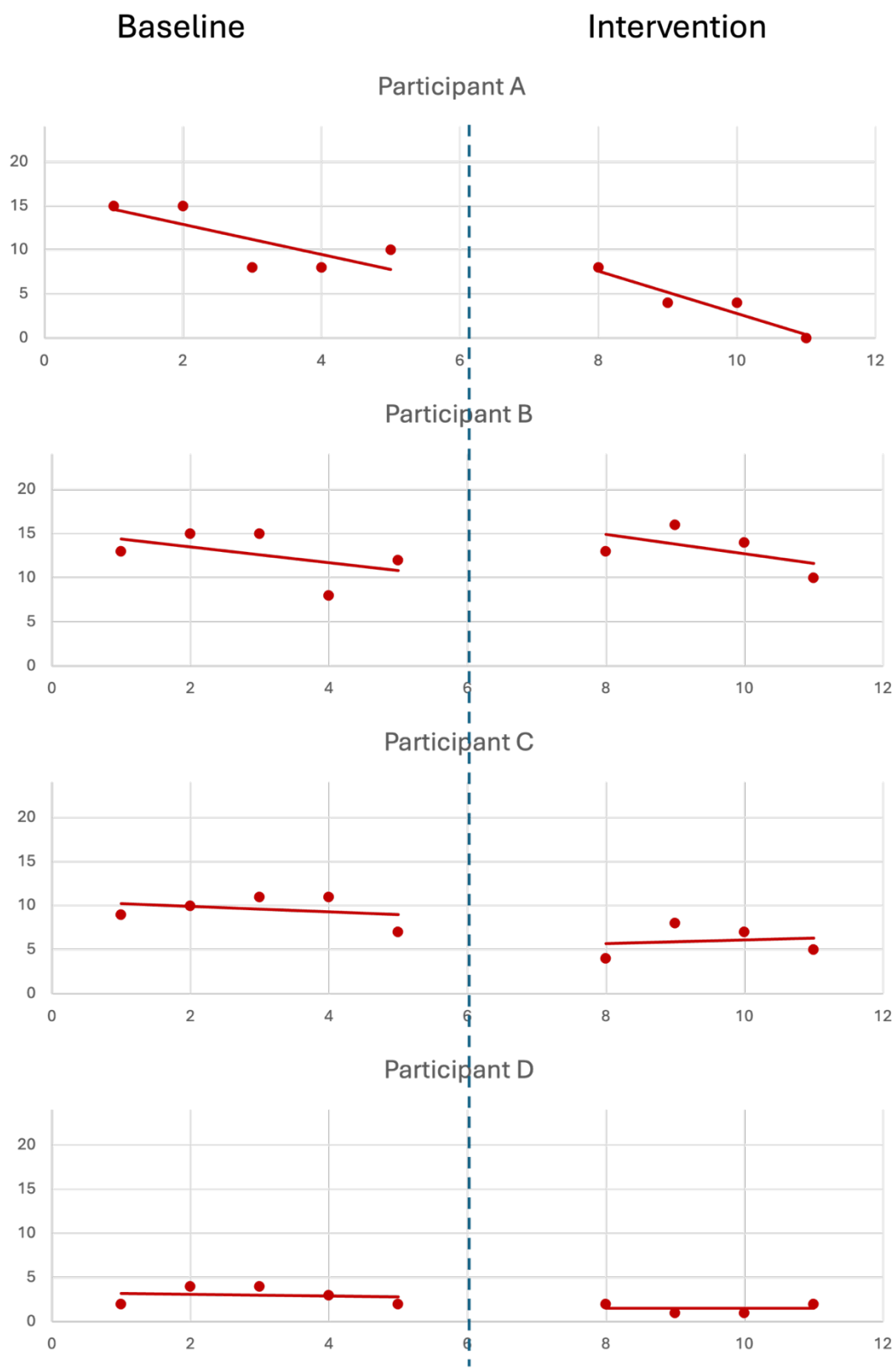
Low-mood

Figure 5 and Table 6 present VA and statistical findings. Participants showed varying baseline trends for low-mood. Decreasing baseline trends were observed for participants A, B, F and G, however these were not statistically significant, therefore baseline corrections were not applied. As shown across most measures, participant G showed high variability in baseline, necessitating caution in the interpretation of their results.

Most participants showed a decrease in central tendency for low-mood from baseline to intervention stage, except participant B. Only participants A, C and H showed significant but gradual improvements in low-mood from baseline to intervention. There was some variability across low-mood scores in the baseline phase, particularly for participants A, B, G and H, however this reduced in the intervention phase. Since, improvements in low-mood were not replicated across all baseline conditions, and VA showing mixed patterns for two participants (A, C), firm conclusions cannot be drawn about the effect of the migration-map intervention on low-mood.

Figure 5.

Visual plots with trend lines for PHQ-8 scores



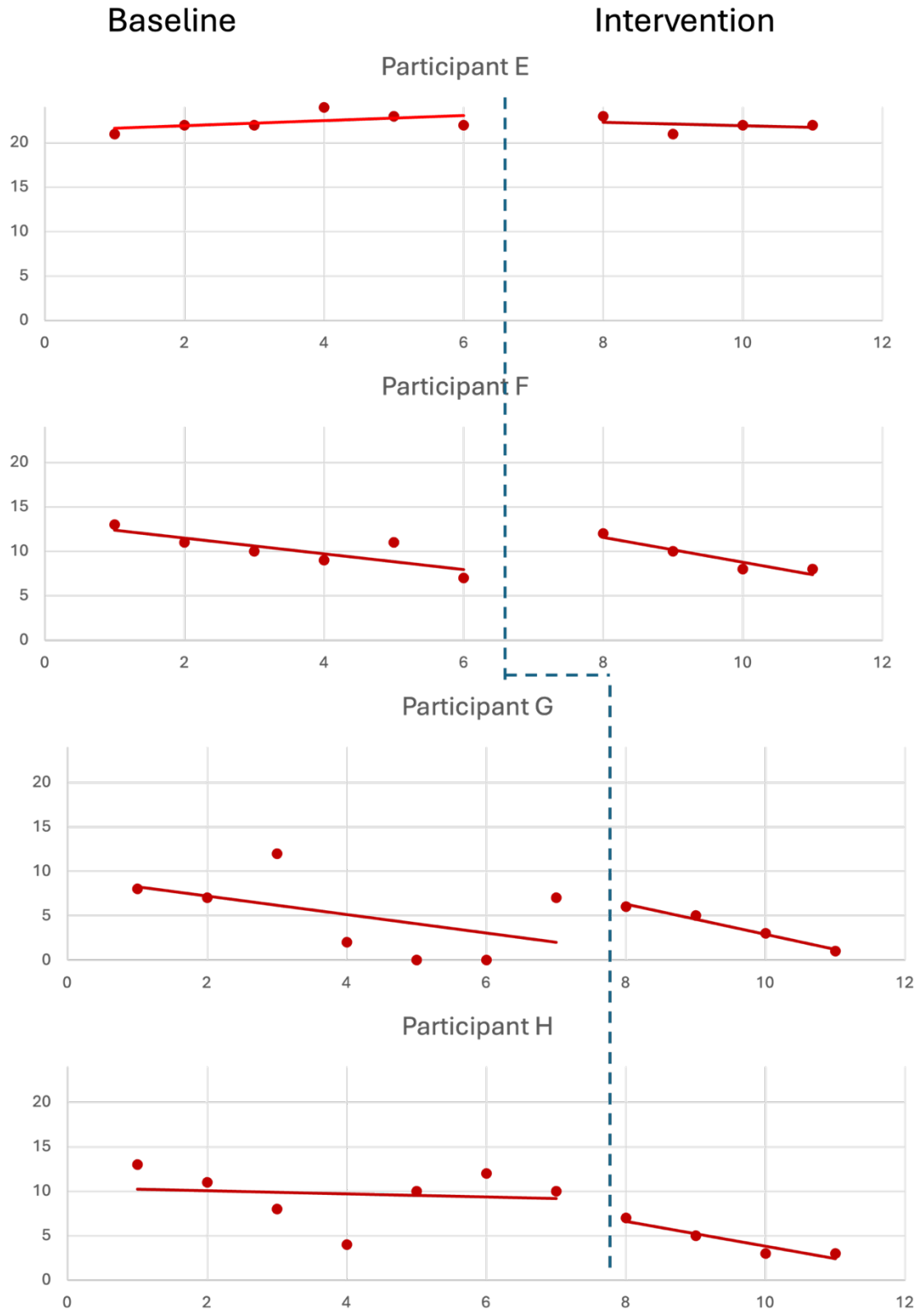

Baseline
Intervention
Participant E
Participant F
Participant G
Participant H
0
5
10
15
20
0
2
4
6
8
10
12

Table 6.

Mean and Standard Deviation for Baseline and Intervention Phases and Tau-U Analysis of Baseline Trend and Baseline Intervention Comparison for PHQ-8 Scores.

Participant	Mean (SD)		Tau-U Analysis	
	Baseline	Intervention	Baseline trend	Baseline vs Intervention
A (B1)	11.2 (3.56)	4 (3.27)	-0.4	-0.9*
B (B1)	12.6 (2.88)	13.25 (2.5)	-0.3	0.15
C (B1)	9.6 (1.67)	6 .0 (1.83)	0.1	-0.85*
D (B1)	3.0 (1)	1.5 (0.58)	-0.2	-0.8
E (B2)	22.3 (1.03)	22.0 (0.82)	0.4	-0.17
F (B2)	10.16 (2.05)	9.5 (1.92)	-0.67	-0.21
G (B3)	5.14 (4.56)	3.75 (2.22)	-0.43	-0.21
H (B3)	9.72 (2.99)	4.5 (1.92)	-0.19	-0.86*

Note: B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3
Lower mean scores indicate lower symptom severity
*Significant change ($p \leq 0.05$)
+Baseline correction applied

Secondary Outcomes- Self-Esteem and Acculturation

Descriptive data by study phase are shown in Table 7. Group heritage scores increased from pre-intervention to post-intervention (follow-up) time point, with a medium effect size (*d = 0.73).* There was a small increase in group mainstream scores from pre-intervention to post-intervention (*d = 0.17).* Most participants showed increases in heritage scores from pre-intervention to post-intervention, except participant A, whose scores decreased. For mainstream, three participants showed small increases in scores, four participants showed small reduction in scores and one participant remained static.

Mean group self-esteem increased slightly from pre-to post-intervention, however effect size was small (*d =0.47).* Most participants' self-esteem scores changed after the intervention, except participant E and F, whose scores stayed the same. Most participants' self-esteem scores were maintained at follow up, except participants A and G whose decreased.

Table 7.

Mean and Standard Deviation for Pre-intervention and Post intervention for All Outcomes

Outcome measures	Pre-intervention	Post-intervention	Follow-up	*d*
EIS Exploration	16.5 (7.03)	20 (4.28)	20.37 (4.66)	0.60
EIS Resolution	10.25 (3.73)	10.88 (2.23)	12.88 (2.10)	0.21
EIS Affirmation	18.38 (7.46)	19.88 (5.25)	19.87 (6.08)	0.23
PHQ-8	9.63 (5.83)	7.75 (7.05)	6.38 (7.19)	0.29
VIA Heritage	55.50 (14.93)	-	64.13 (7.28)	0.73
VIA Mainstream	57.38 (11.56)	-	59.50 (13.36)	0.17
RSE	16 (4.11)	18.38 (5.85)	19.75 (6.04)	0.47

Note: Total scores for all measures: Exploration = 28, Resolution = 16, Affirmation = 24, PHQ-8 = 24, VIA Heritage and Mainstream = 90, RSE = 30. Higher scores are indicative of higher for all scales, apart from PHQ-8 where lower scores indicate lower symptom severity.
Cohen's d change: Pre intervention (end of baseline) and Post intervention (end of intervention) for EIS scales and PHQ-8. For RSE pre intervention and post intervention. For VIA pre intervention and follow-up.

Thematic Analysis of qualitative data

Table 8 summarises emergent themes and sub-themes from TA of open-ended questions from end of intervention survey (See appendix Z for full analysis).

Table 7.

Thematic Analysis of qualitative data from end of intervention survey

Theme 1. Migration – a silenced journey This theme encapsulated participant's perspectives on the lack of opportunity to discuss their migration experiences, both within previous therapy, and amongst family members themselves. This theme highlighted a desire and need for a space to discuss migration and the impact on identity.	
Gaps in therapy	Participants highlighted missed opportunities within previous therapy sessions to discuss their migration experiences *"Having had a history of being in therapy with different therapists throughout my life, I have found the migration map to be a very unique and important therapeutic process which I have never really had the chance to speak about in the past" (P1).* Furthermore, participants identified a need for conversations about migration and its impact on identity and mental health to be prioritised in therapy sessions, *"It was helpful to have sessions focused on my relationship with my ethnic/cultural identity, as I've never had therapy focus so deeply on this aspect of my identity and how it ties in with my mental wellbeing" (P8).*
Silence amongst families	There was a general consensus between participants about the lack of discussion about migration and its impact, within families *"As the daughter of a first-generation immigrant family, migration was treated as almost a given part of our experiences and our future, and I have never really reflected how this has shaped me and my family" (P1).* Some participants highlighted that discussions about migration were lost during busy periods of transition and assimilation *"I was surprised by how little we spoke about migration growing up as we were so busy adapting and had little time to slow down" (P3).* It was further reported that this intervention highlighted the importance of going back and holding these discussions "*this has become more important to learn about over the years" (P3).*

Theme 2. The process of migration maps This theme captured participants' experiences of the process of completing the migration maps which highlighted three important aspects of the intervention: visual features, reflective process and therapeutic process. These aspects were highlighted as important facilitators which enhanced the experience of exploring migration histories.	
Visual features	Participants highlighted the importance of visual features of the migration-- in increasing insight and awareness of their experiences of migration, as well as leading to important realisations about the difficulties encountered during the transition: "*To see all the journey in just one map ,in one visual drawing, give me the opportunity to realise I have been for a lot of hard times and not wonder why I go forward slowly and carefully"* (P7). Distance was an important aspect that became more prevalent with mapping out the migration journey, *"Mapping it out allowed me to recognize how important these migration events in my past were and I have actually made big moves in my life without really giving myself any credit or compassion for struggling with these moves" (P1).* Furthermore, participants perceived the text boxes around the map beneficial in contextualising their migration experiences and organising sequence of events in their life, *"I liked that the migration map had dates of year as this helped the clarity" (P8).* The visual features were also considered *"key to gain insight into important aspects of my identity and my sense of belonging"* (P3), and helped participants notice changes over time *"It was insightful to see my journey in understanding my cultural identity and how this shifted in different contexts" (P3).*
Reflective processes	Participants made reference to the reflective nature of the migration-map intervention which facilitated the experience of exploring migration histories, *"The migration-map itself helped me visualise my experience of migration and ethnicity, while our discussion led to meaningful reflection and realisation" (P6).* The intervention further initiated a two-way process of reflection between the participant and clinician which was considered important to minimise biases and assumptions, *"it resembled more of a reflective exercise that helps both the client and therapist/clinician(s) reflect on their own personal experiences, biases and standings with respect to the therapeutic alliance" (P2)*. The intervention facilitated greater reflection between sessions which was important for a holistic exploration of migration, *"I enjoyed reflecting on*

	my migration journey. I found it helpful and the time between sessions helped me to think more about the impact of migration and remember parts I did not reflect so much on" (P3).
Therapeutic process	Participants also emphasised the importance of the therapeutic process, which was an important factor in creating a *"psychologically safe" (P1)* space for participants to discuss their migration experiences. Self-disclosure from the therapist was an important first step in developing therapeutic rapport and creating a safe space for participants to open up conversations about migration which was recognised by many participants, *"I found it beneficial that she shared her own lived experience and motivation for the research / intervention, as it helped us connect and make me feel like she personally understood some aspects of what I was talking about" (P6*). Participants shared their experiences of feeling validated which is vital for therapeutic alliance*, "processing my migration history with Ikra felt safe as she created an inclusive, warm and non-judgemental space to explore my cultural conflicts" (P1); "I found my experience being validated and heard" (P3).*
Theme 3. 'Key moments of shift'. This theme features participant's perspectives on the gains made during and after the intervention. Key moments of shift are characterised by the following subthemes: processing migration, emotional shifts, re-evaluation of ethnic identity and identity continuity.	
Processing migration	Participants highlighted the importance and value of processing their migration journeys in relation to their identity as a result of the migration-map intervention. The intervention led to important and deep realisations about participant's migration histories and the subsequent impact on the individual, *"I used to use my migration history as a fun fact about myself and mention it in passing in conversation, however with this intervention, I realise how much my migration has truly shaped who I am today and the way that I engage with my culture and perceive myself in relation to my culture"(P1).* For some participants this also facilitated self-awareness and relief, ***"****I found it relieving to reflect on the big impact it had on me as a child. This has helped me to understand myself better" (P8).* Furthermore, participants found it beneficial to dig

	deeper into their experience of migration and process associated emotions, **"***At first, I thought that there was not much to map out because I am the first member of my immediate family to migrate. However, I was prompted and enabled to focus on my experience, express my thoughts and feelings, and reflect on them in a meaningful and empowering way" (P4).* Other participants expressed the importance of an 'individualised' migration map which helped them separate their migration journey from their families', *"It also allowed me to develop a sense of ownership over my past and history, that my migration was my own unique story and not just an extension of my family's past migration" (P1).* For some participants the intervention led to an acknowledgment of strengths associated with migration experien*ces "I was able to realise and celebrate some of my achievements along the way" (P4).*
Emotional shifts	The process of exploring migration in relation to important identity domains involved important emotional shifts. Some participants described experiencing difficult emotions as a result of discussing aspect of their cultural roots which felt uncomfortable to engage with, *"I was also able to realise why I felt so deeply conflicted owing to my shared experiences and histories of intergenerational cultural exchanges, and the inherent sociocultural aspects of my experiences which did not resonate with me. This made me quite uncomfortable but I felt I needed to feel that way to understand the discordance in my experiences and current sense of self" (P2).* Similarly, whilst discussing shame stories led to uncomfortable emotions, it was also *"tinged with hope and self-acceptance"(P2; and "Revisiting shame about my ethnicity was slightly uncomfortable but meaningful, as I explored both the collective experience of shame (i.e. stereotypically negative aspects of my ethnicity) and my personal shame that I am mostly ashamed instead of proud of my ethnic identity" (P4).* Other participants shared similar emotional shifts, *"I wouldn't label this as a difficulty, but I found myself feeling an emotional release (crying and feeling tearful) after sessions as a result of processing my migration history… I understood this for myself as finally being able to acknowledge and discuss my migration and its impacts on myself in a psychologically safe environment" (P1).* Furthermore, many participants reported noticing a reduction in self-criticism and increase in self-compassion as a result of the intervention, *"I am able to give myself more compassion and also allow myself to feel impacted by things (which I would have normally just undermined the impact or not acknowledged it)"(P6).* For some participants this led to greater *"compassion towards myself but also towards my parents (who in my past were very discouraging towards my migration events as they were worried about the impact that they would have on my wellbeing)" (P1).*

Re-evaluation of ethnic identity	This subtheme captured participant's experiences of re-evaluating their relationship with their ethnic identity as well as the important process of re-establishing connections with it. The initial step towards this was for participants to develop an awareness of the link between their migration journeys and disconnection with ethnic identity, *"it made me realize how each migration event in my life (as I have had many) each had a unique impact on my ethnic identity and almost reflected my relationship with my ethnicity. I didn't realize how the two were so interlinked as my migration histories were education driven" (P1).* For some participants this involved processing their feelings about their ethnic identity, *"I found every aspect of the intervention quite valuable and helpful in gaining a deeper understanding of my ethnic identity and my feelings towards it, as well as in revisiting and reframing those feelings with a compassionate approach" (P6).* Participants were able to reframe their feelings towards their ethnic identity and view it as a strength, *"I gained a deeper understanding of my thoughts and feelings about my identity and a newfound appreciation of my ethnic background (P4); "It also helped me embrace my changing identity so I can see it as strength instead" (P8*). An important process of this included discovering, *"That it is ok to have aspects of my culture that I feel aligned with, and others that I don't" (P6).* Participants felt that the migration-map intervention led to *"an increased awareness of ethnicity in general and curiosity about my own ethnic background since the beginning of the intervention. I have also noticed a more positive attitude towards my own ethnicity since the end of the intervention" (P4).* Furthermore, participants expressed feeling more *"empowered in my ethnicity" (P1)* which subsequently resulted in *"exploring my ethic identity and practice meaningful ways to reconnect with it" (P6).* Participants shared a range of ways in which they were able to start to re-establishing meaningful connections with their ethnic identity, including *"e.g. food, music, places, history" (P4).* For other this involved, *"listening to more podcasts related to my culture" (P6),* and *"Courage to ask my dad questions and engaging in more activities to feel connected to my culture" (P3).*
Identity continuity	This subtheme highlighted the nature of ethnic identity development being a part of an 'ongoing journey', and the importance of the migration-map intervention in helping participants identify ways in which they could work towards this,

	"I have taken away valuable insights and realisations, as described in my previous answers, and useful ways to reconnect/maintain a connection with my ethnic identity moving forward" P1. For some participants this involved identifying barriers with maintaining a connection with their ethnic identity, *"That I avoid aspects of my ethnic identity because one of my parents is my only consistent source of connecting with my ethnic identity, and we have a difficult relationship. That there are little steps I can take to re-build a relationship with my ethnicity / culture" (P6) and problem solving, "I feel more comfortable building my own relationship with my ethnicity /culture outside of my relationship with my family" (P6).*
Theme 4. Areas for improvement This theme encapsulated participant's feedback for improvements to the intervention.	
Conversations about trauma	Some participants expressed a desire for more consideration of trauma in migration experiences, *"I think sometimes migration journeys can involve stories about trauma which can play a part in someone's journey due to cultural biases and generational patterns which can be more important to think about". (P3*). However, one participant found it unhelpful to discuss trauma in sessions, *"when the therapist repeats several times that I have passed for trauma. I didn't help' (P7).*
Therapeutic techniques	Participants offered suggestions for incorporating Cognitive Behavioural Therapy techniques within the intervention, *"Can consider cognitive restructuring when challenging biases towards cultures" (P5)* and the implementation of formal between session tasks, "*Maybe some homework for example reading or thought diary?" (P3).* There was also a recommendation for more consideration of, *"life experience as it impacts migration journey and intergenerational patterns. these play a key role in what cultural biases come in" (P3).*

Practicalities	Participants expressed their perspectives on the number of sessions of the intervention, which was considered, *"It's a short intervention while helpful may not be able to address deep rooted mental health difficulties" (P5).* This participant also felt that *"3 sessions is probably not long enough to promote any significant changes." (P5).* Another participant suggested *"to have an additional session after finishing the migration map for any reflections/processing of feelings of what it was like to put together the map. I find myself very goal-oriented when it comes to therapy and I struggle to sit and reflect on my emotions when I know I am meant to be finishing up a task/part of the intervention. Have a week between finishing the map and reflecting on it also allows for people like me (where emotions seem to take their time to settle in) to be able to bring the full experience".* Other suggestions included the use of an 'interactive map', in-person sessions and more detail about what the migration map entails, *"Maybe a bit more detail about what we will do during the intervention before we start? I.e. we will draw arrows, we will write text around the map etc". (P6).*
Measures	Some participants expressed difficulties with completing the questionnaires, *"The weekly questionnaire, some questions are difficult to understand because are asking in present perfect. And it's confusing to answer" (P7); "I think more information about the purpose of the questionnaires and any further information about them to help alleviate how mundane and repetitive they are to complete...." (P6).*

Discussion

This study evaluated a novel migration-map intervention for individuals from DEC feeling detached from their EI, using a multiple baselines SCED. The findings seek to provide a culturally sensitive tool that has potential to facilitate important conversations about clients' cultural identities in therapy.

Primary outcomes

Overall, the intervention appeared to be acceptable to participants, informed by low dropout rates and post-intervention ratings. Three participants dropped out during baseline phase, however there were no further dropouts once the intervention started. The baseline dropouts could be due to a delay between screening and start of study, whilst it underwent ethics changes. Most participants were satisfied with the intervention, felt their expectations were met, and expressed confidence in recommending the intervention to others.

TA of qualitative data provided an understanding of the intervention aspects considered beneficial. The first theme featured participant's experiences of migration being unspoken about, in line with research highlighting the lack of incorporation of cultural identity in therapy (Prajapati & Liebling, 2022). The second theme captured participant's experiences of the process of the migration-map intervention, highlighting the importance of visual features of the map in increasing insights into migration, contextualising experiences and developing links with EI. The third theme highlighted the intervention's value in helping participants process their migration history, re-establish connections with their EI, and facilitating emotional shifts. Theme four highlighted areas for improvement, which included trauma conversations, incorporation of therapeutic techniques to challenge cultural biases and a longer intervention. This theme helps contextualise participants' neutral satisfaction ratings

(n=2), uncertainty about expectations met (n=2) and lack of confidence recommending the intervention to others (n=1).

Outcome data showed the intervention led to significant changes in exploration stages of EI, which was replicated across baseline groups, suggesting a functional relationship between the intervention and changes in one EI stage. Out of six participants that commenced the study with low exploration scores, three participants (E, G H) scores changed to high exploration post-intervention.

For resolution and affirmation, we did not find a clear and consistent picture of improvement. Five participants commenced the study with 'low resolution' scores, however none led to statistically significant improvements post-intervention, which could be due to small changes in level and overlapping data observed in VA. Despite two participants' scores changing in level and trend to 'high' resolution at post-intervention, the non-significant results prevent us from drawing definitive conclusions.

For affirmation three participants showed significant improvements after the intervention, however these were only replicated across two baseline conditions. Participant D's results must be interpreted with caution due to an increasing baseline trend, suggesting the possibility of confounding factors causing changes in scores. Out of four participants starting with low affirmation scores, two (D, F) achieved high affirmation post-intervention.

The intervention led to significant changes in exploration rather than resolution and affirmation. This is in line with theory (Erikson, 1968; Marcia, 1994; Phinney, 1989;) which highlights exploration as a first stage of identity development, through which individuals

achieve resolution about their EI. It is possible that our intervention provided a starting point for participants to re-connect with their EI, and changes to resolution and affirmation require longer term engagement. This is consistent with our qualitative data, where some participants reported three sessions were insufficient to 'promote significant change'. Our intervention focussed on facilitating exploration of EI within the migration context, as well as reflective conversations of 'pride' stories (Hardy & Laszloffy, 1995) to help participants reframe their feelings about their EI. However, it may be necessary to incorporate CBT techniques such as 'cognitive restructuring' to tackle complex feelings about EI.

Secondary Outcomes

Analysis of PHQ-8 outcomes showed no consistent pattern of change across baseline groups. Despite three participants showing significant changes in low-mood from baseline to intervention phase, the data quality undermined confidence in the reliability of these findings, due to decreasing baseline trends and overlapping scores between phases. Due to recruitment difficulties, inclusion criteria was adjusted from moderate-severe low-mood to include mild scores. The inclusion of participants with mild symptoms, may have left little room for improvement, therefore future studies should limit inclusion criteria to moderate-severe low-mood, or delay Phase B until stability is achieved.

A secondary aim explored whether the intervention led to changes in participant's self-esteem and heritage and mainstream dimensions of acculturation. Descriptive analysis revealed small group changes post-intervention and at follow-up, suggesting a tentative link between exploration of EI and positive self-esteem in line with previous research (Phinney & Chavira, 1992; Umaña-Taylor et al., 2002), however our study design precludes causal inferences to be drawn.

Acculturation findings suggest changes in heritage sub-scores with a medium effect size from pre- to post-intervention, and small changes in group mainstream scores. According to Berry's (1997) bi-dimensional acculturation model, integration (the adoption of mainstream cultural norms and maintenance of heritage culture) is the preferred adjustment strategy for migrants. Unsurprisingly we did not see changes in mainstream scores as most participants aimed to build connections with their EI, as opposed to mainstream culture. The conceptualisation of bi-dimensional identity is incongruent with EIFT (Erikson, 1968; Phinney, 1989) which places greater emphasis on the process of developing identity, as opposed to relationships with heritage and mainstream culture.

Limitations

There are limitations to this study which should be addressed in subsequent evaluation. The small sample size and the majority of participants being females aged 25 - 34, limit generalisability to a wider population. We aimed to recruit a diverse sample through social media and in-person approaches, however ages 30+ are underrepresented in our sample. Recruitment methods such as intensive community outreach and flexibility with English proficiency may allow future studies to reach a more inclusive sample.

Our inclusion criteria aimed to recruit a homogenous sample of individuals feeling detached from their EI and experiencing clinically significant depression, however we struggled to recruit a sample meeting both criteria. Future studies should consider recruiting from NHS services to reach a definitive sample of people with clinical need and evaluate the feasibility of the intervention in clinical services. Furthermore, the EIS is a commonly used tool to measure EI in psychological research, developed with the assumption that certain EI components are common amongst all ethnic groups. However, EI is a multidimensional construct that could differ between cultures, thus culture-specific constructs might be missed.

Future research could incorporate idiosyncratic measures of EI or use qualitative methods to allow participants to express their relationship with their EI.

This intervention had not been through a piloting phase, which could have been beneficial for testing recruitment strategies and refining the intervention protocol. Our intervention was designed to be brief, resulting in three intervention sessions and four data points in phase B (Kratochwill et al., 2010, 2013). Future research could increase data points in phase B, reducing the likelihood of overlapping data and giving participants more opportunity to explore their EI and achieve resolution. It is recommended for an additional phase to be included in future research, to evaluate the intervention's longer-term impact (Kratochwill et al., 2013).

This study was not blind as the researcher screened participants, collected outcome data and delivered the intervention. The researcher's dual involvement could have increased risk of social desirability on surveys. To minimise bias in data analysis the supervisor (AC) was involved in all aspects, particularly VA and TA where risk of bias is higher.

Implications and future directions

As identified in the introduction, there is a need for more culturally sensitive interventions targeting culturally relevant factors in therapy for DEC clients. This study has important clinical and theoretical implications:

1. The migration-map intervention was acceptable to individuals from DEC and provided an opportunity to reflect on their migration histories in relation to their EI and mental health. Through qualitative feedback, participants highlighted the lack of opportunity to address these factors in previous therapy sessions. It is

imperative for therapists to create a safe space for these important conversations, as failure to do so, can create an incomplete understanding of presenting difficulties and intervene with effective treatment. Neglect of client's EI could undermine trust, safety and rapport which are key aspects of therapeutic alliance (Young & Mooney, 2024).

2. This study provides initial support for the migration-map intervention in improving EI outcomes. The intervention led to statistically significant improvements for exploration, however a longer intervention may be needed for resolution and affirmation components. This intervention has the potential to offer an experiential way of targeting complex feelings related to EI, that might be difficult to express in therapy conversations. However, further research is warranted, which could involve the development of a randomised controlled trial to assess intervention efficacy and research into therapist's experience of this tool in relation to cultural competence outcomes. The findings add to existing research (Faheem, 2023; Naz et al., 2019) aimed at improving the experiences of psychological therapies for underrepresented groups.
3. Our results show tentative support for the EIFT (Erikson,1968) which posits that identity development occurs through a process of exploration of values and goals related to ethnicity, through which commitment to ethnic group membership can be achieved. Giving participants an opportunity to identify what led to disconnection with their EI during migration, in-turn increased participant's motivation to explore their EI. Future research is needed to examine whether a refinement of the intervention with a greater focus on affirmation and resolution components leads to differential outcomes.

This study was a first step in assessing the acceptability of a novel migration-map intervention for participants from DEC, in relation to outcomes on EI development. Further evaluation of the intervention is warranted, addressing the limitations of this study.

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Executive Summary

A Novel Migration-Map Intervention for People from Diverse Ethnic Communities: A Multiple Baseline Single Case Experimental Study

Background

Leaving one's country of origin involves significant life changes, including the uprooting of important cultural meaning systems linked to one's identity (Bhugra, 2004). Disconnection from ethnic identity is a common experience reported by individuals from Diverse Ethnic Communities (DEC) after migration.

Social Identity Theory (SIT; Tajfel, 1982) proposes self-concept and identity develop from a sense of belonging to a particular group. According to Ego Identity Formation Theory (Erikson,1968) and Phinney's (1989) seminal work, individuals have a universal need to explore important identity domains, including ethnic identity, to conclude who they are and want to become. An 'achieved' ethnic identity is attained after individuals have explored their values, goals and beliefs about their ethnicity (exploration) and committed (resolution) to their ethnic group membership (Phinney, 1989). Greater exploration and resolution of ethnic identity have been linked with psychosocial benefits including, stronger self-concept, higher self-esteem and reduced depressive symptoms (Gonzales-Backen et al., 2016; Phinney & Kohatsu, 1997; Umaña-Taylor, 2016).

This study developed a migration-map intervention to offer individuals from DEC an opportunity to examine the relationship between their migration history and ethnic identity

through a visual tool, and a space to work towards achieving exploration and resolution about their ethnic identity.

Aims

To explore the acceptability and outcomes of a three-session migration-map intervention for people from DEC who are experiencing detachment from their ethnic identity.

Primary objectives:

- Acceptability of the migration-map intervention.
- Impact of the migration-map intervention on people's stages of ethnic identity development, around exploration, resolution and affirmation domains.

Secondary objectives

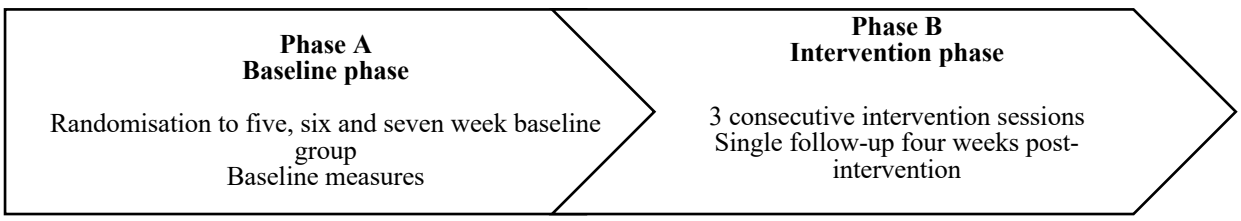
- Impact of the intervention on people's level of low-mood, self-esteem and acculturation (heritage and mainstream domains).

Methods

A multiple baseline Single Case Experimental Design (SCED) with two phases was used in this study. (figure 1).

Figure 1

Overview of Study Phases



- 12 participants from DEC, who felt disconnected from their ethnic identity and experienced mild to severe symptoms of low mood were recruited to this study.
- Participants were randomly allocated to a baseline group of five, six and seven weeks.
- During the baseline phase participants completed weekly measures of ethnic identity and low-mood.
- At the end of the baseline phase participants took part in three weekly sessions, delivered by a trainee clinical psychologist under supervision of a qualified clinical psychologist and systemic psychotherapist.
- Participants completed weekly measures of ethnic identity and low-mood throughout the intervention phase, and at a four-week follow-up.
- Pre and post measures of self-esteem and acculturation were also collected.
- Participants provided feedback at the end of the intervention through a survey.

Key findings

Acceptability of the intervention was evaluated through attendance and drop-out rates, satisfaction ratings and qualitative feedback.

- 12 participants were recruited to the study, three dropped out during the baseline phase prior to completing the measures (2 = did not respond to emails, 1 = change in personal circumstances).
- Nine participants completed the study, there were no drop-outs during the intervention phase.
- Study adherence was deemed good, as informed by attendance rates. All nine participants attended the three sessions, one participant forgot about the final session which was therefore delayed and took two weeks apart.
- 8/9 participants completed their homework in relation to their goals.

- Participants reported being ‘very satisfied’ (n = 2), ‘satisfied’ (n =3) and ‘somewhat satisfied’ (n =1) with the intervention. Two participants were ‘neither satisfied, nor dissatisfied’ with the intervention.
- Majority of the participants felt the migration-map intervention met their expectations (3 = ‘totally’, 3 = ‘moderately’), except two participants who were ‘unsure’.
- Majority of participants felt ‘very confident’ or ‘somewhat confident’ in recommending the intervention to others, except one participant who said ‘not at all’.
- Qualitative data showed that participants found the migration-map intervention to be valuable in processing their migration histories, re-establishing connections with their ethnic identity and facilitating emotional shifts, such as reducing shame and increasing self-compassion. Following areas of improvement were highlighted: facilitating discussions about trauma, incorporation of therapeutic techniques and a longer intervention.

Outcomes of the intervention were assessed using visual analysis, statistical analysis (Tau-U) and descriptive data.

- Significant changes in exploration associated with ethnic identity were observed for four participants. These changes were present across the three baseline groups, which suggested a functional relationship between the intervention and changes to exploration associated with ethnic identity.
- No clear and consistent pattern of improvement observed for resolution and affirmation associated with ethnic identity. Some participants showed a gradual change in level and positive trend from baseline to intervention phase, however no participants showed significant change in resolution outcomes associated with ethnic identity.

- Three participants showed significant improvement in affirmation scores from baseline to intervention phase, however these were only present in 2/3 baseline groups preventing us from concluding a functional relationship between the intervention and affirmation scores.
- Three participants showed significant improvements in low-mood from baseline to intervention phase, since these were not replicated across the three baseline conditions and the data quality of the two participants undermining confidence in the reliability of the results, therefore we cannot conclude a relationship between the intervention and changes in low-mood.
- For the heritage dimension of acculturation, there was a change in group mean from pre – post intervention but little change for the mainstream dimension. Similarly, group self-esteem only increased slightly from pre-intervention to post-intervention.

Implications

The results of this study show that the migration-map intervention appears to be acceptable and preliminary signs of effectiveness were observed for exploration associated for ethnic identity.

Future directions

Future research in this area is warranted, which includes a longer intervention to ensure sufficient time for participants to work on resolution and affirmation associated with ethnic identity, alongside the provision of longer-term follow-up. Future work should involve larger scale research, including the development of randomised controlled trial to assess intervention efficacy.

Reflective Narrative

My thesis presents three individual research projects conducted in different areas of Clinical Psychology, with a core connecting theme of understanding and improving the experiences of individuals from Diverse Ethnic Communities (DEC), to ensure equitable access to psychological support and the profession of Clinical Psychology.

Systematic Review of the Literature (SRL)

I was drawn to the area of cultural differences in the symptomatology of social anxiety disorder during my first year IAPT placement where I screened a social anxiety case presenting concerns of causing distress to others. This sparked my interest into exploring this unique presentation. Upon searching literature, I noticed cultural differences in social anxiety was an under-researched, but important area, for the culturally sensitive treatment of SAD amongst diverse ethnic groups, which is at the heart of my clinical practice.

The SRL was the most challenging aspect of my research journey. I found it difficult to define the scope of my review and during screening, I noticed a meta-analysis completed on this topic, however I am grateful for my supervisors and second reviewer for helping me identify differences of my project, clarifying the scope of the review, and making collaborative decisions along the way.

Due to the nature of the review, the data extraction and synthesis process was difficult. I found myself getting hooked up on excessive detail about the heterogeneity of studies in my review. The process consumed me with doubt, fatigue and anxiety but this disappeared once I was able to focus on the bigger picture and synthesise my findings in relation to the research question. Despite the painstaking process of this review, I feel honoured to have been in a position to contribute to this area. I hope this research will be valuable for enhancing the culturally sensitive treatment of SAD.

Service Improvement Project (SIP)

My interest in this project stems from personal challenges related to the progression of my career journey in Clinical Psychology as a British Pakistani from a working-class family. My journey

involved navigating several layers of difficulty leaving me feeling hopeless about pursuing a career within this field.

I was impressed to see the institute's involvement in positive initiatives through the 'Mind-to-Mind' mentoring scheme, improving support for individuals from DEC which would have made a huge difference to my journey. I was drawn to contribute to this initiative by understanding and improving people's experiences of the scheme. I was supported by Reena to develop a SIP project, exploring both mentors and mentees experiences of the scheme.

Difficulties arose with obtaining ethical approval for the study, causing significant delays with commencing the project. Since the project involved recruiting across multiple organisations, Oxford Health R&D and CUREC weren't set up to provide oversight of the project. Despite feeling frustrated with these challenges, I was grateful to OXICPTR for setting up a course review group to provide approval for my project. I gained valuable insight into the processes of ethical approval and different routes for service evaluations vs research.

Contrary to our expectations, recruitment involved challenges due to low interest from the mentee group. Despite having a low sample (n=4) for mentees, I was empowered by the richness of data collected which contributed to the emergence of informative themes. The project resulted in Thematic Analysis of five datasets and subsequent difficulties with presenting these within the word limit. I felt disheartened moving aspects of the project to the appendix, however designing feasible projects will be at the forefront of my mind in future research.

Theory Driven Research Project (TDRP)

My interest in this area stems from experiencing 'identity conflict' between my cultural identity and professional identity during postgraduate studies. I grew up around a community that made me feel proud of being a British Pakistani Muslim. However, this changed during my postgraduate studies, as a minority on the cohort, I felt I had to change 'who I am' to fit in. I realised, no matter how hard I tried, I was not feeling a sense of belonging which impacted my mental health.

I was referred to an employee mental health service, but I disengaged due to the lack of opportunity to discuss identity challenges related to my mental health. I wondered whether psychological therapies are culturally sensitive enough to target these unique difficulties people from DEC face, which motivated me to undertake this research.

I experienced several difficulties with this project from early stages of planning. Initial challenges included designing a piece of research that met course requirements, alongside defining the target population, recruitment context and finding appropriate measures. After three different research proposals, and eighteen months of rigorous planning, I was pleased my project received approval.

I was excited about learning new clinical and research skills with this project, however the course team's unfamiliarity with case series research resulted in a lot of 'back and forth' with rethinking the research design and further fuelled my anxiety of 'getting it wrong'.

During screening my attention was bought to our cut off score for ethnic identity detachment (not based on validated data), which didn't sit right with my research integrity, leading to further delays whilst the project underwent ethical changes. Though, delivering the intervention involved high amounts of pressure, it was genuinely the most rewarding and fulfilling part of my training.

The findings of this research showed significant improvements in exploration associated with people's ethnic identity which filled me with hope. I was particularly touched by the qualitative feedback which showed the immense value of this intervention to people's lives. While this research requires further work, I hope it adds to the ongoing literature on meeting the needs of diverse groups.

In summary, despite experiencing unique difficulties with my three projects, I have gained valuable insight into the reality of conducting research in under-researched areas and I look forward to pursuing further research to amplify the voices of underrepresented populations within Clinical Psychology. I hope my research projects contribute to bringing meaningful change for Diverse Ethnic Communities.

Acknowledgements

"In the name of God, the most gracious, the most merciful". I would firstly like to thank my Lord for giving me the opportunity to do this work, and for empowering me at every stage of difficulty to complete this Thesis. "Verily with every hardship there is ease".

I express my sincere gratitude to all the participants who took part in my research projects. Their participation and commitment to my research has been invaluable.

I am incredibly grateful to my supervisors Reena, Libby, Vicky, Angie, Alasdair and Mark for your expertise, guidance and support with every step of my research projects. It has been a real pleasure to work alongside you on these important areas of research. I want to say a special thanks to Myra and Louise, and all the experts that provided consultation for my projects. And lastly, my deepest gratitude to Sakshi for all your kindness and time in providing advice on my TDRP and supporting me through the analysis- I could not have done this without you.

To my course tutor, Kathryn, I am indebted by your constant source of warmth, encouragement and support throughout my training journey.

To my family and friends, for your unconditional love, guidance and prayers that have allowed me to get this far in my journey. A special thanks to my friend Lianne for the memories, tears and for being there for me when I needed you the most. To my mum and baba, who are no longer here, but I wouldn't have got this far without your blessings. This Thesis is dedicated to you.

Appendices

Systematic Review of Literature

A: Taijin Kyofusho diagnostic criteria and information

TKS is classified in the DSM-IV under Social Anxiety Disorder and described as a culturally specific feature of SAD amongst Japanese people. Similar to SAD, it is characterised by a fear of negative evaluation in social situations, but more importantly the focus is on causing offence to others due to one's physical features, such as blushing, eye contact and body odour (Lim, 2013). This causes changes in emotions, such as anxiety, fear and shame due to a fear of rejection from others. As such, individuals avoid social or interpersonal situations or endure them with severe anxiety. The specified diagnostic criteria for TKS (Lim, 2013) is as follows:

(A) One of the following symptoms:

- Marked or persistent fear of blushing in the presence of others
- Marked or persistent fear of a stiffening facial expression, trembling or sweating in front of others.
- Fear of physical defects being noticed by others.
- Fear of omitting body odour in the presence of others.
- Fear of line-of-sight being uncontrollable while facing others
- Fear of uncontrollable flatus in the presence of others.

(B) Alongside either of the following

- Fear of being observed by others
- Fear of offending or embarrassing others

(C) Recognition that the fear is excessive or unreasonable

(D) The fear interferes with daily functioning (occupational or social activities or relationships)

(E) Symptoms are present for one year, or for children 6 months.

Appendix B: Search terms

1. (“social anxiety disorder or social anxiety” or social phobia).mp.or Taijin Kyofusho. Ti,ab.
2. ("cultural differences" or ethnic differences or collectivist or Asia*).ab,ti.
3. 1 and 2

Appendix C: Quality assessment of studies

Quantitative Studies	1. Question or objective sufficiently described	2. Design evident and appropriate to answer study question	3. Method of subject selection or source of information/ input variables is described and appropriate	4. Subject characteristics or input variables/ information sufficiently described?	5. If random allocation to treatment group was possible, was it described?	6. If interventional and blinding of investigators was possible, was it reported?	7. If interventional and blinding of subjects to intervention was possible, is it reported?	8. Outcome and exposure measures well defined and robust to measurement / misclassification bias?	9. Sample size appropriate	10. Analysis described and appropriate	11. Some estimate of variance (e.g. confidence intervals, standard errors) is reported for the main results	12. Controlled for confounding	13. Results reported in sufficient detail	14. Do the results support the conclusions?	Total	Rating
Fan and Chang (2015)	1	2	1	2				2	1	2	2	N/a	1	2	16/20	80 %
Suh, et al (2020)	2	2	1	2				2	1	2	1	N/A	2	1	16/20	80 %

Zhu, et al (2014)	2	1	1	2				1	1	1	1	1	0	2	13/22	59%
Sakurai, et al (2005)	2	2	1	1				1	1	2	1	N/A	1	1	13/20	65%
Yu, et al (2019)	2	2	1	2				1	1	2	1	2	2	2	18/22	81%
Wong, et al (2019)	2	2	1	2				2	1	2	1	N/A	2	2	18/22	85%
Choy, et al (2008)	2	1	2	2				1	1	1	1	1	1	2	15/22	68%
Lee et al (2006)	2	2	1	1				2	1	2	1	1	2	2	17/22	77%
Tarumi, et l (2004)	1	1	1	1				1	1	1	1	N/A	1	2	11/20	55%
Watanabe (2015)	2	2	2	2				2	1	2	2	1	2	2	20/22	90%
Arai, et al (2022)	2	2	2	2	2	0	0	2	1	2	1	1	2	2	21/28	75%

Okazaki, et al (2002)	2	2	1	2				2	1	2	1	1	1	2	17/22	85%
Krieg & Xu (2018)	2	2	1	2				2	1	2	2	1	2	2	19/22	86%
Heinrichs, et al (2006)	2	2	1	1				1	1	2	1	1	2	2	16/22	72%
Essau, et al (2012)	2	2	1	2				1	1	2	2	2	2	1	18/22	81%
Lau, et al (2009)	2	2	1	2				2	1	2	1	1	2	2	18/22	81%
Lau, et al (2014)	1	2	1	1				1	1	2	2	1	1	1	15/22	68%
Norasakkunkit, et al (2012)	2	1	2	2				2	1	2	1	1	2	2	18/22	82%

Mixed methods or Qualitative studies	1. Question or objective sufficiently described	2. Design evident and appropriate to answer study question	3. context for study is clear	4. connection to a theoretical framework	5. sampling strategy described, relevant and justified	6. data collection methods described and systematic	7. data analysis clearly described, complete and systematic	8. use of verification procedures to establish credibility of results	9. conclusions supported by the results	10. reflexivity of the account	Total	Rating
Luan, et al (2022)	2	2	2	1	2	2	2	2	2	0	17/ 20	85%
Fan and Chang (2014)	2	2	2	0	1	1	0	0	2	0	10/20	50%
Suh et al (2019)	2	2	2	2	2	1	1	0	1	0	13/20	65%
Yoshinaga et al (2020)	2	2	2	2	1	2	2	2	2	0	17/20	85%
Watanabe (2015)	2	2	2	1	2	1	1	2	2	0	15/20	75%

Appendix D: Prospero proposal changes

Protocol	Final version
Searches: A search will be conducted across three electronic databases (Embase, MEDLINE, PsychInfo via Ovid SP and PubMed). Reference lists of review studies and Google Scholar will be searched. Grey literature will be searched using the databases listed in the Cochrane Handbook for Systematic Reviews of Interventions (Cochrane) (Higgins et al., 2019).	Searches: upon meeting with Librarian the following search databases were agreed: PsychINFO, EMBASE, MEDLINE, Scopus and CINAHL.
Study selection:	Study selection included an additional exclusion criterion: Studies that only measured the prevalence of SA symptoms in EA/SEA samples. These studies only provided a global score on social anxiety measures and were not relevant to our research question which wanted to understand what the differences are in terms of social anxiety symptomatology in EA/SEA.
Data synthesis: Data will be analysed using a narrative approach, specifically thematic synthesis (Thomas & Harden, 2008) will be used to bring together data from qualitative and quantitative research studies.	Data synthesis changed due to the small number of qualitative studies, it was no longer appropriate to conduct thematic synthesis. Instead a narrative synthesis was conducted using Popay et al (2006) guidance.
Supervisor listed as Dr Victoria Roberts.	Additional supervisor involved: Dr Angie Jenkins.

Appendix E: Author guidelines

The author guidelines for our proposed journal: 'The Cognitive Behaviour Therapist' can be found at:

https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/information/author-instructions

Service Improvement Project

Appendix F: Health Education England Action Plan

Action Plan to Improve Equity of Access and Inclusion for Black, Asian and Minority Ethnic Entrants to Clinical Psychology Training

This action plan forms part of Health Education England's plans for delivering:

- The Five Year Forward View for Mental Health's commitment to improve Black, Asian and Minority Ethnic people's experiences of mental health care[1]
- The NHS Long Term Plan's commitment to respect, equality and diversity across the NHS workforce[2]

The delivery of the plan will be overseen by the Health Education England Mental Health Workforce Delivery Board, advised by the Equality and Diversity Subgroup of this Board.

The action plan is intended to increase fairness and equity of access to, and inclusion in, clinical psychology training for Black, Asian and Minority Ethnic candidates[3], to be implemented collaboratively by universities, placement providers, the British Psychological Society as the course accrediting body, and Health Education England. These are equitable actions designed to achieve greater equality of outcomes. It is recognised that implementing these actions and delivering sustainable change will require proper resourcing by all stakeholders. Courses are expected to implement these actions and will be accountable to HEE commissioners on delivering these. Detail of local implementation will require consultation and widespread engagement with local stakeholders. These actions should sit alongside a broader programme that ensures fair access to training across the protected characteristics and recognises the impact of socioeconomic status as an intersectional disadvantage.

Each University provider of clinical psychology training will negotiate a set of locally defined targets and will report quarterly to their regional HEE commissioners demonstrating progress with each action and to provide data in relation to the Equality Act (2010) protected characteristics (including but not limited to applicants, recruitment, enrolment, progression and graduation), this will be stipulated within the contractual obligations and as a key performance indicator. This information will be then be collated to provide a national report, with specific follow up for providers who are not adequately progressing. Future commissioning of programmes will define specific action to be taken, and again will form part of the contractual obligations of providers.

Goal: Sustained, effective action on inclusion and anti-racism before, during and after training. This action will lead to an increase in Black, Asian and Minority Ethnic recruitment to clinical psychology training so that the ethnic diversity within trainee cohorts increasingly reflects the ethnic diversity of the population.

ACTIONS:

1. Leadership Commitment

Leadership at all levels within the training organisations and their partners will evidence continuous commitment to delivering this plan, demonstrating transparency about existing problems and the necessary steps to rectify these problems. Leaders will recognise their positions of power in organisations, paying particular attention to a race, culture and ethnicity perspective, which will inform specific, concrete steps to address racial and ethnic disparities in leadership recruitment and representation.

2. Anti-racist Education for Course Staff and Supervisors

An ability to discuss racism and ethnic discrimination, at both an individual and systemic level, and engage in anti-racism will be treated as a meta-competency for all course staff and supervisors. Courses will be able to evidence development of this meta-competency through an effective programme that is mandatory for all course staff and supervisors. This programme will ensure awareness of race, ethnicity, racism and ethnic discrimination and robustly challenge and remove racism and ethnic discrimination within course and supervision delivery. Unconscious bias training is not seen as fit for this purpose. Training and development will be ongoing and supervisors and course providers will be supported to reflect on race, ethnicity and difference and how this can be engaged with constructively.

3. Curriculum Review

A thorough review of all University Clinical Psychology Curricula, across all aspects of training, to decolonise the curriculum and ensure racism, ethnic discrimination and other forms of discrimination are addressed and content changed as necessary. This review will involve a wide and inclusive range of experts, including Experts by Experience.

4. Support for Black, Asian and Minority Ethnic Trainees

A robust and varied support programme should be available to every Black, Asian and Minority Ethnic trainee and evidence presented that this programme is effective and valued by Black, Asian and Minority Ethnic trainees. This support will be co-produced and a variety of choices will be offered, including informal peer support alongside more formalised course support, in order to create a diversity of spaces where Black, Asian and Minority Ethnic trainees can share their experiences. There will also be a variety of formal and informal routes for raising complaints of racism and ethnic discrimination that are embedded in course policy and procedures.

5. Introduction of Contextual and Anti-Racist Recruitment Processes

Courses should demonstrate that they have taken effective action to:

a. Address race and ethnic discrimination in recruitment, with an awareness of how other protected characteristics and socio-economic status may intersect with race and ethnicity and how this may affect recruitment.
b. Introduce appropriately sophisticated and evidence-based systems of contextual recruitment that ensure selection criteria are applied in light of objective

contextual factors that may have impacted on attainment of qualifications or experience that discriminate for course entry. These processes will be designed to reduce the impact of systemic obstacles to attainment that correlate with race and ethnicity.

c. Evaluate current selection criteria to ensure they do not replicate racial and ethnic disparities at other stages in an applicant's training journey.

6. Reporting of Student Recruitment and Retention Data by Ethnicity

Each course willroutinely and transparently report and publish age, gender and ethnicity data for recruitment and retention each year, including differential success rates by race and ethnicity. This data will then be used by courses to identify areas for equitable improvement.

7. Positive Action Initiatives

Courses will demonstrate positive action, informed by local data about barriers to entry, under the below sections of the Equality Act (2010). Section 149 of the Equality Act also outlines the Public Sector Equality Duty (PSED).

a. Section 149: Courses will update their Equality Objectives to reflect the required changes in this Action Plan.
b. Section 158: Engage in positive action through outreach activities including open days, career talks and mentoring schemes, with a particular emphasis on reaching those at earlier stages of their career journey.
c. Section 159: Undertake direct action at the points of shortlisting and interview on the basis of key protected characteristics, where there is evidence of under-representation in relation to that protected characteristic *and* two candidates are of equal merit.

8. Establishing Racially and Ethnically Representative Selection Processes

Courses should demonstrate action and progress towards establishing racially and ethnically representative selection processes against a target timeframe of no more than one year. The goal will be to align each recruitment process to represent the England population, or the local population if more diverse. This should be embedded as part of a wider commitment to employing more racially and ethnically diverse staff across all levels and sectors of the institution.

9. Improving Equity of Access to Experience

Courses will collaborate with employers to develop, recognise and support schemes that enable more aspiring psychologists to gain relevant experience in paid work, and undertake and evaluate other action to remove cumulative advantage gained by those able to access

certain work and experience. As part of this, courses will value a wide range of both professional and personal experience during the application process.

Appendix G: Phase one results

Table 1: *Summary of conversations with Mentoring Lead and Assistant Psychologist regarding the set-up of the mentoring scheme*

Questions	Summary of conversation
How was the mentoring scheme set up?	Two part-time assistant psychologists were recruited to assist with the delivery of the mentoring scheme. It was considered important to have individuals with lived experience for this role, therefore adverts were open to individuals from minority ethnic backgrounds only. The mentoring team linked in with undergraduate students to receive feedback on the doctoral application process and in response to this feedback they aimed to make the application forms for the mentoring scheme less formal and to use it as an opportunity to get to know the mentees better and their hopes for the scheme.
How were mentees recruited for the scheme?	The application forms were screened by the mentoring team to check for eligibility against the inclusion criteria. As courses in various regions were setting up similar schemes, it was felt important for mentees to be studying, working or living within the Thames Valley region to make the process equitable and to prevent people from receiving support from multiple schemes. Each Mentee was matched with both a trainee and qualified clinical psychologist, with the aim of having at least one mentor from a minority ethnic background.
What did the mentoring scheme involve?	The mentoring scheme consisted of individual sessions with mentors as well as online workshops and a Question & Answer (Q&A) session with current trainees on the Oxford training course. The aims of these were to provide opportunities for learning on a professional level and to open up conversations which could be further explored in individual mentoring sessions. The mentoring team collaborated with the Equality and Diversity lead for Oxford Health Foundation Trust and a Consultant Clinical Psychologist from DEC to deliver workshops on topics relating race/ ethnicity, power and privilege and imposter syndrome. Feedback was sought for individual sessions and workshops.

Appendix H: Study documents and approval
Appendix H1: Participant Information Sheets

Ikra Hameed
Oxford Institute of Clinical Psychology Training
Ikra.hameed@stx.ox.ac.uk

SERVICE IMPROVEMENT PROJECT: PARTICIPANT INFORMATION SHEET

Title: Evaluation of The Mind-to-Mind Mentoring Scheme

My name is Ikra Hameed, and I am a Trainee Clinical Psychologist at the Oxford

Institute of Clinical Psychology Training and Research, working with Dr Reena Vohora and team. This is an invitation to take part in our service improvement project.

Before you decide, it is important that you understand why the project is being done and what it would involve for you. Please take time to read this Participant Information Sheet and discuss it with others if you wish. If there is anything that is not clear, or if you *would like more information, please ask us by emailing the researcher at ikra.hameed@stx.ox.ac.uk*

What is the purpose of the study?

The Mind-to-Mind Mentoring scheme is part of Health Education England's action plan to improve equity of access for people from minority ethnic backgrounds into the profession of Clinical Psychology. We are interested in evaluating how effective the mentoring scheme has been in providing support with your individual pathways into the profession. To do this we want to find out about your experiences of the mentoring programme, particularly how you perceived the support received and how well it was able to address your needs. We are interested in hearing about what worked well for you and possible suggestions for improvement.

Why have I been invited?

You have been invited to this project as you received support from the mentoring programme. We aim to include 6-8 mentees in this project.

Do I have to take part?

No, taking part is completely voluntary. You have the right to withdraw from the project at any point during the study without giving a reason. As the data collected is anonymous you will be unable to withdraw your data once you complete the study.

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

We would like you to contact the researcher using the following email ikra.hameed@stx.ox.ac.uk to express your interest in the study. Your written consent to take part in the project will be sought via a consent form.

The study will be conducted in two parts. Part one will involve filling out a brief questionnaire that will collect demographic information (i.e race, ethnicity and gender) which will take approximately 5-10 minutes. Part 2 will involve taking part in a focus group discussion via MS Teams lasting approximately 45 minutes to an hour. During the focus group you will be asked a series of questions about your experiences of the mentoring programme, including how you were supported by your mentors and the workshops. We will record the focus group in order to have an accurate recording of what has been said. During the focus group, you can let the researcher know if you would rather not answer some of the questions put to you. No preparation is needed in advance of this focus group discussion.

Are there any disadvantages/risks from taking part?

Taking part will take approximately 60 minutes of your time in total. Some of the focus group discussions, inviting you to reflect on your experiences of the mentoring programme and the level of support received with your individual pathways into the profession of Clinical Psychology, may be difficult to reflect on. The questions have been designed with feedback from mentees who have participated in the mentoring scheme. If you find answering any of the questions upsetting, you can either say 'pass' to the question or withdraw from the focus group discussion. At the end of the study, or if you withdraw at any point during completion, you will be provided with contact details of services and third-party organisations that will be able to offer support and guidance if you experience distress.

This study has been reviewed, and approved, by the Oxford Institute of Clinical Psychology Training and Research committee.

What are the possible benefits of taking part?

We hope that your participation in this will help us understand how effective the mentoring programme was in providing support with your individual pathway into the profession. This may contribute to the development of the programme to better suit the needs of aspiring psychologists from minority ethnic backgrounds in terms of the quality of support provided. However, there are no direct benefits to those participating.

What happens with my information?

Data protection regulation requires that we state the legal basis for processing information about you. The University of Oxford is the data controller and is responsible for looking after your information and using it properly.

The information you provide during the study is the **research data**. Any research data from which you can be identified (i.e. email address and telephone number) is known as **personal data** or private information (i.e. race or ethnic origin) is known as **special category personal data**.

Special category personal data and personal data will be stored securely on Oxford Health NHS Foundation Trust OneDrive . Personal data will be stored for 3 months after the study has concluded itself and then permanently deleted.

Other research data (including recordings of focus group discussions) will also be stored securely on a password protected Oxford Health OneDrive folder. Research data will be kept for at least 3 years after publication or public release of the work of the research. This information will then be shredded or permanently deleted and destroyed.

The focus group discussions will be audio recorded using a trust encrypted iPad. All identifiable information will be removed from the transcripts and a pseudonym (i.e a reference number) will be assigned to you. All information will be anonymised before being transferred to external systems.

We will keep information about you safe and secure.

The researchers involved in this study will have access to the research data. Responsible members of the University of Oxford may be given access to the data for monitoring and and/or audit of the research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public. Using the **research data**, we hope to report our findings in academic journals. The findings will also contribute to Ikra Hameed's Doctorate in Clinical Psychology. You will not be identified in any reports or publications arising from the study.

Data Protection

The University of Oxford is the data controller with respect to your personal data, and as such will determine how your personal data is used in the study.

The University will process your personal data for the purpose of the research outlined above.

Further information about your rights with respect to your personal data is available from http://www.admin.ox.ac.uk/councilsec/compliance/gdpr/individualrights/.

What are my choices about how my information will be used?

You can choose to not take part in the project at any time, without giving a reason. If you withdraw from the project, we will destroy any information you have shared with us.

What if there is a problem?

Every care has been taken to ensure your safety during the course of the study. If you have a concern about any aspect of this service improvement project, you can speak to the project team who will do their best to answer your questions.

If you have a concern about any aspect of this study, please contact Ikra Hameed

(ikra.hameed@stx.ox.ac.uk), Dr Reena Vohora (reena.vohora@hmc.ox.ac.uk) or Libby Barnardo (libby.barnardo@hmc.ox.ac.uk). We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with.

I'm Interested! What's Next?

If you would like to participate, please email the following arrange a time for the focus group discussion, ikra.hameed@stx.ox.ac.uk

Thank you for taking the time to read this information sheet and for your interest in the project.



Ikra Hameed

Trainee Clinical Psychologist

Oxford Institute of Clinical Psychology Training

Isis Education Centre

Warneford Hospital

Headington, Oxford

OX3 7JX

Ikra.hameed@stx.ox.ac.uk

You can also speak to the supervisors of the project about any questions or concerns using the details below:

Dr Reena Vohora (Oxford Institute of Clinical Psychology Training and Research)	Reena.vohora@hmc.ox.ac.uk
Dr Libby Barnardo (Oxford Institute of Clinical Psychology Training and Research)	libby.barnardo@hmc.ox.ac.uk

Ikra Hameed
Oxford Institute of Clinical Psychology Training
Ikra.hameed@stx.ox.ac.uk

SERVICE IMPROVEMENT PROJECT: PARTICIPANT INFORMATION SHEET

Title: Evaluation of The Mind-to-Mind Mentoring Scheme

My name is Ikra Hameed and I am a Trainee Clinical Psychologist at the Oxford Institute of Clinical Psychology Training and Research, working with Dr Reena Vohora and team. This is an invitation to take part in our service improvement project.

Before you decide, it is important that you understand why the project is being done and what it would involve for you. Please take time to read this Participant Information Sheet and discuss it with others if you wish. If there is anything that is not clear, or if you *would like more information, please ask us by emailing the researcher at ikra.hameed@stx.ox.ac.uk*

What is the purpose of the study?

The Mind-to-Mind Mentoring scheme is part of Health Education England's action plan to improve equity of access for people from minority ethnic backgrounds into the profession of Clinical Psychology. We are interested in evaluating how effective the mentoring scheme has been in providing support to students from minority ethnic backgrounds with their individual pathways into the profession. To do this we want to find out about your experiences of your experiences of the mentoring programme, particularly what worked well and possible suggestions for improvement.

Why have I been invited?

You have been invited to this project as you participated in the mentoring programme as a mentor. We aim to include 6-8 mentors in this project.

Do I have to take part?

No, taking part is completely voluntary. You have the right to withdraw from the project at any point during the study without giving a reason. As the data collected is anonymous you will be unable to withdraw your data once you complete the study.

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

We would like you to contact the researcher using the following email ikra.hameed@stx.ox.ac.uk to express your interest in the study. Your written consent to take part in the project will be sought via a consent form.

The study will be conducted in two parts. Part one will involve filling out a brief questionnaire that will collect demographic information (i.e race, ethnicity and gender) which will take approximately 5-10 minutes. Part 2 will involve taking part in a focus group discussion via MS Teams lasting approximately 45 minutes to an hour. During the focus group you will be asked a series of questions about your experiences of the mentoring programme, including 1:1 mentoring sessions and the workshops. We will record the focus group in order to have an accurate recording of what has been said. During the focus group, you can let the researcher know if you would rather not answer some of the questions put to you. No preparation is needed in advance of this focus group discussion.

Are there any disadvantages/risks from taking part?

Taking part will take approximately 60 minutes of your time in total. The questions have been designed with feedback from mentors who have participated in the mentoring scheme. If you find answering any of the questions upsetting, you can either say 'pass' to the question or withdraw from the focus group discussion. If you experience distress, you will be provided with contact details of services and thirdparty organisations that will be able to offer support.

This study has been reviewed, and approved, by the Oxford Institute of Clinical Psychology Training and Research committee.

What are the possible benefits of taking part?

We hope that your participation in this will help us understand how effective the mentoring programme was in providing support to students from minority ethnic backgrounds. This may contribute to the development of the programme to better suit the needs of aspiring psychologists from minority ethnic backgrounds in terms of the quality of support provided. However, there are no direct benefits to those participating.

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(ikra.hameed@stx.ox.ac.uk), Dr Reena Vohora (reena.vohora@hmc.ox.ac.uk) or Libby Barnardo (libby.barnardo@hmc.ox.ac.uk). We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with.

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Thank you for taking the time to read this information sheet and for your interest in the project.



Ikra Hameed

Trainee Clinical Psychologist

Oxford Institute of Clinical Psychology Training

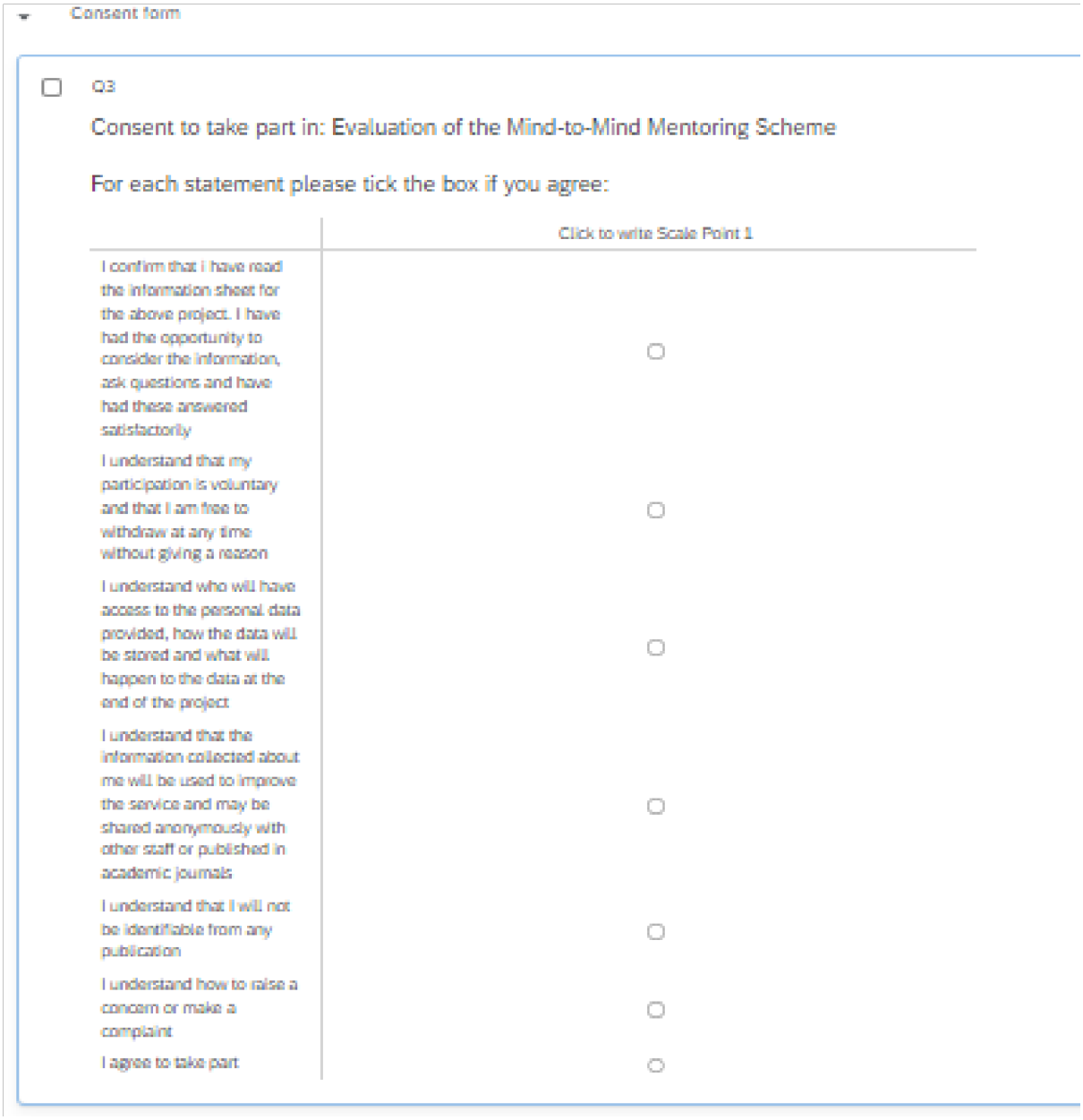
Isis Education Centre

Warneford Hospital

Headington, Oxford

OX3 7JX

Appendix H2: Consent Form



Appendix H3: Focus Group Interview schedule

Focus group (Mentees)

Introduction to the session

Introduction of participants

Before we start, I'd like to know a little bit about each of you. Please tell me:

- Your name
- Current status (employed or student)

Can you tell me a bit about you interest in applying for the mentoring scheme

-motivation to apply (prompt)

Can you tell me about your hopes and fears before starting the scheme?

Can you tell me about your experience of the application process for the scheme? I'm interested in your experience of receiving support from the mentoring scheme… Please tell me about your experience of the Q&A sessions/ workshops?

- What was helpful/ less helpful?
- What did you take forward from these?

Please tell me about your experience of the 1-1 mentoring sessions

- What was helpful/ less helpful?
- structure, pacing, frequency of sessions, power dynamics)

Can you tell me if issues around race/ethnicity/ privilege/ power were considered during your 1-1 sessions?

- Were they brought up?
- How and when did these come up?
- Who raised them?
- Was there anything that helped you do this/ made it more difficult?
- Was there anything you were worried about when discussing this?

Were there any other areas discussed in sessions that were important for you?

- Were there any other areas that you would have liked to discuss but didn't feel able to?
- Why was this?

How well would you say were your expectations of the scheme were met?

Can you tell me a little bit about anything you found particularly helpful and/or have gained from the scheme?

- Advice/ support
- Skill development/ personal and professional development
- Support with DclinPsy applications

- Relationship with mentors
- Developing confidence/ imposter syndrome

Can you tell me a little bit about any difficulties you experienced from being involved in the mentoring scheme?

- Are there any areas of cultural sensitivity that were difficult?
- Relationships with mentors
- Feelings of belonging in the field/ visibility in the profession
- If any, how did mentors manage any difficulties or dilemmas related to ethnicity?

Can you tell me a little bit about your experience of the peer support groups and how you made use of those?

Is there anything that wasn't covered in the scheme that would be important to consider for round 2 of the scheme?

Is there anything else that we haven't yet discussed which would be important for the evaluation of the scheme?

Focus group (Mentors)

Introduction to the session

Introduction of participants

Before we start, I'd like to know a little bit about each of you. Please tell me:

- Your name
- How long have you been practicing/ working in the field
- Areas of specialism

Can you tell me a little bit about what inspired you to take part in the mentoring scheme?

Can you tell me about some of your hopes and fears before volunteering as a mentor on the scheme?

I'm interested in your experience of being a mentor on the scheme…

Please tell me what you thought about the pre-scheme information provided and introductory workshop and how these prepared you for this role?

- Expectations of the preparatory workshop and how well were these met?
- How clear were your roles and responsibilities were communicated by the mentoring team?
- Your experience of contracting and how helpful this was

The scheme consisted of a series of talks and workshops alongside your individual mentoring sessions, please tell me your thoughts on what was helpful/ less helpful about the format of the scheme?

- 1:1 mentoring sessions (structure, pacing, frequency of sessions, power dynamics)
- Who met? (1:1 or as a group, mix?)
- What worked well with setting up sessions and supporting mentees?

Can you tell me if issues relating to race/ethnicity/ privilege/ power arose during your 1-1 sessions?

- How and when did these come up?
- Who raised them?
- Was there anything that helped you do this/ made it more difficult?

- Was there anything you were worried about?
- Is there anything you might want to do differently next time?/would take into consideration next time?

Were there any other areas discussed in sessions that you thought were important?

Can you tell me a little bit about anything you may have gained from being involved in the scheme?

- Skill development/ personal and professional development
- Developing confidence/ imposter syndrome

Were there any challenges associated with your role as a mentor?

- Practical difficulties with setting up sessions or meeting mentees - Are there any areas of cultural sensitivity that were difficult?
- Relationships with mentees
- If any, how did you manage any difficulties or dilemmas related to ethnicity?
- If any, how did you manage any challenges that came up during mentoring sessions?

Is there anything that wasn't covered in the scheme that would be important to consider for round 2 of the scheme? Change for round 2?

Is there anything else that we haven't yet discussed which would be important for the evaluation of the scheme?

Appendix H4: Notification of Ethical Approval

Oxford Clinical Psychology Course - Quality Improvement/Clinical Audit Proposal Form

Title	Evaluation of the Mind-to-Mind Mentoring Scheme		
Directorate	**Oxford Institute of Clinical Psychology Training and Research**	**Team / Ward / Unit**	**Oxford Institute of Clinical Psychology Training and Research**
Name and Title of project lead(s)		**Ikra Hameed, Trainee Clinical Psychologist** **Dr. Reena Vohora, Clinical Psychologist and Mentoring Lead** **Dr. Clare Borsay, Clinical Psychologist and Research Supervisor**	
Contact telephone number			
Contact email address		**Ikra.hameed@stx.ox.ac.uk** **Ikra.hameed@oxfordhealth.nhs.uk**	
Supervising Consultant / Service Manager		**Reena Vohora**	
Proposed start date		**August 2022**	
Proposed finish date		**March 2023**	
This project is a:			
X☐ First audit/ quality improvement		☐ Re-audit/ quality improvement If yes, date of last audit/ quality improvement _____	
What is the resource implication for carrying out project (estimate staff hours, designation, grade and cost)		The project will be undertaken as part of trainee's research requirements in part fulfilment of the doctorate in clinical psychology course. The Trainee Clinical Psychologist (band 6) will complete the majority of the work, with possible support from an Assistant Psychologist in the team. The trainee will ne supervised by two Clinical Psychologists. Focus group	

	Time to develop focus group questions, organise and facilitate group, transcribe group, analyse data and write-up. Questionnaire/ survey Time to develop questions, distribute, analyse data. Analysis of feedback data collected by the service will also take place. All data collected will be analysed and synthesised into a report to help shape the second year of the mentoring scheme. Evaluation forms will be designed so the service can collect feedback for the second round of the scheme.

Reason for audit or evaluation (tick all that are applicable)

☐ National priority	☐ Trust priority	☐ Directorate priority	☐ CCG priority
☐ NICE guidance	☐ SIRI recommendation	X☐ Other (please state) Clinical Psychologist in the team identified the need for service evaluation.	

If NICE guidance, please state which guidelines:

Health Education England (2021) launched an action plan to improve equity of access for people from minority ethnic backgrounds into the clinical psychology profession. Each training course in England received funding to implement a mentoring programme to support individuals from minority ethnic backgrounds gain advice and support with their journey into the profession. This project aims to evaluate the first round of the scheme in order to inform design of the second round of the scheme.

Background to Project

Creating a diverse workforce is an important direction for the National Health Service. The NHS has recognised that its workforce must closely reflect the ethnic make-up of the communities it serves, to improve access to services. Despite this awareness, the field of Clinical Psychology lacks representational diversity.

Health Education England (2021) launched an action plan to improve equity of access for Minority Ethnic Background (MEB) entrants into the profession. Each training course in England received funding to implement a mentoring programme for MEB applicants pursuing an application for training. As a result, the Mind-to-Mind Mentoring Scheme (MMMS) launched at the Oxford Institute of Clinical Psychology Training and

Research (OXICPTR) in October 2021 as a positive initiative action for students from Minority Ethnic

Backgrounds. The aim is for students to receive support with their individual pathways into the profession. The mentoring scheme is currently within its first year of mentoring and the second round will be launched from October 2022, therefore we are keen to evaluate the current model, with a view to discover potential areas of

development and improvement. Dr Reena Vohora (Mentoring Lead) has expressed an interest to learn more about any adaptations that can be made to the programme to ensure it is meeting the needs of mentees.

This project will involve evaluation (via questionnaires and focus groups) of the mentors delivering mentoring, mentees, and staff running the mentoring scheme. The data has been collected during round 1 of the scheme (from October 2021) as part of usual service evaluation.

It is hoped that the results from this project will help to shape the next round of the mentoring scheme (which will be launched in autumn/ winter 2022) and subsequently improve the quality of support provided to people from MEB. Findings may also serve to make additional improvements to the programme (i.e improving the quality of training provided to mentors and mentees via workshops and opportunities for additional types of support for mentees as part of the scheme such as creating peer support groups in addition to direct mentor support)

Standard(s) for audit or quality improvement

(please list all the standards which will be assessed)

Project objectives

To interview mentoring scheme leads to gain an understanding of how the mentoring scheme was developed and what the aims of the mentoring scheme in line with the HEE action plan.

To interview mentees about their experience of receiving support from the mentoring scheme, what has worked well for them and what can be improved.

To interview mentors about their experience of delivering support to students from minority ethnic backgrounds, what worked well and what can be improved.

This will help to develop a greater understanding of the factors that influenced the experience of delivering the mentoring scheme, as well as what changes can be made to improve the quality of support provided to individuals from minority ethnic backgrounds.

Source of standards:

Health Education England's action plan Literature

around mentoring and how it works.

BPS guidelines for supporting this group.

Scope and Methodology for Project

Phase 1:

Consultation of the HEE action plan and scoping interview with Mentoring lead and Assistant Psychologists will provide an understanding of the rationale for developing the scheme, the processes involved in setting up the programme and the outlined aims.

Phase 2:

(A) Analysis of feedback data already collected by the service from October 2021 will provide an understanding of service-user experience of the mentoring scheme. Feedback has been sought four times for mentors and six times for mentees. Feedback will also be collected after each workshop session going forward (See appendix B for summary of feedback responses).

(B) Focus groups with approximately six to eight mentors to explore their perception of the role, perceived impact of the programme for them and their mentees, what has worked well and potential areas for improvement.

(C) Focus groups with approximately six to eight mentees concerning their experience of how they have perceived the support received so far. Supervisors will help identify mentees that would be willing to participate.

Phase 3:

Analysis of all data collected and production of a report to help shape the second year (October/November 2022 onwards) of the mentoring scheme to enhance quality of support provided to MEB students. Data from focus groups will be analysed using Braun & Clarke (2006)'s guidelines on Thematic Analysis. This uses an inductive approach whereby themes are developed from the analysis of data. Initial codes will be generated from the interview transcripts and similar quotes will be extracted and grouped together. Initial codes will be

organised and developed to form overarching themes. Final themes will be reviewed by supervisors for a credibility check.

A focus group or survey with six to eight undergraduate students to discuss the feedback and help to further refine the scheme for the second round.

Evaluation forms will be designed so the service can collect feedback for the second round of the scheme.

How are you going to collect the data (tick all that are applicable)

☐ Case notes (paper/ electronic)	☐ Observations	X☐ Patient/ Staff Survey	X☐ Other (please state) focus group

Data Protection Act

Please tick to confirm "yes" you will comply with:

X☐All data collected will be anonymised ☐No patient or staff identifiable data will be reported

Ethics Screening

Gather any information about a patient beyond that collected in routine patient care	☐Yes X☐ No
Pose any risk for or burden on a patient beyond those of his/her routine patient care	☐Yes X☐ No
Infringe on any patient's rights	☐Yes X☐ No
Risk breaching any patient's confidentiality or privacy	☐Yes X ☐ No
Involve the use of any untested clinical or systems intervention	☐Yes X ☐ No
Do you intend to publish the findings?	X☐Yes ☐ No
Does National Data Opt Out need to be applied to the resulting data set prior to analysis? ☐Yes X☐ No	

Requested Support from the Quality and Audit Team (tick all that are applicable)

☐ Design data collection tool	☐ Data collection
☐ Data analysis	☐ Report writing
☐ Power point presentation design	X☐ None

Course Review Group (Service Evaluation Projects)
Myra Cooper, Louise Johns, Neil Carrigan, Alasdair Churchard, Matt Hotton

Confirmation of approval

Name of Reviewer One: Matthew Hotton.

Signature - Reviewer One: 

Date of Approval – Reviewer One: 27th July 2022

Name of Reviewer Two:……Myra Cooper…….

Signature - Reviewer Two:……Myra Cooper……..

Date of Approval – Reviewer Two:……27th July 2022…….

Form adapted from Oxford Health paperwork, with thanks

Appendix I: Process of Thematic Analysis

Braun and Clarke's (2006) six phases of thematic analysis was used to analyse all qualitative data in this study. The process was dynamic as the researcher moved between phases to review the analysis.

Phase 1: Familiarisation with the data	The author conducted all three of the focus group discussions and completed transcription of the data. Transcripts were read and re-read to become immersed in the data. Initial ideas were written down and parts of the transcript were highlighted.
Phase 2: Generating initial codes	Each transcript was analysed separately, generating codes for interesting features of the data. An inductive, data-driven approach was used and all data was reviewed with equal attention. Open coding was used to analyse the data. The three transcripts were read by the external supervisor and coded. There were few disagreements and any differences were discussed and a consensus was reached.
Phase 3: Searching for themes	Codes were collated into potential themes for each transcript. Initial themes were created on the frequency of codes, similarity of codes and their significance. Themes were reviewed with the external supervisor, discussing differences and reaching a consensus.
Phase 4: Reviewing themes	The themes were revisited to ensure they corresponded to the data set and made sense. The coding and extracts were re-visited to ensure the themes were relating to the data, and to check whether additional data within themes was missed in earlier stages. Any overlapping themes were combined into one and some sub-themes were dropped at this stage. Again themes and extracts were checked by the internal and external research supervisors at this stage, discussing any differences and reaching an agreement.
Phase 5: Defining and naming themes	Final refinement of themes was carried out. The quotes were checked by the primary research
	and research supervisors to ensure they were congruent with the themes.
Phase 6: producing the report	The report was written by the researcher and verbatim quotes to reflect the themes.

Appendix J: Feedback form analysis

Appendix J1: Mentee Feedback timepoints summary

Table 1. *Number of respondents for each feedback point and satisfaction data from workshops*

Feedback time points	**No. of respondents**	**Satisfaction data**					
		Very satisfied	Satisfied	Somewhat satisfied	Neither satisfied not dissatisfied	Dissatisfied	Very dissatisfied
1.Check-in after first mentoring session	12	N/A					
2. Mind-toMind Introductory workshop	15	13	0	2	0	0	0
3. Trainee Q&A session	4	2	0	0	2	0	0
4. Reflective workshop	3	1	0	2	0	0	0
5. End of mentoring feedback form	11	N/A					

Appendix J2: Mentee Thematic Analysis of feedback form data

Summary:

Themes from Open-ended questions on feedback forms:

Four overarching themes and eleven sub-themes arose from analysing open ended questions from the feedback forms.

Table 2: Mentees themes developed from feedback forms.

Theme 1. Understanding roles in mentorship		
Subthemes	Explanation	Example quote
Learning about how to use the space	This subtheme represented mentees experience of the ***Introductory Workshop,*** the aim of which was to increase their understanding about how to use the mentorship to advance their journeys in clinical psychology.	*"Learning more about what a mentor-mentee relationship can look like and the fact that we can use our mentors to provide us different information and opportunities and that we have the freedom to decide this";* ***Timepoint 2*** *"I found it helpful to start having discussions around diversity and to think about how my mentors might be able to support me in my journey applying to the clinical doctorate and in the working world";* ***Timepoint 2***
Factors impacting relationship with mentors	This subtheme portrayed the usefulness of the ***Introductory Workshop*** in increasing mentees insight about factors that could impact the mentor-mentee relationships.	*"The discussion about power was really important. Frankly, it wasn't something that I thought about instantly when thinking about a mentorship scheme ,but having this open discussion about it and helps it address people's concern and raise our awareness on how power might impact/override the mentorship relationship";* ***Timepoint 2***
Theme 2. Support with career journey		

Skill development	This subtheme reflects the part of mentees experience of their ***individual mentoring sessions*** which was valuable for developing skills relating to enhancing their career journeys.	***"****She also offered helping with interviews and applications when they come up. She helped me reflect and know how to write about my personal experiences and culture";* ***Timepoint 5***
Tangible support	This subtheme consisted of mentees reflections on their ***individual mentoring sessions*** and how they valued their mentor's input on providing tangible resources to enhance their career development.	***"****They shared their own resources that they used to prepare for the interviews";* ***Timepoint 5*** *"She was able to signpost me to reading and resources";* ***Timepoint 5***
Space for reflection	This subtheme comprised of mentees hopes for their individual mentoring sessions which involved having a space to reflect on important topics such as the representational issues in the profession.	*"Having a reflective space with mentors on their experience and mine and how it fits into the context of the clinical psychology profession." ;* ***Timepoint 1*** *"How they overcame boundaries in a White dominated space"* ***Timepoint 5***
Building connections	This subtheme features mentees experiences of the ***introductory workshop*** and ***mentoring sessions*** which were important for building connections with others.	*Introductory workshop:* *"Being able to meet/see/speak to other people on the scheme and hearing their goals/worries";* ***Time point 2*** *Mentoring sessions:* *"My trainee mentor was also a ethnic minority which was reassuring when she gave feedback about shared experiences";* ***Time point 1***

		"*But trainee mentor was great and has become a contact that I will remain in touch with."* ***Time point 5***
Theme 3. Importance of a 'safe space'		
Feeling validated and listened to	This subtheme represents mentees experience of their ***individual mentoring sessions*** in which they felt heard and validated, creating a safe space for mentees to open up about their personal experiences.	*"Having someone to validate my experiences and reassuring me giving me the space to reflect that I have so much experience to explore and reflect on when it comes to the application";* ***Time point 1*** *"She created a safe space for me to speak uncensored";* ***Time point 5***
Valuing mentors' position on cultural awareness	This subtheme featured mentees experience of their ***individual mentoring sessions*** and discusses how mentees valued their mentor's positioning relating to cultural awareness.	*"My mentor had previous mentoring experience which was a huge benefit to our sessions. She was very open to reflecting, power dynamics and potential biases she might hold within herself." ;* ***Time point 5***
Theme 4. Aspects that felt difficult		
Practical difficulties and time constraints	Mentees experienced practical difficulties with their individual mentoring sessions and the workshops. *Workshops:* The timing of the workshops was not convenient for some mentees. Some mentees found time allotted for the Q&A session with trainees insufficient as they did not end up receiving answers for all questions.	*"The timing - right after a busy work day it felt a bit hectic for me"* ***Time point 2*** *"There wasn't enough time to answer all the questions but it was generally valuable, those that*

	Mentoring sessions:	*answered questions were friendly an down to earth"; **Time point 3***
	Mentees found time management difficult across the scheme and expressed the need for having more sessions with their mentors;	*"Time management was difficult, I didn't get to utilise as much of the scheme. Wish at the start there would be pre booking of sessions and a full itinerary of upcoming events"; **Timepoint 5***
Mentors background and feelings of difference	Mentees expressed their dissatisfaction with not having a mentor from an ethnic minority background as they did not feel able to use their ***mentoring sessions*** to discuss important issues such as discrimination and lived experience of barriers.	*"I really expected and wished to have had an ethnic minority mentor as I felt a need for a role model who could share their experiences of breaking through barriers and qualifying. My mentor was lovely but couldn't relate to some experiences, she acknowledged and reflected on these. However, in the initial instance of being vulnerable about my experience I didn't feel validated as a non ethnic minority mentor may not relate. Such as talking about covert racism in which discrimination is harder to prove". **Timepoint 5***

Appendix J3: Mentor Feedback timepoints summary

Table 3:

Feedback time points and data from mentors

Feedback time points	No of respondents
1.Mind-to-Mind introductory workshop	**24**
A. Feedback on expectations of the scheme	
Expectations met	20
Expectations partially	2
Expectations not met	2
3. Reflective workshop one	**2**
A. Feedback on expectations of the workshop	
Expectations met	1
Expectations partially met	1
Expectations not met	0
B. Satisfaction data	
Very satisfied	1
Satisfied	0
Somewhat satisfied	1
Neither satisfied nor dissatisfied	0
Dissatisfied	0
Very dissatisfied	0
4. Reflective workshop two	6
A. Feedback on expectations of the workshop	
Expectations met	5
Expectations partially met	1
Expectations not met	0
B. Satisfaction data	

Very satisfied	3
Satisfied	0
Somewhat satisfied	3
Neither satisfied nor dissatisfied	0
Dissatisfied	0
Very dissatisfied	0

5. Mentor pack	**6**
Expectations met	4
Expectations partially met	0
Expectations not met	2

Appendix J4. *Themes from Open-ended questions on feedback forms:*

Four overarching themes and ten sub-themes developed from analysing open ended questions from the feedback forms.

Table 4; Mentors themes developed from feedback forms

Theme 1. Preparing for the role		
Subthemes	Explanation	Example quotes
Understanding roles and responsibilities	This subtheme featured mentors experience of the ***Introductory Workshop*** which facilitated their understanding and clarified expectations of the role.	*"For me it was very helpful … to learn more about the set of the programme and what the course had in mind how we could support mentees moving forward";* ***Time point 1*** *"good overview of the scheme, what is involved and what expected of mentors/ mentees. Helpful context around issues to consider when mentoring";* ***Time point 1***
The appropriateness of contracting	This subtheme portrayed mentors mixed views on the appropriateness of contracting after the ***introductory workshop***.	*"The part around contracting was most helpful";* ***Time point 1*** *"Clear guidance on contracting";* ***Time point 1***

		"I felt like the contracting input was a bit too much, as a draft contract or "things to consider", would have covered similar" ***Time point 1***
		"At times it did feel more like we were talking about a supervisor/supervisee relationship, especially when talking about contracting"; ***Time point 1***
Session guidance	This subtheme featured mentors' views on how much the introductory workshop provided guidance on sessions.	
	One mentor found it helpful to have clear guidance on how to navigate conversations around diversity.	*" Helpful also to have it stated explicitly that it is considered helpful to explicitly raise race and diversity, and to be clear that how much or how little this is discussed in mentoring is their choice";* ***Time point 1***

	Others suggested having more explicit examples of topics to cover in sessions and exercises for skill development:	*"Some more detail on possible themes to consider in mentoring sessions"; **Time point 1*** *"More Examples of exercises (a bit like the reflective ones) or types of topic that you could cover with mentees if they would like to might be helpful in case a mentee has less clear ideas in advance of what they would like to cover"; **Time point 1***
<u>Theme 2. Working together to deliver meaningful support</u>		
Building connections	Mentors valued the opportunity to build connections with others via the ***Introductory Workshop*** and their ***individual sessions.***	Workshop *"It was helpful to meet and connect with others who are keen about mentoring passionate about supporting a diverse clinical psychology workforce with equal opportunities for all"; **Time point 1***

		Mentoring sessions *"I consider this as a great learning opportunity for all of us, so I am very grateful being able to hear and share experiences with two other people in our meetings";* ***Time point 2***
A collective effort to provide support	This subtheme portrayed mentors' perspectives on having another mentor in the group. The feedback was positive and suggested the value of working together to provide support to mentees.	*"I've found it very helpful to be mentoring alongside a more senior psychologist.... It has allowed for broader experiences and knowledge to be discussed, and I feel we are able to offer more to the mentee";* ***Time point 2*** *"Very helpful to have someone able to offer a perspective about more recent experiences of accessing clinical training";* ***Time point 2***
<u>Theme 3. Keeping mentees at the centre</u>		
Understanding mentees needs	This subtheme represents mentors efforts towards providing individualised support to their mentees.	*"To get an understanding of who she is, what her hopes and needs were for the relationship, and working out*

	Mentors dedicated time to understanding mentees needs in their first session and this helped shape future sessions.	*how to best use the space in an efficient and effective way"; **Time point 2***
		*"hearing about where she was at in her career journey and what she would find most helpful to continue move forwards with that journey"; **Time point 2***
Building a 'safe space'	This subtheme featured the importance of building a safe space for mentees to ensure they felt comfortable opening up about their personal journey in their ***individual mentoring sessions***.	
	For some this involved considering positioning in a culturally sensitive way and naming differences.	*"we acknowledged that neither of mentors are from Black Asian Minority Ethnic (BAME) background so how we can still hold and think about this" **Time point 2***
	Others considered the importance of discussing	*"Negotiating boundaries / how much personal info*

	boundaries to gauge what the mentee felt comfortable discussing.	*mentee wanted to share; trying to ensure this felt comfortable for everyone”;* ***Time point 2***
Theme 4. Needing to navigate difficulties		
Mentees positioning and understanding of the role	This subtheme encapsulates some of the challenges mentors experienced with their role due to mentees’ hesitance to have conversations about race/ethnicity and their understanding of what the sessions could be used for.	*“It was somewhat difficult to know what the mentee wanted as she wasn't entirely sure”;* ***Time point 2*** *“I think it would be helpful for mentees to have further guidance to prepare for the sessions”;* ***Time point 2*** *“Mentee's position that they did not want to think together about the impact of race/ethnicity on their journey into psychology”;* ***Time point 2***
Managing power dynamics in the triad	This subtheme represents mentors experience and the difficulties they encountered with managing power dynamics.	*“Management of power dynamics but also not wanting the session to feel awkward”;* ***Time point 2***

		"Bit difficult to know how to strike the balance with all 3 of us in the meeting (e.g. who takes the lead between qualified and trainee)"; ***Time point 2***
Practicalities	This subtheme features practical difficulties such as challenges with finding a time that worked for everyone, delayed responses from mentees/ mentors and not having the time to go through the mentor pack.	*"It was tricky to arrange - took a while for mentee to respond to initial contact then she didn't attend the first meeting; arranged, we agreed to reschedule it and she then attended the second time";* ***Time point 2*** *""it can be quite hard to schedule according to 3 calendars";* ***Time point 2*** *"not all able to find time to go through the pack";* ***Time point 2***

Appendix K: Focus group analysis

Appendix K1: Mentee focus groups Thematic Analysis

Theme	Subthemes/ codes	Example quotes
The journey of personal and professional development	Opening up conversations	**M2**: "erm yeah I just looking forward to more discussions about diversity in relation to clinical psychology" **M3**: "one of my hopes was being able to have a space to talk about erm career progression, but also, like some of the barriers, are specific to people of colour and in open forum as opposed to kind of like the elephant in the room" **M1**: "And I thought it was a good idea to apply for the mentee err programme , because I haven't really heard much discussion about what it's like to be an erm psychologist and also an ethnic minority group. Erm and I think it's quite an important discussion to have. Err so that's why. I thought you know it would be a nice community to discuss these things yeah" **M1**: "I found it quite interesting to hear other people's perspectives. Erm because you know in usual day-to-day situations, you don't really have these discussions with people. Or it can be quite a tricky err situation to navigate.erm So I thought it was really interesting to hear some people have different opinions to me and also some people who felt similarly to how I feel about whatever it was was the workshop was about. Erm so I found that quite interesting. Actually it was ermm refreshing" **M3**: "it was just XXX and I it was really helpful to hear where she was and you know kind of understand what her plan was and compare whether they were similar erm I think in a wider

		group setting it would have been more beneficial just to hear from others”
	‘Finding my tribe’	**M2:** “And I think I was also hoping to meet other people who are from minority backgrounds going through similar journeys to myself” **M2**: “it’s sometimes hard to meet people from diverse background because we are the minority and with schemes like that, we like pull these minorities out and group them together. So this is where we can really, you know, find the tribe that we belong and that's something really nice to have” **M3:** “and to find out more people erm people of colour that are also exploring this field” **M2**: “I felt like yes we all had very similar views very similar things we are passionate in so it felt like we were in our own bubble” **M1**: ““I suppose if I did have at least one mentor, who was from a minority background that would have made me feel more comfortable”

	Reflections & 'digging deeper'	**M1:** "I actually enjoyed it because it gave me a space to reflect on my journey and my education. Also, erm to be honest with you I never really thought about my ethnicity and how it affects my career before seeing this programme and so it forced me to question myself". **M2**: "I think I found it quite refreshing following on that point because this isn't something we will usually be invited to reflect on when we're applying to, you know, some schemes like that" **M3:** "Yeah, it was really one of those having to dig deeper than I normally do for like job applications. But it was also cathartic as well"
	Guidance with the next steps	**M3:** "I joined the scheme because I didn't really know how to get into certain aspects of experience and I wanted to get some advice from a mentor" **M1: "**"I found it very difficult to really understand the way to go if I wanted to become a clinical psychologist. I found those so much conflicting erm you know advice online, and I don't really have anyone erm I could really go to in real life and talk about it too. And so I was really hopeful that I would learn about, you know, some, you know, pathway that I didn't know about before" **M4**: "I think the one for me would definitely be the help with my doctorate application like they were immensely helpful reading the personal statement, re-drafting, reading different parts of it, really giving me pointers on what to say erm how to reflect on it and things" **M1**: ""they gave me some resources like that I could be interested in. so that was really nice of them I think"

		M1: "It also gave me a better idea of my next steps and that was one of my goal so I think it achieved it in that way"
Keeping 'me' at the centre	Feeling empowered	**M1:** "also the way they set up meetings which was kind of revolved around the questions I had and what I needed after the session rather than you know just bombarding me with information" **M2:** "interestingly with my own experience with my mentor XXX in this scheme I felt like that power dynamic wasn't too different. I felt like my opinions were valued on the same level and I also appreciate that he gave me a lot of autonomy to decide erm what how to spend the time doing sessions and what I'd like to discuss with him" **M4: "**I think it was really just helpful to sit down, sit down with them and like think about what I really want to get with this. So they really clearly know what I want from this which was helpful"
	Needing a 'safe space'	**M3:** "And I think because erm my ethnicity and race is a big part of how I am as a clinician and it couldn't not come up eventually. Especially the trainee like erm like one time work was really stressful and one of our session was just me offloading about that and like the way she responded how like warm she was made it really open to then continue to have conversations about race erm with her" **M4**: "it made it easier to talk about some of those things because my mentors bought it up and they were like listen you know we know we are both white and correct us if we assume anything like we don't know anything like try and like tell us and be open like. I don't know I felt more comfortable bringing up some of these

		things because they bought it up first and that was really important to create a safe space” **M2** “overall I think the scheme did allow a safe space for us to talk about race and you know and different things about erm being a minority and how it affects a clinical experience so I think it provided sort of a platform of us to feel safe” **M1**: “the only thing I would kind of errrr have a negative about is I I did have two Caucasian mentors and although I did not mind that it meant that I struggled to kind.. I felt awkward to talk about ethnicity and I suppose that makes me feel it's bit like maybe I'm wasting my opportunity. However, I just, I feel this conversation that too awkward to have and they haven't really tried to bring it up either and so it it's just err its just challenging for me personally”
	Relationships with mentors	**M3: “**I think I would say out of the mentors I found it easier to talk about race with the trainee as opposed to the qualified. Not because like one was less warm or anything but I think the qualified personally probably due to my own experience of white supervisors I found her very much like work supervisor. Whereas the trainee was abit more common ground and relatable”. **M3**: “the trainee was allowing to do the venting to build the rapport that I found it comfortable whereas with the qualified like she was warm and empathetic but it still felt like more like erm like I was being supervised” **M2**: “Yeah XXX I think I I definitely can see that coming like where its come I wonder if it has something to do with age aswell… its usually easier to speak to people of similar age and maybe something quite subconscious where it's like people who has you know a a big age

		gap to me, I think more like they are a supervisor and I'm sort of you know a supervisee” **M2**: “I think personally if there was a more personal you know personal relationship built if there was a better rapport you know there was more connection it would have felt more personal erm I would have been more motivated to get involved”
Barriers to meaningful support	Gaps leading to a sense of disconnection	**M2: ““**I met my qualified I think every two months. Ermmm or maybe three ermm I only met him about four times throughout the year, which to me is a little bit insufficient in a sense It's not enough to build rapport and it's because I guess there's too much gap in between each meeting. It kind of felt like I have to try very hard to remember where where we left the discussion at” **M3**: ““I really struggled with the whole only four times a year thing because (pause) like realistically, to build like a really meaningful rapport with someone you wouldn't see them only four times like yeah. Ermm and maybe that was also why there would be that disconnect and sharing those like personal stories and like how your ethnicity can really impact you. Similarly they did give me a lot of autonomy deciding what topics I wanted to do, but I think if we had more sessions together then maybe they could have given more of an input on things” **M1**: “cos I also didn’t see my mentors for a long time. There was a big gap between every single time erm but we also did the meetings together. I didn't have a separate one with the trainee and qualified so it was really hard to find time when everyone is free. And like XXX and XXX said it's really hard to build a relationship where you feel comfortable with other person if you don't see them very often at all”

		M4: “in terms of like building the rapport and things, I totally like echo what you guys said. It was really difficult and like I think now I'm like 4 ish sessions im towards nearing the end and im like I only feel like I really know them now and have a decent relationship between now and I didn't previously, so it was really hard to discuss some of the things that were more personal” **M3:** “I don’t know maybe like they say for a month like I don’t know maybe have an expectation for the mentors and mentees for the first month or so like regular contact is expected like maybe weekly 30 minute check ins from after that month do the structured four sessions” **M2:** “you know how the duration of the entire scheme right now is a year long would it be possible to maybe cut it shorter so we do like, you know, a quicker turnover, six months for one round of people, but instead of having you know, a meeting every two months we do it for every month. So it's shorter but it's more intensive and it's more intimate in a sense” **M2:** “the trainee and I only got to meet one time and we were meant to meet a couple more times but we just kinda lost contact and I didn’t sort of erm take initiative to email her because she was pregnant at the time. So I thought ermmm you know she’s busy with new life and I I just didn’t really sort of intrude so I actually mainly spoke to erm just the qualified.” **M3: “**Just just to the back up what XXX said I forgot to mention my qualified was also pregnant so it might have been that was the like obviously had life going on and erm and the frequency was an issue for both of my mentee mentors actually”

		M3: "I did feel a lot of responsibility in that we had to make the first contact. It would have been nice, especially when they were let longer gaps erm because obviously we are all busy with life like if they also just checked in and said (pause) erm do you like how are you or do you still want a session cos every two months, erm one of them was four months and it was really like hard to remember where to start again" **M1**: "And every time we did talk about new conversation like you kind of going back to the beginning again rather than feeling comfortable to continue what's being already said and you know going more in depth about things"
	"Choosing what to talk about in sessions"	**M4:** "I think it was kinda tricky in the sessions… So I really had to focus more on what I wanted out of that specific session and do it quite quickly aswell. I was like its just an hour and I've only got four sessions and yeah it was quite stressful I guess choosing and picking what to talk about or what parts of yourself you want to talk about" **M4**: "I felt like I was thinking more about my skills my experiences just professionally erm in clinical psychology and how I can translate that onto my personal statement and things rather than my sort of personal journey in a way I don't know that's sort of me" **M3**: "when you read the scheme on paper you just make up expectations but you kind of infer certain things are possible but I think the way the scheme is structured you can't have them conversations in depth"

	Desire for 'deeper conversations' to be initiated by mentors	**M1**: "maybe if they bought it up first then I would have definitely talked about it. So I think it's it's for me, it's more that initial conversation find it difficult rather than actually talking about it. I'm more than comfortable to talk about ethnicity I just feel uncomfortable bringing it up" **M1**: "for me personally just because I didn't end up having conversation about race and ethnicity it wasn't exactly what I … Just in terms of conversations I don't feel like that it fulfilled that for me but I don't know about other people" **M3**: "mentors taking more of an initiative to ask because the scheme is open to people in university and like working and I think that especially at university I definitely wasn't brave enough to bring up race maybe now I've had some experience in working in NHS yeah maybe but even then that it is challenging and I think if they kind of address it and don't take on a generic way. Like yes I might be XXX but take time to understand what those experiences and identities mean to me and ermmm I do think they my experience is that the mentors could have done abit more just naming it err because they're not naming it they've made it an awkward situation to bring up" **M2**: "erm at times I felt like discussions of minority can go a little bit deeper because even within minority groups there are different people… and for me language used to be a barrier but with the years coming along it got easier. But sometimes it's nice to still reflect on how language can be another added barrier apart from race and I feel like that wasn't really addressed" **M3**: "I think what would have really put this scheme ahead in terms of what their goal was to allow that space and I know I probably sound

		like a broken record but allow that space for those deeper ethnicity and identity issues and not putting people in a box and allowing the exploration of that within applications but also so creating that reflective space for it"
	Desire for face-to-face contact	**M3** "I forgot to say earlier but a key part of why I joined was to network more as I didn't have this opportunity at university. So I think face to face with all the mentors involved and all the mentees erm may have made that like facilitation of interaction a lot easier." **M3**: "and I think because we never met each other face to face we were just randomly allocated to a group it made it even harder to connect with people by email" **M2**: ""So yeah, erm I think my own experience with the one to one, I did enjoy it a lot, but perhaps what could have been better was that if we could have some in person meetings" **M1**: "I wonder if its erm because we haven't met face to face and there haven't been any like team building exercises or anything like that where we can feel closer to people. Instead it is I feel a little bit like we were thrown in the deep end a little bit like just here are your mentors go talk to them. But no one really knows anything about the other person, so I wonder if there could be more exercises to be done face to face, especially to try and strengthen that relationship" **M2:** "Yeah, I definitely agree. Perhaps. Maybe even a day of like bonding activities, having a meal together. Maybe if funding to give each mentor a budget to bring us out for cake and coffee, that would be really nice. Yeah, the face to face element.

		M3: “So I hope the next scheme they are able to try and do face to face event and really encourage it from the beginning…. if they start implementing it earlier as opposed to do it in summer when people might have dropped out of the scheme anyway erm it might be another way to network and to actually you know and give you a chance to find your tribe find other people that are similar that can go beyond from this and have some longevity in relationship building”

Appendix K2: Trainee Mentor focus groups Thematic Analysis

Themes	Subthemes	Example quotes
'Creating a meaningful space'	Wanting to improve the experience of aspiring psychologists	**TM3**: "i'm mindful in the profession its sort of an area that's need to be focussed on in terms of increasing diversity and then both in our cohort and pre-training there were people from minority ethnic backgrounds that sort of described their experiences and I thought I needed to focus a little bit more on that and improving the experiences for people coming into training … yeah so to give abit of support to people coming through that might not have had those connections. **TM4:** "its clearly a problem within Clinical Psychology that we all want to change so erm I thought it would be a good opportunity to take part in"
	'making it individualised'	**TM3:** "I was really mindful of making it a meaningful space in terms of what they wanted for their time and I think that can be really individual" **TM3**: "The contracting and thing was really helpful to think about, yeah I guess making the session with your mentee abit more structured… I would say the material was quite helpful as a guide as I say and then then making it more individual when you got to know your mentee better and what they wanted from the scheme" **TM2**: "Like XXX said I made it quite individualised to what the person wanted" **TM1:** "being quite individualised like what would you like what are your queries"
	Considering positioning in a culturally sensitive way	**TM1**: "I think I wanted to make sure that they could be on the table. So like my mentee essentially I was worried that the mentee might feel awkward bringing them up with me, yes like we said I am a white british person, so I was

		like reiterating at the start like this is a space where you can talk about that" **TM2**: "I was sort of aware so me and her were both ethnic minorities but that by no way meant that that we had similar experience actually at all that I actually came from quite a position of privilege in comparison to her story and background. So I think what help was just having that initial conversations it was literally one of the first things we spoke about was just background and just naming it and that what my position is" **TM3:** "I think I struggled to name that with her and she felt she seemed to feel comfortable talking about it. But on reflection I wonder if maybe I could have also I could name that so she didn't have to bring it all quickly herself" **TM4:** "We tried to sort of self-disclose a bit in terms of our experience of getting onto training, in terms of some barriers we encountered and things like that from different social graces… So I think this the self-disclosure was the way we tried to bring it in but I guess it didn't come up as much as we thought it might be and tried to name that say so this is a space where you can give space to that and she was much and she was quite clear that she didn't want to focus on that… I think giving a space more one to one might have been what she wanted to feel safer with one of us rather than both of us.
	Building personal connections	**TM1**: "I think it was helpful that we met in a very informal way we just like went to the pub after work I think that made it a lot easier for her" **TM4**: ". My trainee and me are still meeting we are still in contact and I think that's okay... Not my trainee sorry my mentee"

		TM3: “we sort of thought about family stories were going on in terms of their views on applying for Psychology, I guess just to get a a sense of where this person is coming into psychology are people on board with that or are they actually against it and that was something that was going on for the person we were working with. So that was quite interesting to get a sense of their position and it opens up discussions”
	Practical support	**TM3**: “she was more about getting advice and things about getting into going down the route of clinical psychology which seems fair enough” **TM3**: “So for clinical psychology now there's so many bits like down the IAPT route and all the rest of it to to give them at least a flavour of what's available and then they can make that decision. It was really hard not to pigeon hole down the route of just clinical psychology known the journey and actually there are other routes if she felt like that cause I guess the age you don't always know that there's a world it yeah within clinical psychology where you can go with it and I think that was quite helpful thing to just give you the options to her to make a decision” **TM2**: “I knew she needed support she was applying to get on to training that year so she needed support with her statement and things like that” **TM1:** “And we ended up talking about a lot of like practical things so my mentee is international student well international applicant and erm so there was loads of really practical stuff about like visas I had to go away and look

		up and things like that and it was erm so I was kind of a bit clueless like trying to find out a bit more"
Navigating the role of a mentor	'Am I the right person'?	**TM2**: "I actually wondered if I'm even in the position to offer people advice about how to get onto training because it's not easy and I think something it's just a fluke how it happens like you interviewed well that day cus I certainly didn't interview well other days so I just wasn't sure err if I'm the right person to offer that kind of mentoring" **TM1**: "I was thinking about like how can I be a contact for somebody and I can help tell them about the profession and the training programme but like I don't want to presume to be able to tell them about what the experience is like being from a minority ethnic background coming onto the course like I cant offer things that I have learnt from my own experience I didn't I was quite conscious of" **TM4**: "in line with what you were saying XXX just kind of being mindful of like I'm obviously a white trainee I don't have that experience wanting to be able to offer support without making you know the reducing the experience of stress they are going through"
	Not wanting to let mentee down	**TM4**: "I was worried like I just you there's this thing like I didn't want to let my mentee down you know I didn't want to disappoint with the support that I can offer" **TM1**: "I think one of my fears was this sounds so silly errm i think one was that I would let the mentee down by being disorganised so I was like I really want to help but like I I'm in total chaos like I have so much going on like I really

		hope I don't let them down like miss an email or something" **TM2**: "I I am also very disorganised (laughs) on the course can I offer time for this person in a way that they'll see helpful, will I be able to do that err or have time for them"
	Confusion and role compensation	**TM2**: "So I met up with my mentee quite a bit I think because the qualified did not like show up. So just gonna say that like she was kind of out of the loop and I think she was really busy. So I think that maybe made me meet up with my mentee abit more cause I knew she needed support she was applying to get on to training that year so she needed support with her statement and things like that" **TM2**: "I overcompensated and met her a lot at first and tried to just give alot. I tried to really give my full support there, which is probably not a good thing coz I couldn't keep that up long term" **TM1**: "I don't think my mentee met with the qualified at all like we could so we couldn't get, we just couldn't find a time that works for all of us and the qualified was quite limited in their availability and then and then essentially I was just like the mentoring programme is just me and the mentee. I think it became like that. Yeah" **TM1**: " I think I kind of wanted to take my mentee under the wing slightly because she was quite isolated in ****** and like lived round the corner and like it's really I could tell did not have a network in ****** at all… I obviously met her informally so it was tricky I was thinking am I not doing enough by not offering to like us to meet at the coffee and like I was always like come out for dinner. Cause you're isolated but then that wasn't the role and like, I didn't but yeah, I kind of took that dilemma

		away with me and was kind of like have I not done enough as a person. But yeah the answer is probably yes but I enjoyed it"
	Giving advice vs. sharing own perspective	**TM1**: "I was very aware of like power I didn't want to tell her that what she should and shouldn't do. So it was obviously a lot of helping her work out what she wanted to do and things… she didn't feel ready to apply even though she had all the qualifications and everything … So I guess my feelings were I really want for her to go for it this year … and then after I was thinking did I push that agenda too much on her… yeah I was like how how much you tell somebody what you think would be would be a good idea because that obviously you're a mentor, there's advice support involved how much do you like do that. So that's something one of my dilemmas erm" **TM4**: "I had that dilemma as well actually because my mentee is considering which which universities and courses to apply for and definitely coming back and forth on a number of courses and really uncertain and sort of asking advice, but then you're not wanting to put too much your perspective on where she should go, right? … how do you help her to problem solve but not give her not takeover and project your view. So certainly, a similar dilemma"
	Frustration at systems of power	**TM2**: "also I was aware the course is well erm Its requirements sometimes don't really give people from other backgrounds the ability to actually apply. For example, A level ratings and my mentee didn't have A levels because she couldn't do them. She had to go into work. So. I came from a course that that was that the kind of sort of requirement and she couldn't apply to it and I actually found it very awkward. I was quite embarrassed that I was on this course and I was telling her these things and then she's saying no point in sort of what I could tell that

		will be useful to do with her like sort of experiences and things that I think that was just more me that I felt quite embarrassed about it. I think she also felt quite strongly and quite angry, rightfully so" **TM2:** "I guess it's just that feeling of embarrassment about being in this position of privilege and from a course that is very privileged and drives those ideals" **TM4:** "my mentee had gone to visit the admissions …and said please can you change the A levels because and I think the lady who runs it she said no. And it was really kind of de-motivating for my mentee and just having that discussion with her, just wanting to be like I wanted to call up the office person myself and be like excuse me, but then knowing that's really not going to make a difference. So just that battle of like you want you do you want to try and solve it with them. But ultimately just validation and that was quite hard." **TM4**: "you know it took me a good sort of 5 years to get on and I know people who tried for longer and thinking it's abit of a unfair process you know we can offer this support it's not like the process is fixed and fair"
Scheme structure	Addressing fears at the outset	**TM3**: "I think the introductory session was really helpful in terms of the workshops to go along just to hear where we were similarly sharing hopes and fears and things with other people and I think it's helpful to normalise a lot of you are going in with the same sort of hopes and concerns and sort of addressing that in the room and what we could do about that" **TM1**: "it did kind of cover everything and like the fears we spoke about, I did feel like they had

		been acknowledged in the introductory workshop which was really good"
	Paperwork and time pressures	**TM2**: "I would say one thing about the paperwork that got sent around and I know loads of effort went into it but it was like a lot of paperwork to read through and kind of work your way through. I skimmed it and like I used bits a pieces but I wouldn't say I followed that kind of structure" **TM2**: "Yeah, I probably should have looked at those things that maybe that would have helped me, but mine was mostly to do with I guess the level of information written down. Like I find it quite hard to read massive documents and retain them as well. So that would be my sort of main thing, like maybe something a bit more focused like XXX said could be helpful" **TM1**: "yeahh I think I really found A) I didn't have the time like to look through things enough to use them helpfully so I think I almost felt like maybe my time is better spent meeting having more meetings with this person and being quite individualised like what would you like what are your queries and maybe rather than looking through paperwork yeah I agree XXX I think that's a good point" **TM1**: "maybe like a little bit more focused information, like maybe like a little bit less (laughs) Yes, but I mean like err more digestible within the erm maybe it's just me and my time management, but I found it quite a lot to like go through" **TM3**: "because the paperwork was sort of coming out as we went through the scheme I think that can be abit more challenging to know how much you sort of dip in and out of that

		when you have already started a certain way with your mentee”
	Contact with the mentoring team	**TM3**: “I don't know if there's more I guess that live document where that could be updated so like common questions that were going back or themes that were coming up. If we can sort of check-in around that in terms of staff. Sort of checking in around issues that might be present, maybe that was there I've not used it yet” **TM4**: “I think maybe there's a possibility I missed some emails, but there it felt disconnected. So we have the kind of meet up at the beginning and then you just kind of went off and it sounds like that we've all had very different experiences, maybe there was a little bit more disconnect between us. It might have been nice to have potentially a few more check ins”
Reciprocal benefits	Satisfaction from ‘doing something different’	**TM1**: “I thought it was lovely, I really liked getting to meet someone that I'm pretty sure I wouldn't have had a chance to meet” **TM1**: “I think it was just sort of refreshing as like a different activity during the course, so like whenever we did meet up I was slightly stressed that day because I had less time but after I met with her I was like that’s a different thing I've just done… It wasn't a lecture wasn't a placement day I've talked to someone who's needs support”
	Deep conversations and reflection	**TM1**: “I guess it keeps your mind a little bit more focused on the bigger picture of erm not just your own narrative or experience desperately trying to get through this course”

		TM3: “it was really nice to hear different perspectives on the journey into Clinical Psychology I think it also increased my self-reflexivity in a way I was thinking actually what did I want to know sort of what led you into psychology and even now so what's biassing your views and really thinking about things like your story when you’ve made it… but also how to just check in with yourself all the time about how different peoples experiences and not making assumptions about that because actually even at different stages of yeah of journey or different backgrounds can make a huge difference on people in the profession” **TM2**: “I think I became a lot better at reflecting with my mentee because and also facilitating reflection and understanding from another person's lens in those different social graces, how they might tackle like a client reflection or case and it was really interesting how differently like we thought about these things, but when we brought them together, we both sort of learned from different perspectives how one could reflect on those things and what decisions and why we’re thinking that way. It’s very like like, deep conversations and reflection
	Building supervisory skills	**TM3**: “there was lots of reflective conversation things about that which I found helpful in terms of both moving forward and how I might set it up, there were questions he used which I thought were quite nice to open up those discussions” **TM4**: “experience I personally learnt a lot from that, and I learned a lot from how she decided to use the programme and how she structured the sessions and what she wanted from it. So I felt like I I gained a lot from working with her”

		TM2: “Also that mentoring and kind of like, you know, the leadership and supervisory kind of things. I've not supervised anyone yet, it's coming up, but it was nice to kinda have like a little opportunity not she was my supervisee, but to just like take someone under wing and get them to understand what the course is like and what what kind of things you have to do. I enjoy doing that and I think it made me want to do it more” **TM1:** “Yeah it made me excited about being someday a supervisor. I know it's different, but it was like it was something fun”

Appendix K3: Qualified Mentor focus groups Thematic Analysis

Themes	Subthemes/ codes	Example quotes
Desire to 'make a difference'	Acknowledging the need for wider representation	**QM1**: ""inspiration for me really was part of the broader conversations we're having in the trust about these kinds of issues in terms of the representational issues in the profession and also more broadly in healthcare" **QM2:** "we had discussions in our wider team erm and trying to reflect on how we felt yeah what was lacking in our clinical practice and erm where erm yeah this should sit. And when I got an email from the course yeah it just really struck me that this is something I wanted to take part in"
	Sharing personal experiences of difference	**QM2:** ""my route to clinical psychology has been ermm different to my peers just because I didn't train in this country I didn't grow up in Britain ermmm and I had a very different approach to Psychology and erm I can't I really say if it was a disadvantage in any way or you know my challenges that I have encountered is different to someone you know from an ethnic minority background but just having that sense of also being different or having a different route in I thought might be useful also for someone else to hear and share experiences" **QM3**: "erm so my grandfather was *ethnic background* so erm its kind of always been abit on my mind about relationship between personal identity and professional erm practice and what being urm a psychologist errr would mean from a minority ethnic background"
	'A sense of empowerment'	**QM3:** "I'm thinking about a sense of empowerment that's how I see a lot of this

		work erm I think erm helping people see that they do fall erm have much of the knowledge and skills they need already erm yeah that's some of the things coming up for me"
Working with mentees to provide meaningful support	Coming to a collaborative agreement	**QM2**: ""I guess you know our own confidentiality agreement, how we want these meetings to be, that we made joint decisions the three of us that we wanted to stay as a group and discuss different options" **QM4:** "So yeah I don't know but I felt that err the input helpful because there is something about someone saying we're setting this up for these reasons I think its really important that you explicitly say we can talk about this this and this." **QM4**: "it felt useful that there had been an explicit it would be good to address this this and this and offer particular topics because I don't know how I would have done otherwise"
	Being led by the needs of mentees	**QM2**: "the mentee was about to apply for clinical psychology they were actually more thinking about the application, we did a mock interview but actually generally more thinking about how personal influences about mental erm health are in the family had impacted on our journey and experiences" **QM2**: "I think the scheme is set up in terms of improving representation in Clinical Psychology but again I would say erm our mentee was sort of trying to work out what they wanted to do not just because it was difficult but what would suit them best. Erm so we ended up talking about different options, different options."

		QM1: "actually I want to talk about IAPT and I don't know about IAPT and I really want to know' **QM4**: "that's kind of the information that people usually need isn't it how to tailor their application form how to tailor their skills kind of thing which is very hard to get without that kind of personal contact and relationship" **QM3**: "so we used the space to think about what the possible opportunities might be and who he might need to talk to and almost sort of assertiveness training like around if you did want these experiences who would be the best to speak to and what he might get out of them if he wanted to go on and getting a clinical job"
	Facilitating connections	**QM1**: "our mentee was about to do this… placement and we we ended up sort of I was like which trust is it for and we looked at the website and we figured out where it was and I said okay I think I know the head of Psychology for that trust and they're also from a minority ethnic background would you like me to introduce you under the umberella of this scheme I'm sure they will give you half an hour and she was like I never thought about that it would be really helpful" **QM2:** "the three of us have said we also happy to stay in contact in a very informal way if any of us need any support because I think we all had things we really valued from our sessions … I'm glad I'm in touch in an informal way with the two people I was in a group with"

Navigating the role of a mentor	Am I the right person to help?	**QM3: "**"for me some of the kind of fears were well that's the first thing that comes up so I don't know what that says but ermm I think ermm one fear I did have was about erm my personal experience of diversity and just very aware for me actually you know I'm fortunate that I haven't come from a family that has experienced you know economic hardship and just thinking about how it relates to someone that might have had a different experience from the erm not had the advantages I've had erm so yeah" **QM2: "**not being sure what I actually could contribute I was very mindful that actually I'm exactly the opposite from people that are looking for support you know erm so like I have said I have been quite privileged I haven't encountered the difficulties in my life ermm so I was sort of like gosh am I even the right person to do this"
	Consideration of power and privilege	**QM2:** "we always met as a three so that and I think yeah that was initially my biggest fear that I don't want to be the qualified psychologist in the room even though ofcourse I am the qualified psychologist equally I don't want to be the white middle class woman in the room and I think around that just that awkwardness" **QM1**: "when the three of us got on to teams there was almost this awkwardness like who's going to talk first and if it is me should I have not done that and also abit of the sense that I was kind of being looked to to say something first because nobody quite knew why they were there or what they were doing so I sort was the person who speaks first"

		QM4: "I wanted the trainee to feel more free to discuss their experiences of training without me being there erm so that could be a factor"
	working together clarify aims/ hopes	**QM3**: "I found quite difficult was erm my mentee was like I don't want to talk about any of these things erm and I was like okay (laughs) erm that's fine (laughs) but then it felt quite difficult to be like okay well ermmm" **QM1:** "I ended up thinking is some of the benefit of the scheme the the its providing that opportunity to have that support in a way that's one of the way the intervention almost or is that in the session you end up spending a lot of time talking about racism and structural barriers. So our one didn't exactly say I don't want to talk about that she was like 'okay that's good to know but that isn't really on top of my mind" **QM1**: "we then had err a training session I think somebody I can't really remember who they were but they were like you must talk about these things they must be bought to the table so we were really laying on the line with the next session that we want to be clear that we are available to talk about these sorts of things it's helpful that that's when we got that okay yeah that's good to know but that's not what I really want to ask you today (laughs) so I suppose that was kind of our experience" **QM1:** "there is something quite interesting about some of the prep that make us think we have to talk about some of these things because we think that's the right thing to do and I ended up thinking its important to create the space where they could talk about them

		but actually we need to stay close to what is useful" **QM4:** "what my mentee bought along to me was that wasn't she didn't feel that was a huge factor it was more she erm the economic difference and feeling kid of economic barriers to erm entering the profession… I wondered if there was something about that erm that idea of intersectionality and erm equipping mentors to think that erm you're quite likely to have conversations about other areas of difference" **QM2**: "I think we did a little bit of that but actually you know just like you said it felt like just for the sake of it because this is what we were told we should talk about actually we didn't really feel like we thought that's what was useful for us as the three being there"
	Re-connecting with the journey towards Clinical Psychology	**QM3**: ""it really falls home for me quite how challenging it is to get into Clinical psychology and its quite difficult to forget that I think you know erm once you're further down the line" **QM1**: "it's sort of reconnected me abit to what it's like being in that stage erm in general actually not from the position of being from a minority group but just generally being an undergraduate, not sure which way you quite want to turn so I was quite struck by some of the off-putting messages being spread that has stayed with me and just the complexity of navigating choices in general"
Scheme structure	Appropriateness of contracting	**QM2:** "I think we were given a supervision contract if that's what it is called and I just remember that I was sitting there thinking that I I am not providing supervision I thought you

		know I I don't want this, that doesn't mean I don't want any structure that doesn't mean there cant be any agreement but this is really not what I had anticipated because I thought it is a exchange between different parties bringing their experience as equal rather than me having any ermm you know me having to lecture someone or teach someone or supervise someone" **QM1:** "I agree with XXX and didn't feel like it was the right framework because it isn't supervision and seemed potentially over formalising yeah just didn't seem It was the right sort of thing to wrap around yeah erm I felt maybe it was inevitably abit awkward" **QM3**: "I did use of a version of the contract… So yeah I don't know but I felt that err the input helpful because there is something about someone saying we're setting this up for these reasons I think its really important that you explicitly say we can talk about this this and this"
	Uncertainty about roles and responsibilities	**QM1:** "I also felt the mentee felt sort of 'I don't know what to expect and I don't quite know what's on the menu' and I don't know if its something just there for you to decide on and what are the more sort of what is the scaffolding around it or is there much because I think that got abit confused" **QM1:** "our erm mentee after the first session we asked for feedback and she said erm it was really different to what she expected but in a positive way and she she had thought it would be she would ask us questions and we would give her advice and it would be kind of Q&A so it made me curious what they had been told to expect in a way"

		QM4: "I'm pretty sure there was a prep session for mentees erm and yet my mentee seemed to come with very little expectation or prep"
	Guidance on endings	**QM2**: "but I had emailed the mentoring lead what actually happens next because I never then actually got any feedback or you know what happens to next. I know we were left to our own you know like how much we need to meet but I was kind of expecting maybe there was second cohort coming would we be expected to do this again or could we informally run with this now and continue… and I didn't get any response back to this date" **QM2:** "I think that's something towards the end I would have appreciated because everything else they usually say if there is a second round or they ask if you want to stay on but there was nothing and I'm glad I'm in touch in an informal way with the two people I was in a group with but erm yeah I don't know if that's the right way" **QM1:** " I think we had a similar dilemma about ending or not ending or whether to carry on informally again because this person is at undergrad stage it seemed potentially helpful to to have more involvement beyond the year but maybe not as formal but again again I missed something that could be possible but none of the three seem to be clear on it"

Appendix L: Service recommendations

Findings	Recommendation	Details
	Scheme structure	
Practical and time barriers were reported by both mentees and mentors. **Mentees reported the 'four sessions' limit insufficient for rapport building and this in-turn impacted how safe they felt to share certain experience and hold certain discussions i.e race, culture. Mentees also thought that having a long gap between each sessions meant that a lot of time was spent 'catching up' rather than continuing the conversation from previous sessions.** **Mentors reported finding it difficult to find mutual time to schedule meetings.**	**Practicalities** To consider reviewing the four-session limit and highlight the expectations of keeping in contact both ways. Also, providing more guidance on how mentees and mentors can make the most of their time together.	If possible, it is recommended that the mentoring team review the guidance on having four sessions throughout the year as mentees found it difficult to build rapport and get the most out of their sessions during this timeframe. Consider suggesting mentors and mentees meet twice in the first month for short sessions to facilitate rapport building. It is recommended that the mentoring team highlight the importance of pre-booking sessions to prevent delays in sessions due to diary clashes. It is also suggested that the mentoring team highlight mentors and mentees responsibilities in replying to emails in a timely manner i.e. within 3-5 working days of receiving an email. It would be helpful for these to be added to consider in the mentoring agreement and introductory workshop.

Both mentors and mentees experienced difficulties with meeting together.		
Mentors reported that mentees came to sessions not knowing what to expect or how to use the space. **Trainee mentors reported confusion around their role and about how much advice to give with career planning. They also reported feeling stuck between being honest about their experiences on the course and 'selling the course'/ putting people off.**	**<u>Defining the role of a 'mentor' and 'mentee</u>** <u>To review current information on the role of a mentee and mentor.</u>	Mentees: It is acknowledged that the introductory workshop did a great job preparing mentees for their sessions and providing guidance on what the individual mentoring sessions could be used for. It is possible that all mentees did not attend this workshop and make use of the advice given. It is therefore suggested that the scheme highlight the expectation for mentees to prepare for their sessions. The introductory workshop could be recorded for mentees to watch if they could not attend- these and other recordings could be made available to mentees through a resource library. It is suggested that the mentoring team make it mandatory for mentees to watch either *watch the introductory workshop* or *read through the mentee pack* prior to their first individual mentoring session. Mentees should also consider items for their agenda for each session. It is also suggested that the mentoring team further highlight the roles of trainee mentors and qualified mentors further. This could include the following: Trainee mentors: To communicate that their role is to provide advice on career pathways and support mentees to make their own decisions. To communicate that there is no expectation for mentees to apply to Oxford and for mentors to feel responsible for this.

		Mentors: To provide advice on mentee's career pathway and to facilitate a supportive space for mentees.
There was mixed feedback on the usefulness of contracting. Specifically, mentors found it unhelpful to have a formal contract as this made it feel like supervision as opposed to mentoring.	**<u>Contracting</u>** To review how guidance around contracting is presented to mentors/ mentees. Review language around 'contracting'.	Review the rationale for having a contract and how this can be achieved differently. i.e, leaving it to the mentors and mentees to decide how 'formal' to have this discussion but as a minimum for all groups to have a discussion around 'things to consider'. Examples include: - frequency of sessions - meeting online or in person - cancellation of sessions - confidentiality discussion - preparing for sessions - areas that mentees don't want to talk about
Trainee mentors reported that the information pack was useful, however it was in a great level of detail and due to time limits they weren't able to read the complete document to then be able to use It helpfully. They also found it unhelpful to receive the document after the mentoring sessions had commenced and they had already had the discussion about how to structure sessions.	**<u>Communication</u>** To review how written information is communicated and to ensure the information packs are sent out before the scheme starts.	The mentoring agreement template is a great resource for mentors and mentees- This could be circulated in an email as a separate resource to be used as it can be easily missed in the mentor pack. Providing a 'frequently asked question' document which has answers to common questions in bullet point format. Some examples are: - What to do if one of the mentor is absent/ not replying - What to do if the mentee doesn't want to reflect on issues relating to diversity/ privilege/ race etc - What might a first session look like/ things to cover

		- What to do if I don't feel like I'm getting the most out of my sessions
Mentors also reported feeling disconnected from the mentoring team and not knowing what to do when issues were raised.	To review process of checking-in with mentors and mentees.	To continue current process of email 'check-in's' but also offer separate drop-in sessions where mentors/mentees can come and speak about any issues that may have come about. To consider having joint communication for mentors and mentees about workshops. Mentors can use this to facilitate discussion in their individual mentoring sessions.
Mentees and mentors both reported that they would benefit from more guidance on what to cover in sessions.	**<u>Guidance on sessions</u>**	It is recommended that the mentoring team consider providing clearer guidance on what a first session might look like and provide examples of what mentees might want to speak about based on the expectations theme. This could include guidance on structuring sessions i.e. having an agenda, reviewing goals and expectations, prioritising agenda items for the session etc. Further guidance on sessions based on what mentees found helpful could include the following: advice on career pathways, resources to help with interviews, providing feedback on personal statements, mock interviews, discussing clinical vignettes. To have an open discussion in the first session about what approach the mentee would like to take i.e., two-way agenda or led by mentee.
Mentees wanted to be led by mentors, but mentors not finding		For mentors to ***initiate*** discussions around race, ethnicity, power and for mentee to decide how and when they want to speak about this. The mentoring agreement can be used to discuss how and when these

this helpful or similar to a supervisory relationship.		conversations will take place, but as a minimum for mentors to name these issues.
Mentees felt most comfortable having 'deeper conversations' when issues such as race and power were named by the mentors.		Suggestion: To consider suggesting to mentees to stay in touch with their mentor via email about any updates and what they would like to discuss in the upcoming sessions.
Mentee reported that the sessions were spaced out and therefore most of the session was spent giving updates on what had changed since the last time which was time-consuming and not a good use of their time together.		
Mentors and mentees both reported being unclear on when to end their sessions and how to manage endings.	**<u>Managing endings</u>** To review current process on endings and communication around this.	Mentoring team to clearly communicate when the sessions are expected to end via email and have a drop-in session before this to answer any questions mentors/mentees have. For mentors and mentees to have a conversation at the start about when the sessions will finish and how to use the space until then.

Mentors also reported feeling unclear about the value of their role and how helpful their mentees have found the sessions.		To consider reviewing goals mid-point and at the end of the mentoring scheme using idiosyncratic measures based on what the mentee wanted to get out of the scheme. i.e. if their goal is around increasing confidence then reviewing this before and after the sessions have ended.
Feedback response rate was low for individual sessions and very low for workshops.	**Feedback**	**Consider outlining mandatory expectations to provide feedback at the start of the scheme.** **Workshops** Consider asking mentors and mentees to rate their knowledge about/ confidence before and after each workshop as this would be useful for evaluating how helpful the workshop has been. Include open ended feedback questions that will allow mentees and mentors to share their reflections from the workshop. i.e. please share your reflection on the workshop and something Keep the following format of questions for workshop feedback forms: - How satisfied were you with the workshop - How much did the workshop meet your expectations - What did you find the most helpful/ least helpful about the workshop

Consider including a question about how satisfied mentors and mentees were with the balance of didactic to experiential/ reflective content.

Provide time at the end of each workshop for mentors and mentees to complete feedback forms to increase response rate.

Individual mentoring sessions

Consider three time points for feedback from individual mentoring sessions i.e. start of scheme, mid-point and end of scheme.

Consider the following format of questions for feedback forms:

Start of scheme

- Current stage of journey (work/ studying)
- Mentoring hopes and aspirations
- How satisfied are you with your mentoring sessions
- Did you feel listened to by your mentors?
- Were you able to speak freely and honestly about your journey?
- What was helpful/ least helpful about your mentoring session
- Were issues relating to diversity discussed in your session

Mid-point

- Have you made any progress towards your goals for the scheme?
- what stage are you at of your journey (work, studying, applying for training)

		- How satisfied are you with your mentoring sessions - Do you feel listened to by your mentors? - Are you able to speak freely and honestly about your journey? - What was been helpful/ least helpful about your mentoring session - Have issues relating to diversity been discussed in your session End of scheme - What were your goals for the mentoring sessions and have these been met? - what stage are you at of your journey (work, studying, applying for training) - How satisfied are you with your mentoring sessions - Did you feel listened to by your mentors? - Were you able to speak freely and honestly about your journey? - What was been helpful/ least helpful about your mentoring sessions - Were issues relating to diversity been discussed in your session
Workshops		
Mentees and Mentors reported difficulties attending workshops due to time constraints.	**Timing and practical barriers**	It is recommended for the mentoring team to ask the current group of mentees and mentors their preference of timings for workshop and accommodating for their preference where possible. It is also suggested to review the timing of workshops so they are not straight after lectures or work. Also recording workshops would be beneficial for people who are not able to attend.

Mentees also reported that they were not able to attend workshops due to limited notice of workshop schedule.		Consider planning of workshops before the scheme starts and provide this itinerary to mentees in advance so they can make arrangements to attend.
We found that mentees would benefit from reflective workshops as opposed to a didactic style.	**Learning style**	It is recommended that the mentoring team consider delivering workshops that provide mentees with an opportunity to reflect in small break out rooms with other mentees.
Mentees provided suggestions for future workshop topics.	**Workshop topics**	Consider offering workshops with the following content: (i) contextual barriers to entering the field and how to approach these (ii) 'day in the life of a trainee' with time to have Q&A and a networking exercise in small groups (iii) skills-based workshop focussing on interview tips and relevant experience hosted by trainees (iiii) culture and stigma and how this impacts clinical work
Other		
Mentees expressed 'networking' as a significant aspiration for joining the mentoring scheme. They further reported that their	**Networking** *Supporting mentees to 'find their tribe'*	To consider face-to-face opportunities for networking, especially the first event to be hosted in-person to make it easier for mentees to socialise and build connections with each other.

expectations for this weren't met due to a lack of networking opportunities, which were further compounded by online barriers and a lack of interest from others.		To offer and review opportunities for mentees to meet up outside of work hours- having two 'social reps' volunteers to arrange events and encourage attendance.
Mentees were most satisfied with mentors who they established a personal connection with that was different to a supervisor-supervisee relationships.	**<u>Facilitating rapport between mentees and mentors.</u>** In response to this finding, consider providing examples of rapport building exercises and highlighting the key differences between supervision and mentoring.	It is recommended that the mentoring team provide examples of exercises/ resources that can be used to facilitate rapport between mentors and mentees. This could include providing mentees and mentors a profile of each other which has the following information: ethnic background/ culture/ religion, professional interests, area of work, 'facts about me' etc. Based on how much mentees and mentors want to share with each other, the following exercises could be used: Reflective exercises sharing Social GRACES, professional journey timeline, family beliefs and values. It is hoped that this will support mentees and mentors to get to know each other on an individual level and strengthen rapport. It is also recommended that the mentoring scheme highlight the differences between supervision and mentoring in the introductory workshops.
Mentees reported the importance of having a safe space to speak about difficult topics such as race and ethnicity. Mentees appreciated mentors naming their position, coming from a position of not knowing and naming topics to speak about. Mentees reported	**<u>'Building a safe space'</u>**	Providing mentors guidance on what has helped mentees feel safe : - Naming difficult topics such as race and ethnicity and opening the space for these conversations - Acknowledging their own position in a culturally sensitive way - Coming from a position of not knowing

that they would have preferred to have a more personal connection with their mentors to feel comfortable about discussing their experiences.	

Appendix M: Self-reflexivity

I am a 27-year-old, British Pakistani female, currently in my second year of doctoral training at the Oxford Institute of Clinical Psychology Training and Research. One of my main clinical interests is improving access to healthcare services for individuals from diverse ethnic communities. Following the research fair, I felt quite certain that I wanted to take part in this service improvement project as I have a keen interest in supporting individuals from diverse ethnic communities in their journeys towards clinical psychology. When I came across this project, I was in my first year of training and remembered very closely how difficult it was for me to get an Assistant Psychologist post after my undergraduate degree. The only option for me was to undertake a Masters degree which provided me with an opportunity to complete a placement as a honorary assistant psychologist. This provided me with a route in the field and opportunity of building connections and receiving support from clinical psychologists. Whilst this was a viable option for me, I understand that everyone's personal circumstances are different and not everyone has the time and financial means to take this route. I thought the Mind-to-Mind mentoring scheme is an excellent initiative to support people from minoritised backgrounds with their individual pathways into the field of clinical psychology.

Discussions between myself and RV (Mentoring Lead and research supervisor) led to us developing the project to meet the requirement of a Service Improvement Project (SIP). We also had support from FC (Assistant Psychologist) and CB (research supervisor) with shaping the project. I had signed up to be a mentor on the scheme and due to my involvement as the primary researcher in this SIP, it felt important for me to drop out from this role to avoid potential biases with the evaluation of the scheme. It was agreed that a mixed methods study design, with analysis of feedback forms data collected by the service and focus group discussions would be the preferred method of data collection. The primary aim of this SIP was to gain a detailed and rich understanding of mentors and mentees experience of the mentoring scheme. We decided to hold three separate focus group discussions with mentees, trainee mentors and qualified mentors to ensure each group was able to speak freely and honestly about their experiences without being influenced by each other. Reflexive thematic analytical methods are considered the most appropriate for studies in which the researchers have no prediction of themes and findings, therefore this epistemological stance was considered to be best suited for the aims of this project.

During the planning stages of this project, a scoping interview was held with one mentee and one trainee mentor on the scheme. The purpose of this scoping interview was to develop the focus group interview schedules and consider topics to explore in the focus group discussions. One of the scoping interviews was held with a trainee mentor on my cohort who did not provide much feedback on the interview schedule perhaps as she knew me closely. I found this difficult and had to ask more direct questions about the appropriateness of certain questions to receive feedback from her. Consultation was also held by two supervising clinical

psychologists and the feedback led to changes in the wording of questions (ensuring they were open ended), the order in which questions were asked, additional prompts and topics to explore (such as asking about the workshops/ peer groups).

The commencement of the project was delayed due to difficulties receiving ethical approval for the project. I spent a lot of time speaking to Oxford Health R&D, CUREC and the research team to understand what route I need to follow for ethical approval. Whilst the project activities came under a service evaluation/ audit, Oxford Health suggested gaining ethical approval from CUREC as the project involved recruiting from multiple organisations (mentors employed by different NHS trusts and mentees at different universities). In the end the research team concluded that the university and Oxford Health were not set up to provide oversight of the project, therefore a course review group was set up to assess the project and it then received ethical approval. I found this process frustrating as I had as I had put in a lot of work to get the project moving so the mentoring team had feedback before the second round of the scheme commenced, however we were very delayed in receiving ethical approval for this study. Despite this it was very rewarding when I finally received ethical approval for the project, and I also learnt a lot about the process of receiving ethical approval for service evaluations vs research.

Furthermore, contrary to our expectations, recruitment proved to be another challenge for this study. I had received good interest from mentors to participate in the focus group discussions, however a very low number of interests from mentees (N=1). This led to us considering different ways of recruitment and potentially a back-up plan of a different data collection method (surveys). I felt very frustrated by this as I had spent a lot of time developing the focus group interview schedules and gaining ethical approval for this study which meant I would have to take a step back and make amendments to my ethics form as well as create new materials for the study. My supervisors suggested I emailed mentees individually, with a personalised email addressed to them, inviting them to participate in the study. This was time consuming and delayed the recruitment process further, although we did receive enough interest to commence with the focus group discussions (N = 4). There were additional pressures of trying to get the project moving before the second round of the scheme ran, I feel like working in a time restricted context increased my frustration further and without this pressure I wouldn't have felt as frustrated by the barriers. In the end I was very pleased by how the focus group discussions were went and received detailed and rich data from each of the groups.

I really enjoyed the process of transcribing the focus group discussions as this allowed me to immerse myself in the data. Following this, the six-step approach of Thematic Analysis (Braun & Clarke, 2022) began. I completed the coding and development of themes according to this method. RV reviewed the codes for all three transcripts and provided suggestions of additional codes to consider. RV and LB provided feedback on sub themes and overall themes for each transcript. This led to taking a step back and ensuring data analysis followed an inductive method where the themes derived from the data itself rather than the questions asked. RV and LB further reviewed the sub-themes and themes until consensus was reached about the wording of themes, content of themes and whether there was any overlap. Myself and RV are both from ethnic minority backgrounds, and the other supervisor (LB) is White British, therefore it is important to consider the three varied perspectives that informed the analysis of the data. LB had no involvement with the organisation of the mentoring scheme and bought a really helpful perspective with the analysis, which was important to avoid biases with the study.

During the write-up of the study, I was mindful that I can go over word count and having a word limit for each section was helpful. However, the write-up of the results section was challenging due to the amount of data gathered from each of the phases and I struggled to keep to the word limit of the project. I found the feedback from both supervisors helpful with condensing quotes to ensure they are illustrating key points. Despite doing this, I was still over word count and had to resort to moving certain phases to the appendix. I felt frustrated by the word count as I had put a lot of effort in conducting each of the phases of data collection and didn't want to move my work to the appendix.

Theory Driven Research Project
Appendix N: Study documents
Appendix N1: Study measures

1. Demographics and migration history

1	Age:
2	How would you describe your gender? ☐ Male ☐ Female ☐ Non-binary or other gender: ☐ Prefer not to say _____
3	What is your ethnic group? ☐ Mixed (White and Black Caribbean / White and Black African / White and Asian) ☐ Other Mixed / Multiple ethnic background: _____ ☐ Indian or British Indian ☐ Pakistani or British Pakistani ☐ Bangladeshi, British Bangladeshi ☐ Chinese ☐ Other Asian background: _____ ☐ Black (Black British / Black Caribbean / Black African / Black other) ☐ Arab ☐ Other ☐ Prefer not to say ☐ Unsure
4	What is your religion? ☐ Christianity ☐ Islam ☐ Hinduism ☐ Sikhism ☐ Judaism ☐ Buddhism ☐ Other religion: _____- ☐ No religion ☐ Prefer not to say

	☐ unsure
5	Did you or one of your family members migrate to this country? ☐ myself ☐ other: _____ ☐ parents ☐ grandparents ☐ great grandparents
6	Date of your or your family members migration _____
7	What was the reason for your or your family members migration? _____ _____
8	Who do you currently live with? Please circle all that apply below. ☐ live alone ☐ academic institution ☐ with spouse / common law partner ☐ with partner ☐ with own children ☐ with parents ☐ with siblings ☐ other: _____
9	What is your highest education level? ☐ SATs (Standardised Assessment Tests – Primary School) ☐ Standard grades/ GCSE/O-levels ☐ Undergraduate degree ☐ Highers/ A-levels / BTEC ☐ Postgraduate qualification ☐ National Vocational Qualification ☐ Unknown
10	What is your current employment status? ☐ Employed ☐ Retired ☐ Unemployed and seeking work ☐ Student ☐ Unemployed due to disability/incapacity ☐ Unknown

	☐ Stay at home parent

2. Patient Health Questionnaire-8 (PHQ-8)

Over the last week, how often have you been bothered by any of the following problems? Please do not omit any item.

	Item	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things.	0	1	2	3
2	Feeling down, depressed, or hopeless.	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4	Feeling tired or having little energy.	0	1	2	3
5	Poor appetite or overeating.	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3

3. Ethnic Identity Scale (EIS)

Ethnicity refers to cultural traditions, beliefs, and behaviours that are passed down through generations. Some examples of the ethnicities that people may identify with are Mexican, Cuban, Nicaraguan, Chinese, Taiwanese, Filipino, Jamaican, African American, Haitian, Italian, Irish, and German. In addition, some people may identify with more than one ethnicity. When you are answering the following questions, we'd like you to think about the last week and what YOU consider your ethnicity to be.

	Does not describe me at all	Describes me a little	Describes me well	Describes me very well
1. My feelings about my ethnicity are mostly negative.	1	2	3	4
2. I have not participated in any activities that would teach me about my ethnicity.	1	2	3	4
3. I am clear about what my ethnicity means to me.	1	2	3	4
4. I have experienced things that reflect my ethnicity, such as eating food, listening to music, and watching movies.	1	2	3	4
5. I have attended events that have helped me learn more about my ethnicity	1	2	3	4
6. I have read books/magazines/newspapers or other materials that have taught me about my ethnicity.	1	2	3	4
7. I feel negatively about my ethnicity.	1	2	3	4
8. I have participated in activities that have exposed me to my ethnicity	1	2	3	4
9. I wish I were of a different ethnicity	1	2	3	4
10. I am not happy with my ethnicity.	1	2	3	4
11. I have learned about my ethnicity by doing things such as reading (books, magazines, newspapers), searching the internet, or keeping up with current events.	1	2	3	4
12. I understand how I feel about my ethnicity.	1	2	3	4
13. If I could choose, I would prefer to be of a different ethnicity.	1	2	3	4
14. I know what my ethnicity means to me.	1	2	3	4

	Does not describe me at all	Describes me a little	Describes me well	Describes me very well
15. I have participated in activities that have taught me about my ethnicity.	1	2	3	4
16. I dislike my ethnicity.	1	2	3	4
17. I have a clear sense of what my ethnicity means to me.	1	2	3	4

4. Vancouver Index of Acculturation

Many of these questions will refer to your heritage culture, meaning the original culture of your family (other than British). It may be the culture of your birth, the culture in which you have been raised, or any culture in your family background. If there are several, pick the one that has influenced you most (e.g. Irish, Chinese, Mexican, African). If you do not feel that you have been influenced by any other culture, please name a culture that influenced previous generations of your family. Your heritage culture (other than British) is:

Please circle one of the numbers to the right of each question to indicate your degree of agreement or disagreement.

1 Strongly disagree	2	3 Disagree	4	5 Neutral	6	7 Agree	8	9 Strongly Agree

Questions	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1. I often participate in my heritage cultural traditions.									
2. I often participate in mainstream British cultural traditions.									
3. I would be willing to marry a person from my heritage culture.									

4. I would be willing to marry a white British person. 5. I enjoy social activities with people from the same heritage culture as myself.									
6. I enjoy social activities with typical British people.									
7. I am comfortable interacting with people of the same heritage culture as myself.									
8. I am comfortable interacting with typical British people.									
9. I enjoy entertainment (e.g. movies, music) from my heritage culture.									
10. I enjoy British entertainment (e.g. movies, music).									
11. I often behave in ways that are typical of my heritage culture.									
12. I often behave in ways that are typically British.									
13. It is important for me to maintain or develop the practices of my heritage culture.									
14. It is important for me to maintain or develop British cultural practices.									
15. I believe in the values of my heritage culture.									
16. I believe in mainstream British values.									
17. I enjoy the jokes and humour of my heritage culture.									
18. I enjoy white British jokes and humour.									
19. I am interested in having friends from my heritage culture.									
20. I am interested in having white British friends.									

5. <u>Rosenberg Self-esteem scale:</u>

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	Strongly agree	Agree	Disagree	Strongly disagree
1. On the whole, I am satisfied with myself.				
2. At times I think I am no good at all.				
3. I feel that I have a number of good qualities				
4. I am able to do things as well as most other people				
5. I feel I do not have much to be proud of				
6. I certainly feel useless at times				
7. I feel that I'm a person of worth, at least on an equal plane with others.				
8. I wish I could have more respect for myself.				
9. All in all, I am inclined to feel that I am a failure.				
10. I take a positive attitude toward myself.				

6. End of Intervention Survey

Questions
Opening
I'd like to start by asking you, in general, how have you found the migration map intervention?
Acceptability
How satisfied are you with the migration map intervention? Very satisfied Satisfied Somewhat satisfied Neither satisfied nor dissatisfied Dissatisfied Very dissatisfied
Did the migration map intervention meet your expectations? Not at all Slightly Unsure Moderately Totally
How confident would you be in recommending these sessions to a friend who experiences similar difficulties? (1) not at all (2) somewhat confident (3) yes very confident
Value
'The migration map intervention was valuable in helping me explore my family migration history'

Strongly agree Slightly agree Neither agree nor disagree Slightly disagree Strongly disagree
‘Seeing the migration journey mapped out made it easier to explore the link between the migration and my ethnic identity’ Strongly agree Slightly agree Neither agree nor disagree Slightly disagree Strongly disagree
Practicalities
What was it like mapping out the migration journey?
Please tell us about whether there was anything that made it more difficult or easier with mapping out yours or your family member’s journey.
Please tell us about your experience of reflecting on your family migration history.
Please tell us about whether you encountered anything difficult when doing this that would be helpful to know about.
Please tell us about how helpful/ unhelpful it was to explore your family migration history in terms of having an impact on your ethnic identity?
If anything, what was valuable about the intervention?

If anything, what will you be taking away from the intervention?
Did you notice any differences in yourself during the time and after ending the intervention?
Has this intervention impacted how you respond to challenges related to your ethnic identity, or life in general?
Suggestions for improvement
What suggestions or recommendations would you like to make to improve the intervention?
What would have made it more feasible to engage with?

Appendix N2: Measure time-points

Table illustrating schedule of measure administration for a participant with seven-week baseline

		Phase A							**Phase B**			**Four-week follow-up**
	Study set up	1	2	3	4	5	6	7	8	9	10	11
Consent	**X**											
Telephone screening	**X**											
Randomisation	**X**											
Demographics		**X**										
Ethnic Identity scale		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
PHQ-8		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Vancouver Index of Acculturation		**X**										**X**
Rosenberg Self-esteem scale		**X**									**X**	**X**
End of Intervention survey												**X**

Appendix O: Details about migration map intervention - with example

The migration map tool was initially developed by Alasdair Churchard, as part of a talk he gave on his family history in an Oxford Health NHS Black History Month event. He felt that migration maps could be a helpful tool in clinical services and developed the concept further with Reena Vohora, Mark Chan and Mohamed Patel.

Following this, conversations took place considering the benefit of this tool for people from DEC feeling detached or disconnected from their ethnic identity. Literature revealed the importance of migration processes on impacting migrant's ethnic identity and psychological well-being (Bhugra, 2004). Research showed that there is a need for more culturally sensitive tools that allow therapists to explore and incorporate people's cultural factors in therapy (Faheem, 2023; Naz et al., 2019), therefore we developed the migration map intervention to fill this gap.

The migration map intervention was developed by incorporating elements of existing frameworks (Falicov, 1995; Hardy & Laszloffy, 1995; Umaña-Taylor & Douglass, 2017). Falicov (1995) and Hardy & Laszloffy, (1995) provided insight into important areas to consider when exploring people's migration histories and links between ethnic identity. The ethnic identity project (Umaña-Taylor & Douglass, 2017) was developed as a mental health promotion intervention for youths in U.S, due to recent events causing interracial conflicts and increasing vulnerability for people from diverse ethnic backgrounds. Building on EIF (Erikson, 1968; Phinney, 1989) theory, the protocol aimed to increase exploration and resolution associated with people's ethnic identity, which would lead to greater identity cohesion and psychological benefits. A

small scale efficacy trial of the ethnic identity project provided support for the intervention's efficacy in increasing exploration and resolution associated with ethnic identity (Umaña-Taylor et al., 2018).

The EIFT (Erikson, 1968; Marcia, 1994; Phinney, 1989) posits that an achieved identity stage is one in which an individual develops a clear sense of their identity (resolution) through a process of meaningful search and exploration, led to our hypotheses that the migration map intervention would give people a chance to explore the relationship between migration and their ethnic identity, and lead to greater exploration and resolution associated with their ethnic identity.

1. Maternal grandparents ethnically Indian, born in Uganda. Forced out of Uganda in 1972, moved back to India.

2. Mum born in India, moved over to the U.K in 1990 to study. Lived in Southall, London.

3. Mum moved over to Scotland to start career Met dad: White British.

4. Born in 1996, Only child, dual heritage: half Indian, half White. Lived in Scotland for 10 years.

5. Moved to UAE with parents 2006

6. Struggled to get sense of belonging in UAE - friends were Arab. Felt judged for being multiple ethnicities.



7. Lived in the UAE for 8 years, then moved back to U.K (London) in 2014.

8. Difficult transition to London, everything felt different. Didn't feel British anymore. Identity clash

9. Tried to assimilate again, but didn't feel accepted 'not Asian enough for Asian friends, not White enough for White friends. Different accent, hobbies and interests

10. Mental health difficulties started first year of university studies. Low mood, lack of belonging and not knowing

11. Turning point: mum reunited with family in India and U.K. Cousins became friends, finally felt a sense of belonging with something.

Hated move over to the UAE. Core memory of crying on last day of school, saying good-bye to friends.

Feeling restricted in the UAE, lack of belonging to the UAE or anywhere, didn't feel Arab or Muslim- difficulties with mixed ethnicity and religion.

Felt forced to be a 'practicing Muslim' – go to the mosque, praying 5 times a day and learning Arabic.

Learning and un-learning- Journey of developing identity

- *Learning to speak Gujarati*
- *Cooking more Indian dishes*
- *Watching Indian TV*
- *Felt more connected to being Indian.*

Appendix P: Participant Information sheet

Ikra Hameed

Oxford Institute of Clinical Psychology Training and Research

Ikra.hameed@stx.ox.ac.uk

Theory Driven Research Project: Participant Information Sheet

Title: Migration and ethnic identity

My name is Ikra Hameed, and I am a Trainee Clinical Psychologist at the Oxford Institute of Clinical Psychology Training and Research, working with Dr Alasdair Churchard and team. This is an invitation to take part in our research project.

Before you decide, it is important that you understand why the project is being done and what it would involve for you. Please take time to read this Participant Information Sheet and discuss it with others if you wish. If there is anything that is not clear, or if you *would like more information, please ask us by emailing the researcher at ikra.hameed@stx.ox.ac.uk*

The study has received ethical approval from the University of Oxford Central University Research Ethics Committee (CUREC Approved Reference No. R88676/RE001) and you can find all information about it below.

What is the purpose of the study?

The purpose of this study is to evaluate the effectiveness of a brief migration map intervention for individuals from Diverse Ethnic Communities (DEC). Migration sets in motion processes that can impact people and their identities; therefore, this intervention aims to provide people an opportunity to explore their migration histories through a geographical map. We hope that a visual representation of the migration journey will be a valuable tool to allow individuals to explore links between the migration experience and their current life. The intervention will consist of three sessions and will be offered once a week for three weeks. We are interested in seeing whether giving people an opportunity

to explore their migration histories via a migration map has an impact on their ethnic identity, levels of acculturation, mood and self-esteem. We are also interested in hearing more about people's experiences of the migration map intervention.

Mental health services struggle to deliver and adapt therapeutic interventions to meet the needs of diverse populations. There are also a lack of culturally sensitive tools available that are appropriate to the needs of individuals from DEC. Please help us gather evidence on the acceptability and effectiveness of the migration map intervention to help develop better support for individuals from DEC who are struggling with their psychological well-being due to their migration histories.

Who can take part in this study?

i) Anyone aged 18 years and over, living in the UK, who identifies with a minority ethnic background (defined as individuals from all ethnic groups except the white British group. This would include all non-European groups, i.e., Afro-Caribbean/ South Asian etc, as well as white minorities such as Gypsy, Roma, and Irish Traveller groups).

ii) Anyone who meets the above criteria and has been feeling detached from their ethnic identity and experiencing difficulties with their mood. Research suggests that people who feel detached from their identity, including ethnic identity, are at greater risk of developing difficulties with their psychological well-being, including mood difficulties.

Do I have to take part?

No, taking part is completely voluntary. You have the right to withdraw from the project at any point during the study without giving a reason. As the data collected is anonymous you will be unable to withdraw your data once you complete the study.

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

We would like you to contact the researcher using the following email ikra.hameed@stx.ox.ac.uk to express your interest in the study. Your written consent to take part in the project will be sought via a consent form.

Part 1: telephone screening call

To find out if you meet the inclusion criterion for the study, the researcher will arrange a telephone appointment where you will be asked some questions about your mood and ethnic identity, as well as personal details (name, address, age, GP details). We are collecting this information in case you highlight any risk concerns; having this information will allow us to support you and inform relevant authorities if we are concerned about your safety. During the screening assessment, and remainder of the study, if you disclose any information which tells us you are distressed or at risk, we will bring the session to a close. If you are currently receiving support from a healthcare provider or your GP we will encourage you to re-contact them for support. If you are not seeking support for your difficulties, we will suggest you contact your GP for support. If you disclose immediate risk of harm to yourself or others around you, we have a duty of care to ensure you are safe and will need to inform relevant authorities such as your GP or emergency services depending on the level of risk.

This section of the study may take between 20 – 30 minutes of your time. The research team will use your responses to determine if you meet the inclusion criteria for the study. If you don't meet the

inclusion criteria, you will be informed by the researcher and your responses to the screening questions will be deleted.

Part 2: migration map intervention

If you meet the inclusion criteria for the study, the researcher will contact you to inform you and to ask you to complete some online measures on Qualtrics to tell us more about your experiences. You will be randomly assigned to one of the three baseline conditions (five, six or seven weeks). Depending on which baseline group you are allocated to, you will either complete the primary outcome measure weekly for five, six, or seven weeks before the intervention starts. Once you have completed the baseline phase, you will be assigned your start date for the intervention. Prior to the first intervention session you will be emailed a Qualtrics link and asked to complete some more online questionnaires – the first week these will take around 30 minutes, but in subsequent weeks these should only take 10 minutes maximum. In the week of the first and the last session of the intervention a few additional questionnaires will be added, which will increase the time required to complete them to around 30 minutes. Four weeks after completing the sessions, you will be asked to complete a final questionnaire pack, again about half an hour to let us know how you are doing and to give feedback on your experiences.

What will the sessions involve?

The researcher will arrange three suitable appointments which will last from 45 minutes to 60 minutes and take place via Microsoft Teams. Session one (assessment/ engagement), will involve the researcher asking you some questions about your migration histories. Session two, (migration map/ formulation) will involve exploring links between your migration history via a migration map. Session three, will be an ending session where summary and consolidation of learning will take place. You will also receive a letter summarising the work completed.

Part 3: one-month post-intervention

You will be emailed a link to complete a survey answering questions about your experience of the intervention and to complete measures. After you have successfully completed all three phases, you will receive your shopping voucher via email.

Are there any disadvantages/risks from taking part?

Taking part will take approximately 4 -5 hours of your time in total. The intervention will involve discussing your families' migration histories, which for some may be difficult to reflect on, or distressing. During sessions you would only be asked to share what feels comfortable to you. If you find this aspect of the intervention challenging, you can take a break or withdraw from the study. We will provide you with contact details of services and third party organisations that can provide you with additional support and guidance if needed.

What are the possible benefits of taking part?

Learning from your experiences is highly important for us. Having your voice heard in research is central to the development of mental health services that are culturally sensitive to the needs of people

from diverse backgrounds. We hope that your participation in this study will help us understand the acceptability and effectiveness of a migration map intervention for individuals struggling with low-mood or feeling detached from their ethnic identity. This may contribute to the development of a culturally sensitive tool for therapists to use when working with diverse populations to ensure their needs are being met. As a direct and personal benefit to you from taking part in this research, we are offering shopping vouchers worth a total of £15. You will receive a £5 voucher after the first intervention session (assessment) and a £10 voucher at the one-month follow-up point, once the measures and end of intervention survey have been completed. We hope that this intervention will give you an opportunity to reflect on your background and help you connect with the strengths associated with your migration history.

What information will be collected and why is the collection of this information relevant for achieving the research objectives?

The information you provide during the study is the **research data**. Any research data from which you can be identified (i.e. email address and telephone number) is known as **personal data** and private information (i.e. race or ethnic origin) is known as **special category personal data**.

Special category personal data and personal data will be stored securely on the University of Oxford's OneDrive. Personal data will be stored for 3 months after the study has concluded and then be permanently deleted.

Other research data will also be stored securely on a password protected University of Oxford servers. Research data will be kept for 3 years after publication or public release of the work of the research. This information will then be shredded or permanently deleted and destroyed.

We will keep information about you safe and secure.
The researchers involved in this study will have access to the research data. Responsible members of the University of Oxford may be given access to the data for monitoring and and/or audit of the research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public. If you respond to the hardcopy version of the study questionnaire, the responses will be stored in a locked file cabinet at the Oxford Institute of Clinical Psychology Training and Research, Isis Education Centre, Oxford. Only the researchers will have access to these. Once all data entry is concluded, the hardcopy questionnaires will be securely destroyed.

Using the **research data**, we hope to report our findings in academic journals. The findings will also contribute to Ikra Hameed's Doctorate in Clinical Psychology. You will not be identified in any reports or publications arising from the study.

Data Protection

The University of Oxford is the data controller with respect to your personal data, and as such will determine how your personal data is used in the study.

The University will process your personal data for the purpose of the research outlined above.

Further information about your rights with respect to your personal data is available from http://www.admin.ox.ac.uk/councilsec/compliance/gdpr/individualrights/.

What are my choices about how my information will be used?

You can choose to not take part in the project at any time, without giving a reason. If you withdraw from the project, we will destroy any information you have shared with us.

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this research, please contact Ikra Hameed (ikra.hameed@stx.ox.ac.uk), Dr Alasdair Churchard (alasdair.churchard.hmc.ox.ac.uk) or Mark Chan (Mark.Chan@oxfordhealth.nhs.uk), and we will do our best to answer your query. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Medical Sciences Interdivisional Research Ethics Committee at the University of Oxford who will seek to resolve the matter as soon as possible: Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Boundary Brook House, Churchill Drive, Headington, Oxford OX3 7GB

I'm Interested! What's Next?

If you would like to participate, please email the researcher on, ikra.hameed@stx.ox.ac.uk

Thank you for taking the time to read this information sheet and for your interest in the project.

Ikra Hameed
Trainee Clinical Psychologist

Oxford Institute of Clinical Psychology Training

Isis Education Centre

Warneford Hospital

Headington, Oxford

OX3 7JX
Ikra.hameed@stx.ox.ac.uk

You can also speak to the supervisor of the project about any questions or concerns using the details below:

Dr Alasdair Churchard (Oxford Institute of Clinical Psychology Training and Research)

Alasdair.churchard@hmc.ox.ac.uk

Appendix Q: Consent form

Participant Consent Form

Migration and Ethnic identity

You have been given the link to this consent form following screening questions to check if this study is the right one for you. Please tick each box if you agree with the statement:

1. I confirm that I have read and understand the participant information sheet version 1.0 dated 4.12.2023 for the above study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand who will have access to the personal data provided, how the data will be stored and what will happen to the data at the end of the project. ☐
4. I understand that I will not be identifiable from any publication or student thesis. ☐
5. I understand that all information will be kept strictly confidential except in rare circumstances in which it is judged that I am, or someone else is, at immediate risk of serious harm, or where information is requested by a court of law. ☐
6. I understand how to raise a concern or make a complaint. ☐
7. I agree to take part in the above study. ☐

Name of Volunteer:	
Date:	

Agreement to take part:	☐ By ticking this box, I declare that I read the information sheet, and the consent form, and agree to take part in this study,

Name of person taking consent:	
Date:	

Appendix R: Telephone screening guide

1) **Contact details:**
   a) Name:
   b) Address:
   c) Email address:
   d) Telephone number:
   e) Age:
   f) GP contact details:

2) **Please respond to the questions below:**

   a) I live in the United Kingdom or Ireland: ( ) Yes, ( ) No.

3) **Do you identify as someone from a minority ethnic background?**
   a) ( ) Yes, ( ) No.

4) **Did you or one of your family members migrate to this country?**
   ( ) myself
   ( ) parents
   ( ) grandparents
   ( ) great grandparents
   ( ) other

5) **Do you have any past or current experience of mental health difficulties?**
   Establish whether client has a diagnosis of severe mental illness.

6) **Are you seeking help from any mental health services?**
   a) ( ) Yes, ( ) No.
   b) If yes, what service are you seeking support from? (establish whether they are under step 4 service)

   9) <u>Risk Assessment</u>

Have you experienced any thoughts that you would be better off dead, or life not being worth living, recently?

If yes, proceed with the following questions:

Active suicidal thoughts:

- Do you have thoughts of wanting to take your life?

Suicidal plans:

- Have you thought about methods to harm yourself/ take your life?
- Did you make a plan of exactly what you might do to harm yourself/ take your life, and when you would do it?
- How long have you had this plan for?
- What is your intent to act on this plan? (0- very unlikely / 10- highly likely)
- Have you been able to resist carrying this out? / what stopped you from putting the plan in action?

7) Complete PHQ-8

8). Complete Ethnic Identity Scale

Appendix S: Randomisation procedure

Randomisation to one of the three baseline groups (five, six and seven weeks) by a random number generator. Randomisation was completed after participants had met eligibility criteria of the study, which was ascertained after the telephone screening interview. Participants were allocated a number between 1 and 12, and the random number generator assigned people to one of the three baseline groups.

Subject	Group assigned
1	A
2	A
3	C
4	B
5	A
6	A
7	B
8	C
9	C
10	B
11	C
12	B

Appendix T: Data Analysis table

	P1 A	P2 B	P3 C	P4 D	P5 E	P6 F	P7 G	P8 H
Baseline Level Trend Variability								
Intervention Level Trend								

Variability								
Comparison Immediacy Overlap (stats) Consistency (across phases) trend, mean variability								

Overall comments (3 demonstrations of effect) Magnitude of effect			

Appendix U: Data Analysis details

Tau-U statistic

Tau-U statistic incorporates Mann-Whitney U (between groups) and Kendall Tau (correlation) to test the separation or 'non-overlap' of data points between different phases. The statistic shows us the proportion of data that is different to the phase it is being compared to. The Tau-U statistic is also used to assess baseline stability, and the online calculator allows us to control for baseline trends that are not stable. In multiple baseline single case experimental designs, the intervention effect is evaluated if significant findings are replicated across three baseline groups.

Tau-U also allows for the calculation of a weighted average which reflects nonoverlap of data across all cases, however this was not considered necessary for our findings due to the lack of replication of significant findings across the three baseline groups for most outcomes.

Thematic Analysis

Braun and Clarke's (Braun & Clarke, 2021) six stage process of thematic analysis was used to analyse the qualitative data from the end of intervention survey.

Phase 1: Data familiarisation	Data from the open-ended questions on the end of intervention survey were transported to a word document for analysis. The author engaged in a process of reading and re-reading the data for familiarisation. At this stage initial ideas were developed and quotes were highlighted.
Phase 2: Generating initial codes	The second stage involved producing codes inductively for interesting features of the data. All data received equal attention and open codes were developed. The coding was completed by IH and checked my AC and MC. There were no disagreements, and further codes were highlighted which were incorporated into the analysis.

Phase 3: Searching for themes	This stage involved collating the codes to produce potential themes for the dataset. Initial themes were developed based on the significance and similarity of codes. Each theme had a central organising concept to define it. Themes were reviewed with both supervisors, differences were discussed and resolved before proceeding to the next stage of the analysis.
Phase 4: Reviewing themes	This stage involved revisiting the themes to ensure they were coherent, and data driven. This was completed by checking the coded transcripts, and making sure the themes reflected the data and important patterns were captured by the themes. Themes were checked by AC at this stage.
Phase 5: Defining and naming themes	This stage involved defining and naming the themes. Themes were checked by both supervisors to ensure they were data driven. Quotes were checked by AC to ensure they were congruent with the dataset.
Phase 6: producing the report	The findings were written by the researcher and checked by AC.

Appendix V: Notification of Ethical Approval

Appendix I. Notification of ethical approval

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE

Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB Tel: +44(0)1865 616575

ethics@medsci.ox.ac.uk

CONFIDENTIAL

Dr Alasdair Churchard & Ikra Hameed 13 December 2023

Oxford Institute for Clinical Psychology Training & Research

Isis Education Centre

Warneford Hospital

Oxford

Dear Dr Churchard and Ikra,

Research Ethics Approval - CUREC 2

Ethics Approval Reference: R88676/RE001

Study title: Migration map intervention for people from minority ethnic backgrounds: A case series

Short title: Migration and ethnic identity

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

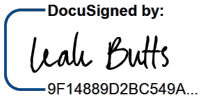
I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **13th December 2023** until **12th June 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

You will be required to submit an annual progress report on each anniversary of study approval, until the study is completed, and your study may be selected for review during an annual audit.

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form. Yours Sincerely



Mrs Leah Butts

Research Ethics Administrator

for

Dr Helen Barnby-Porritt

Research Ethics Manager

Appendix W: Attendance and engagement report

Participant ID	Baseline completed	Missing baseline data	Intervention session 1	Intervention session 2	Homework completed	Intervention session 3	Homework complete	Follow up measures and end of intervention survey
1	Yes	No	Yes	Yes	Yes	Rescheduled for another day in the week.	Yes	Yes
2	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
3	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
4	Yes	No	Rescheduled for following day due to P forgetting session.	Yes	Yes	Yes	No	Yes
5	Yes	No	Yes	Yes	Yes	Yes	No	Yes
6	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
7	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
8	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
9	Yes	Week 4 baseline completed 1 day late	Rescheduled for following day due to P forgetting session.	Yes	No	Rescheduled for following week.	Yes	Yes

Appendix X. End of intervention survey results

Anonymous responses	Q1. How satisfied are you with the migration map intervention? 6-point likert scale (1, very dissatisfied – 6, very satisfied)	Q2. Did the migration map intervention meet your expectations? 5-point likert scale (1, not at all – 5, totally)	Q3. 'The migration map intervention was valuable in helping me explore my family migration history'	Q4. 'Seeing the migration journey mapped out made it easier to explore the link between the migration and my ethnic identity'	Q5. How confident would you be in recommending these sessions to a friend who experiences similar difficulties?
1	Satisfied	Moderately	Strongly agree	Strongly agree	Yes, very confident
2	Neither satisfied, nor dissatisfied	Unsure	Strongly agree	Strongly agree	Somewhat confident
3	Neither satisfied, nor dissatisfied	Unsure	Neither agree nor disagree	Neither agree nor disagree	Not at all
4	Very satisfied	Totally	Strongly agree	Strongly agree	Yes, very confident
5	Satisfied	Moderately	Slightly agree	Strongly agree	Somewhat confident
6	Very satisfied	Totally	Strongly agree	Strongly agree	Yes, very confident
7	Somewhat satisfied	Moderately	Slightly agree	Slightly agree	Somewhat confident
8	Satisfied	Totally	Strongly agree	Strongly agree	Yes, very confident
Summary	Very satisfied (2) Satisfied (3) Somewhat satisfied (1) Neither satisfied, nor dissatisfied (2)	Totally (3) Moderately (3) Unsure (2)	Strongly agree (5) Slightly agree (2) Neither agree nor disagree (1)	Strongly agree (6) Slightly agree (1) Neither agree nor disagree (1)	Yes, very confident (4) Somewhat confident (3) Not at all (1)

Appendix Z: Detailed description of Tau-U analysis for ethnic identity and low-mood outcomes

Appendix Z1 Detailed write-up of results:

Ethnic identity development

Exploration

For ethnic identity development, outcomes were considered across all three stages: exploration, resolution and affirmation. The data for each of these subscales was analysed separately. The visual analysis is presented in Figure 4, and the statistical analysis in Table 5b.

Six participants (C, D, E, F, G and H) commenced the study with low exploration scores at baseline timepoint 1. Visual analysis revealed that Participants A and G had increasing baseline trends, however statistical analysis only showed a significant trend for participant G, therefore baseline corrections were applied. Participants B and F displayed slight decreasing trends in visual analysis, however statistical analysis only showed a significant trend for Participant F, therefore baseline corrections were applied (Table 5b). There was some degree of variability in exploration scores for three participants, with B showing a decreasing trend, and A and G showing an increasing trend.

Most participants showed an increase in level from the baseline to intervention phase, with the exception of participants A and B showing a slight decrease in level for exploration scores (Figure 4, Table 5b). Changes from baseline to intervention phases were gradual, rather than immediately after session one, which may be explained by the completion of the migration map in session two. This may also explain the overlap in scores between baseline and intervention session one for all participants. In line with this, most participants showed an increasing trend in the intervention phase, apart from participant G who had high scores and therefore the trend was stable, and participants A and B who showed slight increasing trends but decrease in level. Though Participant F's trend appears upwards in the intervention phase, there was a slight decrease at the fourth data point which was the four week follow up. Generally, consistency was demonstrated for most participants in level and trend from baseline to intervention phase, bar two participants (A and B) who showed a decrease in level and participant G whose trend was stable.

Out of the five participant's demonstrating improving outcomes on the visual analysis, statistical analysis found significant effects for participants D, E, F and H (Table 5b). This improvement was replicated across the three baseline conditions; therefore, we can conclude a functional relationship between the intervention and changes in exploration associated with participants' ethnic identity. Out of the six participants that commenced the study with low exploration scores, three participant's (E, G H) scores changed to high exploration at the end of the intervention.

Resolution

Five participants (C, D, E, F and H) commenced the study with low resolution scores.

For resolution, participants A and G showed an increasing baseline trend, and participant H showed a decreasing baseline trend, however none required baseline corrections, as informed by the Tau-U analysis (Table 5b). Participants D, E and F's baseline scores for resolution were static, and participant's C's and D's scores were relatively stable. In line with this, there some degree of variability in the baseline phase for Participant's A and G, and little variability for participant's B, C and H.

Visual analysis observed increased changes in level for resolution for most participants (B, C, D, E, F and H), however for participant's B, C and E this change was small. Participant's A and G displayed a decrease in level from baseline to intervention phase (Table 5a). Participant's B, D and H showed an increasing trend in the intervention phase which is in the desired direction, whereas participant G showed a declining trend for resolution. Participant's A C and F showed an upwards trend in direction for resolution; however, these need to be interpreted by caution due to: participant A's level reducing in the intervention phase, and participant C and F had a decrease in scores at one of the timepoints. There was significant overlap in Participant E's scores from baseline to intervention phase, therefore the trend was steady. As seen in Table 4b, the associated statistical analysis revealed no significant improvements in resolution for any of the participants.

In summary, though some participants showed increase in level for resolution in the visual analysis, these changes were not significant. This is in line with the visual analysis results, as some participant's had small changes in level and overlapping data from baseline to intervention phase. The exception is for participants D and H whose visual analysis showed both increase in level and trend and the effect appeared to be immediately after the intervention. Out of the five participants that started the study with low resolution scores, two participant's (D and H) scores changed to 'high resolution' post intervention with further gains at follow-up, and two participant's scores changed to 'high resolution' at follow-up. Since these changes were not statistically significant, firm conclusions can not be drawn about the experimental effect of the intervention.

Affirmation

Four participants (B, D E, and F) started the study with low affirmation related to ethnic identity.

Visual analysis revealed increasing affirmation trends for two participants (D and G), however these were not statistically significant, therefore baseline corrections were not applied (Table 4b). There was some degree of variability within the baseline phase for participants D and G (Table 4a).

Most participants showed an increase in level from baseline to intervention phase, with the exception of participant C, showing a small decrease in level. Some participants (B and D) showed a substantial change in level from baseline to intervention phase, and for participants A, E, F and G this change was small (Table 4a). Moreover, for participants B, D and E the change from baseline to intervention was gradual rather than immediate. It is important to note, four participants (A, F, G and H) had high affirmation scores throughout baseline, therefore room for improvement was little. Most participants showed an increasing trend in the intervention phase, apart from two participants (C and E) who showed decreasing trends, and participants F whose trend remained stable (Figure 3).

The associated statistical analysis for affirmation scores showed significant improvements for three participants (B, D and F), however these were only replicated across two baseline conditions (Table 4b). Participant D's results must be interpreted with caution due to an increasing baseline trend, suggesting the possibility of confounding factors leading to the change in scores, as opposed to the intervention. Out of the four participants that started the intervention with low affirmation scores, only two participants (D and F) achieved high affirmation post intervention, and these were maintained at follow-up.

Low mood

Severity of low-mood symptoms varied between participants at the start of study, from severe (participant E), moderate (participants A, B, H) and mild (C, F and G). Participant D commenced the study with minimal symptoms, however this increased to mild in the baseline stage.

Participants showed varying baseline trends for low mood (Figure 5). Despite visual analysis showing decreasing baseline trends for participants A, B, F and G, these were not statistically significant in the Tau-U analysis (Table 6), therefore baseline corrections were not applied. Participants C, D and E showed stability on the PHQ-8 during baseline, however participants A, B, G and H showed variable baselines. As shown across most measures, participant G showed high variability in baseline, necessitating caution in the interpretation of their results (Table 6).

Most participants showed a decrease in central tendency for PHQ-8 scores from the baseline to the intervention stage, with the exception of participant B who showed a slight increase. Only participants A, C and H showed convincing improvement in PHQ-8 scores from baseline to intervention, and again these were gradual rather than immediately after session one. For these participants, statistical analysis supported the visual analysis showing significant effects (Table 6), however participant A's results must be interpreted with caution due to their decreasing baseline trend in phase A. Similarly, participant C's change was from Phase A to B was not consistent due to an increase in scores shown after session two. Despite the decrease in mean scores for participants D, F and G, it is important to note that this change was small with some overlap in data between the phases.

Five out of the eight participants showed decreasing intervention trends in phase B, however for participants A, B, F and G there was already a slight decelerating trend during baseline, therefore it is unclear whether this change can be attributed to the intervention. Participants D and E showed little change in level from baseline to intervention phase, and their trend also remained stable in the subsequent phase. There was generally some level of variability across PHQ-8 scores in the baseline phase, particularly for participants A, B, G and H, however this reduced in the intervention phase for most participants.

In summary, the results for PHQ-8 scores show a mixed pattern, with some participants showing little or no change, and three participants showing significant improvement from baseline to intervention phase. Since, improvements in PHQ-8 scores were not replicated across all three baseline conditions, and visual analysis showing mixed patterns for two of the three participants, firm conclusions cannot be drawn about the effect of the migration map intervention on low mood.

Appendix Y: Tau-U analysis table

Ethnic identity development

Participant	Exploration				Resolution				Affirmation			
	Baseline Trend (Tau-U)	***P***	**Baseline vs Intervention (Tau-U)**	***P***	**Baseline Trend (Tau-U)**	***P***	**Baseline vs Intervention (Tau-U)**	***P***	**Baseline Trend (Tau-U)**	***P***	**Baseline vs Intervention (Tau-U)**	***P***
A (B1)	0.6000	0.14	-0.8000	0.05	0.8	0.05	-0.3	0.46	-0.1	0.80	0.05	0.90
B (B1)	-0.8000	0.05	-0.7500	0.07	0	1	0.35	0.39	1-0.4	0.33	1*	002
C (B1)	0.2000	0.62	0.6500	0.11	0.2	0.62	0.15	0.71	-0.650.2	0.62	-0.65	0.11
D (B1)	0.2000	0.62	0.8500*	0.04	0	1	0.75	0.06	0.950.3	0.46	0.95*	0.02
E (B2)_	0	1	1*	0.01	0	1	0.5	0.20	-0.133	0.71	0.67	0.09
F (B2)	-0.8*+	0.02	1.25*	0.001	0	1	0.75	0.05	0.2	0.57	0.92*	0.02
G (B3)	0.67*+	0.04	0.36	0.34	0.619	0.05	-0.214	0.57	0.57	0.07	0.07	0.85
H (B3)	0.14	0.65	0.96*	0.01	-0.29	0.37	0.6071	0.11	0	1	-0.21	0.57

PHQ-8 outcomes

Participant	Tau-U Analysis			
	Baseline Trend	***P***	**Baseline vs Intervention**	***P***
A (B1)	-0.4	0.33	-0.9*	0.03
B (B1)	-0.3	0.46	0.15	0.71
C (B1)	0.1	0.81	-0.85*	0.04
D (B1)	-0.2	0.62	-0.8	0.05
E (B2)	0.4	0.26	-0.17	0.67
F (B2)	-0.67	0.06	-0.21	0.59
G (B3)	-0.43	0.18	-0.21	0.57
H (B3)	-0.19	0.55	-0.86*	0.02

Appendix Z: Thematic Analysis of Qualitative data

Theme	Subtheme	Example quotes
Migration – a silent battle	In therapy	"Having had a history of being in therapy with different therapists throughout my life, I have found the migration map to be a very unique and important therapeutic process which I have never really had the chance to speak about in the past". P1 "It was helpful to have sessions focused on my relationship with my ethnic/cultural identity, as I've never had therapy focus so deeply on this aspect of my identity and how it ties in with my mental wellbeing". P8
	General/Between families	"As the daughter of a first-generation immigrant family, migration was treated as almost a given part of our experiences and our future, and I have never really reflected how this has shaped me and my family" P1 "I was surprised by how little I had spoken to my dad about his transition to the UK in more detail, and how this has become more important to learn about over the years" P3 "I appreciate the space to share my personal experience and address cultural issues that we do not often discuss". "I was surprised by how little we spoke about migration growing up as we were so busy adapting and had little time to slow down" "I have never had the chance to reflect on impact of immigration on myself before"

The process of migration maps	Visual features	“It was interesting to see the moves I'd made in visual form - it made me recognise just how far I was physically removed from my country of birth and my culture in many ways” P8 “It's always good to have visuals and formulations shared with the client” P5 “The migration map itself helped me visualise my experience of migration and ethnicity, while our discussion led to meaningful reflection and realisation”. P6 “Physically looking at the world map allowed to reflect on the complex cultural impact immigration has had on me and my family”. (P5) “I liked that the migration map had dates of year as this helped the clarity”. (p8) “It was helpful to do a visual map that looked at my migration journey”. (P5) “Mapping it out allowed me to recognize how important these migration events in my past were and I have actually made big moves in my life without really giving myself any credit or compassion for struggling with these moves”. (p1) “It was interesting to see how far I'd physically moved, how it represented the distance between me and my birth country and culture”. P8

		"Visualising my experience was key to gain insight into important aspects of my identity and my sense of belonging." P4 "Looking at the physical map was helpful" P5 " To see all the journey in just one map ,in one visual drawing, give me the opportunity to realise I have been for a lot of hard times and not wonder why I go forward slowly and carefully". P7 "It helped me visualise my life holistically and emotionally so far, and made me understand the important contributors to my mental health culturally and socially" P2. "It was insightful to see my journey in understanding my cultural identity and how this shifted in different contexts" P3
	Reflective process	"I thought it was quite interesting and also felt it resembled more of a reflective exercise that helps both the client and therapist/clinician(s) reflect on their own personal experiences, biases and standings with respect to the therapeutic alliance". P2 "I enjoyed reflecting on my migration journey. I found it helpful and the time between sessions helped me to think more about the impact of migration and remember parts I did not reflect so much on". "Reflecting on my migration history was quite emotional and empowering". P4.

		“I really enjoyed it. Having a space to reflect in my history and be supported at the same time” p7. “The migration map itself helped me visualise my experience of migration and ethnicity, while our discussion led to meaningful reflection and realisation”. P6
	Therapeutic process	“Additionally, processing my migration history with Ikra felt safe as she created an inclusive, warm and non-judgemental space to explore my cultural conflicts” P1. “I found my experience being validated and heard”. P3. “the prompts led by the clinician definitely helped me understand why I felt a particular way” P3. “I found the intervention to be just right, Ikra was very helpful in helping me think about my migration and made it a safe and warm environment to do so” “finally being able to acknowledge and discuss my migration and its impacts on myself in a psychologically safe environment”. p1 “It was nice to speak with Ikra; I found it beneficial that she shared her own lived experience and motivation for the research / intervention, as it helped us connect and make me feel like she personally understood some aspects of what I was talking about”

'Key moments of shift'	Processing migration	"I was able to navigate the transformation of my identity through various phases in my life, and realise the impact of environmental variables and determinants that conflated my mental health struggles as a queer, Indian immigrant". P2 "I used to use my migration history as a fun fact about myself and mention it in passing in conversation, however with this intervention, I realise how much my migration has truly shaped who I am today and the way that I engage with my culture and perceive myself in relation to my culture". P1 "I greatly valued this intervention; it has changed how I relate to my culture and migration history". P1. **"**I really enjoyed the migration map intervention and found it helpful to organise what has happened in my life and perspective on the impact this has had on me" P8? **"**It was helpful to do a visual map that looked at my migration journey and understand key moments of shift in my journey (for ex: my move to the UK for employment)" P2. **"**It also allowed me to develop a sense of ownership over my past and history, that my migration was my own unique story and not just an extension of my family's past migration" P1. **"**At first I thought that there was not much to map out because I am the first member of my immediate family to migrate. However, I was prompted and enabled to focus on my experience, express my thoughts and feelings, and reflect on them in a meaningful and empowering way". P3.

		"I finally allowed myself to process the impacts that my migration events had on me in relation to my identity but also my wellbeing" P1. " I was able to realise and celebrate some of my achievements along the way". P4 **"**I found it relieving to reflect on the big impact it had on me as a child. This has helped me to understand myself better". P8. 'having a witness of my stories' P7.
	Emotional shifts	"This has allowed me to be more compassionate to myself" P8? "I was also able to realise why I felt so deeply conflicted owing to my shared experiences and histories of intergenerational cultural exchanges, and the inherent sociocultural aspects of my experiences which did not resonate with me. This made me quite uncomfortable but I felt I needed to feel that way to understand the discordance in my experiences and current sense of self" P2. "Difficult, emotionally triggering but also tinged with hope and self-acceptance". "I was able to develop more compassion towards myself but also towards my parents (who in my past were very discouraging towards my migration events as they were worried about the impact that they would have on my wellbeing). I also felt emotional after sessions as I felt I finally allowed myself to process the impacts

		that my migration events had on me in relation to my identity but also my wellbeing. By the end of the intervention, I felt proud of myself but also more compassionate and less self critical". P1 "Revisiting shame about my ethnicity was slightly uncomfortable but meaningful, as I explored both the collective experience of shame (i.e. stereotypically negative aspects of my ethnicity) and my personal shame that I am mostly ashamed instead of proud of my ethnic identity". P4. "Exploring pride about my ethnicity was surprisingly empowering and inspiring". P4. "I wouldn't label this as a difficulty, but I found myself feeling an emotional release (crying and feeling tearful) after sessions as a result of processing my migration history. I dont know if others in the intervention experienced this, but I understood this for myself as finally being able to acknowledge and discuss my migration and its impacts on myself in a psychologically safe environment" P1. "Compassion towards myself for the difficulties of immigration growing up" P8. "Now I look at it not from a negative perspective now I think about what can I bring to experiences with Filipino people and how I can best engage in Filipino culture so I can share this part of my identity with other people" P8. "I think that I am able to process challenges related to my ethnicity and life in general in a more compassionate and less judgmental way".

		"I think I am a little bit compassionate to myself" "I am able to give myself more compassion and also allow myself to feel impacted by things (which I would have normally just undermined the impact or not acknowledged it)".
	Re-connecting with ethnic identity 'transformation of ethnic identity'?	"I greatly valued this intervention; it has changed how I relate to my culture…. And has allowed me to connect to my culture compassionately". P1. "I found every aspect of the intervention quite valuable and helpful in gaining a deeper understanding of my ethnic identity and my feelings towards it, as well as in revisiting and reframing those feelings with a compassionate approach" P6 "At the end of the intervention, I felt empowered to continue exploring my ethic identity and practice meaningful ways to reconnect with it". P6 "It also helped me embrace my changing identity so I can see it as strength instead". "Exploring my migration history was very helpful and definitely had an impact on my perception of ethnic identity." "I gained a deeper understanding of my thoughts and feelings about my identity and a newfound appreciation of my ethnic background, as well as a renewed interest in exploring various aspects of it (e.g. food, music, places, history)". P4.

		“I was also enabled to understand how my perception of my ethnic identity affects my self esteem and confidence and, consequently, my sense of belonging in both my home country and the UK”. P4 “Very helpful, it made me realize how each migration event in my life (as I have had many) each had a unique impact on my ethnic identity and almost reflected my relationship with my ethnicity. I didn't realize how the two were so interlinked as my migration histories were education driven”. P1. “It was very helpful because the context of how many times I moved, stability etc.. all impact making sense of ethnic identity” “That it is ok to have aspects of my culture that I feel aligned with, and others that I don't” P6. “Yes. I'm more conscious about my own safety going around and why some time I do certain things to integrate myself in the community” P7. “I am more aware of my views towards my culture” P2. “Now I look at it not from a negative perspective now I think about what can I bring to experiences with Filipino people and how I can best engage in Filipino culture so I can share this part of my identity with other people” P8.

		"I have noticed an increased awareness of ethnicity in general and curiosity about my own ethnic background since the beginning of the intervention. I have also noticed a more positive attitude towards my own ethnicity since the end of the intervention". "I have started listening to more podcasts related to my culture" P6. "I feel much more empowered in my ethnicity and have taken steps to connect to it more" "Courage to ask my dad questions and engaging in more activities to feel connected to my culture" P3. "In ways that I feel more free to express myself or not" P7. "Yes, I feel stronger about my ethnic identity and more confident"
	Ongoing journey with ethnic identity	"I have taken away valuable insights and realisations, as described in my previous answers, and useful ways to reconnect/maintain a connection with my ethnic identity moving forward" P1. "That I avoid aspects of my ethnic identity because one of my parents is my only consistent source of connecting with my ethnic identity, and we have a difficult relationship. That there are little steps I can take to re-build a relationship with my ethnicity / culture".,

		“the actions I'll be taking away to connect to my culture (1) Connecting more with South Asian couples through your Thesis. 2) Listen to South Asian podcasts/ audios i.e., ‘what we don’t tell our parents’ 3) Having conversations with your dad about migration experiences, ‘defeating the silence’. 4) Travelling to Pakistan and feeling comfortable with feelings of difference.). I also feel I have more courage to speak to my dad about his migration journey and understand it”. P4 “I also have found I am much more curious about Filipino culture. I am now able to be more positive about engaging in Filipino culture”. P8. “I feel more comfortable building my own relationship with my ethnicity /culture outside of my relationship with my family” P6.
Areas for improvement/ missed opportunities??	Conversations about trauma	“I think sometimes migration journeys can involve stories about trauma which can play a part in someone's journey due to cultural biases and generational patterns which can be more important to think about”. P3.

		“I found it difficult to remember some parts of trauma in my past in the short amount of sessions we had”.
	Therapeutic techniques	“For part of the therapist, probably do not interpret people's stories”. P7. “Can consider cognitive restructuring when challenging biases towards cultures” “I would recommend that life experience as it impacts migration journey and intergenerational patterns. these play a key role in what cultural biases come in” “Maybe some homework for example reading or thought diary?”

	Practicalities	“Also 3 sessions is probably not long enough to promote any significant changes.” “Maybe a bit more detail about what we will do during the intervention before we start? I.e. we will draw arrows, we will write text around the map etc”. “I think one suggestion would be to have an additional session after finishing the migration map for any reflections/processing of feelings of what it was like to put together the map. I find myself very goal-oriented when it comes to therapy and I struggle to sit and reflect on my emotions when I know I am meant to be finishing up a task/part of the intervention. Have a week between finishing the map and reflecting on it also allows for people like me (where emotions seem to take their time to settle in) to be able to bring the full experience” “using an interactive map”. “In person would have been better.” “The first and second sessions are slightly repetitive as I found myself repeating/sharing similar personal experience. It's a short intervention while helpful may not be able to address deep rooted mental health difficulties.”

	Measures	“I only had a mild difficulty understanding some of the statements in the questionnaire before the intervention, but I am not sure whether this was caused by a lack of clarity or my own understanding of terms related to ethnicity.”. “It might help if the questionnaires and reminders were sent on a regular day (e.g. Wednesday and then Friday) prior to the intervention, so that participants could establish a routine, albeit a short one” “The weekly questionnaire, some questions are difficult to understand because are asking in present perfect. And it's confusing to answer”. “I think more information about the purpose of the questionnaires and any further information about them to help alleviate how mundane and repetitive they are to complete....”.

Appendix AA: Author guidelines

The author guidelines for our proposed journal: 'The Cognitive Behaviour Therapist' can be found at:

https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/information/author-instructions