

Thesis Submitted in Partial Fulfilment of the Requirements of the Degree of Doctor of Clinical Psychology (DClinPsych)

Eloise Prouten

Oxford Institute of Clinical Psychology Training and Research

Harris Manchester College

University of Oxford

Trinity Term 2024

Word Count by Component

Systematic Review of the Literature (SRL)…….7687

Service Improvement Project (SIP)……..5257

Theoretically Driven Research Project (TDRP)…….....5500

Executive Summary……...434

Connecting Narrative…….....768

Total word count:……18444

Table of Contents

Word Count by Component 2

Abstracts 8

Systematic Review of the Literature (SRL): A systematic narrative review of three factors specified in the cognitive model of paranoia in people with a diagnosis of borderline personality disorder 12

Abstract **13**

Introduction **14**

Method **17**

Results **33**

Discussion **41**

References **51**

Service Improvement Project (SIP): Exploring engagement in CBT treatment for South Asian older adults in Berkshire Talking Therapies 54

Abstract **61**

Introduction **63**

Method **67**

Results **70**

Discussion **87**

References **97**

Theory Driven Research Project (TDRP): "Jumping to conclusions" in the context of personality disorder: comparison with psychosis and general population groups 102

Abstract **103**

Introduction **104**

Method **107**

Results **112**

Discussion **119**

References **127**

Executive Summary 134

Connecting Narrative 136

Acknowledgements 139

Appendices 140

Appendix 1: SRL

1.1 – The cognitive model of paranoia (2016) 140

1.2 – Definitions of mechanisms used to guide study selection 141

1.3 – PRISMA diagram 142

1.4 – Quality assessment table 143

1.5 – Journal guidelines 146

Appendix 2: SIP

2.1 – Cultural influences on mental health model 154

2.2 – Stepped care model used by NHS Talking Therapies Services 1553

2.3 – Interview schedule 156

2.4 – Themes, sub-themes, and quotes from staff focus group responses 158

2.5 – Themes, sub-themes, and quotes from clients who engaged in therapy 170

2.6 – Themes, sub-themes, and quotes from clients who did not engage in therapy 178

2.7 – Journal guidelines 188

Appendix 3: TDRP

3.1 – The cognitive model of paranoia (2016) 197

3.2 – Revised-Green Paranoid Thoughts Scale 198

3.3 – Beads task script 200

3.4 – State Social Paranoia Scale 201

3.5 – State sub-scale of State-Trait Anxiety Inventory 202

3.6 – Ethical approval 203

3.7 – Journal guidelines 204

Table of Tables

Systematic Review of the Literature (SRL)

Table 1.1 - Data extracted from worry studies 23

Table 1.2 - Data extracted from reasoning biases studies 24

Table 1.3 - Data extracted from negative self-belief studies 27

Service Improvement Project (SIP)

Table 2.1 Themes, sub-themes, and quotes from staff focus group 72

Table 2.2 Themes, sub-themes, and quotes from clients who engaged in therapy 78

Table 2.3 Themes, sub-themes, and quotes from clients who did not engage 83

Table 2.4 Key findings and recommendations 93

Theory Driven Research Project (TDRP)

Table 3.1 Demographic data. 114

Table 3.2 Descriptive statistics 115

Table of Figures

Theory Driven Research Project

Figure 1.1…….116

Abstracts

Systematic Review of the Literature (SRL): A systematic narrative review of three factors specified in the cognitive model of paranoia in people with a diagnosis of borderline personality disorder

Paranoia is the belief that others intend to cause you harm. It is associated with lower levels of wellbeing, increased social anxiety, and social exclusion. Paranoia has been widely researched in psychosis, but less so in borderline personality disorder (BPD). This review aims to synthesise evidence for three of the mechanisms specified in the cognitive model of paranoia in people with a diagnosis of BPD. The three specifically cognitive mechanisms; worry, reasoning biases, and negative self-beliefs were chosen. Four databases were searched, using terms related to the three mechanisms, and BPD. This yielded 2038 papers and 27 papers met final criteria. Data was extracted and the quality of each paper was rated by two independent raters. Findings were synthesised in a narrative review. Two papers explored worry, six explored reasoning biases and nineteen explored negative self-beliefs. Higher levels of worry, higher rates of reasoning biases, and more negative beliefs were seen in participants with BPD compared with comparison groups. Despite this, linking these mechanisms specifically to the experience of paranoia in the context of BPD must be done tentatively. Future research should explore causal links between the mechanisms and people with BPD who present with paranoia. Pre-registration with PROSPERO: CRD42022366316.

Service Improvement Project (SIP): Exploring engagement in CBT treatment for South Asian older adults in Berkshire Talking Therapies

Objectives: Berkshire Talking Therapies identified particularly low levels of engagement for older adult clients from a South Asian background in Step 3 CBT treatment. Aims were 1) to explore the experiences of South Asian older adults who had engaged in treatment with Berkshire Talking Therapies, and South Asian older adults who had not engaged, both from the perspective of clients and staff, 2) to provide recommendations to the service for improving engagement for this client group.

Methods: Quantitative data from twenty clients who engaged was analysed, and semi-structured interviews were carried out with ten clients; five who had engaged and five who had not. A focus group was conducted with four members of staff.

Results: A chi-squared analysis revealed that in clients who engaged, proportions significantly differed in presenting problem, discharge reason, and referral source. Thematic analysis revealed four key themes in clients who engaged such as social support and culture, and five key themes in clients who did not engage, such as barriers to engaging and views of talking therapy. Thematic analysis of staff responses revealed four key themes indicating frustrations with service processes, the need to be culturally sensitive, and consideration of stigma.

Conclusions: Recommendations to Berkshire Talking Therapies included up-skilling therapists, considering cultural differences from assessment stages, and providing an additional level of support when supporting clients to engage in treatment. Recommendations were fed-back to the senior leadership team and the Cultural and Ethnic Diversity workstream.

Keywords: South Asian, older adults, cognitive behavioural therapy (CBT), access, talking therap*

Public significance statement: Access to Talking Therapy for older adults from a South Asian background is lower than that of White British counterparts. Through interviewing staff and service users, this study identifies ways in which a Talking Therapies service can support clients from this demographic to engage in CBT treatment.

Theory Driven Research Project (TDRP): "Jumping to conclusions" in the context of personality disorder: comparison with psychosis and general population groups

Paranoia is the unfounded belief that others intend to cause you harm. Associated causal mechanisms in the occurrence of paranoia have been well researched in psychosis, however, less so in personality disorder (PD). The cognitive model of paranoia suggests that one reasoning bias involved in the occurrence of paranoid thoughts is "jumping to conclusions" (JTC). This study applies the cognitive model of paranoia to people with PD to examine whether people experiencing paranoia in PD 'jump to conclusions' more than a general population group, or a group experiencing paranoia in psychosis. Three groups; people experiencing paranoia in psychosis, people experiencing paranoia in PD, and a general population group were assessed for JTC using the 'beads task'. Participants in clinical groups were screened using the R-GPTS for current paranoia. A one-way Kruskal-Wallis test showed significant differences on the beads task between groups. The PD and psychosis groups drew significantly fewer beads the general population group. There were no significant differences in JTC between the two clinical groups. State paranoia was significantly associated with JTC. Results suggest that the mechanism of JTC may be transdiagnostic and could be applied to people experiencing paranoia in PD. Limitations and areas for future research are discussed.

Keywords: personality disorder, paranoia, psychosis, jumping to conclusions, reasoning bias*

Systematic Literature Review

A systematic narrative review of three factors specified in the cognitive model of paranoia in people with a diagnosis of borderline personality disorder

Eloise Prouten

Harris Manchester College

Thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology

Word Count: 6950

New word count: 7687

Trinity Term 2024

Internal Supervisor: Lorna Hogg

External Supervisor: N/A

Proposed Journal: This report is intended for submission to BJPsych Open. This journal has been chosen due its focus of topics pertaining to clinical psychology.

Abstract

Paranoia is the belief that others intend to cause you harm. It is associated with lower levels of wellbeing, increased social anxiety, and social exclusion. Paranoia has been widely researched in psychosis, but less so in borderline personality disorder (BPD). This review aims to synthesise evidence for three of the mechanisms specified in the cognitive model of paranoia in people with a diagnosis of BPD. The three specifically cognitive mechanisms; worry, reasoning biases, and negative self-beliefs were chosen. Four databases were searched, using terms related to the three mechanisms, and BPD. This yielded 2038 papers and 27 papers met final criteria. Data was extracted and the quality of each paper was rated by two independent raters. Findings were synthesised in a narrative review. Two papers explored worry, six explored reasoning biases and nineteen explored negative self-beliefs. Higher levels of worry, higher rates of reasoning biases, and more negative beliefs were seen in participants with BPD compared with comparison groups. Despite this, linking these mechanisms specifically to the experience of paranoia in the context of BPD must be done tentatively. Future research should explore causal links between the mechanisms and people with BPD who present with paranoia. Pre-registration with PROSPERO: CRD42022366316.

Keywords: Borderline personality disorder, paranoia, worry, reasoning biases, self-beliefs

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Introduction

Paranoia is the belief that others intend to cause you harm and is characterised by mistrust, suspiciousness, ideas of reference and persecution, and delusions (1). Paranoia can be viewed as a spectrum, with persecutory delusions at the most severe end (1).The experience of paranoia can be distressing and has been associated with more negative views of the self (2), social exclusion (3), social anxiety (4) and lower psychological well-being (5).

To date, paranoia has most commonly been researched in a psychosis context however paranoia is not restricted to people who experience psychosis (6). For example, Fanti et al., (2023) (6) conducted a scoping review on the current evidence for paranoia in people with a diagnosis of personality disorder. They reviewed 47 studies and found consistent evidence of mild-to-severe paranoia in people with a diagnosis of BPD. Oliva et al., (2014) (7) explored non-delusional paranoia in people with BPD and found that participants with a BPD diagnosis experienced more severe non-delusional paranoia than participants with a diagnosis of schizophrenia. Additionally, Chan et al., (2005) (8) also found that people with BPD exhibited higher levels of paranoid ideation than healthy controls.

Defining paranoia

Often terms such as ‘paranoia’ and ‘persecutory delusions’ are used interchangeably in literature. For the purpose of this review, we define paranoia as a spectrum experience, ranging from more mild experiences of paranoia on the least severe end, and persecutory delusions at the most severe end. Paranoia may encompass ideas of reference and ideas of persecution. Persecutory delusions are strongly held beliefs that harm is occurring, or is going

to occur, and that the persecutor intends to cause harm (Freeman, 2007). Studies cited within this review focus on paranoia.

The cognitive model of paranoia

More recently, studies have focused on examining psychological mechanisms which may contribute to, or maintain, paranoid ideation. In the cognitive model of paranoia (1) (Appendix 1.1), feeling unsafe is at the core, and six psychological mechanisms are said to contribute. Again, the cognitive model of paranoia has mostly been applied to people experiencing paranoia in a psychosis context and has not yet been considered in the context of BPD. Consistent evidence has been found for the mechanisms associated with paranoia, however this review will focus on three 1) worry 2) reasoning biases 3) negative self-beliefs. These have been selected due to their primarily cognitive components, and significant associations with paranoia.

People who experience paranoia have been found to exhibit a worry thinking style similar to the extent of people with generalised anxiety disorder (1). Reasoning biases such as jumping to conclusions, impaired theory of mind, abnormal attributional styles, and an over-anticipation of threat have been found in people experiencing paranoia (9). Negative self-beliefs have also reliably been found in people experiencing paranoia (10). For example, a review of 52 studies on self-esteem and persecutory delusions found that persecutory delusions directly reflected specific negative self-schemas (10). Worry, reasoning biases, and negative self-beliefs are also inter-related. For example, worry is associated with a variety of cognitive biases, including selective attention, and a tendency to exaggerate the probability of future threatening events (11). Attributional styles also play a role in how someone views themselves such as the tendency to attribute negative outcomes to the self when experiencing depression (12).

Despite evidence of paranoid ideation and mistrust in people with a diagnosis of BPD, research into what may be involved in paranoid ideation for people with a BPD diagnosis is limited. Freeman et al., (2016) (1) suggest that the cognitive model may be applicable to disorders other than just psychosis. Currently the presence of the psychological mechanisms from the cognitive model of paranoia in people with a BPD diagnosis have been looked at separately, in individual studies, without the cognitive model as a guiding framework. Additionally, evidence remains sparse for some mechanisms in people with BPD.

Clinical need

There is a clinical need to develop effective psychological interventions for people with a diagnosis of BPD. Spong et al (2021) (60) highlight that long term psychological therapies for people with a diagnosis of BPD are limited (Paris, 2013) (61) and that there is, at times, a reluctance to deliver brief interventions due to fears that they may be harmful for people with BPD, due to difficulties in forming trusting relationships with others (NICE, 2009) (62). Research has also shown that clinicians' judgements and optimism surrounding a client may be influenced by whether they have a diagnosis of BPD or not (Lam et al., 2016) (63). The authors suggest attitudes like these are likely to impact therapeutic approach and expectations of success, of which are likely to affect clinical outcomes. Additionally, clinicians have described clients with a diagnosis of BPD as 'treatment resistant' and 'attention seeking' (Gallop & Wynn 1987) (64).

Current treatment options for paranoia include the Feeling Safe programme (Freeman et al., 2021) which targets psychological mechanisms one by one, leading to reductions in paranoid ideation (Freeman et al., 2021). Identifying factors involved in the occurrence of paranoia in

BPD could lead to these potentially being addressed through the development of mechanistic interventions for specific symptoms, such as paranoia.

The aim of this review is to examine the evidence of three of the factors specified as mechanisms in the cognitive model of paranoia in people with a BPD diagnosis and make recommendations for future research.

Review question:

What evidence is there for worry, reasoning biases, and negative self-beliefs in people who have a borderline personality disorder diagnosis?

Method

Search strategy

This review followed the Preferred Reporting Items for Systematic Review Analyses (PRISMA) guidelines (13). Four databases (Cochrane, PyschInfo, Medline, Scopus) were searched using the search terms below. Preliminary work was conducted to determine search terms. Previous literature was consulted to identify how terms relating to the three mechanisms were defined.

1. "emotionally unstable personality disorder" or "borderline personality disorder" or "complex trauma" or "eupd" or "bpd"
2. "self image" or "self development" or "self regard" or "self affirmation" or "self judgement" or "self focus" or "self esteem" or "self concept" or "self belief" or "self worth" or "self confidence" or "self schema" or "self criticism" or "worry*" or

"ruminati*" or "cognitive bias*" or "reasoning bias*" or "cognitive process*" or "reasoning process*"

The search was conducted in July 2023 and updated in May 2024. One additional paper was added to the review. This review was registered on PROSPERO in October 2022 (CRD42022366316).

Inclusion criteria

- Using quantitative methods
- Adults aged 18 years+
- Studies looking into the presence of a) worry, b) negative self-beliefs, or c) reasoning biases relevant to the cognitive model of paranoia with participants who have a diagnosis of borderline personality disorder
- Published in English
- Peer-reviewed articles
- All publication dates

Exclusion criteria

- Only qualitative methods
- Child/adolescent studies
- Studies investigating the presence of any the three specified mechanisms with participants who do not have a diagnosis of borderline personality disorder
- Studies looking into the presence of any of the three specified mechanisms with participants who have a diagnosis of borderline personality disorder but where the mechanism is not relevant to the cognitive model of paranoia.

- Not a completed research study (i.e, theoretical papers, systematic reviews, meta-analyses, reflective case studies)
- Papers not written in English
- Full text not available

This review was originally planned to include both quantitative and qualitative studies. During full text screening, the decision was made to exclude qualitative studies. Literature found during full text screening was mixed and therefore a review including only quantitative studies was deemed to be most feasible in being able to draw meaningful conclusions. An amendment was made on PROSPERO following this decision being made. A review including qualitative studies would be of value in the future to explore further the experiences of people with a diagnosis of BPD.

Study selection

The PRISMA flowchart (Appendix 1.3) summarises the systematic review process. Database searches retrieved 2038 papers. Grey literature searching retrieved 23 papers. Duplicates were removed and 1344 papers remained. First and second authors independently screened titles and abstracts until an acceptable kappa was achieved. Kappa after 30% of papers were screened was 0.82. Remaining papers were reviewed by the first author. Kappa for independent full text screening was 0.86 after 30% of papers were screened by the first and second author. Discrepancies (n=2) were taken to the third author. 27 papers were included in the final review.

Achieving inter-rater reliability

Poor inter-rater reliability occurred during title and abstract screening due to poor definitions

of mechanisms. Given the breadth of constructs in search results, posthoc work was required to further specify and define mechanisms. Constructs identified in papers were required to be relevant to the cognitive model of paranoia. Previousliterature was consulted further to determine 1) negative self-beliefs most relevant to paranoia (e.g beliefs regarding inferiority and vulnerability, 2) cognitive biases implicated in the occurrence of paranoia such as jumping to conclusions, and 3) worry processes relevant to paranoia. Definitions were therefore specified further (Appendix 1.2). This was not done a priori.

Data extraction

A data extraction tool was developed covering study population details, control group(s) used, study design, verification of BPD, construct measured, measure used, and quantitative findings. Extracted data can be found in tables 1.1, 2.1, and 3.1. Separate data extraction tables were created for each of the three mechanisms.

Quality assessment

The Standard Quality Assessment Criteria Tool (14) was used to assess the quality of each paper. The measure rates papers on 14 items: study objective, study design, selection of participants, sample size, reporting of results, and conclusions made. A summary score is calculated and papers with a score >0.80 are considered high quality, 0.60-0.79 are considered good, 0.50-0.59 are considered average and <0.50 are considered poor quality. The first author and a second rater rated 30% of the papers using the tool and associated manual. Kappa was 0.84 therefore the first rater rated the remaining papers.

Quality of literature

Literature ranged from average to high quality. A key limitation across the literature was that

most studies included mostly female participants. Some studies only included female participants and in studies where both males and females were included, there were often large disparities in numbers of each gender. For example, 1067 participants with BPD were included across studies. Of the studies reporting on gender (n=24), only 250 participants were male. Given that BPD is diagnosed more in women than men (15), this may have been expected however generalisability of results to males is limited. Most studies also used self-report measures to measure the mechanism(s) of interest, which can reduce ecological validity, and may be more influenced by level of insight, self-concept, and social desirability (16).

Relevant participant characteristics were at times missing across studies. Only one study reported on participants' ethnicities (17). Some studies, but not all, reported on education levels and socioeconomic status. Age and gender were reported across the majority of studies.

Additionally, studies included in the review often used different measures, making it more difficult to come to clear conclusions regarding effects.

There was also a difference in the number of studies looking at each mechanism. There were significantly more studies for negative self-beliefs than there were for both reasoning biases and worry. The sparse literature on worry and reasoning biases in people with a BPD diagnosis make generalisation of the results difficult.

Particular strengths across studies included reporting results in sufficient detail, reporting estimates of variance, drawing conclusions supported by study findings, and sufficiently describing objectives or study aims. Studies looking at worry used larger sample sizes than those seen in studies investigating reasoning biases and negative self-beliefs. Characteristics of a strong study in this field were thought to include a clear research question, rigorous study design including an adequate sample size and inclusion of control groups and using a sample

representative of the population. Conducting appropriate statistical analysis, accounting for confounding variables, and accurate reporting of results were deemed to also be important in evaluating quality of studies.

Data analysis

A narrative synthesis was conducted due to the need for hypotheses to be generated rather than answered, and the need for examination of the existence and nature of an effect, rather than its' size. There was also significant heterogeneity in outcome measures across studies. Studies were grouped based on psychological mechanism of interest (e.g worry, reasoning biases, or negative self-beliefs).

Author(s)	Main study population	Gender female: male	Control group(s)	Study design	How BPD was identified/verified	Construct measured	Measure(s) used	Findings including p values	Quality rating
Dell'Osso et al., 2019	50 people with a diagnosis of BPD split into 1) BPD + MD 2) BPD only	Not reported	69 people from general population	Cross-sectional	DSM-IV and SCID-II	Reflection, brooding, and depressive rumination	RRS	BPD + MD group scored significantly higher than people on general population on all RRS scales (p <0.001). Possible role of rumination in BPD psychopathology concluded.	Good (0.70/1
Spada et al., 2021	186 people with a diagnosis of personality disorder, 50 had a diagnosis of BPD	95:91	371 people from general population	Cross-sectional	SCID-II	Worry, rumination	RRS; PSWQ	PD group scored significantly higher on RRS (p< .01) and PSWQ (p<.01)	High (0.90/1.

Author(s)	Main study population	Female: male	Control group(s)	Study design	How BPD was identified/verified	Construct measured	Measure(s) used	Findings including p values	Quality ratin
Nicol et al., 2013	20 people diagnosed with BPD	15:5	21 people from general population	Cross-sectional	SCID-II	Social judgement	Social judgement of faces test	People with BPD rated faces as significantly less approachable and	Good (0.60/

								trustworthy (p < 0.05)	
Puri et al., 2021	30 people diagnosed with BPD	28:2	30 people from general population	Cross-sectional	SCID-II	Cognitive distortions: mindreading, catastrophising, all or nothing thinking, emotional reasoning, labelling, mental filters, overgeneralisation, personalisation, should statements, minimising/disqualifying the positive	CDS	People with BPD had significantly higher CDS interpersonal scores than CDS achievement scores (=0.004). People with BPD had significantly higher scores on CDS (p=0.004).	High (0.95/1
Moritz et al., 2011	20 people diagnosed with BPD	19:1	20 people from general population	Cross-sectional	DSM-IV	Cognitive biases: JTC, catastrophising, threatening event, intentionalising, dichotomous thinking, anomalous perception, emotion-based reasoning	CBQp	People with BPD had significantly higher levels of cognitive biases (p<0.001) apart from intentionalising (p>.20)	High (0.85/1
Puri et al., 2018	28 people diagnosed with BPD	26:2	28 people from the general population	Cross-sectional	DSM-IV	Cognitive biases: JTC, belief inflexibility bias, attention for threat bias, external attribution bias	DACOBS	People with BPD had significantly higher levels of all cognitive biases: JTC (p=0.001) BIB (p<0.001), ATB (p<0.001), EAB (P<0.001)	High (0.80/1
Catalan et al., 2015	26 people diagnosed with BPD	15:11	61 people with FEP, 150 people from the general population	Cross-sectional	DSM-IV	JTC	Beads Task	Significant differences found in JTC between groups (p <	Good (0.75/

								0.05). 44% of people with FEP had JTC bias, 19% of people with BPD had JTC bias, 9% of people from general population had JTC bias. Difference between BPD and general population group not significant.	
Scheunemann et al., 2023	38 people diagnosed with BPD	31:7	30 people from general population	Cross-sectional	DSM-IV and SCID-II	Social judgement	Estimation task	People with BPD rated people as more hostile than people in the general population (p=0.002)	High (0.95/1

Table 1.2 Data extracted from reasoning biases studies

Note. CDS = Cognitive Distortions Scale; CBQp = Cognitive Biases Questionnaire for Psychosis; DACOBS = Davis Assessment of Cognitive Biases Scale

Santangelo et al., 2017	60 people diagnosed with BPD	60:0	60 people from general population	Cross-sectional	DSM-IV and SCID-II	Self-esteem stability	Short form of the RSES over 4 days	People with BPD had significantly lower self-esteem (p<0.001). People with BPD had higher instability in self-esteem (p<0.001).	High (0.85/1.0

Lynum et al., 2008	34 people diagnosed with BPD	28:6	29 people diagnosed with APD, 17 people diagnosed with BPD and APD	Randomised controlled trial	Structured interviews and self-report questionnaires	Self-esteem	ISE	People with BPD had significantly lower ISE scores than people with APD ($p<0.01$) and people with BPD and APD ($p<0.01$)	High (0.90.1.0
Santangelo et al.,	60 people diagnosed with BPD	60:0	35 people symptomatically remitted from BPD and 60 people from general population	Cross-sectional	DSM-IV and SCID-II	Self-esteem stability	Short form of the RSES over 4 days	People with acute BPD had significantly higher instability in self-esteem than people remitted from BPD symptoms, and people in general population ($p<0.001$).	High (0.90/1.0
Vater et al., 2015	24 people diagnosed with BPD	24:0	26 people with MDD, 42 people from general population	Cross-sectional	DSM-IV and SCID-II	Self-concept structure	Card sort task	People with BPD had more compartmentalised self-concept structure than people with MDD and people in general population ($p<0.001$)	High (0.90/1.0

Bonis et al., 1998	17 people diagnosed with BPD and MDD	15:2	12 people diagnosed with MDD and 20 people from general population	Cross-sectional	Diagnosis decided by at least 2 psychiatrists	Self-descriptions	Simplified version of Kelly's Repertory Grid	People with depression both with and without BPD had significantly more negative self-descriptions than people in general population ($p < 0.001$).	Good (0.60/1.0
Winter et al., 2018	31 people diagnosed with BPD	Not reported	30 people from general population	Cross-sectional	SCID-IV and IPDE	Implicit self-esteem and explicit self-esteem	IAT and RSES	People with BPD had significantly lower implicit self-esteem ($p=0.23$) and explicit self-esteem ($p<0.001$)	Good (0.70/1.0
Hedrick & Berlin, 2012	18 people diagnosed with BPD	12:6	18 people with depersonalisation disorder, 35 people from general population	Cross-sectional	DSM-IV, SCID-I and SCID-II	Implicit self-esteem	IAT	No significant differences in implicit self-esteem between people with BPD and people in general population ($p>0.05$).	High (0.80/1.0
Butler et al., 2002	84 people diagnosed with BPD split into two groups	Group 1: 30:12, Group 2: 30:12	204 people diagnosed with other personality disorder	Cross-sectional	Diagnosed with BPD prior to the study	Personality beliefs	PBQ	People with BPD scored significantly higher on the PBQ than people with other personality disorders ($p < 0.001$).	High (0.95/1.0
Jacob et al., 2010	43 people diagnosed with	43:0	Normative data from general	Intervention pilot study	SCID-II	Global self-esteem and state	RSES, SSE	People with BPD scored	Average (0.58/1.0

	BPD		population			self-esteem		significantly lower on measures of both global and state self-esteem than a normative sample from general population (p<0.01).	
Khosravi & Hassani (2022)	110 people diagnosed with BPD	46:64	110 people from general population	Cross-sectional	DSM-IV	Self-esteem	RSES	People with BPD had significantly lower self-esteem (p<0.001).	High (0.95/1.0
Evans et al., 2015	46 people diagnosed with BPD, others who had features of BPD	Not reported	No comparison group	Cross-sectional	SCID-II	Self-concept	Psychological distance scaling task	BPD symptom severity was associated with a using a higher number of negative adjectives (p<0.001). Reporting a higher number of negative adjectives was driven by depression symptoms.	High (0.85/1.0

Vater et al., 2010	41 people diagnosed with BPD	41:0	No comparison group	Cross-sectional	SCID-II and MINI	Implicit self-esteem and explicit self-esteem	Initials preference task and Heatherton and Policy scale	Implicit self-esteem was positively related to severity of symptoms (p=.24)	High (0.85/1.0
Roepke et al., 2011	40 people diagnosed with BPD	40:0	No comparison group	Intervention	DSM-IV	Multidimensional self-esteem	MSES	People with BPD had significantly lower scores on all six facets of the MSES (p<0.05)	High (0.96/1.0
Pohl et al., 2021	35 people diagnosed with BPD	35:0	35 people from general population	Cross-sectional	SCID-II, SCID-I and DSM-IV	Self-compassion, self-kindness, self-judgement, self-esteem	SCS, RSES	People with BPD had significantly lower self-compassion, self-kindness, self-judgement, self-esteem (p<0.001).	High (0.80/1.0
Forster et al., 2021	35 people diagnosed with BPD	35:0	27 people from general population	Cross-sectional	DSM-IV and SCID-II	Self-referential processes and self-esteem	Self-referential processing task, trait-judgement and recall task, RSES	People with BPD recalled significantly fewer positive than negative self-descriptive adjectives in the 'self' condition. People with BPD had significantly lower self-esteem (p<0.001)	High 1.00/1.0

Almeida et al., 2018	41 people diagnosed with BPD split into two groups: self-injury and non self-injury	32:9	No comparison group	Cross-sectional	DSM-IV-TR	Self-esteem	RSES	People with BPD who had self-injured had significantly lower self-esteem than the group who had BPD but had not self-injured ($p<0.001$)	High (0.85/1.0
Vater et al., 2013	26 people diagnosed with BPD	Not reported	44 people from general population and 51 people with a diagnosis of narcissistic personality disorder	Cross-sectional	Not reported	Implicit self-esteem and explicit self-esteem	IAT and MSES	People with BPD had significantly lower ESE than people in general population ($p < 0.001$) No significant differences in ISE ($p = 0.40$)	High (0.90/1.0
Rusch et al., 2006	60 people diagnosed with BPD	60:0	30 people diagnosed with social phobia	Cross-sectional	DSM-IV and MINI	Shame proneness, self-esteem, self-efficacy	Test of self-conscious affect, RSES, generalised self-efficacy scale	People with BPD had significantly lower self esteem ($p<0.001$), self-efficacy ($p<0.001$), higher shame-proneness which measured self-stigma ($p<0.001$).	High (0.90/1.0
Heekerens et al., 2023	49 people diagnosed with BPD	35:14	49 people with depressive disorders and 49 people from general population	Cross-sectional	SCID-I	Self-esteem	4-item scale of RSES	Negative affective arousal and subsequent self-esteem were significantly linked only in the BPD group (significance level not reported)	High (0.86/1.0

Table 1.3. Data extracted from negative self-belief studies

Note. RSES = Rosenberg Self Esteem Scale; ISE = Index of Self-Esteem; IAT = Implicit Association Test; PBQ = Personality Belief Questionnaire; SSE = State Self Esteem Scale; Multidimensional Self Esteem Scale = MSES; SCS = Self Compassion Scale

Results

Twenty-seven studies were included in this review: 2 for worry, 6 for reasoning biases and 19 for negative self-beliefs. All studies included participants with a diagnosis of BPD. Twenty-two studies verified participants' diagnosis using either DSM-IV or SCID-11 criteria. Twenty-three studies were cross-sectional and 24 compared participants with BPD with a control group and for 15 of these, this was a general population group. Three studies compared participants with BPD with participants with other personality disorders. Details of how remaining studies used control groups can be found in tables 1.1, 2.1 and 3.1. Studies will be summarised below, clustered according to mechanism. Where studies investigated multiple constructs, only the mechanism relevant to this review has been reported on.

Worry

Two cross-sectional studies explored worry in people with BPD. A total of 100 participants with a diagnosis of BPD were included across both studies. Different measures were used to examine worry in each study. Both studies compared participants with a BPD diagnosis with people from the general population and both found significantly higher levels of worry in participants with BPD.

Dell'Osso et al (2019) (18) compared participants with only BPD, participants with BPD and mood disorder (MD), and people from the general population on levels of reflection, brooding, and depressive rumination, using the ruminative response scale (RSS). They found that the BPD + MD group scored significantly higher than people from the general population on all scales of the RRS ($p < 0.001$). A possible role of rumination in BPD psychopathology was also concluded as they found that people with BPD, both with and

without MD, showed a significantly greater number of PTSD symptoms than people in the general population ($p < 0.001$).

Spada et al (2021) (19) explored worry and rumination in participants with a diagnosis of personality disorder (PD) and people from the general population. Their sample included 26% of people with a diagnosis of BPD. The PSWQ and RRS were used and people with PD had significantly higher scores the PSWQ and RRS than the general population group, including positive beliefs about worry ($p<0.001$), negative beliefs about thoughts concerning controllability and danger ($p<0.001$), and beliefs about the need to control thoughts ($p<0.001$). They found that positive beliefs about worry and beliefs about thoughts concerning uncontrollability and danger, and cognitive self-consciousness were independent predictors of rumination ($p<0.05$).

Overall, findings indicate that people with BPD exhibited more rumination and worry than people in the general population. Findings from Dell'Osso et al (2019) (18) indicate there may be a role of rumination in BPD psychopathology however participants did not complete a measure of BPD, therefore their conclusion that there may be a role of rumination on BPD psychopathology must be taken tentatively. However their sample size was large, reducing the risk of type 2 errors. A larger sample size also indicates greater generalisability and reduced impact of outliers. Although people with BPD were included in the same for Spada et al (2021) (19), results were not broken down according to diagnoses so limited conclusions can be made about BPD.However, results were reported in sufficient detail and conclusions were supported by results.

Reasoning biases

Puri et al (2021) (20) explored cognitive distortions in people with a diagnosis of BPD and people from the general population. Participants with a BPD diagnosis scored significantly higher than the general population group on all ten subscales ($p = 0.004$), including catastrophising, all or nothing thinking, and emotional reasoning. They found that people with a BPD diagnosis manifested cognitive biases more in social and interpersonal situations compared to professional and achievement-related situations ($p=0.004$). However given the number of measures in the study, increasing the risk of type 1 error, observed results may have appeared more significant than they were. Nicol et al (2013) (21) and Scheunemann et al (2023) (22) both explored social judgement in people with a BPD diagnosis. In Nicol et al (2013) (21), participants were asked to judge faces according to six characteristics Only results for approachability and trustworthiness ratings were significant, with participants with BPD rating faces as significantly less trustworthy and approachable ($p < 0.05$). However, the faces participants had to judge were all Caucasian, and participants' ethnicities were not reported. Judgements of trustworthiness can be influenced by how similar the face may be to a participant (23). Additionally estimates of variance (e.g, standard deviations) were not reported.

Scheunemann et al (2023) (22) investigated participants' social judgements and how confident they were in their decisions. People with a BPD diagnosis rated people as hostile significantly more than the general population group ($p < 0.001$). They found that people with BPD performed similarly to the general population group regarding seeking, evaluating, and integrating socially provided information. Catalan et al (2015) (24) compared people with a BPD diagnosis with people with a diagnosis of FEP and people in the general population. They used the Beads Task (25) which measures jumping to conclusions (JTC) and found that 44% of people with FEP exhibited JTC, compared to 19% of people with BPD and 9% of people in the general population, however the difference between people with BPD and

general population group was not significant. Puri et al (2018) (26) and Moritz et al (2011) (27) also found that people with a BPD diagnosis jumped to conclusions significantly more than people in the general population in their questionnaire studies ($p < 0.001$).

Puri et al (2018) (26) found that as BPD symptomology increased, the propensity to exhibit cognitive biases increased and concluded that cognitive biases may underlie psychopathology in BPD. However, Catalan et al (2015) (24) found that JTC was not associated with level of psychotic symptoms or level of 'delusionality' across groups.

Studies rated as high quality (27) (26) (20) (21) described participant characteristics and presented results in greater detail and reported estimates of variance.

Findings from studies in this area conclude that people with a BPD diagnosis exhibit reasoning biases relevant to the model of paranoia such as JTC (24) (26) (20) and over-anticipation of threat interpersonally (21) (21). Due to conflicting findings between Puri et al (2018) (26) and Catalan et al (2015) (24) it is unclear whether reasoning biases change depending on symptomology in BPD.

Negative self-beliefs

Nine studies explored self-esteem in people with a BPD diagnosis (28) (29) (30) (31) (32) (33) (34) (35) (36). All studies comparing levels of self-esteem in people with BPD to control groups without a diagnosis of BPD found significantly lower self-esteem in participants with BPD ($p < 0.001$). In Almeida & Hort (2018)'s study (28), participants with BPD were split into two groups: one group who answered 'yes' to the question on the SCID-II regarding self-injury behaviour and one group who answered 'no'. People with a diagnosis of BPD who had self-injured had significantly lower self-esteem than those who had a diagnosis of BPD and

had not self-injured ($p < 0.001$). However the sample size used within this study was small, and the effect found may have been more pronounced had the sample size been larger. Lynum et al (2008) (32) compared participants with BPD with participants who had a diagnosis of antisocial personality disorder (APD), and participants who had a diagnosis of both BPD and APD. People diagnosed with BPD had significantly lower scores on the ISE than people diagnosed with APD ($p < 0.01$) and those diagnosed with BPD and APD combined ($p < 0.01$).

A pilot intervention study conducted by Jacob et al (2010) (30) found that participants diagnosed with BPD scored significantly lower on measures of both global and state self-esteem when compared to results from a normative sample from the general population ($p < 0.01$). However, this study scored low on quality assessment due to lack of a clear objective, lack of estimation of variance, and no evidence for controlling for confounding. Additionally, outcome assessors were not blinded, introducing risk of detection bias. A further issue with this study is that of selection bias. Participants were also not assigned by random as intervention participants were recruited first, followed by controls. Roepke et al (2011) (34) also conducted an intervention study where they assessed self-esteem and self-concept. They used the Multi-Dimensional Self-Esteem Scale (MSES) and found that all six facets of self-esteem from the scale were significantly lower in participants with a BPD diagnosis compared with a general population sample ($p < 0.05$). However, their study recruited only from a ward setting therefore increasing the risk of selection bias. Additional findings regarding self-esteem are reported by Khosravi & Hassani (2022) (31) who found that suicidal behaviours had a negative and significant correlation with self-esteem ($r = -0.61$, $p=0.003$) and self-esteem also mediated the effect of emotional intelligence on suicidal behaviours ($b = -0.08$). Khosravi & Hassani (2022)’s study (31) had strengths as they utilised a large sample size and conducted systematic random sampling to allocate participants to

group. They also used fairly equal numbers of females and males, who were matched exactly between clinical and comparison groups, which was rare amongst studies. Vater et al (2010) (37) found that self-esteem related to severity of psychiatric symptoms. In their study, 41 participants with a BPD diagnosis completed a measure of implicit self-esteem (ISE) and explicit self-esteem (ESE) and the authors found that implicit self-esteem moderated the relationship between ESE and symptoms of BPD. ISE was positively related to severity of symptoms ($p=.024$). Further, participants who had less congruent self-esteem reported more symptoms than participants who had congruent self-esteem.

Santangelo et al (2017) (38) and Santangelo et al (2020) (39) both used a short four-item form of the Rosenberg Self-Esteem Scale (RSES) to explore self-esteem instability and affective instability over a 4-day period. Santangelo et al (2017) (38) compared people with BPD to a general population group and found that people with BPD had significantly higher instability in self-esteem ($p < 0.001$), valence ($p < 0.001$), and tense arousal ($p < 0.001$) than people in the general population group. Santangelo et al (2020) (39) conducted their study with people with a diagnosis of acute BPD (BPD-ACU), people who were in remission from BPD (BPD-REM), and people from the general population. They found significantly lower instability of self-esteem in those in remission from BPD compared with those with an acute BPD diagnosis ($p < 0.001$), with a higher probability of extreme changes in self-esteem in the acute BPD group compared with the remitted BPD group ($p < 0.01$). People in both the BPD-REM and BPD-ACU groups had significantly higher instability of self-esteem than people from the general population ($p < 0.001$). However, Santangelo et al (2017) (38) did not use a clinical control group and highlight the need for future research to explore the specificity of self-esteem instability. They also used only female participants in their study, limiting the generalisability to men with a BPD diagnosis. Heekerens et al (2023) (36) compared people with BPD, depressive disorders, and a general population group on levels of current affective

arousal and current self-esteem. Participants were prompted to rate self-esteem levels 52 times within 1 day. They found that levels of self-esteem were significantly lower in people with BPD then people with depressive disorders, and a general population group (p value not reported). Additionally, they found that negative affective arousal and subsequent self-esteem were significantly linked only in the BPD group (p value not reported). Included in measures was a borderline-specific cognitions questionnaire, where the BPD group scored significantly higher than those with depressive disorders and those in the general population group ($p < 0.001$). Authors note limitations including the lack of contextual information to explain changes in affective arousal, which may have also influenced changes in self-esteem scores. Additionally, it is unclear how significance was determined as significance values were not reported.

De Bonis et al (1998) (40), Forster et al (2021) (29), and Evans et al (2015) (41) looked at self-descriptions in people with a diagnosis of BPD. De Bonis et al (1998) (40) compared people with a BPD diagnosis and depression to people without a BPD diagnosis, but with depression, and people in the general population. They used a simplified version of Kelly's Repertory grid to examine self-descriptions. They found that self-descriptions of people with depression both with and without BPD were significantly more negative than those of the general population group ($p < 0.001$). However, some participants in the study who had a diagnosis of BPD also had a diagnosis of another personality disorder, meaning the sample may not have been representative of people with just BPD, reducing generalisability of results.Forster et al (2021) (29) found that their general population group recalled significantly more positive self-descriptive adjectives compared to people with BPD ($p < 0.001$). Forster et al (2021) (29) scored high in the quality check (1.00/1.00) as they sufficiently described their objective, detailed their measures, participants, and results, and their conclusions were sufficiently supported by their findings. Evans et al (2015) used a

psychological distance scaling task and found that using a higher number of negative self-descriptions was associated with BPD symptoms, and that using a higher number of negative adjectives was driven by depression symptoms.

Vater et al., (2015) (42) used a card sorting task to examine self-concept structure in people with BPD, participants with major depressive disorder (MDD), and people from the general population. They found that participants with BPD had a more compartmentalised self-concept structure than participants with MDD and participants from the general population ($p < 0.001$). However, there was a significant difference in age across groups, which may have acted as a confounding factor, increasing confounding bias.

Four studies examined both ISE and ESE. Winter et al (2018) (43) found that both ISE ($p = 0.23$) and ESE ($p < 0.001$) were significantly lower in participants with a BPD diagnosis. However, they used a small sample, and a large proportion of participants had a current major depressive episode. Considering their study looked at self-referential processing, and having a depressive episode could influence self-referential processing (44) this may have confounded results. Hedrick & Berlin, (2012) (45) used the IAT and found no significant differences in ISE between participants with BPD and participants from the general population ($p > 0.05$). Vater et al, (2013) (46) used the Initials Preference Task and the MSES in assessing ISE and ESE in participants with a BPD diagnosis, who acted as a clinical control group, and compared them to participants with a diagnosis of narcissistic personality disorder (NPD). Participants with BPD scored significantly lower on measures of ESE (p value not reported) than the control group but did not significantly differ in levels of ISE (p value not reported). The authors did not specify how a BPD diagnosis was verified within this study, introducing the risk of bias in selection method.

Butler et al., (2002) (17) investigated personality beliefs in 84 people diagnosed with BPD. They completed the Personality Belief Questionnaire and responses were compared with 204 people with a diagnosis of any other PD. Participants with a BPD diagnosis scored significantly higher than participants with other personality disorders on the PBQ. The most significant items included ‘unpleasant feelings will escalate and get out of control’ ($p < 0.001$), ‘I have to be on guard at all times’ ($p < 0.001$), ‘I am helpless when left on my own’ ($p < 0.001$). However, participants within the study did not have their diagnosis verified as part of the study, unlike other studies included within this review. A large sample size was used in the study however, meaning the sample was likely less susceptible to influence of outliers and anomalies, reducing selection bias.

Discussion

This systematic narrative review aimed to synthesise and appraise research exploring the presence of three cognitive mechanisms that contribute to the experience of paranoia, in people with a diagnosis of BPD. This review critically appraised 27 studies and found evidence for each of the three mechanisms in people with BPD. Guided by the literature, this review also considered factors associated with the mechanisms discussed. Evidence was synthesised, and will be discussed below, according to psychological mechanism.

Worry

Both studies found that people with a diagnosis of BPD exhibited more rumination than comparison groups. Dell’Osso et al., 2019 (18) compared people with a BPD diagnosis with people with a diagnosis of BPD and MD. They found that people with a BPD and MD diagnosis displayed higher levels of worry, suggesting that co-morbidity with depression is associated with higher levels of worry. Future research should therefore consider the impact

that co-morbid diagnoses, such as depression, may have.As both studies utilised the RRS to examine rumination and found significant differences in levels of rumination between people with a diagnosis of BPD, and people from the general population, we are able to draw conclusions from these studies more easily. Additionally, results from the PSWQ in Spada et al (2021) (19) supports the findings from the RRS.

Considering how the findings may relate to paranoia, higher levels of worry have been found in people who present with paranoia (47). Clemente et al (2013) (47) found that worry was associated with higher levels of paranoid distress, conviction, and occupation. Worry has also been found to be a predictor of paranoid thinking and may encourage persistence of paranoid thoughts (48)

Overall, research into worry and rumination in people with a diagnosis of BPD is limited however we may tentatively conclude that people with a diagnosis of BPD are more likely to worry, more likely to have more beliefs about the need to control thoughts, more likely to have positive beliefs about worry and more likely to have more beliefs about thoughts concerning uncontrollability and danger, with both of the latter possibly predicting rumination. However, despite large sample sizes used, it is important to be tentative in these conclusions because the existence of an effect here has only been demonstrated in a limited number of studies, meaning whilst there is evidence of an effect, the evidence is sparse. Future research should seek to add to the evidence base in this area. It is also still unclear the role rumination plays in symptomology in BPD.

Reasoning biases

All studies (n=6) demonstrated that participants with BPD exhibited significantly higher levels of reasoning biases than people in the general population. It was found that people with

BPD displayed more cognitive biases in social and interpersonal situations compared to professional and achievement-related situations (20). Considering previous research, which has shown that people with BPD may have less stable interpersonal relationships (49) and more communication problems in interpersonal relationships (50) it may be that reasoning biases influence interpretations, and perceptions of threat for people with a diagnosis of BPD when interacting with others. Over-anticipation of threat appears to be significant for people with a diagnosis of BPD considering Nicol et al., (2013)'s (21) findings that people with a BPD diagnosis rated faces as less trustworthy and less approachable. Research shows that people presenting with paranoia are also more likely judge faces as less trustworthy (51).

Within this review, three studies explored whether participants with a BPD diagnosis exhibited a JTC bias through using questionnaires and a task. JTC has been reliably linked to the experience of paranoia (52). Studies within this review concluded that people with a BPD diagnosis jumped to conclusions more than people in the general population. Considering fact that reasoning biases have been consistently found in people presenting with paranoia in a psychosis context (54), we may hypothesise that a JTC bias may be associated with paranoid ideation in people with a BPD diagnosis also. However, it is important to note that Catalan et al., (2015) (24) found that JTC was not associated with level of psychotic symptoms or level of 'delusionality' across groups.

Regarding future research, there is a need to include a measure of BPD symptomology. Puri et al., (2018) (26) found that as BPD symptomology increased, the likelihood of displaying reasoning biases also increased. Including a measure of BPD symptomology would have enabled further investigation of the link between displaying reasoning biases and BPD symptomology. Given that previous literature indicates that people with a BPD diagnosis display reasoning biases similar to those seen in people with a psychosis diagnosis, future

research should focus on exploring the presence of cognitive biases in people with a BPD diagnosis who present with paranoia. Additionally, considering Scheunemann et al., (2023)'s (22) findings,further research should seek to better understand the specific cognitive biases occurring in people with BPD.

From the reviewed studies within this section, we can conclude that people with a diagnosis of BPD are more likely to view others as less trustworthy, less approachable, and more hostile than people in the general population, and are more likely to jump to conclusions when making these judgements. They may also be less likely to have flexibility around their beliefs, more likely to attribute events to external causes and to perceive situations as potentially threatening. These biases are also more likely to be present in interpersonal situations, and when BPD symptomology is increased. We may tentatively hypothesise that these biases may interact in potentially ambiguous situations, such as meeting a new person, and make it therefore more difficult for someone with a diagnosis of BPD to believe others are trustworthy.

Negative self-beliefs

Studies demonstrated that participants with a diagnosis of BPD have significantly more negative self-beliefs than people from the general population. Negative self-beliefs were mostly explored through self-esteem scores. All studies exploring self-esteem in some form found that people with a BPD diagnosis had significantly lower self-esteem scores than people from the general population, and other groups.

Butler et al., (2002)'s (17) study highlights the prominence of certain beliefs for people with a BPD diagnosis. One item of particular interest for this review is 'I have to be on guard at all times'. This is a belief suggesting a lack of psychological, or actual safety, and feeling unsafe

is at the core of the cognitive model of paranoia (1). Butler et al (2002)'s (17) findings that people with BPD display more negative beliefs about themselves compared with other personality disorder also suggests key differences in self-beliefs between people with BPD and people with other personality disorder diagnoses. Young (1990) (55) observed that people with a BPD diagnosis displayed schemas relating to abandonment, unlovability, dependence, mistrust. The measure used within Butler et al., (2002)'s (17) study included assumptions related to these themes. Further research may focus on how negative self-beliefs further relate to schemas and paranoid thinking in participants with a diagnosis of BPD.

Findings indicate that people with a diagnosis of BPD have lower self-esteem than people in the general population. However, studies included in the review highlight when self-esteem could be even lower for people with a BPD diagnosis. For example, suicidal behaviours, and self-injury were found to be associated with lower self-esteem (31) (28), and symptoms of depression were associated with a higher number of negative adjectives people attributed to themselves.

Self-esteem was found to be related to the severity of psychiatric symptoms. People who had less congruent self-esteem reported more symptoms of BPD (37). In this study, higher self-esteem was associated with fewer clinical symptoms and ISE moderated the relationship between self-esteem and symptoms of BPD in participants with lower ESE. However, it is not clear what 'symptoms of BPD' refers to, or whether this includes paranoid thinking. Alongside having lower self-esteem, people with BPD had significantly higher instability of self-esteem than that of people from the general population (38) indicating that self-esteem in people with BPD may be more variable, and more influenced by external experiences. Findings from Heekerens et al (2023) (36) support this, suggesting that as people with BPD experience emotional fluctuations, they experience more changeable self-esteem levels.

However considering the lack of information of significance within this study, results must be taken with caution.

Self-compassion was found to moderate the relationship between childhood trauma and severity of BPD symptoms (33) suggesting that self-compassion may be a protective factor to the negative consequences of trauma. Considering that a high number of people with a BPD diagnosis experience childhood trauma (56) including emotional abuse, (57) interventions focusing on enhancing self-compassion may be helpful for this client group.

Findings on implicit self-esteem across studies were mixed. Hedrick & Berlin., (2012) (45) and Winter et al., (2018) (43) findings contradict one another therefore conclusions regarding implicit self-esteem in people with BPD cannot be made from this review alone. Future research should seek to clarify this.

Vater et al (2015)'s (42) findings that people with a diagnosis of BPD had a more compartmentalised self-concept than people from the general population suggests that people with BPD have more difficulties integrating aspects of themselves, alongside being flooded with more negative information once one negative self-aspect is activated. This could be related to one reasoning bias, emotional reasoning, which has been found to be higher in people with a BPD diagnosis (20) with negative information being flooded, causing an emotional reaction, leading people with BPD to believe the negative information must be true.

Overall, findings from the reviewed studies suggest that people with a BPD diagnosis have lower explicit, global, and state self-esteem, higher instability in self-esteem, and describe themselves more negatively than comparison groups. Findings also suggest that people with BPD have a more compartmentalised self-concept compared with people in the general population and exhibit higher levels of self-stigma than people with social phobia. Findings

on implicit self-esteem were mixed. Factors such as suicidal behaviours, self-injury, and depression, and negative affective arousal were associated with significantly lower self-esteem levels.

Paranoia

It is important to review the above conclusions in the context of the cognitive model of paranoia, and previous literature on paranoia in people with a diagnosis of BPD. Increased paranoia has been associated with childhood interpersonal trauma (58), has having a diagnosis of BPD (59). It seems understandable that having a higher number of early traumatic life experiences would lead to significantly lower levels of self-esteem, and more negative views of the self, alongside higher levels of worry, and exhibiting reasoning biases, especially over-anticipating threat. Overall, the literature indicates the existence of variables said to contribute to paranoia in people with BPD however causal relationships and possible directionality should be explored in future research through the use of longitudinal, experimental, or treatment methodologies.

Strengths and limitations of the review

A strength of this review is that it is the first review to consider the three psychological mechanisms within the cognitive model of paranoia as a guiding framework. Studies were appraised for quality and this was considered in relation to study findings.

A limitation in conducting this review relates to the definitional difficulties of the three mechanisms. Efforts were made to sufficiently capture papers relating to the mechanisms through consultation of previous literature, and consideration of terms in the context of the

cognitive model, however it is possible that the search terms used may have missed other key concepts. Another key limitation of this review is that of the studies included, it is not known how many participants exhibited paranoid ideation. While it is possible to infer that the mechanisms investigated are present for people with BPD, it is not possible to link this specifically with the experience of paranoia in people with BPD. This means that we cannot conclude, nor rule out, that these mechanisms are involved in paranoia in BPD. As we did not know how many of the participants in the studies were experiencing paranoia, it should be considered that these mechanisms are relevant for people experiencing BPD more generally. Although there is evidence for paranoia in people with a diagnosis of BPD (6), research is still relatively limited, and causal mechanisms have not yet been researched in relation to this in people with a BPD diagnosis.

A further limitation of this review is that articles were not included if full texts could not be found. Had authors been contacted and full texts been made available, it is possible that more studies would have met inclusion criteria and may have been added to the review.

Research and clinical implications

Further research on participants presenting with current paranoia, examining the presence of the mechanisms in the model is also required to enable more accurate conclusions to be drawn regarding the experience of paranoia for people with BPD, and the potential mechanisms underlying the experience. Specifically, causal links between mechanisms and people who present with paranoia in the context of BPD should be explored. Considering the sparse evidence for both worry and reasoning biases in people with a diagnosis of BPD, future research should also examine the presence of both mechanisms more fully in people with a diagnosis of BPD. Evidence should also be reviewed for the remaining three

mechanisms in the cognitive model of paranoia, namely anomalous experiences, safety behaviours and sleep. To ensure future research can specifically explore the association between mechanisms and paranoia, researchers should either screen potential participants for paranoia using a validated measure prior to testing or include a validated measure of paranoia within the study.

Clinically, there are several implications. Low self-esteem and negative beliefs about the self are evidently a problem for people with BPD. This should be considered in the context of other presenting difficulties for people with a diagnosis of BPD. Additionally, the elevated levels of worry and reasoning biases in people with BPD should also be considered in the context of providing psychological treatment for this population. Measures validated for use, focusing on negative self-beliefs, reasoning biases, and worry, with people with BPD should be used where clinically appropriate to better understand a client's presenting difficulties, and potentially provide treatment targets for intervention. Findings from Pohl et al., (2021) (33) on the relationship between self-compassion and severity of BPD symptoms suggests that interventions focusing on enhancing self-compassion in people with BPD may improve symptoms of BPD.

Conclusions

Three of the psychological mechanisms implicated in the occurrence of paranoia, from the cognitive model of paranoia are present in people with a BPD diagnosis. People with a diagnosis of BPD are more likely to worry, more likely to exhibit reasoning biases, and more likely to have negative self-beliefs compared to other groups. However, there is a lack of research on both worry and reasoning biases in this population. Additionally, linking the three mechanisms specifically to the experience of paranoia in the context of BPD must be done

tentatively at this stage. Further, although these cognitive factors are present in BPD, no conclusions can be drawn regarding causality. Further research involving experimental or longitudinal methodologies or treatment studies are needed to explore mechanisms and direction of change.

References

1. Freeman D. Persecutory delusions: a cognitive perspective on understanding and treatment. The Lancet Psychiatry. 2016;3(7):685-92.
2. Garety PA, Freeman D. The past and future of delusions research: From the inexplicable to the treatable. British Journal of Psychiatry. 2013;203(5):327-33.
3. Bell V, Velthorst E, Almansa J, Myin-Germeys I, Shergill S, Fett AK. Do loneliness and social exclusion breed paranoia? An experience sampling investigation across the psychosis continuum. Schizophrenia Research: Cognition. 2023;33(February):100282-.
4. Gilbert P, Boxall M, Cheung M, Irons C. The relation of paranoid ideation and social anxiety in a mixed clinical population. Clinical Psychology and Psychotherapy. 2005;12(2):124-33.
5. Freeman D, Startup H, Dunn G, Wingham G, Černis E, Evans N, et al. Persecutory delusions and psychological well-being. Social Psychiatry and Psychiatric Epidemiology. 2014;49(7):1045-50.

6. Fanti E, Di Sarno M, Di Pierro R. In search of hidden threats: A scoping review on paranoid presentations in personality disorders. Clinical Psychology and Psychotherapy. 2023(July):1-19.

7. Oliva F, Dalmotto M, Pirfo E, Furlan PM, Picci RL. A comparison of thought and perception disorders in borderline personality disorder and schizophrenia: Psychotic experiences as a reaction to impaired social functioning. BMC Psychiatry. 2014;14(1):1-9.

8. Chan MA, Columbia B, Hess GC, Whelton WJ, Yonge OJ. Comparison between female psychiatric outpatients with BPD. Traumatology. 2005;11(1):23-40.

9. Bentall RP, De Sousa P, Varese F, Wickham S, Sitko K, Haarmans M, et al. From adversity to psychosis: Pathways and mechanisms from specific adversities to specific symptoms. Social Psychiatry and Psychiatric Epidemiology. 2014;49(7):1011-22.

10. Kesting ML, Lincoln TM. The relevance of self-esteem and self-schemas to persecutory delusions: A systematic review. Comprehensive Psychiatry. 2013;54(7):766-89.

11. Muris P, Debipersad S, Mayer B. Searching for Danger: On the Link Between Worry and Threat-Related Confirmation Bias in Children.

12. Hertel PT, Mathews A. Cognitive Bias Modification: Past Perspectives, Current Findings, and Future Applications. Perspectives on psychological science : a journal of the Association for Psychological Science. 2011;6(6):521-36.

13. Moher D, Liberati A, Tetzlaff J, Altman D. Reprint--preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Physical therapy. 2009;89(9):873-80.

14. Kmet LM, Cook LS, Lee RC. STANDARD QUALITY ASSESSMENT CRITERIA for Evaluating Primary Research Papers from a Variety of Fields2004.

15. Skodol AE, Bender DS, Ph D. Why Are Women Diagnosed With Borderline Personality Disorder More Than Men. Psychiatric Quarterly. 2003;74(4):349-60.

16. Baird E, Williams A, Hearn L, Amris K. Interventions for treating persistent pain in survivors of torture. Cochrane Database of Systematic Reviews. 2017(8).

17. Butler AC, Brown GK, Beck AT, Grisham JR. Assessment of dysfunctional beliefs in borderline personality disorder. Behaviour Research and Therapy. 2002;40(10):1231-40.

18. Dell'Osso L, Cremone IM, Carpita B, Dell'Oste V, Muti D, Massimetti G, et al. Rumination, posttraumatic stress disorder, and mood symptoms in borderline personality disorder. Neuropsychiatric Disease and Treatment. 2019;15:1231-8.

19. Spada MM, Nikčević AV, Kolubinski DC, Offredi A, Giuri S, Gemelli A, et al. Metacognitions, rumination, and worry in personality disorder. Journal of Affective Disorders. 2021;293(March):117-23.

20. Puri P, Kumar D, Muralidharan K, Kishore MT. Evaluating schema modes and cognitive distortions in borderline personality disorder: A mixed-method approach. Journal of Clinical Psychology. 2021;77(9):1973-84.

21. Nicol K, Pope M, Sprengelmeyer R, Young AW, Hall J. Social judgement in borderline personality disorder. PLoS ONE. 2013;8(11).

22. Scheunemann J, Jelinek L, Biedermann SV, Lipp M, Yassari AH, Kühn S, et al. Can you trust this source? Advice taking in borderline personality disorder. European Archives of Psychiatry and Clinical Neuroscience. 2023;273(4):875-85.

23. Birkás B, Dzhelyova M, Lábadi B, Bereczkei T, Perrett DI. Cross-cultural perception of trustworthiness: The effect of ethnicity features on evaluation of faces' observed trustworthiness across four samples. Personality and Individual Differences. 2014;69:56-61.

24. Catalan A, Simons CJP, Bustamante S, Olazabal N, Ruiz E, Gonzalez De Artaza M, et al. Data Gathering Bias: Trait Vulnerability to Psychotic Symptoms? 2015.

25. Huq SF, Garety PA, Hemsley DR. Probabilistic Judgements in Deluded and Non-Deluded Subjects. The Quarterly Journal of Experimental Psychology Section A. 1988;40(4):801-12.

26. Puri P, Kumar D, Muralidharan K, Kishore MT. Individuals with Borderline Personality Disorder manifest cognitive biases implicated in psychosis. Psychiatry Research. 2018;267:414-9.

27. Moritz S, Schilling L, Wingenfeld K, KÃ¶ther U, Wittekind C, Terfehr K, et al. Psychotic-like cognitive biases in borderline personality disorder. Journal of Behavior Therapy and Experimental Psychiatry. 2011;42(3):349-54.

28. Almeida CM, Horta MP. Self-Esteem and Anger in Borderline Patients with Self-Injury Behavior. Journal of Nervous and Mental Disease. 2018;206(4):251-7.

29. Forster SD, Beblo T, Pohl S, Steuwe C, Gauggel S, Mainz V. Self-referential processing and perspective taking in patients with a borderline personality disorder. Journal of Psychiatric Research. 2021;140:87-94.

30. Jacob GA, Gabriel S, Roepke S, Stoffers JM, Lieb K, Lammers CH. Group therapy module to enhance self-esteem in patients with borderline personality disorder: A pilot study. International Journal of Group Psychotherapy. 2010;60(3):373-87.

31. Khosravi M, Hassani F. From emotional intelligence to suicidality: a mediation analysis in patients with borderline personality disorder. BMC Psychiatry. 2022;22(1).

32. Lynum LI, Wilberg T, Karterud S. Self-esteem in patients with borderline and avoidant personality disorders. Scandinavian Journal of Psychology. 2008;49(5):469-77.

33. Pohl S, Steuwe C, Mainz V, Driessen M, Beblo T. Borderline personality disorder and childhood trauma: Exploring the buffering role of self-compassion and self-esteem. Journal of Clinical Psychology. 2021;77(3):837-45.

34. Roepke S, SchrÃ¶der-AbÃ© M, SchÃ¼tz A, Jacob G, Dams A, Vater A, et al. Dialectic behavioural therapy has an impact on self-concept clarity and facets of self-esteem in women with borderline personality disorder. Clinical Psychology and Psychotherapy. 2011;18(2):148-58.

35. Rusch N, Holzer A, Hermann C, Schramm E, Jacob GA, Bohus M, et al. Self-stigma in women with borderline personality disorder and women with social phobia. The Journal of nervous and mental disease. 2006;194(10):766-73.

36. Heekerens JB, Schulze L, Enge J, Renneberg B, Roepke S. Increases in negative affective arousal precede lower self-esteem in patients with borderline personality disorder but not in patients with depressive disorders: an experience sampling approach. Borderline Personal Disord Emot Dysregul. 2023;10(1):29.

37. Vater A, Schröder-Abé M, Schütz A, Lammers CH, Roepke S. Discrepancies between explicit and implicit self-esteem are linked to symptom severity in borderline personality disorder. Journal of Behavior Therapy and Experimental Psychiatry. 2010;41(4):357-64.

38. Santangelo PS, Reinhard I, Koudela-Hamila S, Bohus M, Holtmann J, Eid M, et al. The temporal interplay of self-esteem instability and affective instability in borderline personality disorder patients' everyday lives. Journal of Abnormal Psychology. 2017;126(8):1057-65.

39. Santangelo PS, Kockler TD, Zeitler ML, Knies R, Kleindienst N, Bohus M, et al. Self-esteem instability and affective instability in everyday life after remission from borderline personality disorder. Borderline Personality Disorder and Emotion Dysregulation. 2020;7(1).

40. De Bonis M, De Boeck P, Lida-Pulik H, Hourtané M, Féline A. Self-concept and mood: A comparative study between depressed patients with and without borderline personality disorder. Journal of Affective Disorders. 1998;48(2-3):191-7.

41. Evans D, Dalgleish T, Dudas RB, Denman C, Howard M, Dunn BD. Examining the Shared and Unique Features of Self-Concept Content and Structure in Borderline Personality Disorder and Depression. Cognitive Therapy and Research. 2015;39(5):613-26.

42. Vater A, Schröder-Abé M, Weißgerber S, Roepke S, Schütz A. Self-concept structure and borderline personality disorder: Evidence for negative compartmentalization. Journal of Behavior Therapy and Experimental Psychiatry. 2015;46:50-8.

43. Winter D, Steeb L, Herbert C, Sedikides C, Schmahl C, Bohus M, et al. Lower self-positivity and its association with self-esteem in women with borderline personality disorder. Behaviour Research and Therapy. 2018;109:84-93.

44. Collins AC, Winer ES. Self-Referential Processing and Depression: A Systematic Review and Meta-Analysis. Clinical Psychological Science. 2023.

45. Hedrick AN, Berlin HA. Implicit self-esteem in borderline personality and depersonalization disorder. Frontiers in Psychology. 2012;3(APR).

46. Vater A, Ritter K, Schröder-Abé M, Schütz A, Lammers CH, Bosson JK, et al. When grandiosity and vulnerability collide: Implicit and explicit self-esteem in patients with narcissistic personality disorder. Journal of Behavior Therapy and Experimental Psychiatry. 2013;44(1):37-47.

47. Clemente J, Gleeson JF, Lim MH. Cognitive Processes in Worry and Paranoia: Investigation of the Looming Cognitive Style. Journal of Experimental Psychopathology. 2013;4(4):303-14.

48. Freeman D, Stahl D, McManus S, Meltzer H, Brugha T, Wiles N, et al. Insomnia, worry, anxiety and depression as predictors of the occurrence and persistence of paranoid thinking. Social psychiatry and psychiatric epidemiology. 2012;47(8):1195-203.

49. Russell JJ, Moskowitz DS, Zuroff DC, Sookman D, Paris J. Stability and Variability of Affective Experience and Interpersonal Behavior in Borderline Personality Disorder. Journal of Abnormal Psychology. 2007;116(3):578-88.

50. Bouchard S, Sabourin S, Lussier Y, Villeneuve E. Relationship quality and stability in couples when one partner suffers from borderline personality disorder. Journal of Marital and Family Therapy. 2009;35(4):446-55.

51. Hooker CI, Tully LM, Verosky SC, Fisher M, Holland C, Vinogradov S. Can i trust you? Negative affective priming influences social judgments in schizophrenia. Journal of Abnormal Psychology. 2011;120(1):98-107.

52. Dudley R, Taylor P, Wickham S, Hutton P. Psychosis, Delusions and the "Jumping to Conclusions" Reasoning Bias: A Systematic Review and Meta-analysis. Schizophrenia Bulletin. 2016;42(3):652-65.

53. Bach B, Farrell JM. Schemas and modes in borderline personality disorder: The mistrustful, shameful, angry, impulsive, and unhappy child. Psychiatry Research. 2018;259(October 2017):323-9.

54. Dudley REJ, Over DE. People with delusions jump to conclusions: A theoretical account of research findings on the reasoning of people with delusions. Clinical Psychology and Psychotherapy. 2003;10(5):263-74.

55. Young JE. Cognitive therapy for personality disorders: A schema-focused approach. Exchange SPR, editor1990.

56. Teicher MH, Anderson CM, Polcari A. Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus,and subiculum. Proceedings of the National Academy of Sciences of the United States of America. 2012;109(9).

57. Laporte L, Paris J, Guttman H, Russell J. Psychopathology, childhood trauma, and personality traits in patients with borderline personality disorder and their sisters. Journal of Personality Disorders. 2011;25(4):448-62.

58. Humphrey C, Berry K, Degnan A, Bucci S. Childhood interpersonal trauma and paranoia in psychosis: The role of disorganised attachment and negative schema. Schizophrenia Research. 2022;241(February 2021):142-8.

59. Yen S, Shea MT, Battle CL. Traumatic Exposure and Posttraumatic Stress Disorder in Borderline, Schizotypal, Avoidant, and Obsessive-Compulsive Personality Disorders: Fingings From the. The Journal of …. 2002;190(8):510-8.

60. Spong AJ, Clare I, Galante J, Crawford MJ, Jones PB. Brief psychological interventions for borderline personality disorder. A systematic review and meta-analysis of randomised controlled trials. Clinical psychology review. 2021;83:

61. Paris, J. (2013). Stepped Care: An Alternative to Routine Extended Treatment for Patients With Borderline Personality Disorder. Psychiatric Services, 64(10), 1035–1037. https://doi.org/10.1176/appi.ps.201200451

62. National Institute for Health and Care Excellence. (2009). Borderline personality disorder: Recognition and management. In Clinical Guideline CG78.

63. Lam D, Poplavskaya, EV, Salkovskis, P, Hogg, L, Panting, H. An experimental investigation of the impact of personality disorder diagnosis on clinicians: can we see past the borderline? Behavioural and cognitive psychotherapy. 2016;44:361-373.

64. Gallop R, Wynn F. The difficult inpatient: identification and response by staff. Can J Psychiatry. 1987 Apr;32(3):211-5. doi: 10.1177/070674378703200310. PMID: 3567837.

Service Improvement Project

Exploring engagement in CBT treatment for South Asian older adults in Berkshire Talking Therapies

Eloise Prouten

Harris Manchester College

Thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Psychology

Word Count:

New word count: 5257

Trinity Term 2024

Internal Supervisor: Dr Reena Vohora

External Supervisors: Rani Griffiths & James Sahr-Momoh

Proposed journal: This report is intended for submission to Cultural Diversity and Ethnic Minority Psychology. This journal has been chosen due to its focus on promoting better service delivery through application of psychological knowledge on culture and ethnicity.

Abstract

Objectives: Berkshire Talking Therapies identified particularly low levels of engagement for older adult clients from a South Asian background in Step 3 CBT treatment. Aims were 1) to explore the experiences of South Asian older adults who had engaged in treatment with Berkshire Talking Therapies, and South Asian older adults who had not engaged, both from the perspective of clients and staff, 2) to provide recommendations to the service for improving engagement for this client group.

Methods: Quantitative data from twenty clients who engaged was analysed, and semi-structured interviews were carried out with ten clients; five who had engaged and five who had not. A focus group was conducted with four members of staff.

Results: A chi-squared analysis revealed that in clients who engaged, proportions significantly differed in presenting problem, discharge reason, and referral source. Thematic analysis revealed four key themes in clients who engaged such as social support and culture, and five key themes in clients who did not engage, such as barriers to engaging and views of talking therapy. Thematic analysis of staff responses revealed four key themes indicating frustrations with service processes, the need to be culturally sensitive, and consideration of stigma.

Conclusions: Recommendations to Berkshire Talking Therapies included up-skilling therapists, considering cultural differences from assessment stages, and providing an additional level of support when supporting clients to engage in treatment. Recommendations were fed-back to the senior leadership team and the Cultural and Ethnic Diversity workstream.

Keywords: South Asian, older adults, cognitive behavioural therapy (CBT), access, talking therap*

Public significance statement: Access to Talking Therapy for older adults from a South Asian background is lower than that of White British counterparts. Through interviewing staff and service users, this study identifies ways in which a Talking Therapies service can support clients from this demographic to engage in CBT treatment.

Introduction

Older adults from ethnic minority backgrounds

Older adults, defined as people aged 65+ years by NHS Talking Therapies services (previously known as Improving Access to Psychological Therapies), from ethnic minority backgrounds are reported to have a similar or higher prevalence of mental health difficulties as older adults from White British populations (Livingston & Sembhi, 2003) however are often underrepresented in mental health services (Veerbeek et al., 2013). Older adults from ethnic minority groups often face multiple layers of difficulty (Rawlings & Bains, 2020) including language insensitivity at referral stages, lack of value recognition, powerlessness, and a perceived threat to cultural identity (Wilson et al., 2009) when accessing services.

The cultural influences on mental health model

The cultural influences on mental health model (Hwang et al., 2007) (Appendix 2.1) states that cultural background can influence the aetiology of psychological distress and attitudes to treatment, with the underutilisation of mental health services by individuals from ethnic minority backgrounds potentially being due to culture-related economic barriers, and stigma. Regarding stigma, Ng (1997) found that in Asian culture, mental health difficulties not only reflected badly on the person who was unwell, but also resulted in diminished economic and marriage value for the family. Research supports this, finding that in Asian cultures, having a mental illness may reflect on the person's family, bring the family shame, and lead to judgements of person with mental health difficulties being aggressive or dangerous (Lauber & Rossler, 2007).

The British South Asian community

The most recent census data (CENSUS, 2021) indicates that the second highest ethnic group in the United Kingdom (UK) is 'Asian, Asian British or Asian Welsh' accounting for 9.3% of the UK population. In Berkshire specifically, the Asian community was found to be the largest minority group, accounting for 8.1% of the population. Concerningly, studies have consistently shown that South Asian (people whose cultural background originate from countries on the Indian subcontinent) communities not only underutilise mental health services (Prajapati & Liebling, 2022) but underutilise them more than other ethnic groups (Baker & Kirk-Wade, 2023).

A literature review exploring barriers to using services and experiences of help-seeking from the perspective of British South Asian clients found that being distanced from services, a dilemma of trust, and a threat to cultural identity may account for low engagement (Prajapati & Liebling, 2022). These difficulties may be exacerbated by the fact that services in the UK often adopt a 'one size fits all' model in which diagnoses can oversimplify complex sociocultural processes such as racial trauma and socioeconomic inequality (Prajapati & Liebling, 2022). Therefore, the voices of those from the South Asian community are at risk of being unheard or misunderstood.

Engagement in NHS Talking Therapies services for older adults from ethnic minority backgrounds

Research found that people over 65 years old, and from diverse ethnic communities were significantly underrepresented within NHS Talking Therapies services (Clark, 2011). Encouragingly, research indicates that although older adults from ethnic minority groups are less likely to present to services, when they do, recovery rates are higher compared to

younger adults from ethnic minority backgrounds (Prina et al., 2014). This emphasises the importance of supporting engagement for older adults from ethnic minority backgrounds, as treatment is effective, and recovery is possible.

The need to support engagement has been acknowledged. Positive practice guidance has been developed for NHS Talking Therapies services to address needs of older adults (BABCP, 2021) and similar recommendations have been made for service provision for diverse ethnic communities (Beck et al., 2019). However, it has been highlighted that ethnic minority groups are often treated as homogenous, leading to inappropriate generalisations, unmet needs, and unsuitable treatment (Rait & Burns, 1997), suggesting the need to consider sub-groups individually.

Potential facilitators to completing treatment for people from a South Asian background are suggested to include education about psychiatric illness, use of a medical model, use of creative treatment strategies, and sensitivity to cultural and religious beliefs (Rastogi et al., 2014). However, little is known about the specific needs of the older adult South Asian community. Better understanding may lead to specific, targeted improvements being made in services. More targeted improvements can serve the community better, facilitating greater engagement and improving outcomes.

Aims

Berkshire Talking Therapies offer evidence-based cognitive behavioural therapy (CBT) to adults over the age of 18 experiencing mild to moderate mental health difficulties. The service would like to improve engagement for marginalised groups and focus on individual sub-groups.

Preliminary analysis of quantitative data from Berkshire Talking Therapies indicated there is a lower rate of engagement for older adults from diverse ethnic backgrounds (i.e. attending fewer than two clinical sessions) and a greater rate of treatment drop-out. There may be difficulties with engagement with the service more generally however it is understood from conversations with service leads that only 13% of older adults from diverse ethnic backgrounds completed either CBT or counselling treatment compared to 38% White counterparts between October 2021 and February 2022. Completion of treatment was a mutually agreed end point between therapist and client. One group identified as having particularly low engagement rates compared to White counterparts were older adults from a South Asian (Indian/Pakistani/Bangladeshi/Tamil) background.

NHS Talking Therapies services execute a stepped care model (Appendix 2.2). Clients experiencing moderate to severe depression or anxiety disorders may be referred for treatment at Step 3. Treatment at this level involves a higher number, and longer duration of sessions.

Key questions:

1. What are the experiences of South Asian older adults who have completed at least one session of Step 3 CBT treatment and South Asian older adults who did not complete at least one session of treatment or assessment in Berkshire Talking Therapies a) from the perspective of clients and b) from the perspective of staff in the team?
2. What targeted improvements for supporting engagement, as defined by completing at least one Step 3 CBT session, can be suggested for an older adult South Asian population, and how can the service implement these?

Method

Design

A mixed-methods approach was taken. During phase 1, retrospective quantitative data from existing IAPTus databases was analysed using SPSS. During phase 2, a qualitative semi-structured interview was used to explore the experiences of clients. A qualitative semi-structured focus group interview was used to explore staff experiences of working with South Asian older adults within the service. Data collection took place between September 2022 and April 2023. During phase 3, recommendations were made to the service.

Equality, diversity, and inclusion service leads RG and JM-S were closely consulted with throughout the development of the project to ensure the project aligned with service aims. The project was approved by Berkshire Healthcare Research & Development department.

Inclusion criteria

Clients

All client participants were older adults (65+ years). In the group who engaged, participants were required to have participated in at least one Step 3 CBT session following psychological wellbeing practitioner (PWP) assessment in the service between April 2019 and December 2022 (as engaging in Step 3 was thought by service leads to indicate a high level of engagement). The group who did not engage were defined as clients who were referred to the service however declined treatment, did not attend, or were referred out of the service either prior to PWP assessment or after PWP assessment between April 2019 and December 2022. This period was chosen because this allowed for identification of clients who had experienced treatment both pre, during, and post-COVID. Specific experiences of the

pandemic were not focused on during interviews or the focus group. Information on whether clients received online, telephone, or face-to-face therapy was not collected.

Staff

Staff members were required to have worked therapeutically with at least one South Asian client, of any age.

Participants

LD (service research lead) and AS (assistant psychologist) collated potential participants using the IAPTus database according to the above inclusion criteria. LD and AS first contacted potential participants and used a study telephone script created by EP to invite participants to take part. An interview time with EP was arranged. A total of 10 clients took part in interviews; five who had engaged with the service and five who had not engaged with the service. An interpreting service used by the Trust was offered to participants who required interpreters however no clients indicated that they needed the interpreting service. Interview duration ranged from 15 to 40 minutes.

LD collated a list of clinicians who had worked with at least one South Asian client. EP emailed 15-20 clinicians to invite them to take part in the focus group. Four staff members (trainee CBT therapist, CBT therapist, counsellor, and PWP co-ordinator) took part in the focus group. The focus group lasted one hour.

Demographic data for clinicians and clients was not collected.

Procedure

Clients

Once interviews were booked, participants were sent the participant information sheet. All interviews took place remotely and were recorded using Microsoft Teams after obtaining consent. Participants were reminded of confidentiality and their right to withdraw until the point of transcription.

The interview schedule (Appendix 2.3) was developed following consultation with two people from ethnic minority backgrounds who had experience of therapy (one South Asian woman who had experience of therapy in Berkshire Talking Therapies and one Italian woman who had experience of CBT), research supervisors, and by considering previous literature.

The interview schedule was edited twice following consultation with supervisors RV, RG and JM-S.

Staff members

EP shared a participant information sheet and consent form with clinicians via email when inviting them to take part. Clinicians consented to the recording of the focus group via Microsoft Teams and were reminded of confidentiality and their right to withdraw until the point of transcription. The focus group schedule was developed following discussions with study supervisors.

Sample size

Group sizes facilitated rich, in-depth information data being collected and analysed, facilitating the emergence of targeted themes and enabling improvements to be recommended to the service.

Analysis

Inductive reflexive thematic analysis was deemed to be appropriate for analysis of both client interviews and staff focus group responses. Inductive reflexive thematic analysis was deemed to be appropriate for analysis of both client interviews and staff focus group responses because we aimed to understand the experiences of participants. We aimed to identify, analyse, and report on themes within the data. An alternative approach, interpretative phenomenological analysis (IPA) was not chosen as we chose to identify broader patterns across the data rather than focusing on the in-depth nuances and personal meaning of the data.Interviews and focus group responses were analysed separately. Although some research suggests facilitators of engagement for people from a South Asian community, and for people from ethnic minority backgrounds, this study looked at a particular group in a particular service. Therefore, a theoretical model was not held in mind throughout coding. Codes were derived purely from the data. This enabled participants' voices to be accurately heard without subjective bias interfering with coding or theme generation. EP completed data familiarisation, initial coding, and development of themes according to guidance (Braun & Clarke, 2022). RV read a section of transcripts from interviews and focus group responses to review codes. RV and EP collaborated to decide final themes for interviews and focus group responses.

This research did not receive any funding. There were no conflicts of interest, financial, personal, or other, in conducting this study.

Results

Phase 1 (Quantitative data analysis)

Twenty South Asian older adults completed at least one Step 3 CBT session between April 2019 and December 2022. For context, 7959 clients in total, 351 older adults, and 326 working age South Asian adults completed at least one Step 3 CBT session in the service between April 2019 and July 2022. Quantitative data from the twenty South Asian older adults who engaged in Step 3 CBT between April 2021 and December 2022 was analysed This sample size was used as there were only twenty South Asian older adults who had engaged in Step 3 CBT in this time frame. Data was analysed statistically to determine if there were statistically significant differences in proportions of variables within the group of people who engaged. This enabled us to contextualise the sample and better understand if there may be certain variables associated with engagement in the service for this group. A chi-square test goodness of fit test was used to determine how closely observed variable values matched expected variable values within the group. The proportion of older South Asian clients who engaged did not significantly differ by gender X^2 (1, N=20) = 1.800, p = .18 or religious group X^2 (4, N = 20) = 6.500, p=.16. However, clients who engaged differed by presenting problem X^2 (4, N=20) = 16.00, p=.003 with 11 out of the 20 clients who engaged being identified as ‘depressive episode’ as their presenting problem, which had been identified by clinicians. The group also significantly differed by discharge reason X^2 (4, N=20) = 16.000, p=.003 with 11 out of the 20 clients being marked as ‘completed treatment’ and referral source X^2 (2, N=20) = 6.100, p=.05 with 11 out of the 20 clients self-referring.

Phase 2 (Qualitative client interviews and staff focus group)

Thematic analysis was conducted for both client interviews and the staff focus group.

Staff focus group

Four themes and thirteen sub-themes were identified. The first theme (client factors) focused on individual differences such as being grateful for therapy, adopting a physical health lens, external factors, and the ability to understand language and therapy-specific terminology.

The second theme (community beliefs) focused on beliefs pertinent to the South Asian community. This included stigma and fear around experiencing mental health difficulties, the role of the family, and cultural factors and views of mental health. Staff noticed that clients often held different beliefs around what it means to experience mental health difficulties.

The third theme (service structure and format) identified aspects of the service which may impact client experiences. This included the use of CBT, practical limitations, and the use of interpreters within the service. Staff also expressed frustrations with time constraints and difficulties in being able to take more 'difficult' client cases to supervision due to an already high workload.

The final theme (therapist factors) looked at individual differences between therapists. For example. showing cultural sensitivity, flexibility and curiosity, and therapist's own fears and self-doubt. Staff reported they consistently used sensitive questioning around culture and noticed the positive impact this had on clients' experience. Themes and quotes are illustrated in Table 2.1 and Appendix 2.4.

Table 2.1. *Themes and quotes from the staff focus group*

Theme 1. Client Factors	
Sub-theme	**Example quotes**
1.1 Being grateful for therapy	One staff member reported that some clients acknowledged that the amount of mental health support offered to them in the UK is greater than what would be offered in their home country: *"she appreciates [it] because if [she] were in India, [she] would have none of this" (S1).* *"they're very grateful…" (S3).*
1.2 Adopting a physical health lens	Two staff members said that the way their client would describe their difficulties was by using physical health symptomology: *"…very physical. You know, my stomach hurts… I get pains in my head'… took a while to get around the idea that we're going to actually look at emotions…very focused on physical symptoms" (S3).* *"A lot of concepts are just foreign to her… she just medicalised things because that's what she's always done. And it's never been presented in any other way" (S1).*
1.3 External factors impacting therapy	Staff reported multiple external factors such as 'discrimination' (S4), 'insecure housing' (S3), 'trauma' (S3), 'abusive relationships' (S1), and bereavement as impacting attendance to and progress within therapy: *"Her dearly beloved son passed away and then her other son who's not the good son is not here and living… in India. And she's on her own." (S1)* *"She was in in insecure housing, she required food vouchers. She'd left her husband's family, so there was all the shame and stigma around that." (S3)* *"...but at the same time didn't seem to be much that we could actually physically change a lot of the things that were bringing them down or causing to be worried were outside of their control, not much ability to change that." (S3)*
1.4 Understanding language and terminology	Three staff members reflected that with older adults in particular, understanding language and nuances, was an additional barrier within

sessions:

“they struggle to understand the language we’re using in terms of terminology… and they also don’t speak English… really crucial elements that are going to make it really difficult to complete even a screening assessment” (S2)

“Especially… the older women…with a few it seems to be that they speak English really well. They understand it, but they don't particularly understand everything” (S4)

“they also don't understand from a language perspective and we're needing the interpreter for, and they're also an older adult, which means that for some older adults, you know, there's longer processing times” (S2)

Theme 2. Community Beliefs

2.1 Stigma and fear

There was a strong sense from staff that clients preferred to keep their mental health to themselves due to fear of judgement or of the potential consequences of speaking out:

“They seem to… keep their mental health quite private because of fear of losing face or shaming their family or being considered to be a dangerous mum.” (S3)

“These women that I've been speaking to, they are being alienated by their daughters and their sons because they're not complying or they've bucked the system in some way.” (S1)

“Just in terms of the view, the older fashioned view of what therapy is and like I shouldn’t be needing this and you know that may be in the way initially to start talking” (S1)

2.2 Role of the family

Two staff members reflected that the role of both immediate and extended family members enters conversations more during sessions:

Family and the wider social family… does tend to enter in the conversations more, even if we're treating something like OCD. (S3)

I've noticed I end up knowing a lot more about extended family… different aunts, views and opinions than I might do for somebody who was typically kind of British born identifying… of that age, of the older age. (S3)

2.3 Cultural factors and views of mental health	One staff member reflected that clients often haven't talked about their mental health difficulties before and often will not have the same words to describe mental health difficulties as the therapists: *"haven't traditionally kind of talked about those sorts of things within their culture. They might not even have words for some of the things we have words for…" (S2).* *"[in India] there's absolutely… no acknowledgement of kind of struggling with your mental health" (S1).* *"The way that mental health is viewed… often didn't match up with ours" (S3)*

Theme 3. Service structure and format

3.1 Talking Therapies	All staff members noticed barriers that the use of CBT brought when working with this client group: *'we struggled with goal setting and… CBT based things…' (S3),* *'working with CBT…we don't go really deep…you know, the impact that may be religion or other kind of backgrounds on their lives' (S4)* *Think I've had a few patients who've struggled with the concept of CBT. And maybe expected something a little bit different saw it more of a medical model. (S3)*
3.2 Practical limitations	All staff members reported time limitations and high workload impacted their work with adults from ethnically diverse backgrounds: *'a 40 minute PWP assessment isn't always long enough to really understand what is going on for someone…' (S2)* *'[bringing more complex clients to supervision] it's very difficult to 'yeah I think the assessment needed to be slower and longer because… I might immediately think oh that's stress'* *'to have another difficult client when… have a really heavy caseload…' (S4)*
3.3 Use of interpreters	All staff members agreed that they did not like using the current interpreting service. They all preferred the old interpreting service,

Mother Tongue compared to BigWord:

'it was a disaster…' (S3)

'… not good I do not enjoy it most of the time' (S1)

'especially if we don't have time to… chat with the translator before… it can be come very problematic very um messy' (S4).

Theme 4. Therapist factors

4.1 Cultural sensitivity and humility	All staff members emphasised the need for cultural competency when working with older adults from a South Asian background: *'the offer is always are you comfortable… with a male therapist and they seem to really appreciate that question…' (S3)* *'magnify the elephant and say… I'm obviously not Asian but how do you feel about working with me' (S1).*
4.2 Flexibility and curiosity	Flexibility and curiosity were highlighted by all staff as key qualities they have found helpful to show during sessions: *'especially at the beginning… in my experiences… needs to be… clear but with some flexibility' (S4)* *'…actually need to listen and explore… look at all the nuances… it might be something very much different that is just not understood in the same way… we need to be… open to hearing that difference which is easy to forget' (S3).*
4.3 Therapist fears and self-doubt	Three staff members reported that fear, pre-conceptions, and being reactive can result in therapist shying away from going above and beyond for clients from ethnically diverse backgrounds: *'unconsciously… affect how we work with these people… if we are aware that… this is gonna be more work… meaning the quality of treatment… does differ even sometimes without us knowing that we're doing it…' (S2)* *"And then there is an element of what is our background? White. Mostly. You know, how much do we know well it depends yeah it's different from every person how fearful are we you know to do or say the wrong thing" (S4)*

Clients who engaged in therapy

Responses from five clients who had engaged with Step 3 CBT within the service revealed four themes and fourteen sub-themes. The first theme (journey through therapy) looked at clients' initial expectations, the role they took in therapy, and reflections after therapy. Generally, clients had not known what to expect, took a proactive approach to therapy and two clients' opinion of therapy changed following treatment.

The second theme (the role of social support) encompassed two sub-themes; friends and family and being encouraged to go to therapy. Two clients reported family being a strong source of support. Four clients said they had been encouraged to go to therapy.

The third theme (the role of culture) revealed cultural factors. Sub-themes focused on the idea that 'you are not to talk to outsiders', the idea of not wanting to be seen as 'crazy', and language barriers. Although none of the clients interviewed required an interpreter, or reported struggling with understanding language during therapy, clients advocated for others who may not speak English fluently.

The fourth theme (experiences of therapy) found that feeling understood, service processes, feeling 'passed around', a preference for face-to-face therapy, and getting unstuck were all pertinent to clients. Both positive and negative therapy experiences were raised. Positive experiences focused on therapists being helpful and sympathetic and there was a sense that therapy had helped. However, clients had felt frustrated with service-specific requirements of therapy. There was a strong preference for face-to-face therapy. Themes and quotes are illustrated in Table 2.2 and Appendix 2.5.

Table 2.2 *Themes and quotes from clients who engaged in therapy*

Theme 1. Journey through therapy	
1.1 Being unsure what to expect	Two clients reported that they did not know anything about Talking Therapies before taking part: *'[I knew] nothing at all about talking therapies or whatever…' (E3)* *'I think that everybody not awareness for talking therapy' (E5). [did you know anything…] "no" (E1)* *'I was expecting quite a different go at it I thought it would be like a consultation one to one things like that' (E5)*
1.2 Taking an active role in therapy	Four out of the five clients interviewed reported taking a proactive approach to therapy. It was highlighted that it's important to take action yourself, and to only expect change if you work at it: *"I mean you have to work with it otherwise if you go and you don't do anything it won't work" (E1)* *"I took lots of decision myself when I was not feeling good" (E1)* *"they don't do everything for you you have to work on them" (E2)* *"therapy is such a thing that you can't take a pill it's not a tangible medicine you take a pill and the worries will go out it is something you have to work at it" (E4)*
1.3 Reflections on the experience of therapy	Two clients said that their attitudes towards talking therapy changed after receiving treatment. More specifically, one client said that they had not initially seen the benefit of therapy however realised the benefit once treatment ended: *'I didn't really think much of it… but afterwards I thought about it… then I could see the benefit' (E3).* *'before I started with the talking therapy… I honestly had a completely different opinion' (E4).*
Theme 2. The role of social support	
2.1 Friends and family	Two clients reported strong sources of support from either friends or family. Having other people to rely on and to speak to appeared to be

important:

"…support I've got my own family here like I said my younger daughter" (E3)

"so she helped me a lot and she arranged talking therapies for me…" (E5)

"if I needed anything I could ring him he could ring me and we could just go" (E3)

"…younger daughter, I got niece, I had good friends so it was a positive environment so I was able to go forward" (E3)

2.3 Being encouraged to go to therapy

Having been encouraged to go to therapy by either a GP, friends, or family was reported by four out of the five clients interviewed. Often family members who encouraged the client had knowledge and a positive view of therapy:

'my husband said you want to go I will go so he went to it and he went a couple of times and he told me look I am okay' (E1)

yeah GP they said look you go to these things…' (E3)

'…my daughter pushed me a lot so I went' (E5)

Theme 3. The role of culture

3.1 'You are not to talk to outsiders'

When asked about culture, three out of five clients felt that in their culture, people tended to keep things like mental health difficulties to themselves. Trust was highlighted as being important:

'people tend to keep to themselves… it just bottles up (E2).

'in our culture you are not to talk to outsiders...' (E2)

'you don't know who's door you're going to knock (E2)

'it's building up the trust' (E4).

3.2 Not wanting to be seen as 'crazy'

Three clients reflected on the stigma which exists around experiencing mental health difficulties in their culture:

'it used to be a taboo of not feeling you can share with it…' (E4)

'this is kind of thing we don't discuss amongst friends I would not tell me friends I'm going to talking therapy or I'm suffering from depression' (E4)

'it was that this is a load of hocus pocus but the term I used was

that they're a bunch of nutters' (E3)
'I got a friend of mine they said are you crazy' (E3)
people will say I'm not going mad why should I go and see that people' (E1)

3.3 Language barriers

Although the clients who took part in the interviews did not report experiencing language barriers themselves, two clients reflected that taking part in therapy would be more difficult if someone had not been able to speak English fluently:

'they would struggle to understand… so they would need people who speak and understand their own language' (E4)
'certain things language is a problem so you can help the therapist understand the client more effectively' (E2)

Theme 4. Experiences of therapy

4.1 Feeling understood

Helpful factors in therapy included the therapist being sympathetic and mature. One client reported that the therapist's ability to focus on just a couple of points was helpful. However this client also reported an experience where they had felt misunderstood, where a 'cultural issue' had been assumed by their therapist:

'she was sympathetic and because she was mature she was a director quite high up' (E4)
"she tried to zoom on a couple of points because they're foundational I've now discovered there are foundational therapy points" (E4)
she asked they thought I had more cultural issues and I was a bit annoyed because you know it wasn't a cultural issue' (E4)

4.2 Service processes

One client gave a lot of feedback regarding frustrations around the requirements of the service in terms of administrative paperwork, time limitations, and homework given during sessions:

"thought it was a lot of admin and [inaudible] and they use some forms and I think that forms are more compliance they use three kinds of compliance forms where you have the score of that was kind of superficial" (E4)

"I didn't find a very customised one to one it was a very much you know one kind of advice fits all" (E4)

"he's only got about 10 minutes to say his problem but I think they're still using some outdated information that's my concern" (E4)

4.3 Feeling 'passed around'

Lack of continuity between therapists at different stages of the process was reported as being a problem. This was a strong theme for one client and led to them feeling 'passed around' from one person to the next:

"it becomes a bit of a marathon where the baton is being passed one person to another so my strong feedback is that it should be the same person because firstly youre dealing with somebody who's got a mental problem" (E4).

"I felt they were passing me round the block" (E4)

"…first person talk to then he passes you to another person then that person might pass you to another person" (E4)

4.4 Preference for face-to-face therapy

Online therapy was highlighted as being less preferable than face to face therapy by two clients. This was seen as particularly important for people who were more socially isolated:

'it was okay but it's not the same as when you're seeing dace to face' (E1).

If you're not seeing friends nobody coming in the house like me just now it's nice sometime I can go sometime I can't go if somebody can come and see and talk about things that are happening that helps as well maybe not talking therapy' (E1)

it would have been better if it was one to one you know over videos calls but that's [inaudible] circumstances' (E2)

4.5 Getting unstuck

Three out of the five clients interviewed said that therapy had been helpful. One client reflected on therapy helping them to move forward:

"the benefit of doing this just to get your mind going forward because you're stuck in a rut or whatever to make the change happen' (E3)"

"after five six sessions I was feeling much much better' (E5)

	the whole point of therapy was to get your forward from the point you were stuck in the rut the mental cloudiness and you could go forward" (E3) *"once I got it we had regular weekly meetings over video calls so that was to put my mind at rest she gave me ideas" (E2)*

Clients who did not engage

Responses from five clients who did not engage revealed five themes and thirteen sub-themes. The first theme (social factors) identified social support, being encouraged to go to therapy, and feeling isolated as important social factors. Some clients had found alternative ways to cope, through friends or family. Most clients had been encouraged to go to therapy. Three clients reported a strong sense of social isolation.

The second theme (views of talking therapy) encompassed expectations and stigma. Clients had a range of expectations regarding talking therapy. They reported taboo surrounding talking about mental health difficulties in the Asian culture. One client said that they didn't believe in therapy and emphasised the role of community support instead.

The third theme (experience of talking therapy) focused on client experiences. Sub-themes included frustrations with service processes, helpful experiences, and unhelpful experiences. There were frustrations with the lengthy process of starting therapy. Two clients felt that no-one at the service cared and one reported being laughed at by a therapist. Helpful experiences included positive experiences with therapists such as finding their conversation 'comfortable' and describing the therapist as a 'nice person'.

The fourth theme (barriers to engaging in therapy) focused on barriers. The first sub-theme was language. One client reported trying to understand, however declined the interpreting

service offered. The second sub-theme was situational factors. Situations making attending therapy difficult included bereavement, being housebound, and being a full-time carer.

The fifth theme (hopes for therapy) focused on clients' hopes for therapy, with sub-themes of a preference for face-to-face therapy, having a therapist from a similar background, and additional support. Clients thought that face-to-face therapy would be better than online therapy. Two clients spoke about the value in having a therapist from a similar background. Two clients would have liked clinicians to follow-up with them more. Themes and quotes are illustrated in Table 3.2 and Appendix 2.6.

Table 2.3. *Themes and sub-themes from clients who didn't engage in therapy*

Theme 1. Social factors	
1.1 Social support	Two out of the four clients interviewed reported seeking support from either friends or family. One client reported that walking and talking with her friends every day helped in her healing: *"And I never went after that because I always believed in my friends and family so that's what I did" (NE3)* *"my husband helps me a lot" (NE4)* *"…I always out with my friends walking and talking about my husband and I think that healed me quite a lot" (NE3)*
1.2 Being encouraged to go to therapy	Two out of the four clients had been encouraged to go to therapy: *"my daughter wanted me to go see the GP about this" (NE1)* *"this psychologist definitely wanted me to see a therapist because I cry" (NE3)* *"GP wanted it" (NE3)* *"my son and my daughter he went on to me mum you need counselling…" (NE3)*
1.3 Feeling isolated	Three clients spoke about the lack of social support in their lives. They described being isolated from others and being unable to speak with

family:

"family who didn't want to talk to me" (NE5)

"Nobody wants to help each other out they're all on their own…"

"My family don't want to talk to me anymore" (NE1)

"…unfortunately in my case I don't have any family you know so that's why I did (NE2)"

Theme 2. Views of talking therapy

2.1 Expectations of therapy

Three clients did not know what to expect from talking therapy. Two clients reported knowing a small amount about what to expect:

"I thought they're helping people if you've got a problem they talk to you" (NE4)

'[they think] nobody will listen to them' (NE5)

'[I knew] nothing at all' (NE5)

'I knew nothing nothing I don't really feel like I know they do anything' (NE2)

"…that they'd give you some suggestions with how to deal with problems but you didn't fully" (NE2)

2.2 Stigma

Two clients spoke about the taboo that exists within their culture about experiencing mental health difficulties:

"I don't believe in therapy because I think you can get a lot of help from talking to friends as Asians we always have" (NE3)

"you know the Asian culture is you know its like a taboo going to therapist or something mentally ill and all that thing but I felt I'm not mentally ill I wanted to get help to recover from my grievances" (NE3)

"they're too scared and too embarrassed to talk about it" (NE5)

"I was never interesting in those things to sit there and telling I don't know who just sitting there" (NE3)

Theme 3. Experiences of talking therapy

3.1 Frustrations with service processes

One client reported that there were some frustrating aspects of engaging with the service:

'doctor asks for talking therapy why can't get the same records

look at them first look at [inaudible] stop there and this is [inaudible] and that's why Asian people give up' (NE5)

'they only give you 6 and then they disappeared then I have to cry and beg from my doctor to beg him' (NE5)

'that's why Asian people give up that's why they don't bother they just say it's a waste of time that puts people off' (NE5)

'Their timing is so so slow' (NE5)

3.2 Unhelpful experiences

Two clients reported unhelpful experiences when engaging with talking therapies. Two clients didn't feel cared for by the service.

'I'm not saying the therapist bad to me but they could have given my a ring a couple of days later nobody ever bothered' (NE3)

"they should come home talk to me what they can do for me or give place for me" (NE4)

'Nobody cared' (NE3)

'I didn't get any help or she didn't say to me don't go like that or never bothered that person to ring me back one day just wanted to say lets have a talk' (NE3)

"… he didn't believe me so that was the end of the story so I told them I didn't want talking therapies anymore" (NE2)

3.4 Helpful experiences

Two clients reported positive experiences with talking therapies:

"when I was there I found it very comfortable I really did and I thought that's made me come out then I thought well I might as well start telling the truth" (NE5)

"Yeah last time I went to talking therapy they did help me a lot" (NE5)

"The manager from last time who was in talking therapy was a nice person and was trying to help me out" (NE2)

Theme 4. Barriers to engaging with therapy

4.1 Language

One client highlighted that language was sometimes difficult, however did not want to use an interpreter during sessions as they believed that they were better off themselves:

'that is a bit difficult yeah I try my best [inaudible] problem my

English but the problem sometimes my English maybe you cant understand what I'm saying or what people mean' (NE1)

'They did offer me [an interpreter]… think myself is better' (NE1)

4.2 Situational factors

Bereavement, being housebound, and being a full-time carer were all raised as external factors which impacted clients' ability to attend and engage with therapy

'Full time carer so that's why I was a full time carer for him and nobody else so that's why I couldn't concentrate on other things' (NE2)

'I was housebound looking after my husband…" (NE2)

"community yeah who don't know me much don't understand my situation my feeling" (NE4)

"my wife passed away and ive got no one in the house" (NE1)

Theme 5. Hopes for therapy

5.1 Preference for face to face

When asked about improvements, three clients suggested that face to face therapy, through visiting people in their homes or meeting in a clinic, would be better:

'it will only improve if I have to see somebody face to face' (NE1)

it could be better if we are much face to face my place or wherever your clinic rather than just the phone' (NE2)

"they should come home talk to me what they can do for me" (NE4)

5.2 Having a therapist from a similar background

Two clients spoke about the value of having an Asian therapist. There was a sense that an Asian therapist would better understand Asian clients compared to an English therapist:

"even if they have 6 Asian people in one group then the lady the counsellor should be Asian and only Asian and then they all speak up… lady she's listening and she's writing down and let everyone else know where you been coming from we've all been to the same place" (NE3)

"but if you have English counsellor they won't know what

	they're talking about" (NE5)
5.3 Additional level of support	Two clients felt that they would have liked the service to follow up with them more after they had disengaged from talking therapies: *'maybe they could have rang me or even if they ring me one day that day ask me do I want o have a talk again that could have been better but nobody did anything' (NE3)* *'helpful they should tell me the nearest place from where I live so I can [inaudible] or give me that number or tell them to call me that's help' (NE4)*

Phase 3

Themes and sub-themes were used to develop recommendations for the service. Findings were presented to the senior leadership team and the Cultural and Ethnic Diversity workstream in Berkshire Talking Therapies in July 2023. Key findings and subsequent recommendations made to the service can be found in Table 2.4.

Discussion

This project aimed to aim to explore the experiences of South Asian older adults who had engaged in assessment and treatment with Berkshire Talking Therapies, and the experiences of South Asian older adults who had not engaged in treatment, from both the perspective of clients and staff. The project aimed to provide targeted improvements for supporting engagement for South Asian older adults in the service.

Similarities

Although interview data was analysed separately, comparison of themes across client groups

revealed key similarities. Both client groups spoke about a sense of perceived stigma around experiencing mental health difficulties. Both client groups had been encouraged to go to therapy, reported helpful experiences when they engaged with the service, and had not known what to expect. Staff also felt that clients had not known what to expect when therapy began.

Both client groups reported frustrations with service processes and some reported unhelpful therapy experiences. Staff spoke about practical frustrations such as lack of time, high workload, and spoke to language barriers when engaging clients. They felt the interpreting service currently used posed a barrier to providing good quality therapy to clients who required an interpreter. One client who engaged felt frustrated at the administrative tasks and the time that completing this took away from therapy. Nearly all clients expressed a strong preference for the return of face-to-face therapy. One client who didn't engage was disappointed that they had only been offered six sessions and said they had to beg their GP to be offered more, suggesting a need for mental health support, and a willingness to engage (Prina et al., 2014). This highlights the limitations of the service in terms of the number of sessions offered.

The idea of not wanting to appear 'crazy' was highlighted by both client groups and staff. Previous literature highlights the attribution of stigma to mental illness in the South Asian community (Anand & Cochrane, 2005). People from an Asian culture may also believe that mental illness is a punishment form God (Fogel & Ford, 2005). In the group who engaged, there was a sense that 'you're not to talk to outsiders', and building up trust with the therapist was important. In the group who did not engage, fear of what others may think was highlighted which may have influenced how clients felt about speaking about their difficulties. As both client groups reported these ideas, this may not be a barrier strong enough in itself to prevent engagement.

In terms of help seeking, research highlights that British South Asians may prefer to seek support from a family member or someone from their social network rather than from mental health professionals (Sheikh & Furnham, 2000). Research also found that alternative ways of coping for South Asian women included crying and talking to others (Hussain & Cochrane, 2002), which one client in the current study reported had helped her to heal. Both client groups reported that in the South Asian culture, people would usually seek help from family members. Both groups had been encouraged to go to therapy by others, particularly by younger family members. More people in the group who engaged group reported this than in the group who did not engage, suggesting that this may be a facilitator to engagement.

Differences between groups

The role of family and friends was important in both groups, but for different reasons. Clients who engaged with therapy reported higher levels of social support and had more contact with friends and family. Clients who did not engage reported greater social isolation, bereavement, and loss of contact with family. Language barriers were highlighted in both client groups however the group who did not engage reported more difficulties with understanding, supporting the cultural influences on mental health model (Hwang et al., 2007), which states that limited availability of services available in a native language may be a barrier to engagement. Clients who engaged in therapy appeared to take an active role in the therapy process, through completing homework tasks and utilising techniques. Clients who did not engage would have appreciated an additional level of support in beginning stages of their engagement, such as more follow-up phone calls after their first contact. The lack of this made them feel as though ‘no one cared’.

Considering the strong evidence base for improved outcomes following CBT treatment in NHS Talking Therapies services (Saunders et al., 2020), it is understandable that clients who were able to engage in treatment reported more positive outcomes. It is important to consider here how the service may be able to support engagement and indeed, previous research has shown that high attendance, being more adherent to completing homework, and high CBT commitment predicted better outcomes in CBT (Glenn et al., 2013).

Staff spoke about self-doubts when working with clients from diverse ethnic communities. Staff felt confused when clients would describe symptoms as physical symptoms indicating training may be needed. Rastogi et al (2014) found that utilising a more medical model facilitated treatment completion for people from a South Asian background. Additionally, previous research has shown that some non-Western cultures may express emotions in ways that view the mind and body as one, whereas Westerners are more likely to focus on the mind and body as separate entities (Ryder et al., 2002). Staff therefore emphasised the need for a skilled and culturally sensitive therapist.

Another key difference between client groups was the impact of external factors. In the group who did not engage, more external factors impacting engagement were reported. One client had no time to engage due to being a full-time carer for her husband. Another client reported being housebound. This may have impacted how proactive this group were able to be in terms of attendance and adherence.

Considering overlaps in themes between groups, it is important to consider that a desire for having a therapist from a similar background to themselves came up only in the group of clients who did not engage. One client who didn’t engage highlighted that having an Asian therapist would understand Asian clients more than a White British therapist, supporting the

cultural influences on mental health model (Hwang et al., 2007) which states that a lack of representation in mental health professionals may act as a barrier to engagement.

Strengths and limitations

Due to the small sample size, findings may not be relevant to every South Asian older adult accessing the service. It is also possible that there was selection bias in the sample. Considering that for half of the client sample, the target population were people who did not engage, it is possible that clients less likely to engage may not have expressed interest in participating. It is possible that information regarding reasons not to engage were therefore not captured by our sample. Clients who did take part may have done so due to having particularly strong feelings about the service. Further research is needed to better determine the needs of older adult South Asian clients more generally. Staff were invited by email to participate. It is possible that staff who were more interested in work with diverse ethnic communities took part. This study was unable to only recruit staff members who had worked with older adults from a South Asian background, as this may have led to lower recruitment rates for the staff focus group. As not every staff member was required to have worked specifically with older adults from a South Asian background, it is possible that information relating to engagement in terms of age and generation was not collected. Additionally, despite many attempts by LD, AS and EP, researchers were unable to recruit clients who required interpreters. These clients were harder to get hold of, typically left until last to be contacted, and were less likely to participate when contacted. Therefore, relevant perspectives of staff and clients may have been missed.

Further limitations relate to the choice of qualitative analysis given small sample sizes across groups. A sample size of six to ten is recommended for small-scale research when using

thematic analysis (Braun & Clarke, 2022). A systematic review by Hennink & Kaiser (2022) found that concluded that a small sample size for saturation in interviews is 9-17. Given our small sample size in interviews, it is possible that saturation was not reached. Being unable to reach saturation can impact on the quality of the study (Fusch & Ness, 2015).

Quantitative data showed a clear discrepancy between the number of South Asian adults who engaged with therapy, and the number of South Asian older adults who engaged with therapy, showing the clinical need to investigate engagement for this group. However, the findings from the quantitative data analysis must also be generalised with caution due to the small sample size. A small sample size means that the results of the quantitative analysis may not be representative of all South Asian older adults in the service. Further, the effect of outliers may have had an undue influence on the results of the statistical analyses given the small sample size. It may have been more appropriate to present descriptive statistics, showing effects and confidence intervals, in place of statistical analysis.

Considering the time frame chosen included the COVID pandemic, in which services were affected, it is possible that this had a confounding impact on data collected. Mateescu (2021) found that impacts of the pandemic on therapy included a lack of intimacy, lack of concentration, and negative impact of screen-mediated interaction, in which interpretation of visual cues from both therapist and client was distorted. Therefore, it is possible that some of the themes derived in our study were exacerbated by the impact of the pandemic. For example, the preference for face to face therapy and non-digital approaches was strong throughout client interview and staff focus group. Therefore, we may have picked up on some issues relating to issues of therapy delivery during the pandemic, rather than issues of delivery due to a lack of sensitivity of the needs of South Asian older adults.

The study had some clear strengths. Service leads were involved in the development of the study, interview schedules and telephone scripts. Interview schedules were also developed in consultation with people with lived experience of therapy. Qualitative analysis adhered to guidance on conducting thematic analyses with frequent meetings held with RV to discuss and review themes (RV is from a South Asian background). The study also contributes to the limited research around the needs of South Asian older adults, a group who experience mental health difficulties however are often under-represented in services (Veerbeek et al., 2013). Interviewing clients who engaged and clients who did not engage enabled comparison of similarities and differences between the groups. Learning that there were core similarities between the groups enabled researchers to target differences as being potential facilitators to engagement.

Service improvement recommendations

Table 2.4. *Key findings and corresponding recommendations for Berkshire Talking Therapies based on client and staff responses.*

Group	Key finding	Recommendation
Clients	Clients were unsure what to expect from therapy.	Whilst resources describing Talking Therapies and CBT are available on the service website, for this client group we may need to consider that digital access is limited and there is a clear preference for non-digital approaches. Therefore, written materials should be available. Written materials should also be considered in other languages for this group. Therapists should provide extra time at the beginning of appointments with this client group to explain what to expect from therapy and explore expectations of therapy.
	Clients highlighted that in their culture, talking to outsiders and sharing information about experiencing mental health difficulties can be a source of concern in regards	In the beginning stages of engaging clients, therapists should explicitly speak with clients about normalising mental health difficulties across age and culture. Space should be given at the beginning of the

	to stigma and judgement.	assessment to ask clients how they feel about speaking about their mental health difficulties and in particular speaking to someone who is an 'outsider'. Issues around confidentiality may be more important for this client group due to views around mental health difficulties being taboo. Outreach community work would be helpful to normalise mental health difficulties within the South Asian community.
	Clients expressed a strong preference for face-to-face therapy. Clients expressed a desire for clinicians to come to their home. Due to circumstances (being a full-time carer, being housebound) it may be difficult for clients to meet clinicians in clinic.	Whilst clients would prefer therapy in their own homes, a move towards move community-based settings may help engagement. Additional consideration around other services that may be able to provide some home-based support should be given.
	Clients felt that they hadn't been cared for by the service and would have preferred the therapist to call them back after the initial phone call. Clients felt frustrated at the lack of continuity between therapists in the beginning stages of engaging with the service.	To engage this client group better, follow-ups after the initial assessment should be conducted, ideally by the same therapist, to allow for continuity and to help these clients better engage with the service. These phone calls could be used to explore client expectations, and views around speaking about mental health difficulties, as mentioned above.
	Clients reported situational factors, such as bereavement, being housebound, and being a full-time carer which made it more difficult to go to therapy.	Therapists to be encouraged to take cases where attendance is a problem to supervision and reflect on barriers that may be present. It may be helpful for staff to ask clients directly about barriers to engaging, and for adaptations to be made where possible. The service should link in with practical support services to support with difficult situational factors.
	Clients who engaged had a higher level of social support around them.	Reach out to support systems and community organisations to raise awareness of the service through outreach and engagement work. For this client group, linking in with clients' families and support systems to aid engagement in therapy, particularly for those who have smaller support systems may help clients engage. For example, inviting family members into the therapy space for additional support.

	Clients advocated for those who may struggle to understand English, stating that therapy would be harder for these clients.	Therapists to be vigilant in offering the interpreting service, and to consider barriers to clients' using it, for examples issues of confidentiality and fear that the interpreter may know them or their family.
Staff	Staff highlighted that clients may present to therapy describing symptoms in a physical way. Staff felt self-doubt when working with older clients from a South Asian background.	Staff could receive supervision or training to be made aware of the differences in how older adult South Asian clients may describe their symptoms. Therapists have generally been taught to elicit symptoms using a Western perspective. The service could liaise with a university course regarding teaching therapists how to recognise symptomology from early stages from different cultural perspectives. The service should utilise in-service skills training around language used and presentation differences for this group of clients, for example the use of a medical model.
	Staff shared their success in engaging South Asian clients through taking a culturally sensitive and curious approach to therapy.	Cultural considerations to be made when working with older adult South Asian clients. For example, ask clients how they feel about speaking about their mental health difficulties with someone who is not from a similar background to them. Male therapists could ask female clients if they are comfortable working with them. It would be helpful to ask clients this at assessment stages. Therapists should share their learning and reflections on building trust and rapport with this client group in a shared space (e.g, specialist supervision groups).
	Staff spoke about not having enough time to take more complex cases, where adaptation may be required, to supervision. Staff expressed self-doubt when working with this client group. Staff reported that clients had often been through very difference experiences to themselves.	An additional specialist drop-in supervision space should be set up in the service. This should focus on engaging, adapting, reflecting, and shared learning when working with this client group. Adaptations may include greater support with completing homework tasks in between sessions. Making adaptations is important because better adherence to homework tasks and therapy in general results in more improved outcomes for clients.

Raising confidence in working with this client group, therapists should look at clients individually, with formulation driven treatment used to guide treatment, rather than personal experience.

Service response

Findings and recommendations were fed-back to the senior leadership team and the Cultural and Ethnic Diversity workstream in Berkshire Talking Therapies in July 2023. Service managers agreed the that recommendations were relevant and began liaising with the older adults workstream regarding implementations.

Acknowledgements

The authors thank study participants and members of public and patient involvement. The authors also Louisa Dosanjh and Alisha Saadiya for their huge help with recruitment. EP was supported by funding for professional clinical psychology training by Oxford Health NHS Foundation Trust.

References

Anand, A. S., & Cochrane, R. (2005). The Mental Health Status of South Asian Women in Britain: A Review of the UK Literature. Psychology and Developing Societies, 17(2), 195-214. doi:10.1177/097133360501700207

Babcp. (2021). Improving Access to Psychological Therapy (IAPT) Positive Practice Guide Older People (2021).

Baker, C., & Kirk-Wade, E. (2023). Mental health statistics: prevalence, services and funding in England. (March).

BecK, A., Naz, S., Brooks, M., & Jankowska, M. (2019). Improving Access to Psychological Therapies (IAPT). Black, Asian and Minority Ethnic Service User Positive Practice Guide 2019. The British Association for Behavioural and Cognitive Psychotherapies, 52-52.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. doi:10.3109/09540261.2011.606803

Fogel, J., & Ford, D. E. (2005). Stigma beliefs of Asian Americans with depression in an internet sample. Canadian Journal of Psychiatry, 50(8), 470-478. doi:10.1177/070674370505000807

Fusch, P., & Ness, L. (2015). Are we there yet? Data saturation in qualitative research. The Qualitative Report, 20(9), 1408-1416. doi: 10.46743/2160-3715/2015.2281

Glenn, D., Golinelli, D., Rose, R. D., Roy-Byrne, P., Stein, M. B., Sullivan, G., . . . Craske, M. G. (2013). Who gets the most out of cognitive behavioral therapy for anxiety disorders? The role of treatment dose and patient engagement. Journal of Consulting and Clinical Psychology, 81(4), 639-649. doi:10.1037/a0033403

Hussain, F. A., & Cochrane, R. (2002). Depression in South Asian women: Asian women's beliefs on causes and cures. Mental Health, Religion and Culture, 5(3), 285-311. doi:10.1080/13674670210130036

Hwang, W.-C., Myers, H. F., Abe-Kim, J., & Ting, J. Y. (2007). A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model. doi:10.1016/j.cpr.2007.05.001

Kleinman, A. M. (1977). Depression, somatization and the "New Cross-Cultural Psychiatry". Social science and medicine, 11(1), 3-9. doi:10.1016/0037-7856(77)90138-x

Lauber, C., & Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. International Review of Psychiatry, 19(2), 157-178. doi:10.1080/09540260701278903

Livingston, G., & Sembhi, S. (2003). Mental health of the ageing immigrant population. Advances in Psychiatric Treatment, 9(1), 31-37. doi:10.1192/apt.9.1.31

Mateescu, V.M. (2021). Distance and boundaries issues in the transition from face-to-face talking therapy to online therapy in the time of COVID-19. Sociologia, 66(2). 113-123. doi: 10.2478/subbs-2021-0010

Ng, C. H. (1997). The stigma of mental illness in Asian cultures. Australian and New Zealand Journal of Psychiatry, 31(3), 382-390. doi:10.3109/00048679709073848

Office for National Statistics. (2022). Ethnic group, England and Wales: Census 2021. ONS website, 1-9. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021

Prajapati, R., & Liebling, H. (2022). Accessing Mental Health Services: a Systematic Review and Meta-ethnography of the Experiences of South Asian Service Users in the UK. Journal of Racial and Ethnic Health Disparities, 9(2), 598-619. doi:10.1007/s40615-021-00993-x

Prina, A. M., Marioni, R. E., Hammond, G. C., Jones, P. B., Brayne, C., & Dening, T. (2014). Improving access to psychological therapies and older people: Findings from the Eastern Region. doi:10.1016/j.brat.2014.03.008

Rait, G., & Burns, A. (1997). Appreciating background and culture: The south Asian elderly and mental health. International Journal of Geriatric Psychiatry, 12(10), 973-977. doi:10.1002/(SICI)1099-1166(199710)12:10<973::AID-GPS686>3.0.CO;2-M

Rastogi, P., Khushalani, S., Dhawan, S., Goga, J., Hemanth, N., Kosi, R., . . . Rao, V. (2014). Understanding clinician perception of common presentations in South Asians seeking mental health treatment and determining barriers and facilitators to treatment. Asian Journal of Psychiatry, 7(1), 15-21. doi:10.1016/j.ajp.2013.09.005

Rawlings, G. H., & Bains, M. (2020). Experiences of depression in older adults from non-white and ethnic minority groups: A thematic synthesis of qualitative studies. Journal of Affective Disorders, 266, 341-348. doi:10.1016/J.JAD.2020.01.165

Ryder, A. G., Yang, J., & Heine, S. J. (2002). Somatization vs. Psychologization of Emotional Distress: A Paradigmatic Example of Cultural Psychopathology. Health/Clinical Psychology and Culture, 10(2). doi:https://doi.org/10.9707/2307-0919.1080

Saunders, R., Cape, J., Leibowitz, J., Aguirre, E., Jena, R., Cirkovic, M., . . . Buckman, J. E. J. (2020). Improvement in IAPT outcomes over time: Are they driven by changes in clinical practice? Cognitive Behaviour Therapist, 13, 1-15. doi:10.1017/S1754470X20000173

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. Social Psychiatry and Psychiatric Epidemiology, 35(7), 326-334. doi:10.1007/s001270050246

J.A. Smith, P. Flower and M. Larkin (2009), Interpretative Phenomenological Analysis: Theory, Method and Research.: London: Sage. Qualitative Research in Psychology, 6(4), 346–347. https://doi.org/10.1080/14780880903340091Veerbeek, M., Oude Voshaar, R., Depla, M., & Pot, A. M. (2013). Mental health care Monitor Older adults (MEMO): monitoring patient characteristics and outcome in Dutch mental health services for older adults. doi:10.1002/mpr.1386

Wilson, M., Ramsden, S., & Clark, M. (2009). Mental Health in England: The importance of pathways. International Review of Psychiatry, 21(5), 427-429. doi:10.1080/09540260802211043

Theory Driven Research Project

“Jumping to conclusions” in the context of personality disorder: comparison with psychosis and general population groups

Eloise Prouten

Harris Manchester College

Thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Psychology

Word Count: 4895

New word count: 5500

Trinity Term 2024

Internal Supervisor: Lorna Hogg

External Supervisors: Dr Stephanie Capon

Proposed journal: This report is intended for submission to Personality Disorders: Theory, Research, and Treatment. This journal has been chosen due to its focus on research on personality disorder and related psychopathology.

Abstract

Paranoia is the unfounded belief that others intend to cause you harm. Associated causal mechanisms in the occurrence of paranoia have been well researched in psychosis, however, less so in personality disorder (PD). The cognitive model of paranoia suggests that one reasoning bias involved in the occurrence of paranoid thoughts is “jumping to conclusions” (JTC). This study applies the cognitive model of paranoia to people with PD to examine whether people experiencing paranoia in PD ‘jump to conclusions’ more than a general population group, or a group experiencing paranoia in psychosis. Three groups; people experiencing paranoia in psychosis, people experiencing paranoia in PD, and a general population group were assessed for JTC using the ‘beads task’. Participants in clinical groups were screened using the R-GPTS for current paranoia. A one-way Kruskal-Wallis test showed significant differences on the beads task between groups. The PD and psychosis groups drew

significantly fewer beads the general population group. There were no significant differences in JTC between the two clinical groups. State paranoia was significantly associated with JTC. Results suggest that the mechanism of JTC may be transdiagnostic and could be applied to people experiencing paranoia in PD. Limitations and areas for future research are discussed.

Keywords: personality disorder, paranoia, psychosis, jumping to conclusions, reasoning bias*

Introduction

Paranoia can be broadly defined as the belief that others intend to cause you (Freeman, 2016) It can be a distressing experience (Startup et al., 2007) associated with negative self-beliefs (Tiernan et al., 2014), feelings of inferior social rank (Freeman et al., 2005), and lower levels of well-being (Garety & Freeman, 2013). Previous literature has established that paranoia is a key feature of psychosis (Garety & Freeman, 2013) and can be seen as a spectrum experience and divided into ideas of reference, and ideas of persecution (Freeman et al., 2019). Persecutory ideas, worries that others are out to get you may range from ‘my neighbours are spreading rumours about me.’ to ‘an evil spirit is out to get me’ (Freeman et al., 2001). Persecutory delusions lie at the most severe end of the paranoia spectrum (Freeman et al., 2019). Understandably, people experiencing paranoia become wary of the outside world and consequently experience difficulties leaving the home (Freeman et al., 2019) and loneliness (Lamster et al., 2017), leading to feelings of social exclusion (Bell et al., 2023).

Paranoia in a psychosis context is well researched, however, people with psychosis are not the only clinical group who worry about other people and their intentions. Fanti et al (2023) conducted a scoping review on the experience of paranoia in people with a diagnosis of personality disorder (PD). Forty-seven studies were reviewed, and consistent evidence of paranoia was found in schizotypal, and paranoid personality disorders, and most studies reporting heightened levels of paranoia in people with borderline personality disorder (BPD). In a study conducted by Oliva et al (2014), all participants with BPD reported at least one symptom of paranoia. Nonetheless, the experience of paranoia and associated mechanisms in people with a PD diagnosis is currently under-researched. Additionally, treatments for people with a diagnosis of PD are limited (Paris, 2013) despite clinical need. However, there are evidence-based treatments for people experiencing paranoia in psychosis, such as the Feeling Safe programme (Freeman et al., 2021), which has been developed following the identification of six mechanisms involved in paranoia. Identification of similar mechanisms involved in paranoia in personality disorder may introduce the idea that some treatment options for paranoia in psychosis may be applicable to those with a diagnosis of PD. Better understanding of psychological mechanisms involved in the occurrence of paranoia in PD may have implications for future treatment.

The cognitive model of paranoia

The cognitive model of paranoia (Freeman et al., 2016) (Appendix 3.1) outlines mechanisms involved in the formation and maintenance of persecutory ideas. The model is based on the idea that paranoia develops due to genetic and environmental factors. It focuses on six psychological mechanisms that perpetuate paranoia. One of the key mechanisms, reasoning

biases, may include belief inflexibility, decreased analytic reasoning, and jumping to conclusions (Freeman et al., 2016).

'Jumping to conclusions'

'Jumping to conclusions' can be defined as needing only a small amount of evidence before making a decision (Dudley et al., 2016) and is one of the most researched cognitive biases believed to contribute to paranoia. For example, Freeman et al (2008) found a significant association between the strength of paranoid ideas and the JTC bias. A review of 12 studies conducted by Fine et al (2007) concluded that the JTC bias contributed to delusional symptomology. Some literature has suggested that people with a PD diagnosis, specifically BPD, may have similar cognitive biases to those implicated in psychosis (Puri et al., 2018), however findings have been mixed. For example, people with a diagnosis of BPD 'jumped to conclusions' more than a general population group in a study exploring whether people with BPD manifest cognitive biases implicated in the maintenance of psychotic symptoms (Puri et al., 2018). They note a limitation of their study as being the lack of a clinical control group of people with psychosis. In contrast, Catalan et al (2015) examined the JTC bias in three groups: people with first episode psychosis (FEP), people with BPD, and people from the general population and found that people with BPD did not jump to conclusions significantly more than people in the general population. These studies did not screen for paranoia specifically and therefore it is not possible to draw inferences about JTC for people with paranoia in the context of PD.

State paranoia and state anxiety

Findings regarding whether rates of JTC are influenced by state anxiety are mixed. There is

some evidence that rates of JTC may be higher when state anxiety is heightened (Lincoln et al., 2010). However, So et al (2008) found that state anxiety did not influence JTC. State anxiety has also previously been found to significantly predict state paranoia in clinical populations (Cowles & Hogg, 2019). A study conducted by Ellett et al (2008) also suggests an association between state paranoia and JTC as they found that following anxiety induction, state paranoia, state anxiety, and JTC all increased. Therefore, the current study controls for both state anxiety and state paranoia to clarify whether either had an impact on rates of JTC.

Current study

While mechanisms involved in paranoia in a psychosis context are well investigated, mechanisms involved in paranoia in PD are not. Furthermore, despite the link between 1) JTC and paranoia, 2) paranoia and personality disorders, and 3) cognitive biases and personality disorders, there are no studies investigating specifically whether the JTC bias is present in people presenting with paranoia in a PD context.

The present study will examine to what extent people experiencing paranoia in PD 'jump to conclusions' compared to a group experiencing paranoia in psychosis and a general population group. We hypothesise that people experiencing paranoia in PD will require significantly less evidence before coming to a conclusion than a general population group. In line with previous literature, we also hypothesise that people experiencing paranoia in psychosis will require significantly less evidence before coming to a conclusion than a general population group. We are also interested in whether there are similarities or differences in the amount of evidence needed between people in the personality disorder and psychosis groups, as well as paranoia scores between the two groups.

Method

Participants

Fifty-one participants were recruited. Recruitment took place between June 2023 and March 2024. Participants were recruited from both NHS care teams and from the community. Participants recruited from NHS care teams had a diagnosis reported by their care co-ordinator. It was not possible to formally verify participants diagnosis for those recruited from community sources however all participants recruited from the community self-reported a formal diagnosis. For experimental groups, participants met the following inclusion criteria: 1) diagnosis of psychosis (F20-29) or personality disorder (F60-69) 2) presenting with current paranoia 3) 18+ years of age. Participants could not take part in the study if they 1) could not give informed consent 2) presented with current, active suicidal ideation, 3) had a diagnosis of *both* psychosis and personality disorder. Participants in the general population group were recruited via a poster on social media and were required to 1) have neither a diagnosis of psychosis or personality disorder and 2) be 18+ years of age. They were screened for diagnoses and excluded if they had either diagnosis. All participants had participant information for at least 48 hours before the online study session was scheduled to ensure adequate time to consider the information. All participants gave informed consent and completed the required minimum data set (see Measures section).

Design

A between-participants, cross-sectional design was employed to compare rates of JTC between groups. The primary outcome measured the jumping to conclusions reasoning bias. State paranoia and state anxiety were controlled for. One person with lived experience of psychosis and one person with lived experience of personality disorder consulted on choice

of questionnaires, experimental task, participant information sheet, and consent form, resulting in changes to language used, wording, and layout of information sheet and consent form. They were reimbursed for their time.

Measures

Demographics

Information on age, sex, ethnicity, employment, mental health diagnosis, previous involvement with mental health services, and co-morbid diagnoses were collected to contextualise the samples.

Paranoia Screen

The Revised-GPTS (R-GPTS; Freeman et al., 2019) (Appendix 3.2) questionnaire was used to screen for paranoia. The measure is split into two parts and consists of 18 items (e.g, “I was sure someone wanted to hurt me”). The scale has been found to have high reliability in detecting paranoia in both clinical and non-clinical populations (Freeman et al., 2019). A score of 10+ on part A and 6+ on part B indicate elevated levels of paranoid thinking compared to the general population (Freeman et al., 2019).

Jumping to conclusions

The ‘Beads Task’ (Huq et al., 1988) was used to measure the jumping to conclusions reasoning bias. Participants are shown two jars of beads, where one jar contains 85 red beads and 15 yellow beads, and the other 85 red beads and 15 yellow beads. The jars are then hidden and the participant is told that beads will be drawn one by one from one jar selected at

random. Participants are asked to state which jar beads are being drawn from and are informed that they can see as many beads as they like before they make a decision. The researcher administered the task using a script (Appendix 3.3) with each participant. The same beads sequence was used every time. The primary outcome is *draws to decision* (number of beads needed before a decision is made). The presence of a JTC bias is usually defined by requesting only one or two beads. In the current study, the beads task was administered via Microsoft Teams.

State paranoia

The State Social Paranoia Scale (SSPS) (Freeman et al., 2007) (Appendix 3.4) was used to control for state paranoia and consists of 20 items (e.g, someone was hostile towards me). Excellent internal reliability, adequate test-retest reliability and convergent validity have been found in both clinical and non-clinical groups (Freeman et al., 2007).

State anxiety

The state subscale of the State-Trait anxiety inventory (STAI) (Spielberger, 1977) (Appendix 3.5) was used to control for state anxiety. The sub-scale examines state anxiety and consists of 20 items (e.g, I feel worried). The measure has been widely used and appropriate internal consistency, structural validity, reliability and divergent validity have been found (Thomas & Cassady, 2021).

Procedure

The online study session took place on Microsoft Teams and lasted around 20-30 minutes. If

participants scored at least 10 on part A and at least 6 on part B on the R-GPTS, indicating elevated levels of paranoia, they were eligible to take part. Informed consent and demographic information were gathered from participants, followed by administration of the SPSS, STAI subscale and beads task. Measures were administered in the same order for each participant. Each participant was given a unique identifier on Qualtrics. All data collected was anonymous.

The study gained IRAS ethical approval: 23/WA/0076 and was pre-registered on OSF (OSF.IO/QRC25) (Appendix 3.6).

Data analytic strategy

Using G* power (Faul et al., 2007) an a priori power calculation to estimate required sample size was conducted. To achieve a power of .90 with alpha of 0.05 and a medium effect size (0.52), a total sample of 51, with 17 participants per group, was required. The effect size of 0.52 was decided based on effect sizes across studies in meta-analyses using the beads task (Dudley et al., 2016). Statistical analyses were conducted using IBM SPSS Statistics version 22 for Windows 10. Data from the beads task was not normally distributed therefore a Kruskal-Wallis test was used to compare mean scores on the beads task between groups. Diagnosis was used as the independent variable and number of beads requested was used as the dependent variable.

Exploratory analyses

An ANCOVA was used to explore the impact of state paranoia and state anxiety on draws to decision. Group was the independent variable, scores on the beads task was the dependent

variable and state paranoia and state anxiety were covariates. Pearsons correlation was used to explore the relationship between scores on the R-GPTS and scores on the beads task.

Results

Sample characteristics

The analysis included 51 participants: 17 per group. Ten people were excluded due to not meeting criteria in screening for paranoia. A breakdown of diagnoses across groups together with clinical and demographic characteristics can be found in Table 1. There were no significant differences in age between groups, $F(2) = 1.69$, $p = .20$. Due to low numbers across categories, differences in gender, referral source, ethnicity, diagnoses and employment status could not be examined statistically. A breakdown of scores on the R-GPTS, SSPS, STAI subscale, and beads task can be found in Table 2.

Group	***Personality disorder (n=17)***	***Psychosis (n=17)***	***General population (n=17)***
Age range (years)			
Mean (SD)	31.4 (12.31)	34.7 (12.9)	28.0 (2.25)
Median (min, max)	25 (19, 57)	32 (18, 59)	28 (24, 33)
Gender			
Female N(%)	14 (82.4)	9 (52.9)	11 (64.7)
Male N(%)	2 (11.8)	7 (41.2)	6 (35.3)
Non-binary N(%)	1 (5.9)	1 (5.9)	0 (0)
Ethnicity			
White/British N(%)	13 (76.5)	13 (76.5)	15 (88.2)
Asian/British N(%)	1 (5.9)	1 (5.9)	0 (0)
Black/British N(%)	0 (0)	1 (5.9)	0 (0)
Asian N(%)	0 (0)	2 (11.8)	0 (0)
Mixed N(%)	2 (11.8)	0 (0)	1 (5.9)
Other N(%)	1 (5.9)	0 (0)	1 (5.9)
Employment			
Full-time N(%)	2 (11.8)	2 (11.8)	15 (88.2)
Part-time N(%)	5 (29.4)	3 (17.6)	1 (5.9)

Retired N(%)	0 (0)	1 (5.9)	0 (0)
Unemployed N(%)	10 (58.8)	11 (64.7)	1 (5.9)
Recruitment source			
NHS service N(%)	10 (58.8)	12 (70.6)	N.A
Recovery college N(%)	1 (5.9)	0 (0)	N.A
Social media N(%)	6 (35.3)	5 (29.4)	17 (100)
Age of first contact with services			
Mean (SD)	18 (10.72)	22.3 (7.91)	N.A
Median (mix, max)	14 (10, 45)	22 (11, 46)	N.A
Co-morbidites			
Yes N(%)	14 (82.4)	11 (64.7)	1 (5.9)
No N(%)	3 (17.6)	6 (35.3)	16 (94.1)
Anxiety	6 (35.2)	4 (23.5)	0 (0)
Depression	9 (52.9)	5 (29.4)	1 (100)
PTSD	7 (41.1)	4 (23.5)	0 (0)
Social anxiety	2 (11.8)	0 (0)	0 (0)
Combat PTSD	1 (5.9)	0 (0)	0 (0)
Generalised anxiety	3 (17.6)	0 (0)	0 (0)
disorder	1 (5.9)	0 (0)	0 (0)
Insomnia	1 (5.9)	1 (5.9)	0 (0)
OCD	1 (5.9)	0 (0)	0 (0)
Mood disorder	1 (5.9)	0 (0)	0 (0)
Alcohol misuse	1 (5.9)	2 (11.8)	0 (0)
ADHD	1 (5.9)	0 (0)	0 (0)
Tourettes Syndrome	0 (0)	1 (5.9)	0 (0)
Addiction	0 (0)	1 (5.9)	0 (0)
Anorexia Nervosa	0 (0)	1 (5.9)	0 (0)
Bulimia Nervosa	1 (5.9)	0 (0)	0 (0)
Diagnoses			
EUPD	14 (82.4)	0 (0)	N.A
Mixed personality disorder	2 (11.8)	0 (0)	N.A
Self-diagnosis (other)	1 (5.9)	0 (0)	N.A
Schizophrenia	0 (0)	4 (23.5)	N.A
Delusional disorder	0 (0)	1 (5.9)	N.A
Psychosis not otherwise specified (NOS)	0 (0)	10 (58.8)	N.A
Schizoaffective disorder	0 (0)	1 (5.9)	N.A
Acute, transient psychosis	0 (0)	1 (5.9)	N.A

Group	Personality disorder (n=17)	Psychosis (n=17)	General population (n=17)
R-GPTS Part A score			
Mean (SD)	20.2 (5.22)	21.3 (5.65)	N.A
Median (min, max)	20 (10, 30)	22 (12, 32)	N.A
R-GPTS Part B score			
Mean (SD)	25.1 (8.32)	22.6 (9.2)	N.A
Median (min, max)	26 (8, 38)	21 (9, 40)	N.A
SSPS score			
Mean (SD)	13.1 (5.62)	16.1 (10.35)	10 (0)
Median (min, max)	10 (10, 28)	10 (10, 40)	10 (10, 10)
STAI score			
Mean (SD)	55.5 (11.7)	46.8 (14. 8)	29.3 (7.48)
Median (min, max)	59 (30, 70)	45 (23, 74)	27 (21, 46)
Beads task			
Mean (SD)	2.2 (1.13)	2.41 (1.22)	3.8 (1.52)
Median (min, max)	2 (1, 4)	2 (1, 6)	3 (1, 7)

Table 3.1. Demographic data across groups

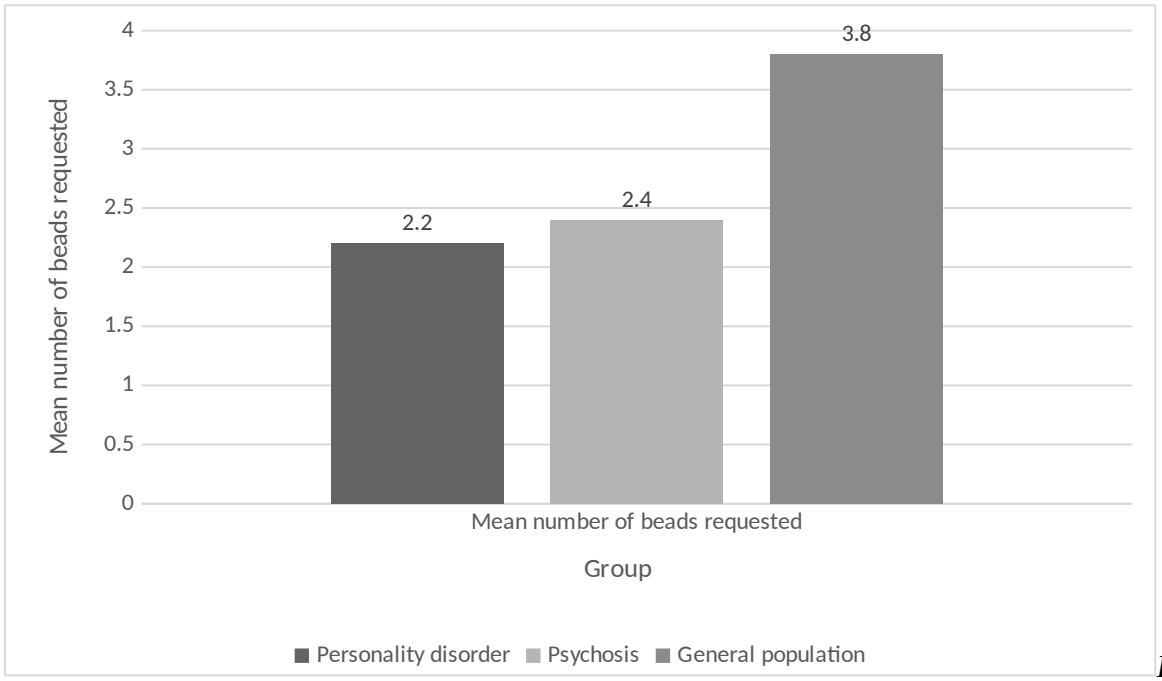
Table 3.2. Descriptive statistics for scores on outcome measures

Main analyses

A Shapiro-Wilk test was conducted to determine whether data was normally distributed for all variables. Data was not normally distributed for the following variables: draws to decision (beads task), $W(34) = 0.83$, $p < 0.01$ and SSPS, $W(34) = 0.63$, $p < 0.01$. Data was found to be normally distributed for Part A of the R-GPTS, $W(34) = 0.98$, $p = 0.84$., part B of the R-GPTS, $W(34) = 0.96$, $p = 0.27$ and the STAI, $W(34) = 0.97$, $p = 0.50$.

A Kruskal-Wallis test showed a significant difference in median scores between groups on the Beads Task, χ^2 (2, 51) = 12.00, $p = 0.002$with a mean rank score of 20.00 for the PD group,

22.35 for the psychosis group, and 35.65 for the general population group. The effect size, as measured by eta-squared was .21, indicating a small to medium effect. Pairwise comparisons using the Dunn's test showed that there were statistically significant differences in draws to decision on the beads task between the PD group and general population group, with the general population group requesting a significantly higher number of beads (p = 0.004, r = 0.60,95% CI for median difference: -3 - 0). There were statistically significant differences in draws to decision between the psychosis group and general population group, with the general population group requesting a significantly higher number of beads (p = 0.006, r = .54, 95% ICI for the median difference: -3 - 0. There were no statistically significant differences in number of beads requested between the PD group and psychosis group (p = 1.00, r = .10, 95% CI for the median difference: -2 to -1).



Pres

e

nce of the bias

Fig 1.1 Mean number of beads requested across groups

The beads task was completed by all 51 participants. Proportions of the bias displayed in groups were: 10/17 participants (58%) in the PD group, 9/17 participants (52%) in the psychosis group, and 2/17 (12%) in the general population group. Presence of JTC bias is defined as requesting less than three beads on the beads task

Exploratory analyses

A Kruskal-Wallis test also showed significant difference in scores on the SSPS between groups, χ^2 (2) = 9.22, p = 0.01, with a mean rank score of 28.94 for the PD group, 30.06 for the psychosis group, and 19.00 for the general population group. The effect size, as measured by eta-squared was 0.15, indicating a small effect. Pairwise comparisons using the Dunn's test showed that there were statistically significant difference in SSPS scores between the PD and general population groups (p = .04, r = .41, 95% CI for the median difference: 0 – 12.00and the psychosis and general population groups (p = .02, r = .41, 95% CI for the median difference: 0 – 1.00. There was no statistically significant difference between the PD and psychosis group (p = 1.00, r = .07, 95% CI of the median difference: 0.49 – 12.00

As data for the STAI was normally distributed, a one-way ANOVA was used to compare scores on the STAI between groups. The mean for the PD group was 55.53 (95% CI: 49.81 – 61.24). The mean for the psychosis group was 46.82 (95% CI: 41.11 - 52.54). The mean for the general population group was 29.29 (95% CI: 23.58 to 35.00). Significant differences between groups on scores of the STAI were found, F (2, 48) = 22.1, p < 0.001. The effect size, as measured by partial eta-squared, was .48, indicating a large effect.A post-hoc Tukey test showed that there were significant differences between the PD and general population groups (p < .001, d = 2.67, 95% CI: 1.75 – 3.60), and psychosis and general population groups (p < .001, d = 1.49, 95% CI: 0.74 – 2.25). There were no statistically significant

differences in scores on STAI between the PD and psychosis groups (p = 0.9, d = 0.65, 95% CI: -0.04 – 1.34).

A one-way ANCOVA was conducted to compare draws to decision whilst controlling for state paranoia and state anxiety. Levene's test was carried out and the data was found to have equal variances (p = .31). The covariate, state paranoia, was significantly related to draws to decision (p = .008). The effect size, measured by partial eta-squared was .07, indicating a medium effect. Adjusted means for the groups were as follows: 2.18 for the PD group (95% CI = 1.56 – 2.80), 2.57 for the psychosis group (95% CI: 1.92 – 3.21), 3.61 for the general population group (95% CI: 2.97 – 4.25). State anxiety was not significantly related to draws to decision (p = .12). The effect size, measured by partial eta-squared was .02, indicating a small effect. The adjusted mean for the groups were as follows: 2.37 for the PD group (95% confidence interval = 1.63 – 3.11), 2.46 for the psychosis group (95% CI: 1.82 – 3.10), 3.53 for the general population group (95% CI: 2.74 – 4.32).

As data on the beads task was not normally distributed, a Spearman's correlation was used to explore whether there was a relationship between paranoia scores on the R-GPTS and draws to decision on the beads task. No significant correlation was found between scores on part A of the R-GPTS and draws to decision, r(32) = -0.04, p = 0.81, CI: -0.40 – 0.30) indicating a very weak negative relationship between the two variables. No significant correlation was found between scores on part B of the R-GPTS and draws to decision, r(32) = -.16, p = 0.37, CI: -0.49 – 0.18) indicating a weak relationship between the two variables.

As data for both parts of the R-GPTS were found to be normally distributed, t-tests were used to compare mean scores between the PD and psychosis groups. There were no statistically significant differences in scores on part A , t(32) = -.57, p = 0.58or part B, t(32) = .82, p = .41between the two groups. The effect size for differences on part A, as measured by

Cohen's d, was 0.19 (95% CI: -0.48 to 0.87) The effect size for differences on part B, measured by Cohen's d was 0.28 (95% CI: -0.39 - 0.96).

Discussion

In line with our primary hypothesis, people experiencing paranoia in a PD context required significantly less evidence before coming to a conclusion than a general population group. Our second hypothesis was also supported: people experiencing paranoia in the context of psychosis required significantly less evidence before coming to a conclusion than a general population group. This is consistent with previous research (Huq et al., 1988; Dudley et al., 2016). However, it is important to note that state paranoia was significantly related to draws to decision, suggesting that state paranoia played a role in the rates of JTC seen. Exploratory analyses showed that there were no significant differences in levels of paranoia between the psychosis and PD groups. No significant relationship was found between paranoia levels and rates of JTC.

This is the first study to demonstrate that people confirmed to be experiencing paranoia in the context of PD 'jump to conclusions' significantly more than a general population group. Previous literature has found that people with a diagnosis of personality disorder 'jump to conclusions' more, however previous studies have not screened participants for paranoia. The current study did not include a control group of people with PD without paranoia, therefore it is difficult to fully establish whether our results relate to people with PD more generally, or whether it is only people with PD and current paranoia. In line with our findings, Moritz et al (2011) found that people with BPD significantly exceeded a general population group on four

cognitive biases, including jumping to conclusions on the Cognitive Biases for Psychosis questionnaire (Peters et al., 2014).

This is also the first study to show that there were no differences in the rate at which people with psychosis and PD who experience current paranoia, ‘jump to conclusions’. Catalan et al (2015) found differences in rates of JTC between people with first episode psychosis, and people with BPD, however paranoia was not measured. In our study, it may be transdiagnostic experience of paranoia that may be key to the lack of differences in JTC we saw between clinical groups. However, it is important to note that a review conducted by De Rossi & Geogiades (2022) summarised two studies (Fraser et al., 2006; Wittorf et al., 2012) who found that JTC was not specific to people with psychosis presenting with delusions. Further research could clarify by conducting a study similar to ours involving people presenting with PD with and without current paranoia.

As our study suggests that JTC may be a transdiagnostic phenomenon beyond people with psychosis, our study contradicts findings by So et al (2016). They conducted a meta-analysis looking at JTC across diagnoses such as OCD, depression and anxiety and found that JTC may be unique to those with a psychosis diagnosis. However, people with a PD diagnosis were not included in reviewed studies, and it is not confirmed whether clinical groups presented with paranoia. Therefore, our study may provide further clarification on the transdiagnostic nature of JTC, and possibly the key role of paranoia. Results from So et al (2016) also clarify that in the current study the presence of the JTC was likely not due to co-morbidities in the clinical groups.

Previous literature has shown that people who experience higher levels of paranoia, including persecutory delusions, are more likely to jump to conclusions (Dudley et al., 2016). In the current study, participants in the PD group were experiencing ‘very severe’ levels of paranoia

on the persecution scale, and people in the psychosis group were experiencing ‘severe’ levels of paranoia. Both levels would indicate the likely presence of a persecutory delusion. From our results, we can conclude that the JTC bias was present amongst some of the participants across the groups. As our groups were experiencing ‘very severe’ or ‘severe’ levels of paranoia, this supports previous research findings that people experiencing delusional ideation are those most likely to exhibit the JTC bias (Moritz & Woodward, 2005).

No significant relationship was found between levels of paranoia and rates of JTC, which contrasts previous literature such as Moritz et al (2012) who found that rates of JTC were correlated with rates of paranoia. Freeman et al (2008) support this, finding that it was the strength of delusional ideaswhich was associated with JTC. Our findings contrast the two, however support those from So & Kwok (2015) who concluded that there was less evidence for a linear relationship between JTC and severity of delusions.

Regarding covariates, state paranoia was found to be significantly related to draws to decision and when accounting for state paranoia, there were no significant difference between groups. This suggests that rates of JTC may change depending on levels of state paranoia, suggesting that JTC may fluctuate. This is in line with previous research which has found that JTC is both stable and fluctuating (Ludtke et al, 2017). Additionally, Ellett et al (2008) found that in an induced anxiety condition, rates of state anxiety and state paranoia increased, as did rates of JTC, suggesting an association between state paranoia and JTC, which would fall in line with our results. However, our results do contrast previous literature regarding the effect of state anxiety on JTC (Lincoln et al., 2010). In our study, state anxiety was not found to be significantly related to draws to decision. Further research could conduct a study looking specifically at the causal link between state anxiety, state paranoia, and JTC.

Clinical implications

The study aimed to explore ways in which one aspect of the cognitive model of paranoia could be applied to people experiencing paranoia in a PD context. Targeting reasoning biases such as JTC as a component of CBTp has been effective in treating delusional conviction in the context of psychosis (Waller et al., 2011). The current study provides evidence that people experiencing paranoia in both the contexts of psychosis and PD exhibit a similar reasoning bias: JTC. Therefore, there are possibly clinical implications for applying current modes of treatment for those with psychosis to people with PD.. Based on our findings, clinicians should be mindful that people experiencing paranoia in the context of PD may be experiencing 'severe' or 'extremely severe' levels of paranoia, which are likely to have a significant impact on daily life and interpersonal relationships (Hajduk et al., 2019).Adaptations regarding engagement may therefore be helpful for people with PD Such as For example, taking a commitment to openness, collaboration, and acceptance, and openly making sense of therapeutic difficulties (Lawlor et al., 2015). Evidence-based approaches to target the JTC bias within therapy could also be considered in the treatment of paranoia for people with PD for examples through interventions such as the Feeling Safe programme (Freeman et al., 2021) and CBTp (Bighelli et al., 2018).

Limitations and future research

There are number of limitations to consider when interpreting results from the current study. The measure of JTC was based on a single item and was not conducted multiple times as has been done in previous studies, such as Jolley et al (2014). Conducting further trials, including 'distractor sequences' has been found to improve the reliability of the task (McLean et al., 2017). Different measures of JTC have also found different rates of JTC in previous literature (Pytlik et al., 2020; Balzan et al, 2017) Discrepancies in scores on JTC measures in previous literature point to the need for more reliable measurement of the bias. Future research could

include multiple measures of JTC. Additionally, regarding whether there is a difference in rates of JTC between people with PD and experiencing paranoia and people with PD not experiencing paranoia, questionnaire data would be of interest and would provide greater specificity on the link between paranoia and the JTC bias. It could also be beneficial to repeat the current study on a general population group experiencing high levels of state paranoia, to test whether our results were a result of state paranoia alone, or state paranoia in the context of a clinical diagnosis. Further research using participants exhibiting lower levels of paranoia may again provide greater specificity on the link between JTC and paranoia, as this would allow greater exploration of the relationship between JTC and paranoia levels. It may also be helpful to control for comorbid diagnoses to provide specificity between a diagnosis of PD and the JTC bias.

In error, the a priori power calculation was conducted for a one-way test, without the addition of covariates. It would have been more accurate to conduct the power calculation accounting for covariates and for a two-tailed test, which would have resulted in a larger sample size. This means that the study was likely underpowered. There was an additional error in the effect size chosen for the power calculation. A medium effect size suitable for a t-test was used (0.52) whereas a medium effect size suitable for an F test should have been used (0.25). The results of the study may have been different had it been powered sufficiently. As it is underpowered, it is not clear if non-significant effects are because there is no effect or due to the study lacking power to detect the effect, introducing the risk of type 2 error. In future research, this study should be replicated with a larger sample to be sufficiently powered. Nonetheless, a small to medium effect size was found in the study, giving some indication of an effect, and this effect size can be used for future a priori power calculations.

Additionally, JTC was coded as a continuous variable in our analyses, rather than dichotomously defining whether participants displayed the bias. Coding dichotomously for analyses would have given greater understanding specifically of the rates of the bias across groups. Treatments targeting the JTC bias specifically would be more applicable to participants in the study.

Additionally, for some of the community sample we relied on self-report of diagnosis, meaning there may have been diagnostic variation within the samples. It is possible that some may have not had a diagnosis from an appropriate clinician. Furthermore, participants from NHS care teams were not screened for either clinical diagnosis, again introducing the possibility of diagnostic variation within the groups, possibly limiting the generalisability of results to clinical samples.

Conclusions

Our study introduces the idea that the mechanism of JTC may be transdiagnostic and demonstrates that this can be applied to people experiencing paranoia in the context of personality disorder.

Despite methodological limitations, results for our clinical control group, the psychosis group, are in line with previous literature, giving greater confidence in interpreting our results from the personality disorder group.

Overall, the results support the notion proposed by the cognitive model that people experiencing paranoia, in the context of both personality disorder and psychosis, are more likely to jump to conclusions. However, rates of JTC may be dependent on levels of state paranoia, and questions have been raised surrounding the use of the beads task to measure JTC more generally, which should be taken into consideration when interpreting results.

Acknowledgements

The authors thank study participants and members of public and patient involvement. The authors also thank clinicians within clinical services who supported their clients in being able to take part. The authors thank Dr Sarah Rakovshik for contributing to the development of the study. EP was supported by funding for professional clinical psychology training by Oxford Health NHS Foundation Trust.

References

Balzan, R. P., Ephraums, R., Delfabbro, P., & Andreou, C. (2017). Beads task vs. box task: The specificity of the jumping to conclusions bias. Journal of Behavior Therapy and Experimental Psychiatry, 56, 42-50. doi:10.1016/j.jbtep.2016.07.017

Bell, V., Velthorst, E., Almansa, J., Myin-Germeys, I., Shergill, S., & Fett, A. K. (2023). Do loneliness and social exclusion breed paranoia? An experience sampling investigation across the psychosis continuum. Schizophrenia Research: Cognition, 33(February), 100282-100282. doi:10.1016/j.scog.2023.100282

Bighelli, I., Salanti, G., Huhn, M., Schneider-Thoma, J., Krause, M., Reitmeir, C., . . . Leucht, S. (2018). Psychological interventions to reduce positive symptoms in schizophrenia: systematic review and network meta-analysis. World Psychiatry, 17(3), 316-329. doi:10.1002/wps.20577

Catalan, A., Simons, C. J. P., Bustamante, S., Olazabal, N., Ruiz, E., Gonzalez De Artaza, M., . . . Angel Gonzalez-Torres, M. (2015). Data Gathering Bias: Trait Vulnerability to Psychotic Symptoms? doi:10.1371/journal.pone.0132442

Cowles, M., & Hogg, L. (2019). An Experimental Investigation into the Effect of State-Anxiety on State-Paranoia in People Experiencing Psychosis. Behavioural and Cognitive Psychotherapy, 47(1), 52-66. doi:10.1017/S1352465818000401

De Rossi, G., & Georgiades, A. (2022). Thinking biases and their role in persecutory delusions: A systematic review. Early Intervention in Psychiatry, 16(12), 1278-1296. doi:10.1111/eip.13292

Dudley, R., Taylor, P., Wickham, S., & Hutton, P. (2016). Psychosis, Delusions and the "Jumping to Conclusions" Reasoning Bias: A Systematic Review and Meta-analysis. Schizophrenia Bulletin, 42(3), 652-665. doi:10.1093/schbul/sbv150

Ellett, L., Freeman, D., & Garety, P. A. (2008). The psychological effect of an urban environment on individuals with persecutory delusions: The Camberwell walk study. Schizophrenia Research, 99(1-3), 77-84. doi:10.1016/j.schres.2007.10.027

Fanti, E., Di Sarno, M., & Di Pierro, R. (2023). In search of hidden threats: A scoping review on paranoid presentations in personality disorders. Clinical Psychology and Psychotherapy(July), 1-19. doi:10.1002/cpp.2913

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: a flexible statistical power analysis program for the social, behavioral, and biomedical sciences. Behav Res Methods, 39(2), 175-191. doi:10.3758/bf03193146

Fine, C., Gardner, M., Craigie, J., & Gold, I. (2007). Hopping, skipping or jumping to conclusions? Clarifying the role of the JTC bias in delusions. Cognitive Neuropsychiatry, 12(1), 46-77. doi:10.1080/13546800600750597

Fraser, J., Morrison, A., & Wells, A. (2006). Cognitive processes, reasoning biases and persecutory delusions: A comparative study. Behavioural and Cognitive Psychotherapy, 34(4), 421-435. doi:10.1017/S1352465806002852

Freeman, D. (2016). Persecutory delusions: a cognitive perspective on understanding and treatment. The Lancet Psychiatry, 3(7), 685-692. doi:10.1016/S2215-0366(16)00066-3

Freeman, D., Emsley, R., Diamond, R., Collett, N., Bold, E., Chadwick, E., . . . Twivy, E. (2021). Comparison of a theoretically driven cognitive therapy (the Feeling Safe Programme) with befriending for the treatment of persistent persecutory delusions: a parallel, single-blind, randomised controlled trial. The Lancet Psychiatry, 8(8), 696-707. doi:10.1016/S2215-0366(21)00158-9

Freeman, D., & Garety, P. A. (2000). Comments on the content of persecutory delusions: Does the definition need clarification? British Journal of Clinical Psychology, 39(4), 407-414. doi:10.1348/014466500163400

Freeman, D., Garety, P. A., Bebbington, P. E., Smith, B., Rollinson, R., Fowler, D., . . . Dunn, G. (2005). Psychological investigation of the structure of paranoia in a non-clinical population. British Journal of Psychiatry, 186(MAY), 427-435. doi:10.1192/bjp.186.5.427

Freeman, D., Garety, P. A., & Kuipers, E. (2001). Persecutory delusions: Developing the understanding of belief maintenance and emotional distress. Psychological Medicine, 31(7), 1293-1306. doi:10.1017/S003329170100455X

Freeman, D., Loe, B. S., Kingdon, D., Startup, H., Molodynski, A., Rosebrock, L., . . . Bird, J. C. Psychological Medicine The revised Green et al., Paranoid Thoughts Scale (R-GPTS): psychometric properties, severity ranges, and clinical cut-offs. doi:10.1017/S0033291719003155

Freeman, D., Pugh, K., & Garety, P. (2008). Jumping to conclusions and paranoid ideation in the general population. Schizophrenia Research, 102(1-3), 254-260. doi:10.1016/j.schres.2008.03.020

Freeman, D., Pugh, K., Green, C., Valmaggia, L., Dunn, G., & Garety, P. (2007). A measure of state persecutory ideation for experimental studies. Journal of Nervous and Mental Disease, 195(9), 781-784. doi:10.1097/NMD.0b013e318145a0a9

Garety, P. A., & Freeman, D. (2013). The past and future of delusions research: From the inexplicable to the treatable. British Journal of Psychiatry, 203(5), 327-333. doi:10.1192/bjp.bp.113.126953

Hajdúk, M., Klein, H. S., Harvey, P. D., Penn, D. L., & Pinkham, A. E. (2019). Paranoia and interpersonal functioning across the continuum from healthy to pathological – Network analysis. British Journal of Clinical Psychology, 58(1), 19-34. doi:10.1111/bjc.12199

Hennink, M & Kaiser, B.N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. Social Science & Medicine 292(6). doi: 1016/j.socscimed.2021.114523

Huq, S. F., Garety, P. A., & Hemsley, D. R. (1988). Probabilistic Judgements in Deluded and Non-Deluded Subjects. The Quarterly Journal of Experimental Psychology Section A, 40(4), 801-812. doi:10.1080/14640748808402300

Jolley, S., Thompson, C., Hurley, J., Medin, E., Butler, L., Bebbington, P., . . . Garety, P. (2014). Jumping to the wrong conclusions? An investigation of the mechanisms of reasoning errors in delusions. Psychiatry Research, 219(2), 275-282. doi:10.1016/j.psychres.2014.05.051

Lamster, F., Lincoln, T. M., Nittel, C. M., Rief, W., & Mehl, S. (2017). The lonely road to paranoia. A path-analytic investigation of loneliness and paranoia. Comprehensive Psychiatry, 74, 35-43. doi:10.1016/j.comppsych.2016.12.007

Lawlor, C., Hall, K., & Ellett, L. (2015). Paranoia in the therapeutic relationship in cognitive behavioural therapy for psychosis. Behavioural and Cognitive Psychotherapy, 43(4), 490-501. doi:10.1017/S1352465814000071

Lincoln, T. M., Lange, J., Burau, J., Exner, C., & Moritz, S. (2010). The effect of state anxiety on paranoid ideation and jumping to conclusions. An experimental investigation. Schizophrenia Bulletin, 36(6), 1140-1148. doi:10.1093/schbul/sbp029

Lüdtke, T., Kriston, L., Schr, J., Lincoln, T. M., & Moritz, S. (2016). Negative affect and a fluctuating jumping to conclusions bias predict subsequent paranoia in daily life: An online experience sampling study. doi:10.1016/j.jbtep.2016.08.014

McLean, B. F., Mattiske, J. K., & Balzan, R. P. (2017). Association of the jumping to conclusions and evidence integration biases with delusions in psychosis: A detailed meta-analysis. Schizophrenia Bulletin, 43(2), 344-354. doi:10.1093/schbul/sbw056

Moritz, S., Schilling, L., Wingenfeld, K., KÃ¶ther, U., Wittekind, C., Terfehr, K., & Spitzer, C. (2011). Psychotic-like cognitive biases in borderline personality disorder. Journal of Behavior Therapy and Experimental Psychiatry, 42(3), 349-354. doi:10.1016/j.jbtep.2011.02.003

Moritz, S., Van Quaquebeke, N., & Lincoln, T. M. (2012). Jumping to Conclusions Is Associated with Paranoia but Not General Suspiciousness: A Comparison of Two Versions of the Probabilistic Reasoning Paradigm. Schizophrenia Research and Treatment, 2012, 1-9. doi:10.1155/2012/384039

Moritz, S., & Woodward, T. S. (2005). Jumping to conclusions in delusional and non-delusional schizophrenic patients. British Journal of Clinical Psychology, 44(2), 193-207. doi:10.1348/014466505X35678

Oliva, F., Dalmotto, M., Pirfo, E., Furlan, P. M., & Picci, R. L. (2014). A comparison of thought and perception disorders in borderline personality disorder and schizophrenia: Psychotic experiences as a reaction to impaired social functioning. BMC Psychiatry, 14(1), 1-9. doi:10.1186/s12888-014-0239-2

Paris, J. (2013). Stepped Care: An Alternative to Routine Extended Treatment for Patients With Borderline Personality Disorder. Psychiatric Services, 64(10), 1035–1037. https://doi.org/10.1176/appi.ps.201200451

Peters, E. R., Moritz, S., Schwannauer, M., Wiseman, Z., Greenwood, K. E., Scott, J., . . . Garety, P. A. (2014). Cognitive biases questionnaire for psychosis. Schizophrenia Bulletin, 40(2), 300-313. doi:10.1093/schbul/sbs199

Puri, P., Kumar, D., Muralidharan, K., & Kishore, M. T. (2018). Individuals with Borderline Personality Disorder manifest cognitive biases implicated in psychosis. Psychiatry Research, 267, 414-419. doi:10.1016/j.psychres.2018.06.040

Pytlik, N., Soll, D., Hesse, K., Moritz, S., Bechdolf, A., Herrlich, J., . . . Mehl, S. (2020). Problems in measuring the JTC-bias in patients with psychotic disorders with the fish task: a secondary analysis of a baseline assessment of a randomized controlled trial. BMC Psychiatry, 20(1), 1-10. doi:10.1186/s12888-020-02959-5

So, S. H., & Kwok, N. T. (2015). Jumping to conclusions style along the continuum of delusions: delusion-prone individuals are not hastier in decision making than healthy individuals. PLoS One, 10(3), e0121347. doi:10.1371/journal.pone.0121347

So, S. H. w., Siu, N. Y. f., Wong, H. l., Chan, W., & Garety, P. A. (2016). ‘Jumping to conclusions’ data-gathering bias in psychosis and other psychiatric disorders — Two meta-

analyses of comparisons between patients and healthy individuals. Clinical Psychology Review, 46, 151-167. doi:10.1016/j.cpr.2016.05.001

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1977). State-trait-anxiety-inventory for adults self-evaluation questionnaire STAI form Y-1 nad form Y-2. In (pp. 5-5).

Startup, H., Freeman, D., & Garety, P. A. (2007). Persecutory delusions and catastrophic worry in psychosis: Developing the understanding of delusion distress and persistence. Behaviour Research and Therapy, 45, 523-537. doi:10.1016/j.brat.2006.04.006

Thomas, C. L., & Cassady, J. C. (2021). Validation of the State Version of the State-Trait Anxiety Inventory in a University Sample. SAGE Open, 11(3). doi:10.1177/21582440211031900

Tiernan, B., Tracey, R., & Shannon, C. (2014). Paranoia and self-concepts in psychosis: A systematic review of the literature. Psychiatry Research, 216(3), 303-313. doi:10.1016/J.PSYCHRES.2014.02.003

Waller, H., Freeman, D., Jolley, S., Dunn, G., & Garety, P. (2011). Targeting reasoning biases in delusions: A pilot study of the Maudsley Review Training Programme for individuals with persistent, high conviction delusions. Journal of Behavior Therapy and Experimental Psychiatry, 42(3), 414-421. doi:10.1016/j.jbtep.2011.03.001

Wittorf, A., Giel, K. E., Hautzinger, M., Rapp, A., Schnenberg, M., Wolkenstein, L., . . . Klingberg, S. (2012). Specificity of jumping to conclusions and attributional biases: A comparison between patients with schizophrenia, depression, and anorexia nervosa. Cognitive Neuropsychiatry, 17(3), 262-286. doi:10.1080/13546805.2011.633749

Executive summary

"Jumping to conclusions" in the context of personality disorder: comparison with psychosis and general population groups

Paranoid thoughts are thoughts that others intend to cause you harm. Experiencing these thoughts can cause people significant distress and lead to social exclusion, loneliness, and poor quality of life. Many people with a diagnosis of psychosis experience paranoid thoughts and factors contributing to such thoughts for this group have been widely researched. However other groups, such as people with a diagnosis of personality disorder, also experience paranoid thoughts. Currently there is not much research on what contributes to experiencing paranoia for people with personality disorder.

Research conducted on paranoid thoughts in psychosis shows us that a reasoning bias called 'jumping to conclusions' may be involved. When someone jumps to a conclusion, they need less evidence about a topic to come to a conclusion. Studies have found that targeting reasoning biases, such as jumping to conclusions, reduces the strength of a paranoid thought. There is some research on jumping to conclusions in people with personality disorder, but none specifically linking this to the experience of paranoia.

We therefore wanted to explore whether people with personality disorder, who were experiencing current paranoia, 'jumped to conclusions'. Three groups were used within the

study: people experiencing paranoia in personality disorder, people experiencing paranoia in psychosis, and a general population group who were not experiencing paranoia. We predicted that people with personality disorder and with psychosis would jump to conclusions more than people from a general population group. We were interested in whether there were differences in how much people from the personality disorder and psychosis groups jumped to conclusions.

We used the ‘beads task’ to measure jumping to conclusions across groups and found that, in line with our predictions, people with personality disorder and people with psychosis jumped to conclusions more than people in a general population group. We also found that if state paranoia (e.g people experiencing paranoia in the moment) was higher, people were more likely to jump to conclusions.

We can conclude that ‘jumping to conclusions’ may be something that is present in people experiencing paranoia in personality disorder, in a similar to way in which it is present in people experiencing paranoia in psychosis. It may therefore be helpful to look at how this reasoning bias is addressed in therapy for people with psychosis and look at whether the same could be applied to people experiencing paranoia in personality disorder. However, there were some limitations with how we measured jumping to conclusions, and so future research should include multiple measures of jumping to conclusions in their studies.

Connecting Narrative

Prior to clinical training, I had the opportunity to work with people experiencing severe and enduring mental health difficulties. I had previously worked with men with a diagnosis of personality disorder in a secure forensic unit, and with people who had experienced psychosis as part of a randomised controlled trial. Through these experiences, I saw the impact that stigma and lack of access had on a person's recovery journey. Coming into training, I was unsure how to develop research projects and so it felt natural to gravitate toward thinking about clients I had previously worked with, and what they had struggled with. Reflecting on my projects now, while not a conscious choice, it appears that each group included in my research has in common: experiences of being marginalised and difficulties in accessing or engaging with mental health services. As I come to the end of training, I'm reminded of the privileged position we hold, where we have skills not only in the core competencies relating to clinical psychology, but also in advocacy and research. I hope that as I move into a qualified position, I use this knowledge to continue to understand experiences of those from stigmatised groups and contribute to the research base further.

Conducting all three research projects was a challenge, but small moments with participants kept me motivated throughout. Whether it was consulting with people with lived experience or listening to participants' stories when I met with them, I was reminded of the value of conducting research and of the potential impact that these projects might have in the future.

When it came to specific topics, I was inspired during early conversations with supervisors to think about the transdiagnostic nature of difficult experiences, such as paranoia. I looked to the literature for what was currently established on the experience of paranoia, and when I saw that the cognitive model of paranoia was mostly researched in the context of psychosis, I wondered if it could be applied to people experiencing paranoia in other contexts. Having worked with people with a diagnosis of personality disorder previously, I knew that the experience of paranoia was relevant, and distressing for this group. This was confirmed through conversations with clinicians in clinical teams, and research supervisors. For these reasons I chose to focus on this topic for two out of my three research projects.

Systematic Review of the Literature

I took my above reflections forward when thinking about my systematic review of the literature. It was helpful to conduct this project alongside recruiting for my TDRP, where I was speaking regularly to people experiencing paranoia in the context of personality disorder. This helped me to stay engaged with, and thoughtful about, my reasons for wanting to conduct this review.

Service Improvement Project

My service improvement project felt enjoyable to design, conduct, and write up. It was rewarding to work with a service on a specific problem they had identified. It was also rewarding to speak to service users of the service and find out about their experiences of therapy. This was my also my first experience of conducting thematic analysis, which I discovered I enjoyed, and would like to take this further into research I conduct once

qualified. It was enjoyable to make sense of a person's experience in a methodologically robust way by identifying themes and sub-themes. What sticks most with me from conducting this project are the things I learnt about South Asian culture. I went into the project with little knowledge of the culture and came out of the project with greater knowledge not only of topics relevant to mental health within the culture, but also of the culture more generally, such as family values, and ways in which South Asians support and care for one another.

Theory Driven Research Project

This was the most challenging project to conduct. The main reason for this was due to difficulties recruiting participants. We hypothesised that this was somewhat due to the nature of the client group we were trying to recruit; people experiencing paranoia. Many potential participants, who would have likely been eligible, chose not to take part when approached by their care co-ordinator. Difficulties recruiting from clinical teams led me to conduct a consultancy project in an Early Intervention in Psychosis service, where I explored how clinicians' direct clients to research projects. Difficulties with recruitment also led us to recruit from community samples, despite the limitations this brings to the study. Here it was interesting to see that people with a personality disorder diagnosis often came forward to take part, whilst those with psychosis were more difficult to reach. This made me wonder whether there are differences in the presentation of paranoia between the two groups.

Acknowledgements

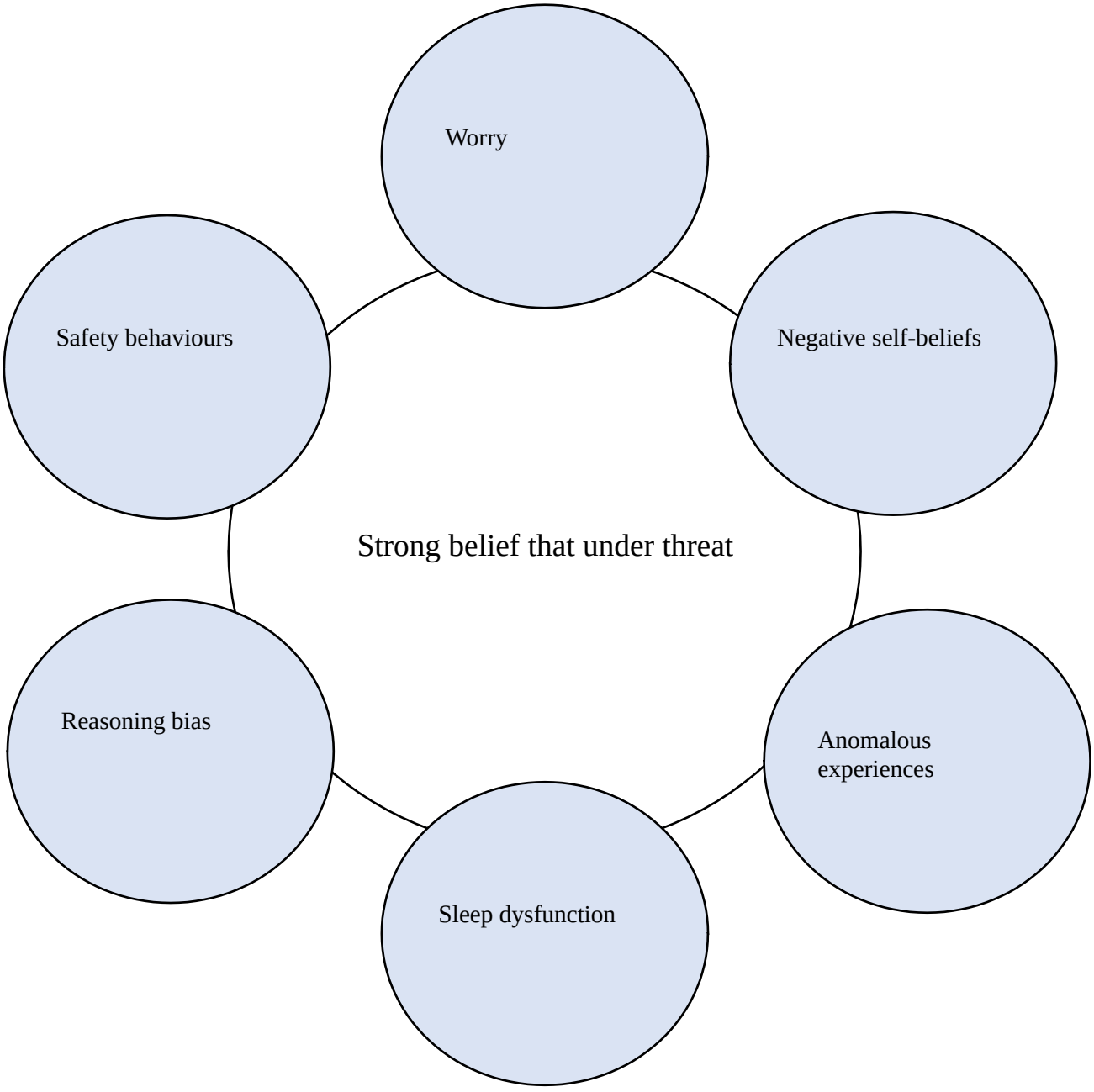
Firstly, I would like to thank everyone who participated in my projects, or who was involved in public and patient involvement. Thank you for choosing to take part and for trusting me with your time and stories. The time you gave to help me with this research is hugely appreciated and I hope I can do your contribution justice going forward. Thank you to the clinical services who supported this research, and to the clinicians within services for supporting their clients to take part.

I'd like to thank my research supervisors, Lorna Hogg, Dr Reena Vohora, Rani Griffiths, James Sahr-Momoh, and Dr Stephanie Capon. Your guidance and direction throughout has been so valuable. I'd like to say a huge thank you to my course tutor, Dr Fiona McFarlane, who has provided compassion, stability, and containment over the past three years. I'm also very grateful for the support of my personal tutor, Dr Felicity Waite, for the years of encouragement both pre and during clinical training.

A huge thank you to the 2021 cohort, and to my good friends on the course, who I feel lucky to have met and shared this experience with. To my housemates, who the past three years would not have been the same without. Thank you for the many laughs, rants, and therapy walks. Finally, thank you to my friends, family, and partner, for your love and support throughout.

Appendices

Appendix 1.1 – The cognitive model of paranoia (Freeman, 2016)



Appendix 1.2 – Definitions of mechanisms used to guide study selection

1. Worry

- Any study reporting on worry or rumination in people with BPD

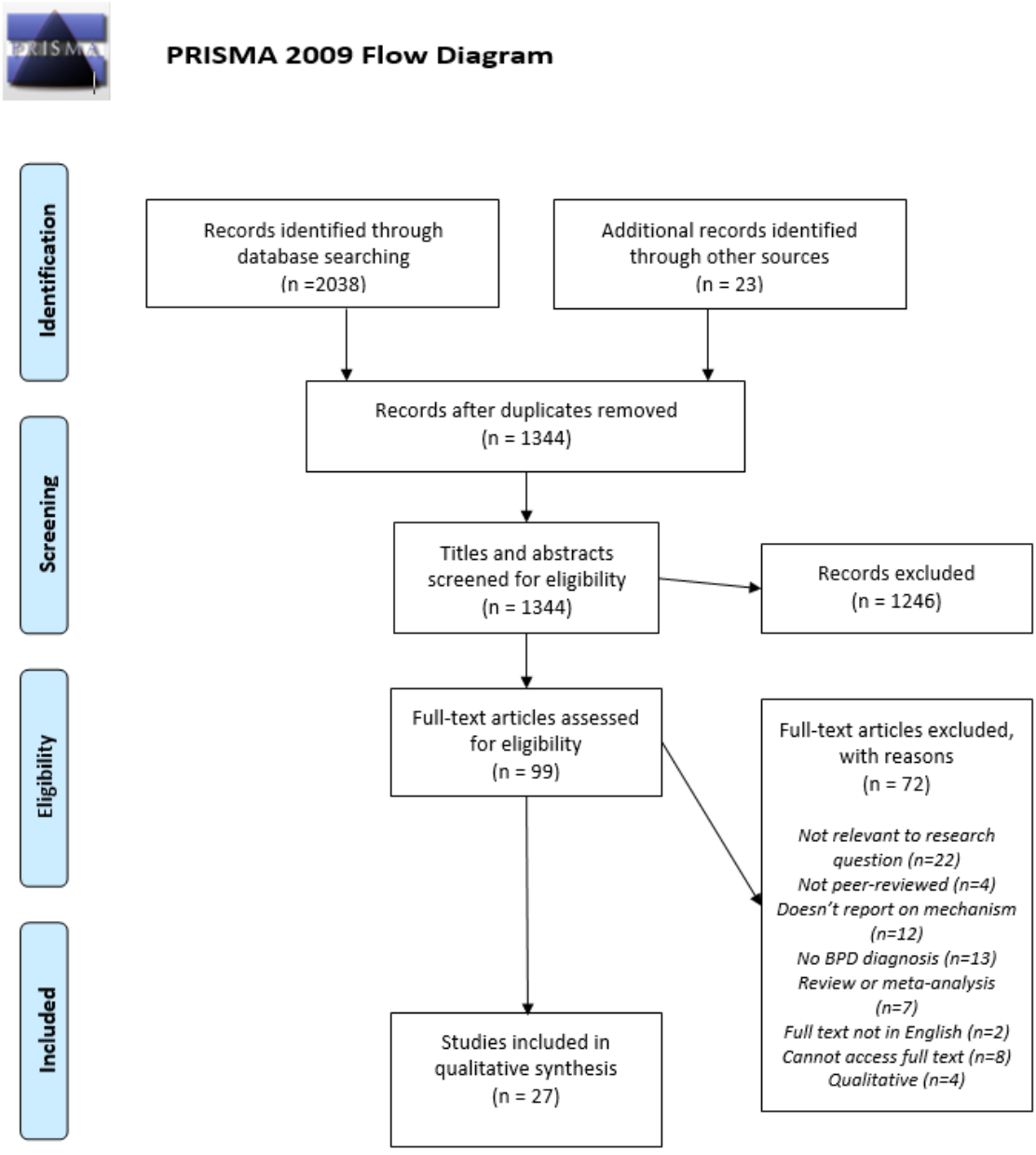
2. Reasoning biases

- Any study reporting on reasoning/cognitive biases relevant to the cognitive model of paranoia in people with BPD. For example, Bentall (2014) report that there are four main cognitive mechanisms implicated in paranoia: jumping to conclusions, impaired theory of mind, abnormal attributional styles, over-anticipation of threat.

3. Negative self-beliefs

- Any study reporting on negative self-beliefs relevant to the cognitive model of paranoia in people with BPD. For example, beliefs focusing on interiority, vulnerability. Beliefs focusing on constructs such as body image are not relevant.

Appendix 1.3– PRISMA diagram



Appendix 1.4 – Quality assessment table

Author	Item Score (0 = no, 1 = partial, 2 = yes)														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Calculated score (out of 1.00)
Worry															
Dell'osso et al (2019)	2	1	1	0	N/A	N/A	N/A	2	2	2	1	N/A	2	1	0.70
Spada et al (2021)	2	1	2	1	N/A	N/A	N/A	2	2	2	2	N/A	2	2	0.90
Reasoning biases															
Puri et al (2021)	2	2	2	2	N/A	N/A	N/A	2	1	2	2	N/A	2	2	0.95
Nicol et al (2013)	1	1	2	1	N/A	N/A	N/A	2	1	2	0	N/A	1	1	0.60
Moritz et al (2011)	1	1	2	2	N/A	N/A	N/A	2	2	2	2	N/A	2	2	0.85
Puri et al (2018)	1	1	2	1	N/A	N/A	N/A	2	1	2	2	N/A	2	2	0.80
Catalan et al (2015)	2	1	2	2	N/A	N/A	N/A	2	1	2	1	N/A	0	2	0.75
Scheunemann et al (2023)	2	2	2	2	N/A	N/A	N/A	2	2	1	2	N/A	2	2	0.95
Negative self-beliefs															
Santangelo et al (2017)	2	1	2	2	N/A	N/A	N/A	2	1	2	2	N/A	2	1	0.85
Lynum et al (2008)	2	1	2	2	N/A	N/A	N/A	2	1	2	2	N/A	2	2	0.90
Santangelo et al (2020)	2	2	2	1	N/A	N/A	N/A	2	2	2	1	N/A	2	2	0.90
Vater et al (2015)	2	2	2	2	N/A	N/A	N/A	2	2	2	0	N/A	2	2	0.90
De Bonis et al (1998)	1	2	0	2	N/A	N/A	N/A	2	1	2	0	N/A	1	1	0.60
Winter et al (2018)	1	1	1	1	N/A	N/A	N/A	2	2	1	1	N/A	2	2	0.70
Hedrick et al (2012)	1	1	1	2	N/A	N/A	N/A	2	2	2	1	N/A	2	2	0.80
Butler et al (2002)	2	2	2	2	N/A	N/A	N/A	2	2	2	1	N/A	2	2	0.95

Jacob et al (2010)	0	1	1	2	0	N/A	N/A	2	2	1	0	0	2	1	0.58
Knosravi & Hassini (2022)	2	2	2	2	N/A	N/A	N/A	2	2	2	2	N/A	2	1	0.95
Evans et al (2015)	1	2	2	2	N/A	N/A	N/A	2	2	1	1	N/A	2	2	0.85
Vater et al (2010)	2	2	1	1	N/A	N/A	N/A	2	2	1	2	N/A	2	2	0.85
Roepke et al (2011)	2	2	2	1	N/A	N/A	N/A	2	2	2	2	0	2	2	0.86
Pohl et al (2021)	1	1	1	2	N/A	N/A	N/A	2	2	2	2	N/A	2	1	0.80
Forster et al (2021)	2	2	2	2	N/A	N/A	N/A	2	2	2	2	N/A	2	2	1.00
Almeida et al (2018)	2	1	2	2	N/A	N/A	N/A	1	2	1	2	N/A	2	2	0.85
Vater et al (2013)	2	2	2	1	N/A	N/A	N/A	2	2	2	2	N/A	1	2	0.90
Rusch et al (2006)	2	1	2	2	N/A	N/A	N/A	2	1	2	2	N/A	2	2	0.90
Heekerens et al (2023)	2	2	2	2	N/A	N/A	N/A	2	2	2	2	N/A	1	2	0.86

1.5 – Journal guidelines for BJPsych Open

Preparing your Submission

Checklist: What to Include

Authors will be asked to confirm the following elements are included during submission. Any omissions may cause delays.

Word Document:

1. **Title** – The title should be brief and relevant. Titles should not announce the results of articles and (apart from editorials) they should not be phrased as questions.
2. **Author Names** – The full names of the authors should appear on the title page in the form that is wished for publication. When submitting a manuscript authored by a group, please specify the name of the group and identify the group members on the title page who can take credit and responsibility for the work as authors. Other group members (non-author contributors) should be listed under Acknowledgements or in Supplementary Material.
3. **Main Text** – See relevant Article Type for individual specification.
4. **Clinical Trials Registration** – In accordance with ICMJE guidelines, *BJPsych Open* requires all clinical trials to be registered in a public trials registry at the beginning of the research process (prior to patient enrolment). Trial registration numbers should be included in the abstract, with full details of the trial in the Methods section.
5. **Materials, equipment and software** – The source of any compounds not yet available on general prescription should be indicated. The version number (or release date) and manufacturer of software used, and the platform on which it is operated (PC, Mac, UNIX etc.), should be stated. The manufacturer, manufacturer's location and product identification should be included when describing equipment central to a study (e.g. scanning equipment used in an imaging study).
6. **Ethics Statement** – All authors are required to follow the ICMJE guidelines on the protection of research participants. Reports on research involving human participants must include the following statement in the Methods section: *The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. All procedures involving human subjects/patients were approved by [name of the relevant local, regional or national review body and approval number].*
   Ethical Oversight / Research with Humans or Animals. We expect any authors who submit content to *BJPsych Open* to have obtained the necessary ethical approvals and consents for their research and its publication, and to be able to produce evidence of this if requested. For more information on clinical trial requirements and consent statement requirements, see the 'Preparing your submission' section.
7. **Consent Statement** – Authors must include a statement in the Methods section detailing the procedure for obtaining consent from study participants. For example:
   - Written [or verbal] informed consent was obtained from all subjects/patients.
   - Verbal consent was obtained from all subjects/patients. Verbal consent as witnessed and formally recorded.
   This confirms that any participant has consented to the inclusion of material pertaining to themselves, that they acknowledge that they cannot be identified via the manuscript; and that the participant has been fully anonymized by the author.
   If consent was not obtained from all participants, please state the reasons for this and

note whether this was approved by the ethics committee.
If research participants are identifiable, authors should complete and upload a **Consent Form**. Where someone is deceased, authors must obtain written consent from the family or estate.

8. **Author Details** – At the end of the manuscript list the affiliations and countries at the time the work described in the paper was carried out. Identify one corresponding author with an email address appropriate for publication. For further information please read CUP's Corresponding Author guidance.
9. **References** – References should be numbered in the order that they appear in the text and listed at the end of the manuscript using the Vancouver style. Unpublished doctoral theses may be cited but no other citation of unpublished work, including unpublished conference presentations, is permissible. Authors are responsible for checking all references for accuracy and relevance before submission. Read our guide to Vancouver referencing here.

Required Statements:

1. **Declaration of Interest**- Authors should include a Declaration of Interest statement in their manuscript, detailing all conflicts of interest. Conflicts of interest are situations that could be perceived to exert an undue influence on an author's presentation of their work. They may include, but are not limited to, financial, professional, contractual or personal relationships or situations. Conflicts of interest do not necessarily mean that an author's work has been compromised. Authors should declare any real or perceived conflicts of interest in order to be transparent about the context of their work. If the manuscript has multiple authors, the author submitting the manuscript must include a Declaration of Interest statement relevant to all contributing authors. Example wording for your declaration is as follows: "Declaration of Interest: Author A is employed at company B. Author C owns shares in company D, is on the Board of company E and is a member of organisation F. Author G has received grants from company H." If no conflicts of interest exist, your declaration should state "Declaration of Interest: None".
2. **Funding** – Authors must include a Funding Statement in their manuscript. Within this statement please provide details of the sources of financial support for all authors, including grant numbers; for example: "Funding Statement: This work was supported by the Medical Research Council (grant number XXXXXXX)". Grants held by different authors should be identified as belonging to individual authors by the authors' initials; for example: "Funding Statement: This work was supported by the Wellcome Trust (AB, grant numbers XXXX, YYYY), (CD, grant number ZZZZ); the Natural Environment Research Council (EF, grant number FFFF); and the National Institutes of Health (AB, grant number GGGG), (EF, grant number HHHH)." Where no specific funding has been provided for research, you should include the following statement: "Funding Statement: This research received no specific grant from any funding agency, commercial or not-for-profit sectors."
3. **Acknowledgements** – Authors may acknowledge individuals or organisations who provided non-financial advice and/or support. Names and descriptions of the contributions of all non-author contributors should be included (as identified in the ICMJE guidelines). We are aware that authors sometimes receive assistance from technical writers, language editors, artificial intelligence (AI) tools, and/or writing agencies in drafting manuscripts for publication. Such assistance must be noted in the Acknowledgements section. Failure to acknowledge assistance from technical writers, language editors, AI tools and/or writing agencies in drafting manuscripts for

publication in the Acknowledgements section may lead to disqualification of the paper. If a professional medical writer has been employed in connection to the work, the writer must submit a completed ICMJE Conflicts of Interest form and be named in the Acknowledgements section with their contact information. Examples of how to acknowledge assistance in drafting manuscripts: • "The author(s) thank [name and qualifications] of [company, city, country] for providing [medical/technical/language] writing support/editorial support [specify and/or expand as appropriate], which was funded by [sponsor, city, country]." • "The author(s) made use of [AI system/tool] to assist with the drafting of this article. [AI version details] was accessed/obtained from [source details] and used with/without modification [specify and/or expand as appropriate] on [date(s)]."

4. **Author Contribution** – All authors should meet all four ICMJE criteria for authorship. Please provide a very brief description of the contribution of each author to the research including their roles in formulating the research question(s), designing the study, carrying it out, analysing the data and writing the article. The journal will follow COPE guidance to investigate if ghost, guest or gift authorship is suspected in a paper.
5. **Transparency Declaration -** The lead author and manuscript guarantor will be required to affirm that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.
6. **Data Availability –** In the interests of research transparency, authors are required to maintain accurate records of data associated with their manuscript, and to supply or provide access to these data on reasonable request for purposes of reproducing results or replicating procedures. Authors are encouraged to deposit data in a recognized data repository that can mint a persistent digital identifier (e.g. DOI), provides timestamped entries and recognizes a long-term preservation plan. Please include a brief statement indicating whether the materials supporting the findings are available, and if so, where readers may access them. For example:
    - The data that support the findings of this study are openly available in [repository name] at http://doi.org/[doi], reference number [reference number].
    - The data that support the findings of this study are available on request from the corresponding author, [initials]. The data are not publicly available due to [restrictions e.g. their containing information that could compromise the privacy of research participants].
    - Data availability is not applicable to this article as no new data were created or analysed in this study.
    - The data that support the findings of this study are available from the corresponding author, [author initials], upon reasonable request. Please find more sample statements here.

Thesis Citing

The journal welcomes research that has been completed as part of a thesis. All submissions are required to meet the standards of the journal and will be subject to the usual peer review process.

In accordance with the journal's Publishing Ethics Policy, it is mandatory for authors to disclose whether the research is part of a thesis by following the below points:

- Authors are required to indicate in ScholarOne and disclose in their covering letter their work is part of or is a whole thesis.
- Authors are required to update the title page of the thesis with a link to the new version of record.
- Authors are required to cite and reference their thesis.
- Authors should refer to the general rights detailed in the thesis and confirm they hold copyright/have permission to reuse this material in the new paper.
- Authors are reminded that final decisions are at the discretion of the Editor in Chief.

Failure to disclose this information will result in the submission being withdrawn and the University notified.

Other Documents:

1. **Tables** - Tables should be numbered (e.g. Table 1, Table 2…) and referenced in the text of the manuscript. Authors must indicate the desired position of the table in the manuscript. Authors must obtain permission from the original publisher if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table as follows: *Permission to replicate this table has been given to the authors by XXX.* Please ensure that tables are a reasonable size. Tables over two typeset pages (around 1,400 words) will be moved to supplementary material.
2. **Figures** - Figures should be numbered (e.g. Fig 1, Fig 2, Fig 3…) and referenced in the text of the manuscript. Authors must indicate the desired position of the figure in the manuscript. Please consult the journal artwork guide for a detailed specification on accepted file formats. Authors must obtain permission from the original publisher if they intend to use figures from other sources, and due acknowledgement should be made in the legend as follows: *Permission to replicate this figure has been given to the authors by XXX.*
   Any figures supplied in colour will be published online in colour.
3. **Supplementary Material** – Material related to a paper but not essential to a general understanding of the paper will be published as an online data supplement. Supplementary material is peer reviewed but will not be copyedited or typeset and should be supplied as authors wish to appear online. Supplementary material should be uploaded as a separate file and referenced in the manuscript. This material includes, but is not restricted to:
   - Additional data presented as tables or figures
   - Details of a search strategy employed in a literature review
   - Details of the literature retrieved but not further discussed in the body of the manuscript
   - Technical details of specialist (but not novel) methodology, statistical analysis and supporting references
   - Authors who have contributed in some sense to the paper but don't qualify for an authorship credit (e.g. group authorship) should be added to supplementary material rather than included in the footnote or acknowledgement section.

- Long lists of contributors who don't qualify for an authorship credit (e.g. group authorship) should be added to supplementary material. Shorter lists can be included in the acknowledgement section.

4. **Publication Agreement -** A signed author publication agreement must be submitted online when submitting a revised version of the manuscript, or immediately after acceptance if no revision is required.
5. **CONSORT, PRISMA, or CHEERS Checklist/Flow Diagram** – If relevant, see here for more information.

Paper

- The word count should be between 3000 and 5000 words in length (excluding references, tables and figure legends) and may include up to 40 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study.
- Structured abstract of up to 250 words with the headings: **Background; Aims; Method; Results; Conclusions (Trial Registration Number** and **Data Set Information** where appropriate). Please find further guidance on writing an effective abstract here.
    - Quantitative studies: abstracts should provide effect sizes with confidence intervals (not *P*-values alone).
    - Conclusions, in isolation, are likely to be used by others citing or promoting the work and must therefore be an accurate reflection of the study's main findings.

- **Tables and Figures -** there is no limit for tables and figures unless the number becomes cumbersome and detracts from the paper. We recommend that large tables and figures (exceeding one journal page) should be included as supplementary material.
- **Main Text** - The main text should include the following sections: **Introduction, Method, Results and Discussion.**
    - Introductions should normally be no more than one paragraph. Longer introductions may be permissible but should be split with subheadings if they exceed two paragraphs.
    - Discussion section should always include limitations of the paper to ensure balance, use of subheadings is encouraged in this section.
    - A Conclusions section is not required in the main text.

Review

- There is no word limit or maximum number of references, tables or figures.
- The abstract and main text should be structured in the same way as Papers.
- We require authors to register the protocol for **systematic reviews** before data extraction on an accessible, searchable site such as PROSPERO. Please include the registration number in the abstract. If the review has not been registered, we are unable to consider your submission.

- Systematic reviews are preferred, narrative reviews will be published only under exceptional circumstances.
- Previously published Reviews for groups such as the Cochrane Collaboration and the National Institute for Health and Care Excellence should be submitted with the latest version of the parent review and its status, so an informed decision can be made about the added value of the submitted paper.

Cost-of-illness and cost studies

Cost-of-illness and cost studies will be treated as regular papers, short papers or reviews based on the data submitted and authors should adhere to the associated word count and reference limitations. These papers require a structured abstract.

Economic evaluations

BJPsych Open will consider all economic evaluations submitted for publication that meet appropriate methodological and reporting standards. Priority will be given to trial-based economic evaluations submitted to *BJPsych Open* that meet the following criteria (in order of importance):

- Submitted with the main clinical trial outcome results in a single manuscript
- Submitted alongside the main clinical trial manuscript, or subsequent to the main clinical trial manuscript being accepted for publication in *BJPsych Open* and demonstrating added value in the form of original and important results not reported in the clinical trial manuscript
- Submitted in isolation from the main clinical trial manuscript, published elsewhere and demonstrating added value in the form of original and important results not reported in the clinical trial manuscript.

Authors must abide by the following guidelines and documentation, if applicable:

- CONSORT guidelines: **Randomised controlled trials** (submit a completed checklist and flowchart)
- STROBE guidelines: Cohort, case-control, and cross-sectional **observational studies in in epidemiology**
- PRISMA guidelines: **systematic reviews or meta-analyses of evaluations studies** including randomised controlled trials (submit a completed checklist and flowchart)
- MOOSE guidelines.: **meta-analyses of observational studies in epidemiology**
- CHEERS guidelines: **economic evaluations** (submit a completed checklist)
- SAGER Guidelines: We encourage authors to consult the Sex and Gender Equity in Research (SAGER) Guidelines for reporting sex and gender information in study design, data analyses, results and interpretation. Authors should use the terms sex and gender carefully in order to avoid confusing both terms and

include separate reporting and interpretation of the data by sex and gender. If sex and/or gender information are not reported, this should be explained.
- PPI Guidelines: The journal encourages active patient and public involvement (PPI) in research. If appropriate, please report PPI in your manuscript using GRIPP2-LF, a longer checklist for studies where PPI forms the primary focus of a study or GRIPP2-SF, a short checklist for studies where PPI is a secondary or tertiary focus.

Statistics

Attention should be paid to providing a clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any post hoc analyses carried out. The value of test statistics used (e.g. t, F-ratio) should be given as well as their significance levels so that their derivation can be understood. Standard deviations and errors should not be reported as ± but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends. The use of percentages to report results from small samples is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination and estimates of error should be given for statistics. Use of confidence intervals is encouraged but not mandatory. Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient, and comment should be made about the magnitude and direction of change.

Qualitative research

BJPsych Open welcomes submissions of reports of qualitative research relevant to the scope of the journal. These manuscripts will be evaluated in terms of design, conduct and reporting of the study, which need to be of sufficient quality and merit to warrant inclusion in *BJPsych Open*.

The Editorial team recognises that the term 'qualitative research' encompasses diverse methods, manuscripts will be evaluated based on the appropriateness of the selected framework, the coherence of the report and its adherence to quality criteria consistent with the methodology and method as follows:

Epistemological and/or theoretical frameworks

- The epistemological underpinnings and/or theoretical framework are made explicit and applied consistently

Study design and method

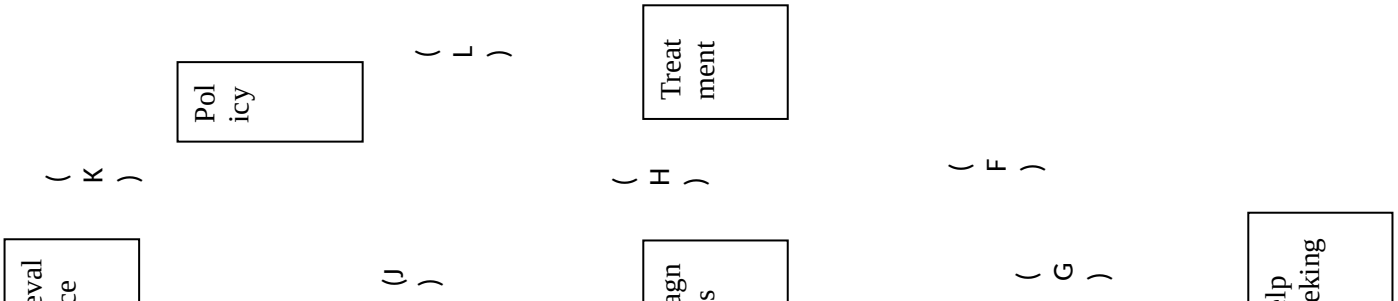
- The research goal is clear, justified and in context regarding the literature
- The approach matches the purpose of research and is justified

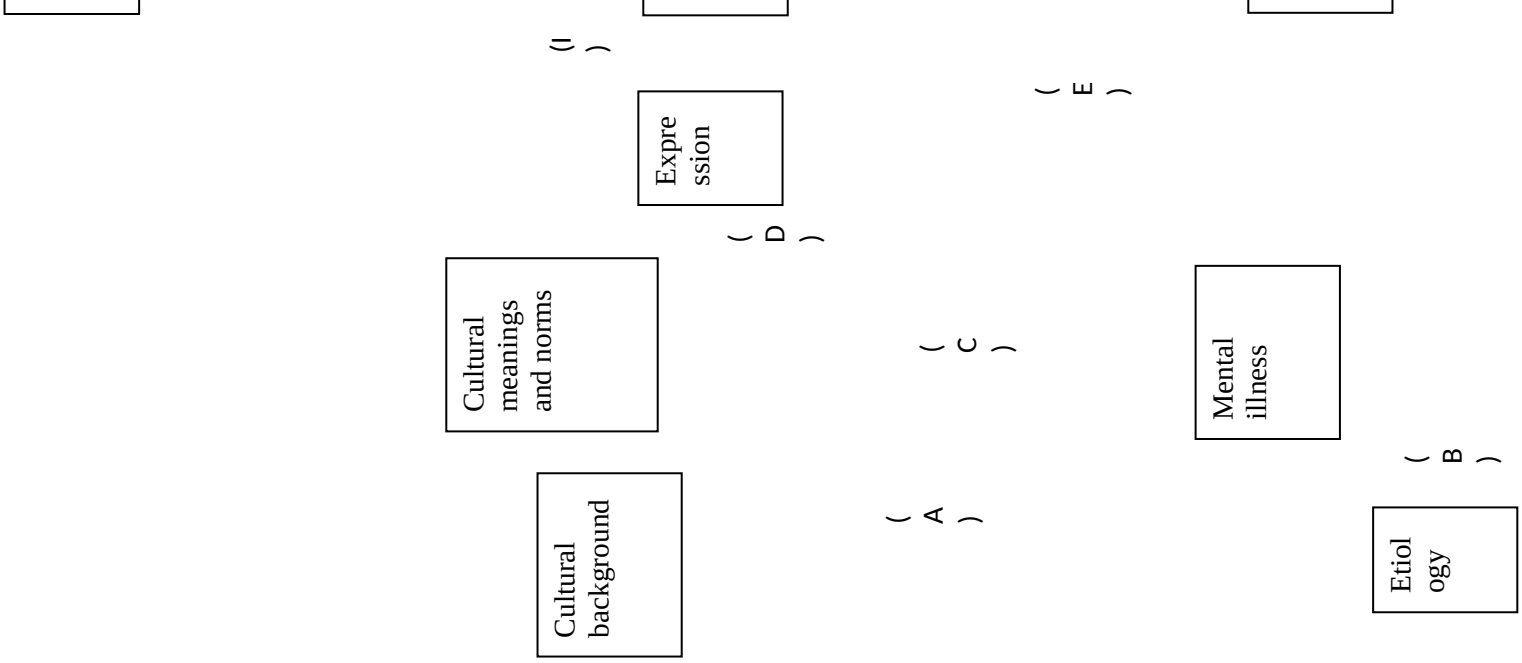
- Methods of sampling, data collection, data management and analysis are made explicit and consistent with the methodology
- Analytical and interpretative processes are described in full

Findings, discussion and implications

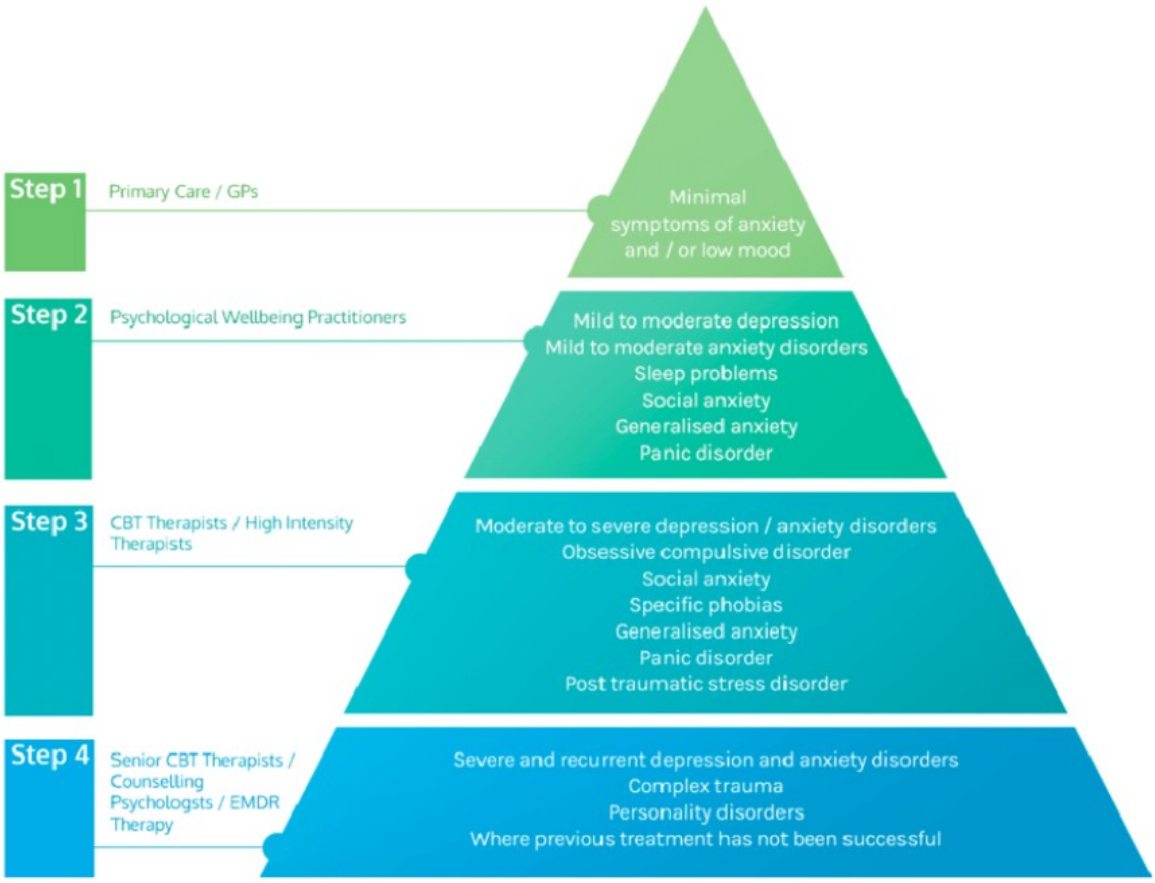
- Findings represent the depth and breadth of data
- Findings and interpretations are supported by the data
- Direct quotations, exemplars or other data presentations are used judiciously to illustrate the findings
- Findings are presented in a way that is consistent with the methodology, method and study aims
- Authors are appropriately cautious about knowledge claims
- Findings are explored theoretically and applications discussed

Appendix 2.1 - The Cultural Influences on Mental Health Model (Hwang et al., 2007)





Appendix 2.2 - Stepped care model used by NHS Talking Therapies Services (*Mental health matters*, 2023)



Appendix 2.3 - Interview schedule

Questions for people who did engage:

1. What did you know about therapy before your first contact with the service?
2. What was your opinion on seeking help for mental health difficulties before you spoke to someone from the service?
3. In your culture, how would someone usually seek help if they were struggling with their mood/mental health?
4. Did you have any worries about therapy which made it difficult to go to appointments?
    a. If yes, what were these worries?
    b. If no, what made you want to go to therapy?
5. Did you face any other challenges which made it difficult to go to therapy?
    a. If yes, how did you overcome these?
6. Were there specific things that you found helpful about the service?
7. Were there specific things that you found less helpful about the service?
8. Was it easy to understand the therapist during your sessions?
    a. Did you feel that the therapist was able to understand you?
9. If you could speak to someone like yourself who was considering taking part in therapy with the service, how would you encourage them to take part?
10. Do you think that the service could be improved?

    a. If yes, in what ways?

Questions for people who did not engage:

1. What did you know about therapy before your first contact with the service?
2. What was your opinion on seeking help for mental health difficulties before you spoke to someone at the service?
3. In your culture, how would someone usually seek help if they were struggling with their mood/mental health?
4. Did you have any worries about therapy which made it difficult to go to appointments?
    a. If yes, what were these worries?
    b. If no, what made you want to go to therapy?
5. Did you face any other challenges which made it difficult to go to therapy?
    a. If yes, how did you overcome these?
6. Can you talk me through the process of you deciding not to/feeling unable to engage with the service?
7. Were there specific things that you found helpful about the service when you initially spoke to someone?
8. Were there specific things that you found less helpful about the service when you initially spoke to someone?
9. Did you think it might have been hard to understand the therapist or hard for them to understand you?
    a. If yes, what do you think would have helped here?
10. Is there anything that you think could have supported you to engage with the service in terms of:
    a. The service itself
    b. The therapist
    c. Being referred
    d. Family, community, or social support
11. Do you think that the service could be improved?
    a. If yes, in what ways?

Appendix 2.4 – Themes, sub-themes, and quotes from staff

CLIENTS	
1.1 Being grateful for therapy	*'All of them have always attended and been very proactive in their own cause of looking for solutions and ways that they can cope better. So yeah, the people who have entered and I've worked with have been very engaged and grateful' (S1)*
	'But she appreciates [it] because if I was in India, I would have none of this' (S3)
	'...quite a few of [clinician 1]'s point I'd kind of mimic in that they're very grateful' (S3)
1.2 Use of a medical model	*'She kind of almost saw me as akin to her GP was very much focused on the physical symptoms , took quite a while to get around the idea that we're going to actually look at the emotions and her thought.' (S3)*
	'[the way symptoms are described] it's very physical. You know, my stomach hurts... I get pains in my head.' (S3)
	'Just what she again explained very medical model. My tummy hurts, my head hurts, type explanations and with the interpreter... we weren't understanding each other.' (S3)
	'I had a lady. It turned out it was PTSD... but the way that she was describing it first made me concerned that she was in a very dangerous, vulnerable situation. We established that it wasn't actually happening and it was flashbacks.' (S3)
	'A lot of concepts are just foreign to her. Like, as you say, she just medicalized things because that's what she's always done. And it's never been presented in any other way.' (S1)

	'It's like, what can I take to make me myself feel better? You know, what? Is there a pill for me?' (S1)
	'I'd sometimes be doing an assessment with somebody new and I'd be thinking, is this psychosis? What what is this? And the way that the symptoms are described?' (S1)
	'you can see how a PWP and a 40 minute assessment might get might not be able to figure that out [the way symptoms are being described]' (S2)
	'[regarding being confused with how symptoms are described] I imagine if you're in a PWP assessment and you're hearing some of this stuff you're less likely to put it through for a therapy and more likely to refer back to the GP or refer up to second your care, and then they get lost…' (S3)
1.3 External factors impacting therapy	*'Attendance became a big problem and she was kind of cancelling last minute because she'd been invited to events.' (S4)*
	'If they have arrived to this country, if they are sponsored in terms of work that they are doing, then that might be impacting their mental health as well.' (S4)
	'There is a lot of experience of discrimination, especially in the workplace and that seems to have a big impact on them, on mental health in general, for example… they've been gaslighted… then that has an impact on the depression but also on the self-esteem they start comparing themselves to others and feeling less than others.' (S4)
	'And she's never asked for help before and she is pretty isolated' (S1)
	'Her dearly beloved son passed away and then her other son who's not the good son is not here and living… in India. And she's on her own. You know what? What can she really do to change her circumstances? So it's really quite tricky' (S1)

	'She was in in insecure housing, she required food vouchers. She'd left her husband's family, so there was all the shame and stigma around that. We were working on rebuilding her connections with her religion and kind of getting her involved in the local community . And there was her family back home, and she was now a strain on them because she'd left. The in-laws house there was, I mean, the trauma from that experience. We didn't even manage to touch on.' (S3)
	'Almost every single client I've had, particularly the woman have had… a huge amount of trauma in their background it's never been spoken about it's just you know part of how it how life is for them.' (S1)
	'Kind of talking about gangs and shoot ups and hiding in a house for four weeks unable to leave and it's just unimaginable in our culture.' (S3)
	'And a lot of it doesn't happen in this country as well. So many women are backwards and forwards between you know with the arranged marriages thing situation and it's deeply deeply traumatic for them you know they separate from their families they get shipped somewhere and then they come back and usually almost always seem to be involved in abusive relationship so it's complex the work you get into.' (S1)
	'…but at the same time didn't seem to be much that we could actually physically change a lot of the things that were bringing them down or causing to be worried were outside of their control, not much ability to change that.' (S3)
1.4 Understanding language and terminology	*'Especially… the older women…with a few it seems to be that they speak English really well. They understand it, but they don't particularly understand everything.' (S4)*
	'All the nuances, the way that maybe we use phrases and stuff, especially if there is a not a technical psychological language.' (S4)
	'Thing that comes on to with older people I think often… is they need interpreters so this adds another layer of struggles.' (S1)
	'So she doesn't read even her own language very well so I can't get her to look at the forms before. So we

	spent a lot of time going through the forms.' (S1)
	'[needing to use interpreters] And I think it is an additional barrier.' (S2)
	'Some older adults… are more difficult to contain. They take longer to complete the MDS with you, then we've got, if there's a cultural factor thrown in, that means that they struggle to understand the language we're using in terms of terminology words that we're using and they also don't speak English… three really crucial elements there that are going to make it really difficult to complete even a screening assessment with them.' (S2)
	'they also don't understand from a language perspective and we're needing the interpreter for, and they're also an older adult, which means that for some older adults, you know, there's longer processing times.' (S2)
	'She then chose to come back to me. Without an interpreter. I think there was something about having the conversation in her own language made it too intense for her.' (S3)
2. Community beliefs	
2.1 Stigma and fear	*'There's also stigma for people from certain cultural backgrounds.' (S2)*
	'We are a team, you have the answer, this is CBT, ask me questions, it's not about losing face.' (S4)
	'They seem to… keep their mental health quite private because of fear of losing face or shaming their family or being considered to be a dangerous mum.' (S3)
	'Especially if you're a woman, you live with your husband's family so you know that can be complicated so you don't really want to let the rest of the family know what is happening , especially the mother-in-law, because then your ranking within that might go down and then of course the impact of you as a mum on

	your children might be diminished.' (S4)
	'These women that I've been speaking to, they are being alienated by their daughters and their sons because they're not complying or they've bucked the system in some way.' (S1)
	'They might not say that actually they really struggle with English…because they fear that they might know the translator or their translator might know their family somehow or they might want someone from their own family that they say they trust to actually be the translators.' (S4)
	'And even the men I've worked with they also have a huge stigma attached to them not coping.' (S1)
	'Just in terms of the view, the older fashioned view of what therapy is and like I shouldn't be needing this and you know that may be in the way initially to start talking.' (S1)
2.2 Family	*'Family and the wider social family… does tend to enter in the conversations more, even if we're treating something like OCD.' (S3)*
	'I've noticed I end up knowing a lot more about extended family… different aunts, views and opinions than I might do for somebody who was typically kind of British born identifying… of that age, of the older age.' (S3)
	'The people in my experience… it's very much a case of feeling disconnected from their families with the older woman that I've spoken to.' (S1)
2.3 Cultural factors and views of mental health	*'That could mean that understanding of what treatment is , that understanding of anxiety and depression… it can be a bit of a generational thing.' (S2)*
	'Haven't traditionally kind of talked about those sorts of things within their culture. They might not even have words for some of the things that we have words for…' (S2)
	'… push pull feeling with their religion and their culture, wanting to embrace being someone who's in a

	Western culture but at the same time they don't want to lose some of their identity.' (S1)
	[in India] 'There's absolutely nothing, no acknowledgement of kind of struggling with your mental health.' (S1)
	'What happens is it seems to be that the cultural expectations and religious expectations are very dominant in these difficult situations and the individuals feelings and emotions and experiences not considered a lot of the time.' (S1)
	'It's just impossible to separate the cultural and religious struggles from personal struggles in all the cases I've ever worked with I think.' (S1)
	'The way that mental health is viewed… often didn't match up with ours.' (S3)
	'It [cultural factors] does influence, you know, engagement, treatment, effectiveness, all of those things.' (S2)
	'Women from a South Asian background… there's cultural factors for them as opposed to men as well.' (S2)
	'…also there is a difference between classes if you are from a Indian background and the caste system.' (S4)
	'Just in terms of the view, the older fashioned view of what therapy is and like I shouldn't be needing this and you know that may be in the way initially to start talking' (S1)
3. Service structure/format	
3.1 CBT	*'Think I've had a few patients who've struggled with the concept of CBT. And maybe expected something a little bit different saw it more of a medical model' (S3)*

	'We struggled with goal setting and trying to find kind of CBT based things. So I'm wondering whether CBT maybe wasn't the right approach for that person' (S3)
	'Working with CBT, we work in the here and now so but although with depression we do a longitudinal kind of explorations as well. But we don't go really deep… in that way we discuss, you know, the impact that may be religion or other kind of backgrounds on their lives' (S4)
	'Within low intensity, there isn't really space for those sorts of conversations [around culture]' (S2)
	'actually the way that I work with somebody from a South Asian background would probably be the same as how I work with someone from a white British background. And I think that is very typical of low intensity CBT that actually it doesn't always allow for as much of a kind of nod to, you know, those cultural factors that might be playing a part or having an influence' (S2)
	'step three, CBT and counselling allows for more of that [cultural conversations] to be brought into the sessions. And it allows for that to be named and talked about a bit more' (S3)
	'Because I mean, just the nature of of of the counselling thing, we're not, we're not as goal based' (S1)
	'you could perhaps invite people to have in the beginning some just free counselling sessions that you can then use that more as an assessment tool for someone like this because you don't know where it's gonna…' (S1)
	'If I'm working with someone and something comes out and I go…we need to let you function better in life and be able to find some coping techniques. I will then refer them within the service to you guys. You CBT peeps' (S1)
3.2 Shortness of resources and time in IAPT	*'Anyway, with lots of the presentations that we see as a service that a 40 minute PWPS assessment isn't always long enough, isn't enough to really understand what is going on for someone and I think that can*

	then act as a barrier to them going on to have treatment with us that might be very helpful for them' (S2)
	'that is true in general… of PWP assessment and the shortness of time. My experience of working with both men and women of Asian backgrounds, the therapeutic relationship, seems to be like with any other working in our field seems to be crucial because that kind of element of trust' (S4)
	'It's embedded in that IAPT system to have a structure clear supervision and line management where actually you know there are sometimes those kind of boxes and it's very difficult to have a discussion and sometimes we get so tired that even having that discussion can be difficult' (S4)
	'Yeah, I think the assessment needs to be slower and longer because what I might immediately think ohh that's stress' (S3)
	'to have another difficult client when maybe we have a really a heavy caseload, yeah. And there might be those barriers as well that we are we haven't spoken or we haven't had time today to speak about' (S4)
3.3 Interpreting service	*'[talking about interpreter service] not good I do not enjoy it most of the time but Yeah I think particularly my my most current one that is on the phone, it is just you know this isn't a fault of anyone but the service sometimes that we use a big word thing and [inaudible] technical problems' (S1)*
	'There is an element of physicality that you know that is quite important. For example, if you had the interpreter in a room and the person can, you know, there is a language that is a physical language as well and you might notice some of the way that they look or not look at you and eye contact and proximity or distance' (S4)
	'especially if we don't have the time to actually have a chat with the translator before. I think the discussion it can become very problematic. Very um messy' (S4)
	'the quality of interpreting that they offered was next level compared to what we do receive from big word… because we had a very good working relationship with them and they were consistent and a lot of it was in person and you know they were really good at doing the brief and the debrief…' (S2)

	'And I think that was a huge loss when we lost the mother tongue interpreters and I and I, you know, be quite interesting to see actually what engagement has been like using big word as oppose to when we were able to use mother tongue' (S2)
	'you know, you knew who you were getting and actually their interpreters had actual counselling training so they knew what counselling was about they understood the nuances [talking about mother tongue interpreters]' (S1)
	'to know that you getting that same interpreter that must be a comfort because you become like a team, don't you' (S1)
	'When you've got big word and you just kind of get delivered something, you're not sure what it is, but you gotta juggle with it' (S1)
	'So initially she required an interpreter with big word and it was a disaster . I had no idea what was going on' (S3)
	'The interpreters wouldn't show up . It would be the wrong type of dialect . One lady turned up and she was in a park to do the interpreting' (S3)
	'we might have the fear of having to use an interpreter system that doesn't work or you know, those barriers that won't be solved in 12 sessions or 15 or 16' (S4)
4. Therapist factors	
4.1 Cultural competency	*'the offer is always are you comfortable to work first of all with a male therapist and they seem to really appreciate that question although they are taken a little bit aback' (S4)*
	'magnify the elephant and say, look, this is it. You know, I'm obviously not Asian, but how do you feel about working with me' (S1)

	'I've seen all sort of and heard you know, amazing things you know, we've including included art and music. And as I said, food you know as part of moving from that really deep down depression and up the spiral of depressions'' (S4)
	'I could have maybe done even even better a job with her or, you know, really helped with eight her understanding even more if I had named it and if I had been more aware of it or had had discussions or supervision so that I knew how to bring that in as part of the therapy that we were doing' (S2)
	'I know that I have never named that or brought that up [cultural influences] or asked them about it or explored it. And you know it could be that if I had, it might have meant that engagement was better or treatment was more effective' (S2)
	'And actually need to listen and explore that and look at all the nuances because it might be something very much different that is just not understood in the same way. So we need to kind of be open to hearing that difference and which is easy to forget' (S3)
4.2 Flexibility and curiosity	*'as [clinician 3] was saying of looking at you and CBT as having the answers . And so it takes a little bit of time' (S4)*
	'concept of time might be a little bit looser. And the way that maybe they explain thing, it takes a little bit longer and it's how to accommodate that' (S4)
	'especially at the beginning and in my experience, needs to be explained . Clear, followed. But but with some flexibility' (S4)
	'Maybe you know I've been discriminatory here and it's that kind of tentative asking for permission like you would anyway with other people and openness to really learn and understand and be sincerely and caring in some ways curious about what might help them' (S4)
	'you that you need to be aware of it, that you need to be having those conversations in your supervision. Having thinking about how to have those conversations with clients bringing bringing it in as as a as a factor as as a thing you know it it does matter' (S2)

	'that kind of caring humility understanding and curiosity and really you know find the time to educate' (S4)
	'And actually need to listen and explore that and look at all the nuances because it might be something very much different that is just not understood in the same way. So we need to kind of be open to hearing that difference and which is easy to forget' (S3)
4.3 Therapist fears/self-doubt	*'maybe some fears ourselves or pre concepts about, you know, maybe I'm not asking the right thing' (S4)*
	'Maybe you know I've been discriminatory here and it's that kind of tentative askin g for permission like you would anyway with other people and openness to really learn and understand and be sincerely and car ing in some ways curious about what might help them' (S4)
	'We are bit reactive I think in IAPTus environment to deal with a little bit complicated C yeah, we we deal with complicated presentations, but then the situations that allows us to give you know the best of our therapists yeah it's not always possible it's not always there' (S4)
	'you know, we sometimes are shy away from going above and beyond almost or or, you know, striving to make sure that we can engage a client as much as we can' (S2)
	'When you were really had the interest of the client at heart. And I think sometimes we can be kind of like, this isn't working. This isn't gonna work and kind of, you know, almost have a bit of a, you know, I give up sort of attitude and actually you know, it's so important that we don't see these things as you know a dead end that actually we can sometimes work around them' (S2)
	'And then there is an element of what is our background? White. Mostly. You know, how much do we know well it depends yeah it's different from every person how fearful are we you know to do a side the the wrong thing' (S4)
	'And it's almost like unconsciously, does that affect how we work with these people, if subconsciously we

	are aware that, you know, this is gonna be more work, gonna have to try and use big word every time. Is that you know, meaning that the type of quality of treatment or the way that we're working with someone does differ even sometimes without us even knowing that we're doing it because we have all of those other factors going on that are affecting our behaviour almost (S2)'

Appendix 2.5 - Themes, sub-themes and quotes from clients who engaged in therapy

1. Journey through therapy	
1.1 Being unsure what to expect	*'[I knew] nothing at all about talking therapies or whatever…' (E3)*
	'I think that everybody not awareness for talking therapy' (E5)
	[did you know anything…] 'no' (E1)
	'No I didn't know what to expect at all' (E2)
	'I was expecting quite a different go at it I thought it would be like a consultation one to one things like that' (E5)
	'When a person goes into this talking therapy hes expecting specialist like going to consultant for my knee' (E5)
	'I thought I would be put with people to discuss divorce or people who had gone through very bad experiences divorce things like that' (E5)
1.2 Taking an active role in therapy	*I mean you have to work with it otherwise if you go and you don't do anything it won't work' (E1)*
	'I took lots of decision myself when I was not feeling good' (E1)

	'she used to give me paperwork and I used to do that' (E1)
	'there was no problem doing things I have got no they're not good on this and that they are good' (E1)
	'and you do the work it does help' (E1)
	'they don't do everything for you you have to work on them' (E2)
	'after that once I got myself independent started doing things' (E3)
	'therapy is such a thing that you cant take a pill its not a tangible medicine you take a pill and the worries will go out it is something you have to work at it' (E4)
	'it did work for me it did work for me yes it did and I used to write every night how I'm feeling all day so I did quite a lot to get out of the depression' (E1)
1.3 Reflecting on the experience of therapy	*'I didn't really think much of it you know… but afterwards I thought about it… then I could see this is the benefit of doing this' (E3)*
	'I can see that now when these things happen you get cloudy its good to talk and get a third opinion' (E3)
	'can see value in it to a certain point and once its got it for you… you've dropped the baggage… you're in a better position and you can go forward' (E3)

	'before I started with the talking therapy… I honestly had a completely different opinion' (E4)
	'they gonna offer you this kind of help but the one you get is quite different so I mean of course my opinion has changed and I'm trying to be constructive' (E4)
2 The role of social support	
2.1 Friends and family	*'my children elder daughter doing good, younger daughter, I got niece, I had good friends so it was a positive environment so I was able to go forward' (E3)*
	'if I needed anything I could ring him he could ring me and we could just go' (E3)
	'I still have some of my old school friends we've been friends for donkeys years' (E3)
	'plus I had a very good friend of mine who just about 4 5 doors away from me' (E3)
	'…support I've got my own family here like I said my younger daughter' (E3)
	'so she helped me a lot and she arranged talking therapies for me…' (E5)
	'that was a very big help and she is the biggest supporter' (E5)
2.2 Being encouraged to go to therapy	*'my husband said you want to go I will go so he went to it and he went a couple of times and he told me look I am okay' (E1)*

	'then I said okay ill come with you and then I went with him and it was good' (E1)
	'yeah GP they said look you go to these things…' (E3)
	'my sisters also said go and take therapy and things like that…' (E4)
	'…she helped me a lot and she arranged talking therapies for me…' (E5)
	'…my daughter pushed me a lot so I went' (E5)
3 The role of culture	
3.1 "You are not to talk to outsiders"	*'people tend to keep to themselves quite a bit and don't talk about it just bottles up' (E2)*
	'*in our culture you are not to talk to outsiders and don't know what help you're going to get and its building up the trust' (E2)*
	'depends sometimes not possible to talk about certain things… you don't know who's door you're going to knock' (E3)
	'it's a funny culture' (E4)
	this is kind of thing we don't discuss amongst friends I would not tell me friends I'm going to talking therapy or I'm suffering from depression' (E4)

3.2 Not wanting to be seen as "crazy"	*'it used to be a taboo of not feeling you can share with it…' (E4)*
	'most of the people will say I'm not going mad why should I go and see that people' (E1)
	'I'm not thinking I'm mad or things like that but first time when he said why don't you go see a counsellor I said no why should I go see a counsellor' (E1)
	'it was that this is a load of hocus pocus but the term I used was that they're a bunch of nutters' (E3)
	'I got a friend of mine they said are you crazy' (E3)
3.3 Language barriers	*'certain things language is a problem so you can help the therapist understand the client more effectively' (E2)*
	'it is a barrier [speaking about language] knowing [inaudible] different languages [inaudible] confidence of the therapist…' (E2)
	'you know some people their English may not be very good and erm you know they would struggle to understand all or they might not understand English very well so they would need people who speak and understand their own language' (E4)
4. Experiences of therapy	
4.1 Feeling understood	*'only one lady during covid who really helped me she was the ex director of NHS and she was the only one*

	who really helped me' (E4)
	'she was sympathetic and because she was mature she was a director quite high up' (E4)
	'she tried to zoom on a couple of points because there foundational ive now discovered there are foundational therapy points ' (E4) *'she asked they thought I had more cultural issues and I was a bit annoyed because you know it wasn't a cultural issue' (E4)*
4.2 Service processes	*'thought it was a lot of admin and [inaudible] and they use some forms and I think that forms are more compliance they use three kinds of compliance forms where you have the score of that was kind of superficial' (E4)*
	'this lady I didn't find a very customised one to one it was a very much you know one kind of advice fits all' (E4)
	'but a lot of us are in the medium you know and those forms are you struggle what I answer and I still to this day that ive been using them for five years and to this day they haven't updated it and the first talk was I thought wasn't beneficial' (E4)
	'hes only got about 10 minutes to say his problem and then it comes oh we will allocate somebody to you and this and that and to be honest with you to this day ive found the service very wishy washy you know' (E4)
	'so I've had about 35-40 sessions and theyre still its centred on a booklet centred on this you might have seen if you haven't ask them for a booklet its still centred on this and I think I would have thought by now they would have moved on modernised it' (E4)
	'so many people are doing it but I think they're still using some outdated information that's my concern

	too' (E4)
	'I don't think they are very good at it I think there are tremendous improvements and they should customise it with the resources and like I have highlighted to you' (E4)
	'*I wasn't too happy because after six sessions they leave you to tackle it' (E4)*
	'80% of the person they have a light depression they can tackle It with a booklet but if its got a long problems if after two years im still struggling with certain things on my mind' (E4)
4.3 Feeling 'passed around'	*'it becomes a bit of a marathon where the baton is being passed one person to another so my strong feedback is that it should be the same person because firstly you're dealing with somebody who's got a mental problem' (E4).*
	'she wants continuation she doesn't want one person to the other I know I'm giving you a lot I've had about four sessions with them differently and there was only one lady during covid who really helped me' (E4)
	'I felt they were passing me round the block but that is something I think if the patient cannot speak or understand then there should be some kind of a mother tongue therapy' (E4)
	'first person talk to you then he passes you to another person then that person might pass you to another person' (E4)
4.4 Preference for face-to-face therapy	*'it was okay but it's not the same as when you're seeing face to face' (E1)*
	'on the phone I mean it's okay but I would prefer face to face and more be better and getting out from home as well' (E1)
	'Not better in sense you know just talking over phones you know should go back to face to face talking this makes quite lot of difference' (E1)

	'you're seeing the person if someone is alone all the time in the house and youre talking on the telephone only if you see somebody that makes a different doesn't it' (E1)
	'If you're not seeing friends nobody coming in the house like me just now it's nice sometime I can go sometime I can't go if somebody can come and see and talk about things that are happening that helps as well maybe not talking therapy' (E1)
	'Yeah which I think lost [inaudible] one to one able to express more and from the other side of the [inaudible] a bit more but because youre on video call you don't really get to see a lot of it' (E2)
	'it would have been better if it was one to one you know over videos calls but that's [inaudible] circumstances' (E2)
4.5 Getting unstuck	*'after five six sessions I was feeling much much better' (E5)*
	'the whole point of therapy was to get your forward from the point you were stuck in the rut the mental cloudiness and you could go forward' (E3)
	the benefit of doing this just to get your mind going forward because you're stuck in a rut or whatever to make the change happen' (E3)
	'I can see the purposes of after gone through all this of doing talking therapies' (E3)
	'once I got it we had regular weekly meetings over video calls so that was to put my mind at rest she gave me ideas' (E2)

Appendix 2.6

Themes, sub-themes and quotes from clients who did not engage in therapy

1. Social Factors	
1.1 Social support	*'And I never went after that because I always believed in my friends and family so that's what I did' (NE3)*
	'cried to people whoever I speak to and I thought after I cry i I feel much much better in myself and I never stayed in my house all the time I always out with my friends walking and talking about my husband and I think that healed me quite a lot' (NE3)
	'I have lots and lots of good friends so because of that I don't need any of those kind of things' (NE3)
	'I have always talked everything to my friends not just one or two friends I have got a lot of friends' (NE3)
	'my husband helps me a lot' (NE4)
1.2 Being encouraged to go to talking therapy	*'my daughter wanted me to go see the GP about this' (NE1)*
	'my son and my daughter he went on to me mum you need counselling and antidepressant for me to get better' (NE3)

	'this psychologist definitely wanted me to see a therapist because I cry' (NE3)
	'[went to the session because] GP wanted it' (NE3)
1.3 Feeling isolated	*'family who didn't want to talk to me' (NE5)*
	'not seeing your family it really hurt me because I've been left without my family' (NE5)
	'Nobody wants to help each other out they're all on their own they're all on their own mind even phone them up they say this and that it's the end of the story nobody's interested at all these days in anybody's family all this young generations they don't want to know anything about it it's the old age people' (NE1)
	'My family don't want to talk to me anymore' (NE1)
	'The family mentally could help but unfortunately in my case I don't have any family you know so that's why I did' (NE2)
2. Views of talking therapy	
2.1 Expectations of therapy	*'that they'd give you some suggestions with how to deal with problems but you didn't fully' (NE2)*

	'I thought they're helping people if you've got a problem they talk to you' (NE4)
	'[they think] nobody will listen to them' (NE5)
	'In my culture they try to come to your house in my culture they're with family or people around you they try to come and talk to you as much as they can' (NE4)
	'nobody will listen to them' (NE5)
	'[I knew] nothing at all' (NE5)
	'I knew nothing nothing I don't really feel like I know they do anything' (NE2)
	'I thought they're helping people if you've got a problem they talk to you' (NE4)
	'I was thinking they would help me you know if they help me to get my mental health better' (NE4)
	'I was thinking they would help me you know if they help me to get my mental health better' (NE4)
2.2 Stigma	*'kids don't bother with them because they're embarrassed' (NE5)*

	'they're too scared and too embarrassed to talk about it' (NE5)
	'I was never interesting in those things to sit there and telling I don't know who just sitting there' (NE3)
	'they've come out in the community everybody will know' (NE5)
	'well last time it did help me out' (NE1)
	'[following MH difficulties] yeah my sons my boys were taken away from me when they were 8 and 3 years old' (NE5)
	'I don't believe in therapy because I think you can get a lot of help from talking to friends as Asians we always have' (NE3)
3. Experience of talking therapy	
3.1 Frustrations with service processes	*'doctor asks for talking therapy why can't get the same records look at them first look at [inaudible] stop there and this is [inaudible] and that's why Asian people give up' (NE5)*
	'talking therapy why can't they have say 6 like you when you got drug problem you go in a group why can't they have that in group' (NE5)

	'they only give you 6 and then they disappeared then I have to cry and beg from my doctor to beg him' (NE5)
	'that's why Asian people give up that's why they don't bother they just say it's a waste of time that puts people off' (NE5)
	'Their timing is so so slow' (NE5)
	'They said they was the wrong team for me and I'm still waiting' (NE5)
	'it was covid sessions you can't go and no one will come to you so you become more depressed and distressed' (NE2)
	'any appointment GP on the phone it's not the same as face to face' (NE2)
	'had I been face to face the things could be slightly better to understand rather than just on the phone' (NE2)
3.2 Unhelpful experiences	*'I said can you bring my husband back and I think that was the first question I asked and they said I can't do that so I said well there is no point in talking that's it' (NE3)*
	'whoever is sitting on the other side they will come to say to me its not like that we can help you to heal this what no one said anything like that to me so that was the first and the last session of my therapy' (NE3)

	'I didn't get any help or she didn't say to me don't go like that or never bothered that person to ring me back one day just wanted to say let's have a talk' (NE3)
	'it didn't even last 5 minutes that conversation so other than that if it was anything helpful they should be ringing back [inaudible] I can help you to get better nothing like that' (NE3)
	'but I didn't find it much interest in them they just saying do this do that' (NE3)
	'Yeah they told me some places to go but didn't give me details' (NE3)
	'I'm not saying the therapist bad to me but they could have given my a ring a couple of days later nobody ever bothered' (NE3)
	'they should come home talk to me what they can do for me or give place for me' (NE8)
	'I thought if somebody care about me they would be ringing me back or you know she must be still grieving and I'll give her a ring to see why she wanted to talk or didn't want to talk they didn't do any of this they not bother' (NE3)
	'Nobody cared' (NE3)
3.3 Helpful experiences	*"when I was there I found it very comfortable I really did and I thought that's made me come out then I thought well I might as well start telling the truth" (NE5)*

	"Yeah last time I went to talking therapy they did help me a lot" (NE5)
	'The manager from last time who was in talking therapy was a nice person and was trying to help me out' (NE2)
4. Barriers to therapy	
4.1 Language	*'that is a bit difficult yeah I try my best [inaudible] problem my English but the problem sometimes my English maybe you can't understand what I'm saying or what people mean' (NE1)*
	'They did offer me [an interpreter]… think myself is better' (NE1)
	'practical yeah their advices and suggestions to put into practice is a difficulty in my case' (NE1)
4.2 Situational factors	
	'there are a lot of Asian ladies who've got mental problems right the thing is they've got their granny flats and put them on the side they don't go to different places nobody want them' (NE5)
	'I lost my sisters brothers I lost my boys same day everything and now I was all alone in the world I want somebody talk to one person that I can tell my secrets to' (NE5)
	'I've been stuck in this flat for nearly 2 weeks my friends been helping me out I have no one to talk to' (NE5)

	'my wife passed away and ive got no one in the house at the moment im on my own doing everything on my own' (NE1)
	'Nobody wants to help each other out' (NE1)
	'Full time carer so that's why I was a full time carer for him and nobody else so that's why I couldn't concentrate on other things' (NE2)
	'I mean I lost a daughter nearly 2 years and I lost a husband nearly a year but still thinking about these things about why these things happen' (NE2)
	'I was housebound looking after my husband full time carer so I didn't [inaudible] myself wasn't going out needed to look after him day and night' (NE2)
	'community yeah who don't know me much don't understand my situation my feeling' (NE4)
5. Hopes for therapy	
5.1 Preference for face-to-face therapy	*'it will only improve if I have to see somebody face to face' (NE1)*
	'Yes rather than just the phone come and see me or I should be going to see like you know I don't know where you are but I think it could be better if we are much face to face my place or wherever your clinic rather than just the phone' (NE2)
	'just inviting me rather than just on the phone I don't know' (NE2)

	'Face to face that's what I would think you can assess it then you can really help it but on the phone you have seen me' (NE2)
	'they should come home talk to me what they can do for me or give place for me' (NE4)
	'No I think they should come to peoples house and talk to them come to my house talk to me and tell me where to go what I have to do to get better' (NE4)
5.2 Therapist from similar background	*'even if they have 6 asian people in one group then the lady the counsellor should be Asian and only Asian and then they all speak up and listen and say yes my husband used to beat me up and all this and that and that lady whose the lady she's listening and she's writing down and let everyone else know where you been coming from we've all been to the same place' (NE3)*
	'That person can understand what all the ladies or gents Asian people talking about she can write down but if you have English counsellor they won't know what they're talking about then it'll be all over the place shouting this and that but if you talk in our language she or she listening it'll be better cause you'll know what they're talking about' (NE5)
5.3 Additional level of support	*'maybe they could have rang me or even if they ring me one day that day ask me do I want o have a talk again that could have been better but nobody did anything' (NE3)*
	'helpful they should tell me the nearest place from where I live so I can [inaudible] or give me that number or tell them to call me that's help' (NE4)

2.7 Journal guidelines

Style of manuscripts

When providing racial or ethnic designations, please use initial capital letters. *Webster's New World Dictionary of American English, 3rd College Edition*, is the accepted source for spelling. Define unusual abbreviations at the first mention in the text.
The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.
Please highlight all changes made in revised manuscripts in yellow.

Author contributions statements using CRediT

The APA *Publication Manual* (7th ed.) stipulates that "authorship encompasses…not only persons who do the writing but also those who have made substantial scientific contributions to a study." In the spirit of transparency and openness, *Cultural Diversity & Ethnic Minority Psychology* has adopted the Contributor Roles Taxonomy (CRediT) to describe each author's individual contributions to the work. CRediT offers authors the opportunity to share an accurate and detailed description of their diverse contributions to a manuscript.
Submitting authors will be asked to identify the contributions of all authors at initial submission according to this taxonomy. If the manuscript is accepted for publication, the CRediT designations will be published as an Author Contributions Statement in the author note of the final article. All authors should have reviewed and agreed to their individual contribution(s) before submission.
CRediT includes 14 contributor roles, as described below:

- **Conceptualization** : Ideas; formulation or evolution of overarching research goals and aims.
- **Data curation** : Management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later re-use.
- **Formal analysis** : Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data.
- **Funding acquisition** : Acquisition of the financial support for the project leading to this publication.
- **Investigation** : Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection.
- **Methodology** : Development or design of methodology; creation of models.
- **Project administration** : Management and coordination responsibility for the research activity planning and execution.
- **Resources** : Provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools.

- **Software** : Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components.
- **Supervision** : Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team.
- **Validation** : Verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs.
- **Visualization** : Preparation, creation and/or presentation of the published work, specifically visualization/data presentation.
- **Writing — original draft** : Preparation, creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation).
- **Writing — review & editing** : Preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision — including pre- or post-publication stages.

Authors can claim credit for more than one contributor role, and the same role can be attributed to more than one author.

Title page

The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address, telephone and fax numbers of the author responsible for correspondence.
Please include the word count of the text and abstract.
Authors should also provide a short title of not more than 45 characters (including spaces), and up to 5 key words, that will highlight the subject matter of the article.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. For commentaries and special section/issue introductions, the abstract is limited to 150 words. For research and review articles, the abstract is limited to 250 words and the following headings are required:

- **Objectives:** Study aims or hypotheses. The abstract must begin with this heading (i.e., no sentences should precede the objectives heading)
- **Methods** : Sample description (including size, race or ethnicity, gender, average age) and research design
- **Results:** Results that pertain to study aims or hypotheses
- **Conclusions:** Implication of findings
- After the abstract, please supply up to five keywords or brief phrases. Phrases are limited to three words maximum.

Public significance statements

Authors submitting manuscripts to *Cultural Diversity & Ethnic Minority Psychology* are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper.

This description should be included within the manuscript on the abstract/keywords page. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility.

All such descriptions will also be published as part of the table of contents, as well as on the journal's web page. This policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

Examples of these 2–3 sentences include the following:

- "It has been suggested that when people read words, they think of the images and sensations that are linked to that word. That idea was supported by the results of this study, which showed that people seemed to think of words' visual and sensory characteristics, even though they were not required to do so."
- "Different countries have different systems of math education. The basic arithmetic concepts of adults educated in China and Canada were compared. The adults educated in China had stronger knowledge of arithmetic than did the adults educated in Canada, likely due to differences in the way math concepts are taught."
- "People tend to remember words better after reading them aloud than after reading them silently. The reasons for this production effect were examined, and results suggested that there are multiple explanations: saying words aloud seems to make them more distinctive and also seems to store them more effectively in memory."

To be maximally useful, these statements of public significance should not simply be sentences lifted directly from the manuscript. They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

Journal Article Reporting Standards

Authors are to adhere to the APA Style Journal Article Reporting Standards (JARS) for quantitative, qualitative, and mixed methods research. Updated in 2018, the standards offer ways to improve transparency in reporting to ensure that readers have the information necessary to evaluate the quality of the research and to facilitate collaboration and replication.

The new JARS:

- recommend the division of hypotheses, analyses and conclusions into primary, secondary and exploratory groupings to allow for a full understanding of quantitative analyses presented in a manuscript and to enhance reproducibility;
- offer modules for authors reporting on N-of-1 designs, replications, clinical trials, longitudinal studies and observational studies, as well as the analytic methods of structural equation modeling and Bayesian analysis; and

- include guidelines on reporting on registration (including making protocols public); participant characteristics, including demographic characteristics; inclusion and exclusion criteria; psychometric characteristics of outcome measures and other variables; and planned data diagnostics and analytic strategy.

JARS-Qual are of use to researchers using qualitative methods like narrative, grounded theory, phenomenological, critical, discursive, performative, ethnographic, consensual qualitative, case study, psychobiography, and thematic analysis approaches. The guidelines focus on transparency in quantitative and mixed methods reporting, recommending descriptions of how the researcher's own perspective affected the study as well as the contexts in which the research and analysis took place.

Participant description and informed consent

The method section of each empirical report must contain a detailed description of the study participants, including (but not limited to) the following:

- age
- gender
- ethnicity
- nativity or immigration history
- SES
- clinical diagnoses and comorbidities (as appropriate)
- any other relevant demographics (e.g., sexual orientation)

The method section also must include a statement describing how informed consent was obtained from the participants (or their parents/guardians) and indicate that the study was conducted in compliance with an appropriate Internal Review Board.

Manuscripts that report on clinical trials using randomized controlled trial designs must include as a figure the CONSORT flow diagram which displays the progress of all participants through the trial. Additionally, authors should follow the 25-item CONSORT checklist when writing the study methods and results. The CONSORT flow diagram and checklist are located on the CONSORT website.

Update: Authors must be sure to report study participant characteristics related to socioeconomic status (SES). SES demographic characteristics allow researchers and journal readers to properly contextualize and interpret research findings. We recognize that there is no standard definition or measurement criteria for SES and related indicators (e.g., social class, income, education, occupation), but authors must document SES demographic characteristics to the best extent possible in their manuscript submission. Additionally, authors are strongly encouraged to incorporate such demographics in future research studies and to take these factors into consideration when developing research questions, conducting analyses, and interpreting results.

For reference, authors are encouraged to read the following article on SES conceptualization and measurement: Diemer, M., Mistry, R., Wadsworth, M., Lopez, I., & Reimers, F. (2013). Best practices in conceptualizing and measuring social class in psychological research. Analyses of Social Issues and Public Policy, 13, 77-113. doi:10.1111/asap.12001.

When providing racial or ethnic designations, please follow APA's language guidelines. See the *Publication Manual of the American Psychological Association* (APA, 2001, pp. 75–76). Use initial capital letters (i.e., Black and White instead of black and white). Do not use the term Caucasian when describing Whites or people of European descent. Manuscripts using

the term Caucasian will be returned without review until the correction is made. Authors are encouraged to review Thomas Teo's article, "Psychology Without Caucasians" (2009, Canadian Psychology, Vol. 50, pp. 91–97) for more information on the use of racial descriptors.

Constraints on generality

In a subsection of the discussion titled "Constraints on generality," authors should include a detailed discussion of the limits on generality (see Simons, Shoda, & Lindsay, 2017). In this section, authors should detail grounds for concluding that results are specific to characteristics of the participants and address limits on generality not only for participants but for materials, procedures, and context. They should also specify which methods the authors think could be varied without affecting the result and which should remain constant.

Measures, study design, and data analysis

The Method section of empirical reports must contain a sufficiently detailed description of the measures used so that the reader understands the item content, scoring procedures, and total scores or subscales. Evidence of reliability and validity with similar populations should be provided.

The policy of *Cultural Diversity & Ethnic Minority Psychology* is to publish papers where authors follow standards for disclosing key aspects of the research design and data analysis. Authors are encouraged to review the standards available for many research applications from http://www.equator-network.org/ and use those that are relevant for the reported research applications.

Statistical reporting of effect size and confidence intervals

We now require that authors report means and standard deviations for all continuous study variables and the effect sizes for the primary study findings. Note that the *Publication Manual of the American Psychological Association* (APA, 2001, pp. 25–26) emphasizes the importance of reporting effect sizes in addition to the usual tests of statistical significance. Effect sizes, or similar statistics such as "goodness-of-fit" indicators for structural equation modeling, can be generated by most statistical packages that are used in the behavioral sciences. If effect sizes are not available for a particular test, then authors should convey this in their cover letter at the time of submission.

Citations in the text

In the text, references should be cited by the name and date system. Both names are cited for a work with two authors. When a work has fewer than six authors, cite all names the first time the reference in the text appears; subsequent citations should only cite the first author's name, followed by "et al." When a work has six or more authors, cite only the first author's surname, followed by "et al." Refer to the following citation examples.

- in a similar case study, Haley (1973) utilized…
- one authority (Green, 1991) suggested…

Data citation

All data, program code and other methods must should be appropriately cited. Such materials should be recognized as original intellectual contributions and afforded recognition through citation.

- All data sets and program code used in a publication should be cited in the text and listed in the reference section.

- References for data sets and program code should include a persistent identifier, such as a Digital Object Identifier (DOI). Persistent identifiers ensure future access to unique published digital objects, such as a text or data set. Persistent identifiers are assigned to data sets by digital archives, such as institutional repositories and partners in the Data Preservation Alliance for the Social Sciences (Data-PASS).
- Data set citation example:

Alegria, M., Jackson, J. S., Kessler, R. C., & Takeuchi, D. (2016). Collaborative Psychiatric Epidemiology Surveys (CPES), 2001–2003 [Data set]. Inter-university Consortium for Political and Social Research. http://doi.org/10.3886/ICPSR20240.v8

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.

Examples of basic reference formats:

Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Publications policies

For full details on publication policies, including use of Artificial Intelligence tools, please see APA Publishing Policies.

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Full Disclosure of Interests Form (PDF, 41KB)
- Download Full Disclosure of Interests Form (PDF, 41KB)

In addition to the publication policies applicable to all APA journal articles, *Cultural Diversity & Ethnic Minority Psychology* requires that all identifying details regarding the client(s) / patient(s), including but not limited to name, age, race, occupation, and place of residence, be altered to prevent recognition.

If a manuscript includes excerpts from transcripts of therapy sessions, you must obtain a signed release authorizing publication of the transcript from the client. Because the identity of

patients may be confidential, we ask that you do not submit the signed release forms with the manuscript; you must, however, retain the signed release forms for your files.
All statements in, or omissions from, published manuscripts are the responsibility of authors, who will be asked to review proofs prior to publication.
Reprint order forms will be sent with the page proofs. No page charges will be levied against authors or their institutions for publication in the journal.

Data, analytic methods (code), and research materials transparency
The policy of *Cultural Diversity & Ethnic Minority Psychology* is to publish papers where authors indicate whether the data, methods used in the analysis, and materials used to conduct the research will be made available to any researcher for purposes of reproducing the results or replicating the procedure.
Authors must, in the author note and at the end of the method section, indicate whether they will or will not make their data, analytic methods, and study materials available to other researchers. If an author agrees to make materials available, the author must specify where that material will be available. If an author does not make data, methods, and materials publicly available, the authors should note their ethical or legal reasons for not doing so and are expected to abide by APA's data preservation policies, specified below under "Ethical Principles."
Authors must disclose any prior uses of data reported in the manuscript in the author note and in the cover letter, which should include a complete reference list of these articles as well as a description of the extent and nature of any overlap between the present submission and the previous work.
Authors must disclose all sources of financial support for the conduct of the research (e.g., "This research was supported by NIDA grant X"). If the funding source was involved in any other aspects of the research (e.g., study design, analysis, interpretation, writing), then clearly state the role. If the funding source had no other involvement other than financial support, then simply state that the funding source had no other role other than financial support. Also provide a conflict-of-interest statement disclosing any real or potential conflict(s) of interest, including financial, personal, or other relationships with other organizations or companies that may inappropriately impact or influence the research and interpretation of the findings. If there are no conflicts of interest, this should be clearly stated.
If the manuscript has been posted to a preprint archive, include a link to the preprint.

Open science badges
All authors publishing in *Cultural Diversity & Ethnic Minority Psychology* may apply for open science badges. Introduced in 2013 by the Center for Open Science's Open Science Framework, these badges may be awarded to authors for making data or materials public or for preregistering their studies. Meant to encourage the sharing of data and materials, as well as pre-registration of studies and analysis plans, these badges are digital objects associated with journal articles and are available in four types:

Open Data:
All data necessary to reproduce the reported results that are digitally shareable are made publicly available. Information necessary for replication (e.g., codebooks or metadata) must be included.

Open Data: Protected Access:
A "PA" (Protected Access) notation may be added to open data badges if sensitive, personal data are available only from an approved third-party repository that manages access to data to

qualified researchers through a documented process. To be eligible for an open data badge with such a notation, the repository must publicly describe the steps necessary to obtain the data and detailed data documentation (e.g. variable names and allowed values) must be made available publicly. View a list of approved repositories .

Open Materials:
All materials necessary to reproduce the reported results that are digitally shareable, along with descriptions of non-digital materials necessary for replication, are made publicly available.

Preregistered:
At least one study's design has been preregistered with descriptions of (a) the research design and study materials, including the planned sample size; (b) the motivating research question or hypothesis; (c) the outcome variable(s); and (d) the predictor variables, including controls, covariates, and independent variables. Results must be fully disclosed. As long as they are distinguished from other results in the article, results from analyses that were not preregistered may be reported in the article.

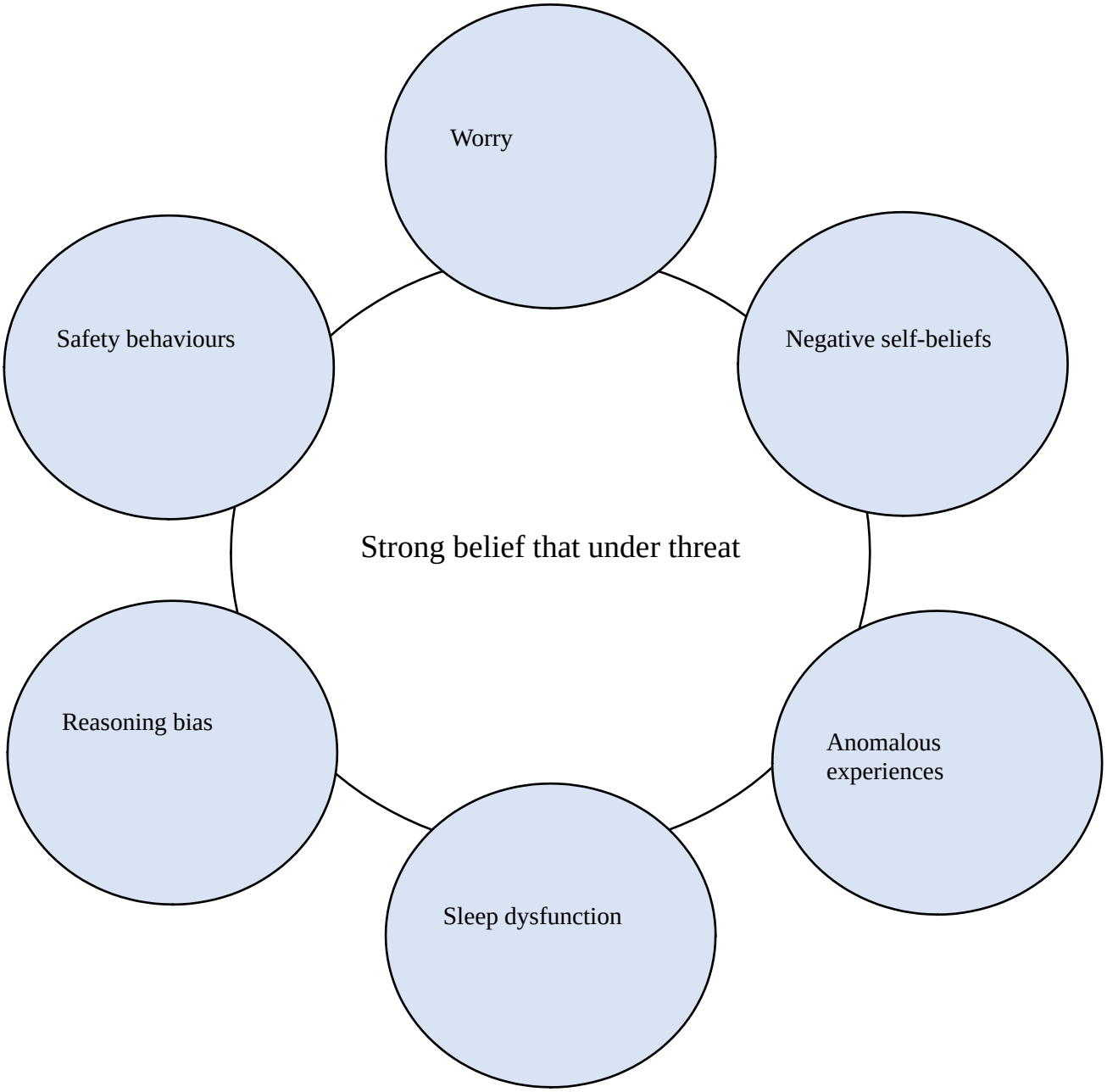
Preregistered+Analysis Plan:
At least one study's design has been preregistered along with an analysis plan for the research — and results are recorded according to that plan.

In addition, notations may be added to badges or open practices notes to indicate, for example, that an analysis plan was registered before the observation of outcomes (DE, Data Exist) or that there were strongly justified changes to an analysis plan (TC, Transparent Changes).
For all badges, items must be made available on an open-access repository with a persistent identifier — and in a format that is time-stamped, immutable, and permanent. For the preregistered badge, this is an institutional registration system (e.g., ClinicalTrials.gov, Open Science Framework, and so on).
Data and materials must be made available under an open license allowing others to copy, share, and use the data, with attribution and copyright as applicable. At submission, authors must confirm that criteria have been fulfilled in a signed badge disclosure form (PDF, 33KB)badge disclosure form (PDF, 33KB) that must be submitted as supplemental material. If all criteria are met as confirmed by the editor, the form will then be published with the article as supplemental material.
Authors should also note their eligibility for the badge(s) in the cover letter.
Authors must, in acknowledgments or the first footnote, indicate if they did or did not preregister the research with or without an analysis plan in an independent, institutional registry.
If an author did preregister the research with an analysis plan, the author must:

- Confirm in the text that the study was registered prior to conducting the research with links to the time-stamped preregistrations at the institutional registry, and that the preregistration adheres to the disclosure requirements of the institutional registry or those required for the preregistered badge with analysis plans maintained by the Center for Open Science.

- Report all preregistered analyses in the text, or, if there were changes in the analysis plan following preregistration, those changes must be disclosed with explanation for the changes.
- Clearly distinguish in text analyses that were preregistered from those that were not, such as having separate sections in the results for confirmatory and exploratory analyses.

Appendix 3.1 – Cognitive model of paranoia (Freeman et al., 2016)



Appendix 3.2 – Revised Green Paranoid Thoughts Scale (Freeman et al., 2019)

R-GPTS

Part A

Name: _____

Date: _____

Please read each of the statements carefully. They refer to thoughts and feelings you may have had about others over the last month.

Think about the last month and indicate the extent of these feelings from 0 (Not at all) to 4 (Totally).

(Please do not rate items according to any experiences you may have had under the influence of drugs.)

		Not at all				Totally
1.	I spent time thinking about friends gossiping about me.	0	1	2	3	4
2.	I often heard people referring to me.	0	1	2	3	4
3.	I have been upset by friends and colleagues judging me critically.	0	1	2	3	4
4.	People definitely laughed at me behind my back.	0	1	2	3	4
5.	I have been thinking a lot about people avoiding me.	0	1	2	3	4
6.	People have been dropping hints for me.	0	1	2	3	4
7.	I believed that certain people were not what they seemed.	0	1	2	3	4
8.	People talking about me behind my back upset me.	0	1	2	3	4

R-GPTS

Part B

Name: _____

Date: _____

Please read each of the statements carefully. They refer to thoughts and feelings you may have had about others over the last month.

Think about the last month and indicate the extent of these feelings from 0 (Not at all) to 4 (Totally).

(Please do not rate items according to any experiences you may have had under the influence of drugs.)

		Not at all				Totally
1.	Certain individuals have had it in for me.	0	1	2	3	4
2.	People wanted me to feel threatened, so they stared at me.	0	1	2	3	4
3.	I was certain people did things in order to annoy me.	0	1	2	3	4
4.	I was convinced there was a conspiracy against me.	0	1	2	3	4
5.	I was sure someone wanted to hurt me.	0	1	2	3	4
6.	I couldn't stop thinking about people wanting to confuse me.	0	1	2	3	4
7.	I was distressed by being persecuted.	0	1	2	3	4
8.	It was difficult to stop thinking about people wanting to make me feel bad.	0	1	2	3	4
9.	People have been hostile towards me on purpose.	0	1	2	3	4
10.	I was angry that someone wanted to hurt me.	0	1	2	3	4

Appendix 3.3 – Beads task script

Can you see and hear me clearly? (if yes continue)

In front of me I have two jars of beads.

This is jar number 1 (shows mostly red jar)

This is jar number 2 (shows mostly yellow jar)

I'm going to randomly select one of the jars and begin to take beads from it

I will show you the beads I take out one by one. I will always return the beads to the jar before taking out a new bead. After I show you a bead, I'd like you to tell me whether you'd like to see another bead, or whether you have made a decision.

Your job is to decide which jar the beads are coming from.

You can ask for as many beads as you like before you make a decision.

Do you understand? (if yes administer task, if no repeat instructions)

Appendix 3.4 - State Social Paranoia Scale (Freeman et al., 2007)

Please select how much you agree or disagree with the following statements:

1 = Do not agree
2 = Agree a little
3 = Agree moderately
4 = Agree very much
5 = Totally agree

1. Someone was hostile towards me
2. No one had any particular feelings about me
3. Someone had bad intentions towards me
4. Someone was friendly towards me
5. Someone was trying to make me distressed
6. I felt very safe in their company
7. Someone stared at me in order to upset me
8. Everyone was trustworthy
9. Someone wanted me to feel threatened
10. I wasn't really noticed by anybody
11. Someone had kind intentions towards me
12. Someone would have harmed me in some way if they could
13. Someone had it in for me
14. Everyone was neutral towards me
15. Someone was trying to intimidate me
16. Everyone was pleasant
17. Someone was trying to isolate me
18. No one had any intentions towards me
19. Everyone seemed unconcerned by my presence
20. Someone was trying to irritate me

Appendix 3.5 – State subscale of STAI (Spielberger et al., 1983)

State-Trait Anxiety Inventory (state portion)

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then *circle* the appropriate number to the right of the statement to indicate *how you feel right now*, that is, *at this moment*. There is no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

Statement		Not at all	Some what	Moderately so	Very much so
(1)	I feel calm	1	2	3	4
(2)	I feel secure	1	2	3	4
(3)	I am tense	1	2	3	4
(4)	I feel strained	1	2	3	4
(5)	I feel at ease	1	2	3	4
(6)	I feel upset	1	2	3	4
(7)	I am presently worrying over possible misfortunes	1	2	3	4
(8)	I feel satisfied	1	2	3	4
(9)	I feel frightened	1	2	3	4
(10)	I feel comfortable	1	2	3	4
(11)	I feel self-confident	1	2	3	4
(12)	I feel nervous	1	2	3	4
(13)	I am jittery	1	2	3	4
(14)	I feel indecisive	1	2	3	4
(15)	I am relaxed	1	2	3	4
(16)	I feel content	1	2	3	4
(17)	I am worried	1	2	3	4
(18)	I feel confused	1	2	3	4
(19)	I feel steady	1	2	3	4
(20)	I feel pleasant	1	2	3	4

Appendix 3.6 – IRAS Ethical approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Eloise Prouten
Trainee Clinical Psychologist
Oxford Health NHS Foundation Trust
Oxford Institute of Clinical Psychology Training & Research
Isis Education Centre, Warneford Hospital
Headington, Oxfordshire
OX3 7JXN/A

Email HCRW.approvals@wales.nhs.uk

03 May 2023

Dear Miss Prouten

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Reasoning biases and paranoia in the context of personality disorder**
IRAS project ID:	315977
Protocol number:	1
REC reference:	23/WA/0076
Sponsor	**Oxford Health NHS Foundation Trust**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

Appendix 3.7 – Journal guidelines

Submission

Personality Disorders: Theory, Research, and Treatment® (*PD:TRT*) is now using a software system to screen submitted content for similarity with other published content. The system compares each submitted manuscript against a database of 25+ million scholarly publications, as well as content appearing on the open web.
List five keywords on the title page to facilitate the selection of peer reviewers. Additionally, provide a cover letter indicating the proposed category under which the manuscript was submitted (e.g., Brief Report) and up to four suggestions for potential reviewers. Suggested reviewers should generally not include those with possible conflicts of interest (COI). In most cases, this would include frequent collaborators, mentors, departmental colleagues, current or previous lab mates, or close personal friends. In some rarer cases in which the research is done in a very small, niche area it may be impossible to avoid suggestions with some COI. In these cases, please include information pertaining to this issue in the cover letter.

Transparency and openness

APA endorses the Transparency and Openness Promotion (TOP) Guidelines by a community working group in conjunction with the Center for Open Science (Nosek et al. 2015).
Empirical research, including meta-analyses, submitted to the *PD:TRT* must at least meet the "requirement" level (Level 2) for citation; data, code, and materials transparency; design and analysis transparency; and study and analysis plan preregistration. Authors should include a subsection in the method section titled "Transparency and Openness." This subsection should detail the efforts the authors have made to comply with the TOP guidelines.
For example:

- We report how we determined our sample size, all data exclusions (if any), all manipulations, and all measures in the study, and we follow JARS (Appelbaum et al., 2018). All data, analysis code, and research materials are available at [stable link to repository]. Data were analyzed using R, version 4.0.0 (R Core Team, 2020) and the package *ggplot*, version 3.2.1 (Wickham, 2016). This study's design and its analysis were not pre-registered.

Data, materials, and code

Authors must state whether data and study materials are posted to a trusted repository and, if so, how to access them, including their location and any limitations on use. If they cannot be made available, authors must state the legal or ethical reasons why they are not available. Trusted repositories adhere to policies that make data discoverable, accessible, usable, and preserved for the long term. Trusted repositories also assign unique and persistent identifiers. Recommended repositories include APA's repository on the Open Science Framework (OSF), or authors can access a full list of other recommended repositories.
In a subsection titled "Transparency and Openness" at the end of the method section, specify whether and where the data and materials are available or note the legal or ethical reasons for not doing so. For submissions with quantitative or simulation analytic methods, state whether the study analysis code is posted to a trusted repository, and, if so, how to access it (or the legal or ethical reason why it is not available).
For example:

- All data have been made publicly available at the [trusted repository name] and can be accessed at [persistent URL or DOI].

- Materials and analysis code for this study are not available [for ethical or legal reason].
- The code behind this analysis/simulation has been made publicly available at the [trusted repository name] and can be accessed at [persistent URL or DOI].

If you cannot make your data available on a public site, authors are required to follow current APA policy to make the materials and data used in a published study available in a timely manner to other researchers upon request.
If an author has multiple studies, the repository landing page should clearly identify how to access the specific type of information for each study and the links.
Download a quick guide on how to organize this information (PDF, 310KB)

Disclosure of prior uses of data
Upon submission of a manuscript, the authors must disclose any prior uses in published, accepted, or under review papers of data reported in the manuscript. The cover letter should include a complete reference list of these articles as well as a description of the extent and nature of any overlap between the present submission and the previous work.

Citation standards
Upon submission, all data sets, materials, and program code created by others must be appropriately cited in the text and listed in the reference section. Such materials should be recognized as original intellectual contributions and afforded recognition through citation. Where possible, references for data sets and program code should include a persistent identifier assigned by digital archives, such as a Digital Object Identifier (DOI).
Data set citation example:
Campbell, Angus, & Kahn, Robert L. (1948). *American National Election Study* [Data set]. ICPSR07218v3.

Interuniversity Consortium for Political and Social Research (Ann Arbor, MI) [distributor] (1999). [Data set]. http://doi.org/10.3886/ICPSR07218.v3

Design and analysis transparency
Authors must adhere to the Journal Article Reporting Standards (JARS) (PDF, 220KB). See also the specific section editorials and instructions on information to include in method and results sections. It is particularly important to provide justifiable power considerations and specific details related to sample characteristics.

Preregistration of studies and analysis plans
Preregistration of studies and specific hypotheses can be a useful tool for making strong theoretical claims. Likewise, preregistration of analysis plans can be useful for distinguishing confirmatory and exploratory analyses. Investigators may reregister prior to conducting the research via a publicly accessible registry system (e.g., OSF, ClinicalTrials.gov, or other trial registries in the WHO Registry Network). There are many available templates; for example, APA, the British Psychological Society, and the German Psychological Society partnered with the Leibniz Institute for Psychology and Center for Open Science to create Preregistration Standards for Quantitative Research in Psychology (Bosnjak et al., 2022).
At the same time, we recognize that there may be good reasons to change a study or analysis plan after it has been preregistered, and thus encourage authors to do so when appropriate so long as all changes are *clearly and transparently* disclosed in the manuscript.
Articles must state whether or not any work was preregistered and, if so, where to access the

preregistration. Preregistrations must be available to reviewers; authors may submit a masked copy via stable link or supplemental material. Links in the method section should be replaced with an identifiable copy on acceptance.
For example:

- This study's design was preregistered; see [STABLE LINK OR DOI].
- This study's design and hypotheses were preregistered; see [STABLE LINK OR DOI].
- This study's analysis plan was preregistered; see [STABLE LINK OR DOI].
- This study was not preregistered.

Whether or not a study is preregistered, *PD:TRT* stresses the importance of transparency in reporting and expects researchers to fully disclose in their manuscript all decisions that were data-dependent (e.g., deciding when to stop data collection, what observations to exclude, what covariates to include, and what analyses to conduct after rather than before seeing the data).

Replication and Registered Reports

Personality Disorders: Theory, Research, and Treatment acknowledges the significance of replication in building a cumulative knowledge base in our field. We therefore encourage submissions that attempt to replicate important findings. Major criteria for publication of replication papers include (i) theoretical significance of the finding being replicated, (ii) statistical power of the study that is carried out, and (iii) the number and power of previous replications of the same finding.
Other factors that would weigh in favor of a replication submission include: pre-registration of hypotheses, design, and analysis; submissions by researchers other than the authors of the original findings; and attempts to replicate more than one study of a multi-study original publication. *Personality Disorders: Theory, Research, and Treatment* publishes Registered Reports, which are particularly well-suited for planned replications (but not limited to such content). Such submissions will consist of a detailed research proposal, including an abstract, introduction, hypotheses, method, planned analyses, and implications of the expected results. We recommend that authors initially contact the editor before submitting a Registered Report. For Registered Reports, the proposed research will be reviewed and, if approved, should then be carried out in accordance with the proposed plan. To the extent that the study is judged to have been competently performed, the paper will be accepted (pending any necessary revisions) regardless of the outcome of the study.

Types of manuscripts

Four types of manuscripts will be accepted:

- full-length articles
- brief reports
- target conceptual articles
- practice reviews (jointly written by a researcher and primary clinician)

Further, the journal will operate an open-access message board to foster continuing dialogue on the target conceptual article.

Full-length articles

Manuscripts presenting empirical findings may be submitted as full-length articles. Full-length articles should not exceed 36 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font

(e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double-spaced.
PD:TRT requires that reports of randomized clinical trials conform to CONSORT reporting standards, including the submission of a flow diagram and checklist. Nonrandomized clinical trials must conform to TREND criteria.

Brief reports

In addition to full-length manuscripts, *PD:TRT* will consider brief reports of empirical findings. Brief reports are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 18 pages.

Target conceptual articles

Manuscripts that evaluate and synthesize the research literature and/or make important theoretical contributions are sought for target conceptual articles. Four commentaries invited by the journal will be published on the *PD:TRT* homepage, along with the author's response to the commentaries.
Target conceptual articles are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 40 pages. Please note that these are typically invited submissions. If you have an idea for a manuscript or a prepared manuscript that may be relevant for this mechanism, please email the editor-in-chief prior to submission for initial consideration.

Reviews

Meta-analytic and narrative reviews are appropriate for submission to *PD:TRT* with a preference for quantitative reviews when possible. These reviews can be a maximum of 40 pages; for meta-analyses, references to studies summarized can be included in supplemental materials, if necessary. Narrative reviews in particular must provide a systematic, integrative synthesis of the empirical literature in a given area and/or should be a springboard to the development of a new theory or model. Mere reviews of the literature without integrative synthesis or model/theory development will not be considered.

Practice reviews

In line with the journal's commitment to bridging science and practice, practice reviews will present an issue from clinical practice, review relevant research, and provide a practical recommendation informed by the reviewed research.
Practice reviews must be coauthored by at least one individual with a primary focus in clinical practice and at least one individual with a primary focus in research. This partnering of individuals with a different professional emphasis is crucial for practice reviews to provide a credible bridge between research and practice.
When submitting a practice review, provide a description of each individual's primary professional focus in the cover letter. Manuscripts not meeting this partnering requirement will be returned without review. New collaborations are especially encouraged.
Practice reviews are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 30 pages.

Manuscript preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).
Review APA's Journal Manuscript Preparation Guidelines before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

APA can place supplemental materials online, available via the published article in the APA PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd

ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

- All color line art and halftones: 300 DPI
- Black and white line tone and gray halftone images: 600 DPI

Line weights

- Adobe Photoshop images
    - Color (RGB, CMYK) images: 2 pixels
- Grayscale images: 4 pixels
- Adobe Illustrator Images
    - Stroke weight: 0.5 points

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., “the red (dark gray) bars represent”) as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.