A novel self-practice/self-reflection programme for CBT therapists from minoritised ethnic backgrounds: A multiple baselines single case experimental study

Sakshi Shetty Chowdhury

Doctorate in Clinical Psychology Thesis (Volume 1)
2023

University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature: 

Name: Sakshi Shetty Chowdhury

Date: 14/06/2023

Overview

This thesis sets out the rationale for and the evaluation of a novel Self-Practice/Self-Reflection (SP/SR) programme for therapists from minoritised ethnic backgrounds.

Part One is a conceptual introduction, which sets out the context and rationale for the development of the above programme. An overview of CBT and its provision in the UK is given, followed by a review of the key issues and developments in the provision of CBT for people from minoritised ethnic backgrounds. The CI then reviews the cultural competence of therapists, identifying some crucial gaps, before exploring the literature around the experiences of therapists from minoritised ethnicities. Finally, the CI will provide a brief description of SP/SR, the novel intervention and the aims of the current research project.

Part Two is the empirical paper, which describes the quantitative evaluation of the SP/SR programme, using a multiple baselines single case experimental design. The aims of this study were to explore the impacts of the programme on therapists' skills in working with ethnicity, on their own ethnic identity development, as well as on their personal and professional wellbeing. The findings provide some evidence for the impact of the programme on therapist skill development, with overall positive trends across outcomes. The results also highlight the differential impact of the programme, across levels of engagement and experience.

Part Three is a critical appraisal, which provides reflections on the process of carrying out this research.

This evaluation has been done in parallel with a qualitative evaluation, which aimed to explore participants' experiences of completing the SP/SR programme (Malik, 2023).

Impact Statement

Although Self-Practice/Self-Reflection (SP/SR) is a well-evidenced therapist training methodology, this paper sets out and quantitatively evaluates the first programme to have adapted SP/SR for CBT therapists from minoritised ethnic backgrounds. The aim of the programme was to offer therapists a supportive space to explore their ethnic identity and its impact on their practice, as well as to develop therapists' skills in working with ethnicity. The experiences and personal and professional development of therapists from minoritised ethnic backgrounds remain under-researched areas within the literature. In particular, a lack of consideration of their unique training needs is highlighted within the wider cultural competence literature. Therefore, both the conceptual introduction and the empirical paper seek to add to research in this much-needed area.

The findings from the empirical paper offer some evidence for the impact of the programme on the development of therapist skills in working with ethnicity. These findings could have implications for the professional training of CBT therapists from minoritised ethnic backgrounds, where experiential training methods like SP/SR may be supportive in developing skills in working in a culturally competent and responsive way. This is seen to be a key competency for CBT therapists. While this was not an investigated outcome in the current study, it is also possible the development of therapists' skills in working with ethnicity in their practice would improve the care of service users from minoritised ethnic backgrounds, which is a significant issue within CBT research and practice.

The research design and findings in this study also add to the research base around SP/SR. The use of a multiple baselines single case experimental design and systematic visual and statistical analysis builds on the available quantitative methods for evaluating SP/SR programmes. In addition, the findings from the empirical paper strengthen the assertion that

SP/SP offers differential impacts and levels of benefit for different people, which may inform the development of future SP/SR programmes.

The idea for the SP/SR programme and the related evaluations was presented at the 2021 European Association for Behavioural and Cognitive Therapies Conference. The findings from this evaluation will be further disseminated at the upcoming 2023 British Association for Behavioural and Cognitive Psychotherapies Conference, as well as through publication in a relevant journal.

Contents

List of Tables and Figures

Part One: Conceptual Introduction

Part Two: Empirical Paper

Acknowledgements

I am incredibly grateful to my internal supervisor, Dr Henry Clements, for all of his time, support and encouragement and for being alongside me through every step of this process.

I would also like to thank my two external supervisors, Dr Alasdair Churchard and Dr Richard Thwaites. It has been a real pleasure to work together on this important and needed programme and I appreciate all of the support and advice you have provided over the last two and a half years.

I would like to thank Leila Lawton, who has been a key member of the team, for your support and regular, thoughtful words of encouragement. I would also like to thank Carla Quan-Soon, for her warmth, providing me with a much-needed space to consider the personal journey I have had with this project.

To all of the experts who consulted with us on this project, I am so grateful for your kindness in offering your time to this project. Dr Isaac Akande, Dr Reena Vohora, Dr Chris Gaskell and Dr Steve Kellett, your input into the design and evaluation has been invaluable.

I am so grateful to have had the opportunity to do this project alongside Zara Malik – I honestly could not have done this without you!

To my parents, partner and friends – thanks for the unwavering love and support, even when the thesis stress got the better of me. Eilidh and Tala, you have been the best friends and library pals I could ask for.

Finally, I am truly grateful to all of the wonderful therapists who participated and stuck with us through the programme and evaluations. Your commitment to this programme has been inspiring and I do hope this research can do justice to your experiences.

Part One: Conceptual Introduction

A clear need and a new opportunity: Setting the context for the development of a novel Self-Practice/Self-Reflection programme for therapists from minoritised ethnic backgrounds.

Word Count: 8891

Introduction

Cognitive Behavioural Therapy (CBT) is one of the most widely implemented psychological therapies but it is often criticised for not adequately acknowledging and incorporating an individual's cultural and ethnic background (Hays, 2019). This gap is also apparent within the UK's Improving Access to Psychological Therapies (IAPT) programme where issues of access and acceptability are commonly reported for service users from minoritised ethnic backgrounds (Baker & Kirk-Wade, 2023; Faheem, 2023b; Prajapati & Liebling, 2022). There is a growing research base around more culturally responsive CBT, including the provision of culturally adapted and culturally sensitive CBT (Beck, 2016; Beck et al., 2019). Alongside the development of these approaches, attending to and developing the cultural competence of CBT therapists has also been recommended (Beck et al., 2013; Naz et al., Williams et al., 2020). Related key issues that are highlighted, include a training and practical skills related gap, as well as the lack of consideration of the differential and unique needs of therapists from minoritised ethnicities (Bassey & Melluish, 2012; Faheem, 2023; Kadaba et al., 2022). The latter point also relates to the underrepresentation of the voices and experiences of therapists from minoritised ethnic backgrounds more generally (Chang, 2022).

This Conceptual Introduction (CI) will attempt to give a brief overview of CBT, its provision in the UK, and importantly, the issues around its provision to service users from minoritised ethnic backgrounds. The CI will then consider the concept of the cultural competence of therapists, before summarising some of the reported experiences of therapists from minoritised ethnic backgrounds. The paper will also draw on and integrate relevant clinical psychology and counselling research, where the CBT research base is limited.

This CI also gives a brief overview of Self-Practice/Self-Reflection (SP/SR), which is an established and well-evidenced therapist training methodology (Bennett-Levy, 2001, 2003). This is done to set the context for the development of a novel application of SP/SR for

CBT therapists from minoritised ethnic backgrounds which aims to provide therapists with an opportunity to explore the impact of their ethnic identity on their personal and professional lives, as well as to support them to develop skills in working with ethnicity in their clinical practice. Finally, the CI will conclude by introducing the evaluation of this novel application of SP/SR for CBT therapists from minoritised ethnic backgrounds.

Despite shared experiences, the lives of people from minoritised ethnic groups will always be individual and nuanced. Therefore, while this CI attempts to explore a number of key issues and ideas, it will not be able to wholly represent the range of experiences and nuances within these discussions. In addition, while the proposed SP/SR programme is pitched at the individual therapist level, the author acknowledges the existence and pervasive nature of systemic racism and the need for change at a structural and systemic level to address its impacts.

Definitions

In this paper, the terms 'people from minoritised ethnicities' or 'minoritised ethnic backgrounds' are primarily used. These terms are used to refer to individuals who do not identify as being from a White-British background or a White-majority group within non-UK-based research. The term 'minoritised' is purposely chosen because, as defined by the Law Society (2023), it signifies the social processes by which people who do not identify as White-British are put into a minoritised position, such as power and oppression, as opposed to the idea of just being in a statistical minority within the UK. Several other terms have been used to make reference to this group of people, such as Black and Minority Ethnic (BME), Black, Asian and Minority Ethnic (BAME), however, these acronyms can often be seen as being an unhelpful shorthand for a diverse group of people. Recently, there is a move to use the term 'People from the Global Majority', as this more appropriately and properly

represents that this group of people make up approximately eighty per cent of the world's population, as well as not centring White as the norm (Campbell-Stephens, 2020).

While this CI will consider the concept of ethnicity, research and writing often use the concepts of race and ethnicity interchangeably. This CI will use ethnicity to encompass the idea of race and extend beyond it. It is important to note that "race" is understood to be a social construct that mainly categorises people based on physical attributes, such as skin colour, and is rooted in harmful White Supremacist ideology (Law Society, 2023). On the other hand, ethnicity is understood to be a wider concept, making reference to people with "shared cultural experiences, religious practices, traditions, language or national origins" (Law Society, 2023).

This paper will also broadly consider the ideas of racism, microaggressions and structural racism, mostly in the context of its impact on service users and therapists from minoritised ethnic backgrounds. Williams, Faber and colleagues (2022) provide a helpful overview of the different forms that racism can take, however, the definitions of microaggressions and structural racism are provided below:

Microaggressions are "small, covert acts of racism, which may be committed outside of conscious awareness. Often they are in the form of patronising statements and backhanded compliments" (p. 4, Williams, Faber, et al., 2022). Structural racism can be understood as "the development of policies, procedures, laws and customs of practice to benefit and maintain White people in power" (p. 4, Williams, Faber, et al., 2022).

Finally, although this paper does not explicitly focus on 'culture', it does refer to related ideas of transcultural practice, cultural competence and cultural safety. There is a lot of debate around the term 'culture', and the following definition from Fernando (2010, as cited in Fernando 2012) helpfully captures its complexity: "'Culture' is something that is difficult to define or pin down, something living, dynamic and changing – a flexible system

of values and worldviews that people live by, a system by which we may define aspects of our identities and negotiate our lives" (p. 113). It is important to note that in this paper, we specifically focus on one aspect of culture: ethnic identity. This is done as we recognise the salience of ethnic identity within the experiences of service users and therapists who are minoritised. However, we acknowledge the importance of intersectionality and that there will always be other identities that influence upon these experiences (Chantler, 2005; Crenshaw, 1989)

Cognitive Behaviour Therapy

Cognitive Behavioural Therapy (CBT) is one of the most extensively researched and implemented therapies globally. Infusing ideas of cognitive therapy within existing behavioural approaches, CBT is centred around some key principles: emotions and behaviours are highly influenced by cognition; behaviour is key in sustaining and shifting psychological and emotional states; and the different systems of cognition, emotion, behaviour and physiology interact with each other and the environment someone is in. Therefore, within CBT, the understanding of difficulties and what maintains them is within the context of these principles, which is usually done via the establishment of a sound working alliance between therapist and service user. Another important hallmark of CBT is empiricism, where theories and treatments are evaluated as a key part of the therapeutic process (Kennerly et al., 2016).

CBT has an extensive research base and is found to be highly effective in the treatment of various difficulties (David et al., 2018; Hofmann et al., 2012). In the UK, CBT is recommended by the National Institute for Health and Care Excellence (NICE) guidelines as the first-line treatment for a range of difficulties, including depression (NICE, 2022), anxiety disorders (NICE, 2011).

CBT and the UK context – The Improving Access to Psychological Therapies Programme

In the UK, CBT has been widely delivered via the Improving Access to Psychological Therapies (IAPT) programme, which is the largest publicly funded psychological therapies programme globally (Clark, 2018).IAPT was borne out of the recommendation for psychological therapies as the first line of intervention for depression and anxiety, however, long waiting lists for existing mental health services at the time meant that this was difficult to access (Clark, 2019). Since its inception in 2008, there are now over 200 IAPT services across the country (Clark, 2018). In the last year (2021 to 2022), IAPT services received 1.81 million referrals for talking therapies, where 1.24 million subsequently accessed services and a further 664,087 of those completed a course of therapy (NHS Digital, 2022). While CBT is delivered more widely within other NHS services and in private practice, this CI will mainly focus on the IAPT programme, due to its size and impact.

The IAPT Manual (National Collaborating Centre for Mental Health, 2023) outlines the three key features of IAPT services:

1) The delivery of NICE-recommended evidence-based therapies, which are matched to the mental health problem and delivered at what is deemed an appropriate intensity and duration. This is also often referred to as the "stepped-care model", where greater symptom severity is treated with a greater intensity of therapeutic support. Although a range of evidenced-based therapies are offered within IAPT services, for example, CBT, Interpersonal Psychotherapy (IPT), Couples Therapy, Eye Movement Desensitisation Reprocessing (EMDR), CBT remains the most frequently delivered therapy (NHS Digital, 2022).
2) The IAPT Manual (National Collaborating Centre for Mental Health, 2023) outlines the importance of an appropriately trained and supervised workforce. IAPT services

differentiate between the Low-Intensity and High-Intensity workforce. The former refers to Psychological Wellbeing Practitioners (PWPs), who are in the process of, or have completed, an IAPT training course and typically deliver interventions to people with mild to moderate difficulties. In contrast, the latter consist of practitioners who have been trained and received accreditation in particular therapeutic modalities, such as CBT, counselling or couples therapy, and deliver interventions to people deemed to have moderate to severe difficulties or more significant care needs (NHS Benchmarking Network, 2022).

3) Finally, the routine monitoring of outcomes is recommended, which is completed on a session-by-session basis and is closely looked at to monitor progress (National Collaborating Centre for Mental Health, 2023). This feature is considered to be a particular hallmark of the IAPT programme, where mental health services have previously placed a relatively small emphasis on monitoring outcomes (Clark, 2018).

Wakefield and colleagues (2021) carried out a systematic review of the practice-based evidence of the IAPT programme. This review of 47 studies concluded that overall, there were large treatment effects for the reduction in depression ($d = 0.87$, 95% CI [0.78–0.96], $p < .0001$) and anxiety ($d = 0.88$, 95% CI [0.79–0.97], $p < .0001$) in IAPT studies, and a medium effect in improvements in work and social adjustment ($d = 0.55$, 95% CI [0.48–0.61], $p < .0001$). However, it was noted that the majority of studies included in the review did not provide sufficient follow-up data, so the longer term intervention effects are unclear (Wakefield et al., 2021).

Despite the relative successes of the IAPT programme in improving access to psychological therapies, there have been a number of criticisms and calls for reform. Most commonly, authors have argued that the true outcomes of the programme may be more

conservative than routinely published outcome data would suggest, and have also highlighted the need for more independent reviews of the effectiveness of IAPT (Marks, 2018; Scott, 2018). In addition, Binney (2015), has critiqued the highly manualised, outcome-driven and diagnostically-based model of IAPT, which he argues is often seen as synonymous to what CBT is and can be. He highlights that often within IAPT services, there is an emphasis on intervention that is informed by diagnosis, which he argues both assumes the validity of diagnostic categories, as well as runs the risk of overshadowing individual context and experience. He also suggests that the manualised and protocol-driven interventions that are offered, often leave less room for the consideration of the practical, social and systemic issues that may contribute to distress (Binney, 2015).

In sum, the above section has provided an overview of the provision of CBT in the UK, mainly via the IAPT programme. Since its initial pilot in 2008, the programme has grown exponentially over the years to become one of the largest providers of psychological therapies in the world and there is good evidence for success of the programme in treating anxiety and depression. However, the programme has also drawn some criticism, calling into question its true impact as well as its highly manualised approach to delivering therapies.

CBT and its provision to individuals from minoritised ethnic backgrounds – some key issues

There is increasing discussion around the acceptability of CBT for people from minoritised ethnic backgrounds. CBT is often critiqued as being underpinned by European-American values, where ideals of individualism, independence and personal autonomy are centred (Hays and Iwamasa, 2006). In line with these values, the exploration and modification of cognitions and core beliefs are central to therapeutic intervention (Hays, 2019; Naeem, 2019; Rathod et al., 2015). However, these values can be seen as being at odds

with wider non-western cultural norms where, for example, an interdependent view of the self is valued (Rose & Kitayama, 1991). It is crucially understood that culture and cultural norms play a role in shaping beliefs as well as the way in which distress is experienced and manifested (Gone and Kirmayer, 2010). Hays (2019) writes that the ideas of ethnicity and culture have often been left out of CBT research, and where the cultural aspects of someone's environment are considered, it is often the negative influences of culture that are emphasised.

Another key issue that is often levelled against CBT and its evidence base is the failure of studies in recruiting people from minoritised ethnic backgrounds within samples, or the lack of reporting around ethnicity within studies (Kirmayer, 2012; Morgan, 2011). Despite more recent developments in CBT research in low and lower middle income countries, Rathod and colleagues (2019) assert that the majority of research around CBT has been conducted in high and higher middle income countries. Therefore, these limitations make it more difficult to generalise the effectiveness of CBT across ethnicities and cultural groups.

Within the UK, related issues have also been noted for individuals from minoritised ethnicities. Annual mental health briefing reports show a pattern of inequity of referrals, treatment and improvement and recovery between ethnic groups year on year (Baker, 2018; Baker & Kirk-Wade, 2023). In an improvement from previous years, people from Black or Black British backgrounds showed similar rates of improvement and recovery to those from White British backgrounds, however, inequalities persist for Asian/Asian British, Mixed or Other Ethnic groups (Baker & Kirk-Wade, 2023). Further people from White British backgrounds were more likely to enter and complete talking therapies within IAPT (Baker & Kirk-Wade, 2023). These inequalities are also replicated within local and service-level data, where two studies found that minoritised racial and ethnic groups were less likely to be assessed and receive treatment than the White-British group, as well as had lower recovery

rates once in treatment (Harwood et al., 2021; Lawton et al., 2021) Of note, people from minoritised groups were also less likely to self-refer to IAPT services, which was attributed to lower levels of trust or previous negative experiences of services (Harwood et al., 2021). To this end, Lawton and colleagues (2021) argue the need for formal frameworks, for example, the standardised implementation of the BAME Positive Practice audit tool (Beck et al., 2019) for services to evaluate and address inequities in the provision of care for minoritised groups.

Understanding the experiences of people from minoritised ethnic backgrounds within mental health services (and of receiving CBT) is crucial in informing considerations and adaptations to make services and therapeutic support more acceptable and accessible and some recent studies help illustrate these experiences (Faheem, 2023b; Prajapati & Liebling, 2022). A theme of cultural dissonance has been highlighted across studies, where therapy often did not meet expectations of support and was sometimes at odds with family, religious or cultural values and expectations. A fear of stigma from communities as well as a lack of trust in healthcare services was commonly described. People also reported a want for greater consideration and exploration of culture within therapy and expected greater cultural competence from therapists (for example, wanting therapists to ask about their culture, beliefs and background and making an attempt to 'get to know' them). Further, there also appeared to be a difference in individuals' conceptualisations of their distress, and faith and religious coping were often not adequately considered within therapy (Faheem, 2023b; Jameel et al., 2022; Mir et al., 2019; Prajapati & Liebling, 2022). CBT in particular was experienced as being prescriptive and homework tasks were often reported as being less helpful and difficult to implement outside of the therapy room (Faheem, 2023b)

This section has outlined some of the key issues around the provision of CBT for people from minoritised ethnic backgrounds. These include some of the more Eurocentric

values that underpin CBT, as well as the lack of a robust research base that considers ethnicity. More specific to the UK, this section has also outlined some of the key issues that minoritised ethnic groups face in their access to CBT via IAPT, alongside lower rates of recovery. This includes the acceptability of this modality for these groups, where the experience of cultural dissonance, and a lack of exploration and consideration of ethnic and cultural identity is frequently reported by service users. These experiences sit within the broader issues of systemic and structural racism, that significantly and negatively impact on individuals from minoritised ethnicities (Beck, 2016; Lawton et al., 2021).

The current status of culturally responsive CBT for people from minoritised ethnic backgrounds

Where the previous section considered some of the issues around access and acceptability, as well as some of the theoretical underpinnings of CBT, there have been some advances in the delivery of culturally responsive CBT. Some authors have put forward that that are a number of features of CBT, such as its collaborative nature and consideration of individual needs, which may lend itself well to its application cross-culturally (Beck, 2016; Hays and Iwamasa, 2006; Naeem et al., 2019). Further, the scale of the IAPT programme and the delivery of CBT within the UK may offer an important opportunity for culture and ethnicity to be considered more explicitly within the design and delivery of psychological therapy for people from minoritised ethnic backgrounds. The following sections will outline some of these key developments, including culturally sensitive and culturally adapted CBT, working with racial trauma, as well as calls for wider structural and systemic change.

Beck (2016) groups recent advances in the provision of culturally responsive CBT into two broad categories: culturally sensitive CBT and culturally adapted CBT. These will be explored with examples below:

Culturally sensitive CBT refers to CBT practice which is largely similar to CBT that is offered to service users from white majority backgrounds but with some adaptations made based on the individual needs of each service user. For example, in such an approach, clinicians draw on particular principles or ideas, such as that of collaboratively exploring the cultural background and critically considering the appropriateness of using disorder specific models in practice with that service user (Beck, 2016). Therefore, culturally sensitive practice encompasses a wider approach or stance to work with clients from diverse ethnic backgrounds. Literature around culturally sensitive practice is mainly in the form of practice guidelines for therapists. Beck (2016) writes about the exploration and incorporation of ethnicity and culture within assessment and formulation, by mapping family systems, gaining accounts of migration histories and understanding levels of acculturation within individuals and their systems. The consideration and exploration of ethnic and cultural background are often helpful in building trust and have contributed to a positive experience of the therapeutic relationship (Faheem, 2023b; Gurpinar-Morgan et al., 2014). Beck (2019) also suggests that when trust is established within the therapeutic relationship, it is important for clinicians to explore experiences and impacts of racism. Other practice based research and guidance suggest similar ideas, as well as emphasising interventions at an organisational level, such as addressing issues of access and community engagement (Beck et al., 2019; d'Ardenne et al., 2005; Hinton & Patel, 2018). However, the majority of existing literature around the delivery of culturally sensitive practice is aimed at white therapists working with clients from minoritised ethnicities.

In CBT that is culturally adapted, the core components of CBT are retained alongside the incorporation of distinct and culturally mediated aspects of the way in which mental health difficulties are understood and expressed by a community (Beck, 2016). Therefore, this is different from culturally sensitive CBT in that culturally adapted CBT is typically

developed with particular groups or communities in mind (Beck, 2016). One of the often-cited cultural adaptations of CBT is by Mir and colleagues (2015) where CBT, specifically Behavioural Activation (BA), was adapted for Muslim clients. An adapted manual, mainly aimed at therapists, includes a focus on the interplay between adverse social circumstances and depression, the experience of depression in Muslim populations, and notably highlights the role of religion and religious coping as a part of behavioural activation. This adapted version was found to be acceptable to both clients and therapists and has been successfully delivered as training to therapists (Mir et al., 2015, 2019). There are numerous other examples of the cultural adaptation of CBT for different groups and communities, both from within and outside of Western countries (Hinton & Bui, 2019; Jameel et al., 2022; Kada, 2019), as well as difficulty-specific adaptations, for example, social anxiety (Jankowska, 2019). A paper by Naeem (2019) provides a comprehensive summary of recent advances in the cultural adaption of CBT. Alongside adaptation studies, some authors have also created adaptation frameworks to guide further adaptions to CBT practice. One of the earliest but still cited adaptation frameworks was propounded by Bernal & Sáez-Santiago (2006), which considers eight dimensions to "culturally-centre" an intervention, including language, culturally adapting metaphors and the content, goals and method of therapy. A more recent evidence based framework has been proposed by Rathod and colleagues (2019), which considers philosophical orientation, practical considerations, technical adjustment of method and skills, and the theoretical adaptation of concepts. Their paper also helpfully sets out the process and foci of cultural adaptation.

In addition to the provision of culturally adapted and culturally sensitive CBT, CBT has also been used to address the impacts of racism, racial trauma and internalised racism (Steele, 2020; Williams, Kanter, et al., 2020; Williams, Holmes, et al., 2022). Racial trauma can be understood as, "the severe mental and emotional injury caused by the cumulative

traumatic effect of racism experienced throughout one's life." (Williams et al, 2021, p.168). There is increasing recognition of the impact of racism and microaggressions on the health and wellbeing of individuals from minoritised ethnicities (Wallace et al., 2016). The Healing Racial Trauma protocol outlines specific adaptations within a CBT framework to support clients who may be experiencing racial stress and trauma, from assessment through to intervention (Williams, Holmes, et al., 2022,). The protocol is split into three parts: first, a stabilisation phase to "Stop the Bleeding"; second, a "Healing" phase, which aims to reduce shame, increase control and build skills in responding to racism; and finally, an "Empowerment" phase, where post-traumatic growth, meaning making and social action and activism are prioritised. Steele (2020) adopts a similar empowerment-based approach in work with internalised racism, using a CBT approach and case conceptualisation. In working with racial stress and trauma, the role of ethnic identity development is also promoted, where a positive ethnic identity is seen to be a protective factor against experiences of racism and discrimination (Williams, Rouleau, et al., 2020).

Alongside developments within individual practice with clients from minoritised ethnic backgrounds to make CBT more acceptable, there is an increasing acknowledgement of the wider service-level, structural and systemic changes that are needed to make CBT, IAPT and mental health services generally more accessible for these groups. Authors highlight the need for engagement with local communities, the involvement of clients in service-design, particularly the involvement of clients from minoritised ethnic backgrounds, as well as adaptations to service provision, for example, attendance policies, to support access for minoritised groups (Beck & Naz, 2019; Naz et al., 2019; Roy-Chowdhury, 2013). Suggestions are also made around adequate training for therapists in providing culturally responsive and competent support, as well as investment from service managers within this, which will be considered in more detail in the following section. Lawton and colleagues

(2021) go further to recommend the inclusion and implementation of service and national standards for the provision of care to people from minoritised ethnic backgrounds, both from healthcare, commissioning and professional bodies.

A recent meta-analysis of adapted interventions for people from minoritised ethnic groups considered the impact of therapist-related adaptations (e.g. training), content-related adaptations (e.g. translated resources, modified resources) and organisational-specific adaptations (e.g. access, length of intervention, Arundell et al., 2021). The results of this meta-analysis suggested that adapted interventions were overall more efficacious than non-adapted interventions and the inclusion of organisational-specific adaptations appeared to have greatest benefit. Similarly, moderate to large effects of adaptations were also found in another review paper (Rathod et al., 2018). However, both studies caution that these conclusions only suggest that adaptations appear to be better than usual care and highlight the dearth of active comparison studies.

This section has outlined promising developments and successes in the provision of culturally sensitive and adapted therapies to people from minoritised ethnic backgrounds. While the former is typically aimed at therapists in their work with ethnically diverse service users, the latter is usually developed with the needs and cultural considerations of specific communities in mind. As has been described in this section, protocols have also been developed for the use of CBT in addressing racial trauma. It is important to highlight that all of these approaches focus on the exploration and understanding of how ethnicity and cultural identity impact upon the experience and expression of difficulties, as well as attempting to focus on strengths and resources that are associated with ethnic identity. However, as noted above, it is crucial for these approaches and adaptations to sit alongside organisational and systemic changes for CBT and mental health support more widely to be truly appropriate for these groups.

The Cultural Competence of CBT Therapists

A key part of providing culturally responsive therapies to service users from diverse ethnic backgrounds involves the cultural competence of the therapists working with them. While some CBT literature has considered this (Beck et al., 2019; Naz et al., 2019; Williams, Rouleau, et al., 2020), much of the work around cultural or multicultural competence comes from the wider counselling and clinical psychology literature (Hays, 2019). This section will aim to define cultural competence, consider some of the approaches to developing cultural competence in clinicians, as well as to identify some of the current gaps.

There are a number of definitions and ways of understanding cultural competence (Curtis et al., 2019 provide a comprehensive summary of definitions). Williams and colleagues (2022, p.2) write that cultural competence is "the ability to understand, appreciate and interact with individuals who have different cultures or belief systems". From the multicultural counselling literature, Sue and Torino (2005) offer a multi-level definition, which centres values of social justice, and this understanding is commonly used within the wider literature. They suggest that cultural competence is "the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counselling competence is defined as the counsellor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups" (Sue & Torino, 2005, p.8). Encompassed within this definition, they offer three domains of cultural competence at the level of the individual counsellor, namely, awareness (of one's own values assumptions and biases), knowledge (of the cultural and historical background and life experiences of different ethnic groups, including socio-political and

psychological consequences) and skills (gaining particular skills and techniques that are congruent with help-seeking in different groups). These domains are commonly considered within attempts to develop the cultural competence of clinicians, for example, in training programmes (Papadopoulos et al., 2004).

In relation to CBT and its practice in the UK, key CBT professional and practice guidelines all emphasise the importance of the cultural competence of clinicians. The British Association for Behavioural and Cognitive Psychotherapies (BABCP), the leading organisation for CBT practice and training in the UK, include the provision of culturally competent therapy in the recently updated Core Curriculum and Minimum Training Standards for CBT practitioners (BABCP, 2021, 2022). Further, recommended practice guidelines such as the BAME Positive Practice Guide (Beck et al., 2019) as well as practice papers (Beck, 2019; Maura & Kopelovich, 2019; Williams, Faber, et al., 2022) suggest specific techniques, approaches and adaptations that clinicians can make in their practice with people from minoritised ethnic backgrounds. However, it is important to note that the majority of these guidelines are aimed at White clinicians working with service users from minoritised ethnicities, and seldom consider other clinician-service user dyads. Further, despite the inclusion of cultural competence within CBT training standards, a clear definition of cultural competence is not provided and it is less clear how this is translated into teaching and implemented across different training courses (Bassey & Melluish, 2012).

In addition to the inclusion of cultural competence within professional training courses, other initiatives have typically involved short-term training programmes for clinicians. Some IAPT services have delivered specific training programmes for staff teams to work with service users from minoritised ethnicities, such as training in delivering culturally sensitive and adapted CBT as well as working with specific ethnic groups (Odusote et al., 2022; Transformation Partners in Health and Care, n.d.). Within mental health and

healthcare more broadly, a number of authors have conducted reviews of cultural competence training programmes (Benuto et al., 2019; Bhui et al., 2007; Clegg et al., 2016; Jones et al., 2016; Jongen et al., 2018; Soto et al., 2018; Truong et al., 2014). These studies have noted high degrees of variability in length, content and approach, where training programmes have been delivered via lectures, peer learning and discussions, reflective and experiential learning, problem- or scenario-based learning and cultural immersion, among others. A paucity of UK-based research around cultural competence training is noted (Clegg et al., 2016). While a number of the above initiatives have appeared to include self-reflective elements, some recent initiatives have centred this within programmes, while explicitly focussing on themes of power, anti-racism and decolonisation within curriculums (Kadaba et al., 2022; White et al., 2018). Overall, cultural competence trainings appear to be experienced as useful by healthcare staff and clinicians (Benuto et al., 2019; Haque et al., 2021). However, the evidence for their effectiveness presents a mixed picture. While some studies and reviews have found positive clinician-reported outcomes, it is hard to delineate what types or aspects of training programmes are most effective (Jones et al., 2016; Jongen et al., 2018). It is also less clear how these improvements at the clinician level impact on service user outcomes and generally methodological issues are noted across studies, such as inconsistencies between studies in how cultural competence is defined and operationalised and the over-reliance on clinician self-report measures (Clegg et al., 2016; Soto et al., 2018; Truong et al., 2014). Further, it is argued that cultural competence training at the individual clinician level is insufficient in bringing about transformative and long-term change, and therefore, change at the organisational and systemic level are needed alongside this (Bhui et al., 2007; Castillo & Guo, 2011; Clegg et al., 2016; Truong et al., 2014).

Despite the relative success of the initiatives described above, there are a number of important issues around the understanding and development of cultural competence within healthcare systems. These are considered below:

First, an important training gap is reported by clinicians, where cultural competence teaching within professional training courses has often been described as insufficient and this is particularly noted within CBT training (Bassey & Melluish, 2012; Benuto et al., 2019; Faheem, 2023b; Hakim et al., 2019). This gap often leaves clinicians to use their own initiative and motivation to develop their transcultural practice (Bassey & Melluish, 2012; Faheem, 2023a; Iwamasa, 1996). Where training has been received, this has typically involved short term training or workshops within a service context, and these spaces are valued and experienced as a commitment from services to improving their provision for minoritised groups (Benuto et al., 2019; Faheem, 2023a; Haque et al., 2021).

A second issue within the cultural competence literature is that training programmes tend to focus more on developing cultural knowledge and focus less on developing an awareness of clinician's own identities, beliefs and biases, and even less so on skill development (Bassey & Melluish, 2012; Jones et al., 2016; Jongen et al., 2018; Reynolds, 2011). Naz and colleagues (2019) note that CBT therapists often report feeling under-equipped and under-confident to explore ethnicity, culture and experiences of racism within their practice, which they attribute to a lack of training and support within the area of cultural competence. A common theme that emerges from research in this area is the desire from clinicians (including CBT therapists) for greater training that focuses on more practical and technical skills (for example, skills on how to explore ethnicity and how to make cultural adaptations to therapy), as well as greater space for reflection and consideration of own identity, values, assumptions and biases (Bassey & Melluish, 2012; Benuto et al., 2019; Faheem, 2023a; Haque et al., 2021; Naz et al., 2019).

A third issue, which is touched on briefly above, is that there is an overwhelming emphasis on the experience and practice of White clinicians working with service users from minoritised ethnic backgrounds. Kadaba and collagues (2022) note that there is a real lack of consideration of the training needs of clinicians from minoritised ethnicities, who are often left unsupported within this work. This gap is similarly identified by Sue and Sue (2015), who speak to the experience of clinicians from minoritised ethnicities working both with white and minoritised ethnic service users, and the unique challenges that arise from these different dyads. For example, they highlight issues of dealing with expressions of racism and needing to prove competence when working with White service users. When working with service users who are also from minoritised ethnicities, they describe possible experiences of overidentification or clashes in cultural values (Sue & Sue, 2015).

Finally, some theoretical arguments are advanced against the concept of cultural competence and related research. The fact there is no accepted definition for what cultural competence is and what is encompassed within it, poses a number of challenges for measuring this construct and understanding what is needed to develop the cultural competence of clinicians (Clegg et al., 2016). An agreed definition would need to include a reflective component, which is currently lacking (Bassey & Melluish, 2012; Faheem, 2023a; Haque et al., 2021) Although doing a comprehensive review of the literature and suggesting future developments is beyond the scope of this CI, it could be an important first step to operationalise cultural competence. Perhaps a clear definition provided by regulatory bodies, such as the BABCP, may help to understand this further within CBT practice and research specifically. On a different note, Curtis and colleagues (2019) take the view that a narrow understanding of cultural competence can be problematic, as it runs the risk of homogenising groups of people, ignoring the organisational and systemic factors that perpetuate inequality, as well as holding an implicit view that cultural competence is an achievable end point. They

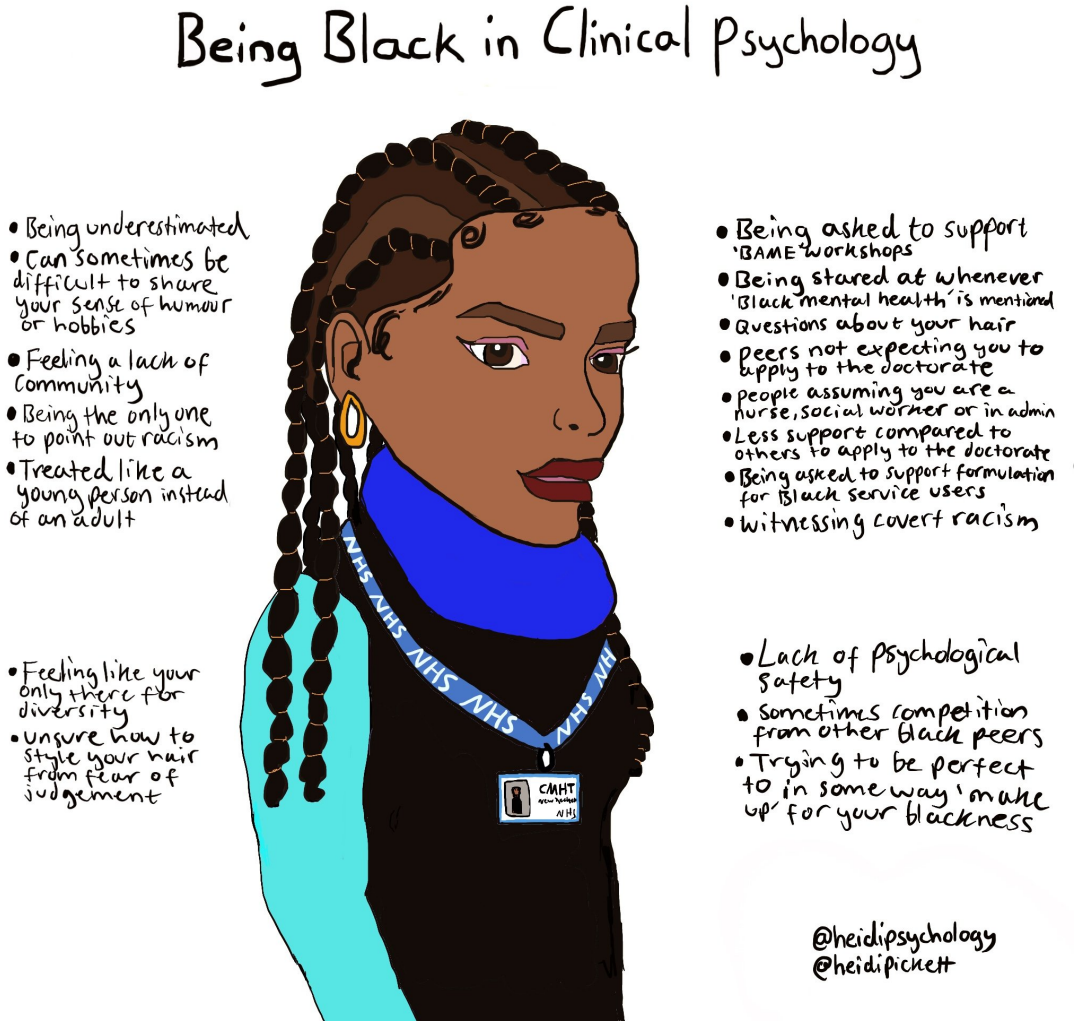
suggest instead moving towards cultural safety, which centres power relations within healthcare interactions; promotes critical consciousness, ongoing self-reflection and accountability; as well as encouraging change at an individual and organisational/systemic level (Curtis et al., 2019). Other authors have proposed alternative understandings, such as that of 'cultural competemility', which infuses the concept of cultural humility within that of cultural competence (Campinha-Bacote, 2018; Stubbe, 2020).

In summary, there are a number of ways to define cultural competence, the components of which many understand to be cultural awareness, cultural knowledge and cultural skills. As described above, the development of cultural competence is typically delivered via short-term training programmes and initiatives. However, there appear to be some key gaps within cultural competence development and its research base. First, CBT therapists and related professionals identify that professional training courses often have inadequate teaching and training in this area. Further, where training initiatives are delivered, there is often a focus on gaining cultural knowledge, and comparatively less of a focus on reflecting on one's own cultural awareness and developing skills. Crucially, teaching and training is disproportionately aimed at white therapists, and the particular needs of therapists from minoritised ethnic backgrounds are often neglected. Secondly, there has been criticism of the construct of cultural competence, which has included advocating for alternative understandings, such as that of cultural safety. Despite these debates within the literature, there appears to be a growing recognition that developing cultural competence is a process rather than an end goal, where self-reflection around one's own identity, assumptions and biases are all key ingredients. Finally, there is a wider acknowledgement that change needs to happen at multiple levels, particularly at a systemic and organisational one, for it to have a widespread and lasting impact for people from minoritised ethnic backgrounds.

The Experience of Therapists from Minoritised Ethnic Backgrounds

This CI has so far considered the issue of CBT and its use with service users from minoritised ethnic backgrounds, as well as the cultural competence of therapists delivering this. The following section aims to explore the experiences of ethnically minoritised therapists, particularly within the context of their professional roles, some named challenges and what is experienced as supportive. It is important to highlight that there appears to be a real dearth of literature that considers the experiences of therapists from minoritised ethnic backgrounds. While the research base is small, anecdotal accounts shared on social media seem to provide an alternative avenue to understand the minoritised ethnic therapist experience. Where relevant, this section will draw upon some of these accounts, however there is a wealth of experience that this paper will not have the opportunity to do justice to. For example, Figure 1 shows an illustration from Heidi Pickett, where she highlights the experience of being Black within the Clinical Psychology Profession. This illustration summarises some of the key and often conflicting experiences of therapists from minoritised ethnic backgrounds, which is described in detail below. Where the CBT literature is particularly limited, this section will also borrow from the wider clinical psychology and counselling literature because this may speak to some of the possible experiences of CBT therapists working within similar structures and systems in the UK.

Figure 1
Being Black in Clinical Psychology



From: *Heidi Pickett (@heidipsychology) ©Heidi Pickett (Permission received).*

Iwamasa (1996) has authored one of the few available papers on the experience of being a CBT therapist from a minoritised ethnic background. In this paper, she reports the results of an exploratory survey of 31 therapists. The survey demonstrated that the majority of respondents found that their ethnicity impacted upon their work, which brought with it both strengths and challenges. Many also indicated that being a therapist from a minoritised ethnic background brings with it a different experience, as opposed to being a non-minoritised therapist. Therapists shared examples of how their ethnicity and experiences

facilitated their therapeutic relationship with service users, allowed for greater exploration and understanding of the minoritised experience, as well as allowed for therapy to take place in different languages. In contrast, more challenging experiences were also highlighted, such as being met with negative perceptions, facing experiences of racism and discrimination, and feeling a need to prove their competence and credibility as professionals, both with service users and colleagues. The survey highlighted a particular experience of being positioned as an expert on minority issues by colleagues, which was often experienced negatively by the respondents (Iwamasa, 1996).

Although this paper was authored over 20 years ago, similar themes appear to be reflected in more recent accounts, both from CBT therapists and the wider psychology professions. A common experience that is reported is this paradoxical experience of invisibility and hypervisibility, both within training and in the workplace (Chang, 2022; Paulraj, 2016). On the one hand, people report that training courses and services often take a "colourblind" approach, where there is not adequate acknowledgement and understanding of their unique and nuanced experiences as people and professionals with minoritised ethnic identities, making their experiences less visible within courses and the wider professions (Paulraj, 2016; Prajapathi et al., 2019; Shah et al., 2012; Spalding et al., 2019). Conversely, there is also a parallel experience of hypervisibility, where individuals are seen predominantly through the lens of their ethnicity, as well as being expected to speak to this experience and lead on initiatives around diversity and inclusion (Beck et al., 2019; Chang, 2022; Paulraj, 2016; Naz et al., 2019; Shah et al, 2012). Naz (2021) highlights this in an article, where she writes about being positioned as an expert in the experiences of all minoritised ethnic communities by others, and further internalising this role, where she has ended up feeling an overwhelming sense of responsibility around these issues. This is further

compounded by a lack of time, resources and recognition in doing this work (Beck et al., 2019; Hakim et al., 2018; Naz et al., 2019).

A number of recent clinical psychology doctoral research projects have brought to light some other important experiences of those from minoritised ethnic background within these professions. One such experience is that of negotiating between ethnic/cultural and professional identities, which are often perceived by others and society as being incompatible (Paulraj, 2016; Prajapathi et al., 2019; Shah et al., 2012). For many, this process is experienced as challenging and emotionally demanding, however others understand this as a unique ability to be a "cultural chameleon", where they are simultaneously able to hold on to their personal and professional identities (Paulraj, 2016; Prajapathi et al., 2019; Shah et al., 2012). Authors similarly highlight a number of other strengths that being a therapist or clinician from a minoritised ethnic background brings, such as an ability to empathise and better understand the experiences of service users who are also from minoritised ethnic backgrounds as well as to allow for an exploration of difference within the therapeutic relationship (Faheem, 2023a; Shah et al., 2012).

Although representation is often cited as an issue when speaking about the experiences of minoritised therapists and clinicians (Williams et al., 2022), the most recent IAPT workforce census showed that the workforce is largely representative of the general population in England in terms of ethnicity (NHS Benchmarking Network, 2023). In an improvement from previous years, 72% of the workforce was from a White or White British background; 3% identified as being from a mixed heritage, 8% as Asian or Asian British, 5% Black or Black British and 2% from a Chinese or Other background (to note: 10% did not state ethnicity, NHS Benchmarking Network, 2023). However, despite these improvements, authors argue that increasing diversity within the profession and workforce in and of itself is not enough. Instead, there needs to be greater accountability and scrutiny within the

profession of its theories, methods and practices, as well as greater support for trainees and professionals from minoritised ethnicities (Prajapathi et al., 2019; Wood & Patel, 2017). A second core issue is that of racism and discrimination within courses, services, the NHS and wider society. Authors write about the nature and impact of these challenging and painful experiences, which are experienced within clinical practice, but more so from peers and colleagues (Beck et al., 2019; Iwamasa, 1996; Naz, 2021; Paulraj, 2016; Prajapathi et al., 2019; Spalding et al., 2019). The NHS Workforce Race Equality Standard (WRES) data shows that staff from minoritised ethnic backgrounds are more likely to experience harassment and bullying and more likely to enter into disciplinary processes, but in contrast they are less likely to be appointed into jobs and senior positions within services (NHS England, 2022; Lawton et al, 2021). This is likely experienced in addition to the usual job pressures as well as the high levels of burnout that are reported within IAPT (Westwood et al., 2017; Williams et al., 2022).

Given these unique and often challenging experiences, some research has described what is experienced as supportive and sustaining within this work. First, there appears to be overwhelming support for the existence and establishment of peer support communities and spaces, specifically for individuals who identify as being from a minoritised ethnic background. For example, Addai and colleagues (2019) write about the establishment of a group for DClinPsy trainees from minoritised ethnic backgrounds and Tong and colleagues (2019) about the establishment of the Black Clinical Psychology Network. Both groups highlight the importance of being a part of a collective, where experiences and resources can be shared, as well as that of creating a space that challenges the wider problem-saturated discourses around minoritised ethnic identity. Secondly, particularly within the CBT research, authors advocate for the exploration of the cultural and ethnic identities of therapists (Faheem, 2023a; Haque et al., 2021; Naz, 2021). The development of a positive

sense of ethnic identity is seen to be an important protective factor for ethnically minoritised individuals (Chang, 2022; Williams et al., 2020, 2022). Additionally, the importance of good quality supervision for therapists from minoritised ethnic backgrounds is highlighted, where space is given for the consideration of the cultural identities of supervisees and service users, where issues of power, privilege and racism can be addressed, and culturally competent skills and practice can be developed (Faheem, 2023a; Iwamasa et al., 2006; Patel, 2013). Finally, there is also a recognition of the action that service managers and institutions can take in creating supportive workplaces for staff from minoritised ethnic backgrounds (Naz et al., 2019).

In summary, there is very little research that has considered the experiences and needs of therapists and related professionals from minoritised ethnic backgrounds. What research is available describes how therapists experience their ethnic identity and how it relates to their professional identities, bringing with it both strengths and challenges. Of note, many therapists have elaborated on the experience of being positioned as experts and expected to lead on work around diversity and inclusion. Given these challenges, opportunities and experiences of support are incredibly valuable.

A clear need and a new opportunity: The novel application of Self-Practice/Self-Reflection (SP/SR) to minoritised ethnic identity

So far, this CI has extensively considered the research around CBT and its provision to individuals from minoritised ethnic backgrounds. Important issues of access and acceptability have been considered, especially within the UK and IAPT context. Developments in the provision of culturally responsive care have highlighted the importance of culturally sensitive and culturally adapted practice, which incorporates the ethnic identities of service users.

At an individual level, the cultural competence of therapists is also key to the delivery of culturally responsive and acceptable care. From the perspective of therapists, it is apparent that there is a real gap in the training and development around cultural competence, particularly in the areas of self-awareness/reflexivity and skill development. Further, the unique development needs of therapists who are also from minoritised ethnic backgrounds are often overlooked within this research, where their voices and experiences are already under-represented within different professional contexts. There has also been an emphasis on the importance of peer support spaces and communities, where ethnic identity and how it relates to professional identity and practice can be considered in a safe way.

In order to address some of these issues, a new adaptation of the existing Self-Practice/Self-Reflection (SP/SR) training methodology was developed specifically for CBT therapists from minoritised ethnic backgrounds (Churchard & Thwaites, 2022). The following empirical paper has aimed to quantitatively evaluate this programme. A brief overview of SP/SR is given below, alongside an overview of the novel programme and its associated evaluation.

Self-Practice/Self-Reflection (SP/SR)

Experiential self-practice and self-reflection has increasingly been integrated within CBT to develop therapist competence - a paper by Laireiter & Willutzki (2003) provides a helpful overview. Self-Practice/Self-Reflection (SP/SR) is one such CBT therapist training methodology, developed by Bennett-Levy and colleagues (Bennett-Levy et al., 2001, 2003). It involves therapists applying CBT to themselves, thereby experiencing CBT "from the inside" (Bennett-Levy et al., 2003). In this method, there is an experiential component, self-practice, where therapists practise CBT methods and techniques on themselves. This is followed by a reflective component, self-reflection, where they engage in a formal process of

reflecting on the experience, from a personal and then a professional perspective (Bennett-Levy & Haarhoff, 2019). Therefore, SP/SR is a unique training method in that it engages both the "personal self" and "therapist self", and this bridging of the two selves is seen to be key for development (Bennett-Levy, 2006; Bennett-Levy & Finlay-Jones, 2018; Bennett-Levy & Haarhoff, 2019). Personal and professional development through SP/SR is explained by the Declarative-Procedural-Reflective (DPR) model of therapist skill development (Bennett-Levy, 2006) and the more recent Personal Practice (PP) model (Bennett-Levy & Finlay-Jones, 2018). Bennett-Levy and Haarhoff (2019) provide a helpful overview of SP/SR within the context of these two conceptual models.

There is a growing research base around SP/SR, and it has been found to develop the competence, meta-competence and artistry of both novice and experienced therapists (Thwaites et al., 2014). SP/SR has primarily been found to develop conceptual knowledge, technical, interpersonal and reflective skills in therapists (Bennett-Levy et al., 2001; Bennett-Levy, 2003; Chaddock et al., 2014; Davis et al., 2014; Haarhoff et al., 2011; Thwaites et al., 2017). In addition, therapists also report outcomes related to their personal and professional development, with some more recent studies additionally suggesting the role of SP/SR in promoting therapist wellbeing and reducing burnout (Bennett-Levy et al., 2015; Chigwedere et al., 2021; Fraser & Wilson, 2010; Gale & Schröder, 2014; Scott et al., 2020). Given these benefits, SP/SR has been implemented in a number of different formats and has increasingly been implemented in a number of professional training courses (Thwaites et al., 2014).

Despite the use of SP/SR in developing a range of generic and CBT-specific skills and competencies, SP/SR has not previously been used for the development of therapist cultural competence.

A Self-Practice/Self-Reflection (SP/SR) Programme for CBT Therapists from Minoritised Ethnicities: A Pilot

A novel SP/SR programme was developed by Churchard and Thwaites (2022) for CBT therapists from minoritised ethnic backgrounds. The programme aims to give therapists an opportunity to reflect on their ethnic identity and any implications for their clinical practice. In doing so, the programme intends to offer therapists a safe and supportive space to explore and hopefully develop a positive sense of their own ethnic identity, while also allowing for the development of skills in working with clients who are also from a minoritised ethnic background (Churchard & Thwaites, 2022).

The programme is delivered in the form of a workbook comprising nine modules. These modules guide therapists through a series of self-practice exercises using a CBT approach, exploring their ethnic identities and backgrounds. Following each exercise, the programme invites them to reflect on the process of this. The programme predominantly takes a strengths-based approach to ethnic identity, whilst also acknowledging and supporting therapists to address some of the challenges associated with being from a minoritised ethnic background. Therapists participating in the programme are also invited to join a facilitated fortnightly reflective group space, which takes place at the end of each module.

The Current Research Project: Aims and Evaluation

As the programme described above is a novel adaptation of SP/SR, two evaluations were carried out to explore the impacts and experience of participating in the programme. The current research project is comprised of the quantitative evaluation of the impacts of the programme, the aims of which are described below.

The primary aim of this evaluation was to explore the impact of the programme on:

1. Therapist self-rated skill in working with ethnicity within their clinical practice.

2. The ethnic identity development of therapists themselves, particularly around the exploration, resolution and affect associated with their ethnic identities.
3. The wellbeing of therapists in relation to their professional and personal selves.

A secondary aim was to consider if any impacts were maintained following the completion of the programme.

As this was the first quantitative evaluation of this programme, the research project was exploratory in nature. However, given the existing research around SP/SR and the intended aims of the project, it was hypothesised that the current intervention would positively impact the areas of skill development, ethnic identity development and wellbeing.

The programme was evaluated using a multiple baselines single case experimental design. This design was chosen in order to explore the idiosyncratic impacts of the programme for therapists, in addition to any overall impacts. Outcome measures relating to the given areas of therapist skill in working with ethnicity, ethnic identity development and wellbeing were adapted and developed for the purpose of this evaluation. Outcomes were completed weekly by therapists participating in the programme, during a baseline, intervention and follow-up period lasting a total of 31 weeks. Outcomes were then analysed using visual and statistical analysis.

In addition to this quantitative research project, a parallel qualitative evaluation was also carried out, which aimed to explore participating therapists' experiences of the programme as well as any implications on their ethnic and racial identity (Malik, 2023).

References

Addai, C., Birch, K., & Nicholas, J. (2019). From safety to bravery: Creating trainee spaces to discuss racism and Whiteness in clinical psychology. Number 323–November 2019, 323, 25.

Arundell, L.-L., Barnett, P., Buckman, J. E. J., Saunders, R., & Pilling, S. (2021). The effectiveness of adapted psychological interventions for people from ethnic minority groups: A systematic review and conceptual typology. *Clinical Psychology Review*, *88*, 102063. https://doi.org/10.1016/j.cpr.2021.102063

Baker, C. (2018). Mental Health Statistics for England: prevalence, services and funding. UK Parliament. http://allcatsrgrey.org.uk/wp/download/public_health/mental_health/SN06988-1.pdf

Baker, C & Kir-Wade, E. (2023). Mental health statistics: prevalence, services and funding in England. UK Parliament. https://commonslibrary.parliament.uk/research-briefings/sn06988/.

Bassey, S., & Melluish, S. (2012). Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: A template analysis focus study. *Counselling Psychology Quarterly*, *25*(3), 223–238. https://doi.org/10.1080/09515070.2012.711528

British Association for Behavioural and Cognitive Psychotherapies (BABCP) (2021). Core Curriculum. https://babcp.com/Portals/0/Files/About/Core%20Curriculum%20Jul%202022.pdf?ver=2023-05-11-145433-467

British Association for Behavioural and Cognitive Psychotherapies (BABCP) (2022). Minimum Training Standards.

https://babcp.com/Portals/0/Files/About/Minimum%20Training%20Standards%201222.pdf?ver=2022-12-15-155902-380

Beck, A. (2016). *Transcultural cognitive behaviour therapy for anxiety and depression: A practical guide.* Routledge.

Beck, A. (2019). Understanding Black and Minority Ethnic service user's experience of racism as part of the assessment, formulation and treatment of mental health problems in cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, *12*, e8. https://doi.org/10.1017/S1754470X18000223

Beck, A., & Naz, S. (2019). The need for service change and community outreach work to support trans-cultural cognitive behaviour therapy with Black and Minority Ethnic communities. *The Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X18000016

Beck, A., Naz, S., Brooks, M. and Jankowska, M. (2019). Black, Asian and Minority Ethnic Service User Positive Practice Guide.

Bennett-Levy, J. (2006). Therapist Skills: A Cognitive Model of their Acquisition and Refinement. *Behavioural and Cognitive Psychotherapy*, *34*(1), 57–78. https://doi.org/10.1017/S1352465805002420

Bennett-Levy, J., & Finlay-Jones, A. (2018). The role of personal practice in therapist skill development: a model to guide therapists, educators, supervisors and researchers. Cognitive Behaviour Therapy, 47(3), 185–205. https://doi.org/10.1080/16506073.2018.1434678

Bennett-Levy, J., & Haarhoff, B. (2019). Why therapists need to take a good look at themselves. In S. Dimidjian (Eds.), *Evidence-based practice in action: Bridging clinical science and intervention (pp. 380-394).* The Guildford Press.

Bennett-Levy, J., Lee, N., Travers, K., Pohlman, S., & Hamernik, E. (2003). Cognitive therapy from the inside: Enhancing therapist skills through practising what we preach. Behavioural and Cognitive Psychotherapy, 31, 145–163. doi:10.1017/S1352465803002029

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, *29*(2), 203–220. https://doi.org/10.1017/S1352465801002077

Bennett-levy, Wilson, S., Nelson, J., Rotumah, D., Ryan, K., Budden, W., Stirling, J., & Beale, D. (2015). Spontaneous Self-Practice of Cognitive Behavioural Therapy (CBT) by Aboriginal Counsellors During and Following CBT Training: A Retrospective Analysis of Facilitating Conditions and Impact. *Australian Psychologist*, *50*(5), 329–334. https://doi.org/10.1111/ap.12154

Benuto, L. T., Singer, J., Newlands, R. T., & Casas, J. B. (2019). Training culturally competent psychologists: Where are we and where do we need to go? *Training and Education in Professional Psychology*, *13*(1), 56–63. https://doi.org/10.1037/tep0000214

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, *34*(2), 121–132. https://doi.org/10.1002/jcop.20096

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research*, *7*(1), 15. https://doi.org/10.1186/1472-6963-7-15

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal*, *20*, 79–83. https://doi.org/10.1108/MHRJ-11-2014-0044

Campbell-Stephens, R. (2020). *Global Majority; Decolonising the language and Reframing the Conversation about Race*. https://www.leedsbeckett.ac.uk/-/media/files/schools/school-of-education/final-leeds-beckett-1102-global-majority.pdf

Campinha-Bacote, J. (2018). Cultural Competemility: A Paradigm Shift in the Cultural Competence versus Cultural Humility Debate – Part I. *OJIN: The Online Journal of Issues in Nursing*, *24*(1). https://doi.org/10.3912/OJIN.Vol24No01PPT20

Castillo, R., & Guo, K. (2011). A Framework for Cultural Competence in Health Care Organizations. *The Health Care Manager*, *30*, 205–214. https://doi.org/10.1097/HCM.0b013e318225dfe6

Chaddock, A., Thwaites, R., Bennett-Levy, J., & Freeston, M. H. (2014). Understanding individual differences in response to Self-Practice and Self-Reflection (SP/SR) during CBT training. *The Cognitive Behaviour Therapist*, *7*, e14. https://doi.org/10.1017/S1754470X14000142

Chang, Y. Y. (2022). *Asian Canadian therapists' experience and coping with racial microaggression: A qualitative examination with interpretative phenomenological]*Doctoral dissertation, University of Windsor]. Electronic Theses and Dissertations. https://scholar.uwindsor.ca/cgi/viewcontent.cgi?article=9696&context=etd

Chantler, K. (2005). From disconnection to connection:'Race', gender and the politics of therapy. *British Journal of Guidance & Counselling*, *33*(2), 239-256

Chigwedere, C. Bennett-Levy, J., Fitzmaurice, B., & Donohoe, G. (2021). Personal practice in counselling and CBT trainees: the self-perceived impact of personal therapy and

self-practice/self-reflection on personal and professional development. Cognitive Behaviour Therapy, 50(5), 422–438. https://doi.org/10.1080/16506073.2020.1846608

Churchard, A. (2022). How can psychotherapists improve their practice with service users from minoritised ethnicities? An application of the Declarative-Procedural-Reflective (DPR) model of clinical skill development. *The Cognitive Behaviour Therapist*, *15*, e1. https://doi.org/10.1017/S1754470X21000386

Churchard, A. & Thwaites, R. (2022). A Self-Practice / Self-Reflection (SP/SR) Programme for CBT Therapists from Minoritised Ethnicities. [Unpublished manuscript].

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, *23*(4), 318–327. https://doi.org/10.3109/09540261.2011.606803

Clark, D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. *Annual Review of Clinical Psychology*, *14*(1), 159–183. https://doi.org/10.1146/annurev-clinpsy-050817-084833

Clark, D. M. (2019, February 13). IAPT at 10: Achievements and challenges. *NHS England.* https://www.england.nhs.uk/blog/iapt-at-10-achievements-and-challenges/

Clegg, S., Heywood-Everett, S., & Siddiqi, N. (2016). A review of cultural competence training in UK mental health settings. *British Journal of Mental Health Nursing*, *5*(4), 176–183. https://doi.org/10.12968/bjmh.2016.5.4.176

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 139.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve

health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Rathod, S., Kingdon, D., Pinninti, N., Turkington, D., & Phiri, P. (2015). Cultural adaptation of cognitive behavioural therapy: Principles and challenges. In *Cultural Adaptation of CBT for Serious Mental Illness* (pp. 14–45). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781118976159.ch2

d'Ardenne, P., Capuzzo, N., Ruaro, L., & Priebe, S. (2005). One size fits all? Cultural sensitivity in a psychological service for traumatised refugees. *Diversity in Health and Social Care*, 2 (1), 29-46.

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in psychiatry*, 4.

Davis, M. L., Thwaites, R., Freeston, M. H., & Bennett-Levy, J. (2015). A Measurable Impact of a Self-Practice/Self-Reflection Programme on the Therapeutic Skills of Experienced Cognitive-Behavioural Therapists: Self-Practice/Self-Reflection Enhances Skill in Experienced CBT Therapists. *Clinical Psychology & Psychotherapy*, *22*(2), 176–184. https://doi.org/10.1002/cpp.1884

Faheem, A. (2023a). 'It's been quite a poor show' – exploring whether practitioners working for Improving Access to Psychological Therapies (IAPT) services are culturally competent to deal with the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist*, *16*, e6. https://doi.org/10.1017/S1754470X22000642

Faheem, A. (2023b). 'Not a cure, but helpful' – exploring the suitability of evidence-based psychological interventions to the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist*, *16*, e4. https://doi.org/10.1017/S1754470X22000599

Fernando, S. (2012). Race and culture issues in mental health and some thoughts on ethnic identity. *Counselling Psychology Quarterly*, *25*(2), 113-123.

Fraser, N., & Wilson, J. (2010). Self-case study as a catalyst for personal development in cognitive therapy training. *The Cognitive Behaviour Therapist*, 3, 107–116. doi:10.1017/S1754470X10000097

Freeston, M. H., Thwaites, R., & Bennett-Levy, J. (2019). 'Courses for Horses': Designing, adapting and implementing self practice/self-reflection programmes. *The Cognitive Behaviour Therapist*, *12*, e28. https://doi.org/10.1017/S1754470X19000138

Gale, C., & Schröder, T. (2014). Experiences of self-practice/self-reflection in cognitive behavioural therapy: A meta-synthesis of qualitative studies. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*(4), 373–392. https://doi.org/10.1111/papt.12026

Gone, J. P., & Kirmayer, L. J. (2010). On the wisdom of considering culture and context in psychopathology. In T. Millon, R. F. Krueger, & E. Simonsen (Eds.), *Contemporary directions in psychopathology: Scientific foundations of the DSM-V and ICD-11* (pp. 72–96). The Guilford Press.

Gurpinar-Morgan, A., Murray, C., & Beck, A. (2014). Ethnicity and the therapeutic relationship: Views of young people accessing cognitive behavioural therapy. *Mental Health, Religion & Culture*, *17*(7), 714–725. https://doi.org/10.1080/13674676.2014.903388

Haarhoff, B., Gibson, K., & Flett, R. (2011). Improving the Quality of Cognitive Behaviour Therapy Case Conceptualization: The Role of Self-Practice/Self-Reflection. *Behavioural and Cognitive Psychotherapy*, *39*, 323–339. https://doi.org/10.1017/S1352465810000871

Hakim, N., Thompson, A., & Coleman-Oluwabusola, G. (2019). An evaluation of the transition from BAME community mental health worker to IAPT low intensity psychological wellbeing practitioner. *The Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X18000296

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., Hall, J., MacCrimmon, S., Rimes, K. A., Woodhead, C., & Hatch, S. L. (2021). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*, 1–12. https://doi.org/10.1017/S0033291721002518

Haque, F., Thapa, B., & Kunorubwe, T. (2021). *Reflections on Cultural Competence Training in IAPT*. *49*, 18.

Hays, P. A. (2019). Introduction. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision (2nd ed.).* (pp. 3–24). American Psychological Association. https://doi.org/10.1037/0000119-001

Hays, P. A., & Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. American Psychological Association.

Hinton, D., & Bui, E. (2019). Cultural Considerations in Anxiety and Related Disorders. In B. O. Olatunji (Ed.), *The Cambridge Handbook of Anxiety and Related Disorders* (pp. 394–418). Cambridge University Press. https://doi.org/10.1017/9781108140416.015

Hinton, D., & Patel, A. (2018). *Culturally Sensitive CBT for Refugees: Key Dimensions: Theory, Research and Clinical Practice* (pp. 201–219). https://doi.org/10.1007/978-3-319-97046-2_10

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive therapy and research*, *36*, 427-440.

Iwamasa, G. Y. (1996). On being an ethnic minority cognitive behavioral therapist. *Cognitive and Behavioral Practice*, *3*(2), 235–254. https://doi.org/10.1016/S1077-7229(96)80016-2

Iwamasa, G. Y., Pai, S. M., & Sorocco, K. H. (2006). Multicultural Cognitive-Behavioral Therapy Supervision. In Hays, P. A., & Iwamasa, G. Y. (Eds.). Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision. American Psychological Association. https://doi.org/10.1037/11433-000

Jameel, S., Munivenkatappa, M., Arumugham, S. S., & Thennarasu, K. (2022). Cultural adaptation of cognitive behaviour therapy for depression: A qualitative study exploring views of patients and practitioners from India. *The Cognitive Behaviour Therapist*, *15*, e16. https://doi.org/10.1017/S1754470X22000137

Jankowska, M. (2019). Cultural modifications of cognitive behavioural treatment of social anxiety among culturally diverse clients: A systematic literature review. *The Cognitive Behaviour Therapist*, *12*, e7. https://doi.org/10.1017/S1754470X18000211

Jones, J. M., Kawena Begay, K., Nakagawa, Y., Cevasco, M., & Sit, J. (2016). Multicultural Counseling Competence Training: Adding Value With Multicultural Consultation. *Journal of Educational and Psychological Consultation*, *26*(3), 241–265. https://doi.org/10.1080/10474412.2015.1012671

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: A systematic scoping review. *BMC Health Services Research*, *18*(1), 232. https://doi.org/10.1186/s12913-018-3001-5

Gale, C., & Schröder, T. (2014). Experiences of self-practice/self-reflection in cognitive behavioural therapy: A meta-synthesis of qualitative studies. *Psychology and Psychotherapy*, 87(4), 373–392. https://doi.org/10.1111/papt.12026

Kada, R. (2019). Cultural adaptations of CBT for the British Jewish Orthodox community. *The Cognitive Behaviour Therapist*, *12*, e4. https://doi.org/10.1017/S1754470X18000120

Kadaba, M. L., Chow, J. S., & Briscoe-Smith, A. (2022). Recommendations for Creating and Teaching a Graduate Psychology Course Exclusively for Black, Indigenous, and People of Color Students. *Teaching of Psychology*, 00986283211070012. https://doi.org/10.1177/00986283211070012

Kennerley, H., Kirk, J., & Westbrook, D. (2016). *An introduction to cognitive behaviour therapy: Skills and applications*. Sage.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine*, *75*(2), 249–256. https://doi.org/10.1016/j.socscimed.2012.03.018

Laireiter, A. R., & Willutzki, U. (2003). Self-reflection and self-practice in training of cognitive behaviour therapy: An overview. Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 10(1), 19-30.

Lawton, L., McRae, M., & Gordon, L. (2021). Frontline yet at the back of the queue – improving access and adaptations to CBT for Black African and Caribbean communities. *The Cognitive Behaviour Therapist*, *14*, e30. https://doi.org/10.1017/S1754470X21000271

The Law Society (2023, February 24). A guide to race and ethnicity terminology and language. https://www.lawsociety.org.uk/topics/ethnic-minority-lawyers/a-guide-to-race-and-ethnicity-terminology-and-language

Malik, Z. (2023). Untitled DClinPsy thesis [Unpublished thesis]. University College London.

Marks, D. (2018). IAPT under the microscope. *Journal of Health Psychology*, *23*, 1131–1135. https://doi.org/10.1177/1359105318781872

Maura, J. (2020). *Cultural Considerations in Applying Cognitive Behavioral Therapy to Racial/Ethnic Minority Groups with Serious Mental Illness*. 6.

McGillivray, J., Gurtman, C., Boganin, C., & Sheen, J. (2015). Self-Practice and Self-Reflection in Training of Psychological Interventions and Therapist Skills Development: A Qualitative Meta-Synthesis Review. *Australian Psychologist*, *50*(6), 434–444. https://doi.org/10.1111/ap.12158

Mir, G., Ghani, R., Meer, S., & Hussain, G. (2019). Delivering a culturally adapted therapy for Muslim clients with depression. *The Cognitive Behaviour Therapist*, *12*, e26. https://doi.org/10.1017/S1754470X19000059

Mir, G., Meer, S., Cottrell, D., McMillan, D., House, A., & Kanter, J. W. (2015). Adapted behavioural activation for the treatment of depression in Muslims. *Journal of Affective Disorders*, *180*, 190–199. https://doi.org/10.1016/j.jad.2015.03.060

Morgan, L (2011). Minority and Gender Representation in Cognitive Behavioral Therapy (CBT) Research: An Analysis of the Literature. University of Hartford.

Naeem, F. (2019). Cultural adaptations of CBT: A summary and discussion of the Special Issue on Cultural Adaptation of CBT. *The Cognitive Behaviour Therapist*, *12*, e40. https://doi.org/10.1017/S1754470X19000278

Naeem, F., Phiri, P., Rathod, S., & Ayub, M. (2019). Cultural adaptation of cognitive–behavioural therapy. *BJPsych Advances*, *25*(6), 387–395. https://doi.org/10.1192/bja.2019.15

The National Collaborating Centre for Mental Health. (2023). *The improving access to psychological therapies manual. https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf*

National Institute for Health and Care Excellence. (2011). *Generalised anxiety disorder and panic disorder in adults: management* [CG113]. https://www.nice.org.uk/guidance/cg113

National Institute for Health and Care Excellence. (2022). *Depression in adults: treatment and management* [NG222]. https://www.nice.org.uk/guidance/ng222

Naz, S. (2021). Where am I really from? *CBT Today,* 49 (1), p28.

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *The Cognitive Behaviour Therapist*, *12*, e22. https://doi.org/10.1017/S1754470X19000060

NHS Benchmarking Network. (2023). *Health education england NHS talking therapies for anxiety and depression workforce census. https://www.hee.nhs.uk/sites/default/files/documents/HEE%20NHS%20Talking%20Therapies%20for%20Anxiety%20and%20Depression%20Workforce%20Census%202022%20-%20National%20Report.pdf*

NHS Digital. (2022). *Psychological Therapies, Annual report on the use of IAPT services, 2021-22*. NDRS. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22

NHS England. (2022). *NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts. https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/*

Odusote, F., Klejny, K., Al-Nassery, R., Haque, F. & Kunorubwe, T. (2022, July). Qualitative Evaluation of Training on Culturally Sensitive Treatments within IAPT

(Talking Change - Portsmouth) [Poster Presentation]. https://www.researchgate.net/profile/Taf-Kunorubwe/publication/362158445_Qualitative_Evaluation_of_Training_on_Culturally_Sensitive_Treatments_within_IAPT_Talking_Change_-Portsmouth/links/62d94d2578e4d13106add15f/Qualitative-Evaluation-of-Training-on-Culturally-Sensitive-Treatments-within-IAPT-Talking-Change-Portsmouth.pdf

Papadopoulos, I., Tilki, M., & Lees, S. (2004). Promoting cultural competence in health care through a research based intervention in the UK. *Diversity in Health and Social Care*, *1*(2), Article 2.

Patel, N. (2013). Difference and power in supervision: The case of culture and racism. In I. Fleming & L. Steen (Eds.), *Supervision and clinical psychology: Theory, practice and Perspectives* (pp. 96-117). Routledge.

Paulraj, P. S. (2016). *How do black trainees make sense of their identities in the context of clinical psychology training?* [Doctoral dissertation, University of East London]. https://doi.org/10.15123/PUB.5401

Pickett, H [@heidipsychology]. (2023, March 24). *Being black in clinical psychology* [Illustration]. Instagram. https://www.instagram.com/p/CqLrSzBMUQ9/?igshid=MmJiY2I4NDBkZg==

Prajapati, R., Kadir, S., & King, S. (2019, November). Dealing with racism within clinical psychology training: Reflections of three BAME trainee clinical psychologists. In *Clinical Psychology Forum* (Vol. 323, pp. 20-24).

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. https://doi.org/10.1007/s40615-021-00993-x

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., Munshi, T., & Naeem, F. (2018). The current status of culturally adapted mental health interventions: A practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment*, *14*, 165–178. https://doi.org/10.2147/NDT.S138430

Rathod, S., Kingdon, D., Pinninti, N., Turkington, D., & Phiri, P. (2015). *Cultural Adaptation of CBT for Serious Mental Illness: A Guide for Training and Practice*. John Wiley & Sons, Ltd.

Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, *12*, e10. https://doi.org/10.1017/S1754470X18000247

Reynolds, A. (2011). Understanding the Perceptions and Experiences of Faculty Who Teach Multicultural Counseling Courses: An Exploratory Study. *Training and Education in Professional Psychology*, *5*, 167–174. https://doi.org/10.1037/a0024613

Rose, H., & Kitayama, S. (1991). *Culture and the Self: Implications for Cognition, Emotion, and Motivation*.

Roy-Chowdhury, S. (2013). How can an IAPT service increase its cultural sensitivity. Clinical Psychology Forum, 241, 45–50.

Scott, M. J. (2018). Improving Access to Psychological Therapies (IAPT)—The Need for Radical Reform. *Journal of Health Psychology*, *23*(9), 1136–1147. https://doi.org/10.1177/1359105318755264

Scott, J., Yap, K., Bunch, K., Haarhoff, B., Perry, H., & Bennett-Levy, J. (2021). Should personal practice be part of cognitive behaviour therapy training? Results from two self-practice/self-reflection cohort control pilot studies. *Clinical Psychology and Psychotherapy,* 28(1), 150–158. https://doi.org/10.1002/cpp.2497

Shah, S., Wood, N., Nolte, L., & Goodbody, L. (2012). The experience of being a trainee clinical psychologist from a black and minority ethnic group. A qualitative study. Clinical Psychology Forum, 232, 32–35.

Soto, A., Smith, T. B., Griner, D., Domenech Rodríguez, M., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology*, *74*(11), 1907–1923. https://doi.org/10.1002/jclp.22679

Spalding, B., Grove, J., & Rolfe, A. (2019). An exploration of Black, Asian and Minority Ethnic counsellors' experiences of working with White clients. *Counselling and Psychotherapy Research*, *19*(1), 75–82. https://doi.org/10.1002/capr.12194

Steele, J. M. (2020). A CBT Approach to Internalized Racism among African Americans. *International Journal for the Advancement of Counselling*, *42*(3), 217–233. https://doi.org/10.1007/s10447-020-09402-0

Stubbe, D. E. (2020). Practicing Cultural Competence and Cultural Humility in the Care of Diverse Patients. *FOCUS*, *18*(1), 49–51. https://doi.org/10.1176/appi.focus.20190041

Sue, & Sue, D. (2015). *Counseling the culturally diverse: theory and practice* (7th ed). Wiley.

Sue, D. W., & Torino, G. C. (2005). Racial-cultural competence: Awareness, knowledge, and skills. In Carter, R. T. (Eds.), *Handbook of Racial-Cultural Psychology and Counseling* (pp. 3-18). John Wiley & Sons Inc.

Thwaites, R., Bennett-Levy, J., Cairns, L., Lowrie, R., Robinson, A., Haarhoff, B., Lockhart, L., & Perry, H. (2017). Self-practice/self-reflection (SP/SR) as a training strategy to enhance therapeutic empathy in low intensity CBT practitioners. *New Zealand Journal of Psychology*, *46*(2), 63-70.

Thwaites, R., Bennett-Levy, J., Davis, M., & Chaddock, A. (2014). Using self-practice and self-reflection (SP/SR) to enhance CBT competence and metacompetence. In A.

Whittington & N. Grey (Eds.), *How to become a more effective CBT therapist: Mastering metacompetence in clinical practice* (pp. 241–254). Wiley Blackwell.

Tong, K., Peart, A., & Rennalls, S. J. (2019, November). Reframing our stories: Addressing barriers faced by Black people trying to access a career in clinical psychology. In *Clinical Psychology Forum* (Vol. 323, pp. 14-19).

Transformation Partners in Health and Care. (n.d.). *Culturally responsive initiatives within IAPT services*. https://www.transformationpartnersinhealthandcare.nhs.uk/iapt-transformation/specific-population-groups/different-ethnic-groups/culturally-responsive-initiatives-within-iapt-services/#heading4

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, *14*(1), 99. https://doi.org/10.1186/1472-6963-14-99

Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology*, *60*(1), e12259. https://doi.org/10.1111/bjc.12259

Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative Effect of Racial Discrimination on the Mental Health of Ethnic Minorities in the United Kingdom. *American Journal of Public Health*, *106*(7), 1294–1300. https://doi.org/10.2105/AJPH.2016.303121

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health*, *26*(2), 172–179. https://doi.org/10.1080/09638237.2016.1276540

White, A. A., Logghe, H. J., Goodenough, D. A., Barnes, L. L., Hallward, A., Allen, I. M., Green, D. W., Krupat, E., & Llerena-Quinn, R. (2018). Self-Awareness and Cultural Identity as an Effort to Reduce Bias in Medicine. *Journal of Racial and Ethnic Health Disparities*, *5*(1), 34–49. https://doi.org/10.1007/s40615-017-0340-6

Williams, M. T., Faber, S. C., & Duniya, C. (2022). Being an anti-racist clinician. *The Cognitive Behaviour Therapist*, *15*, e19. https://doi.org/10.1017/S1754470X22000162

Williams, M. T., Holmes, S., Zare, M., Haeny, A., & Faber, S. (2022). An Evidence-Based Approach for Treating Stress and Trauma due to Racism. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2022.07.001

Williams, M. T., Kanter, J. W., Peña, A., Ching, T. H. W., & Oshin, L. (2020). Reducing microaggressions and promoting interracial connection: The racial harmony workshop. *Journal of Contextual Behavioral Science*, *16*, 153–161. https://doi.org/10.1016/j.jcbs.2020.04.008

Williams, M. T., Rouleau, T. M., La Torre, J. T., & Sharif, N. (2020). Cultural competency in the treatment of obsessive-compulsive disorder: Practitioner guidelines. *The Cognitive Behaviour Therapist*, *13*, e48. https://doi.org/10.1017/S1754470X20000501

Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099

Part Two: Empirical Paper

A novel self-practice/self-reflection programme for CBT therapists from minoritised ethnic backgrounds: A multiple baselines single case experimental study

Word Count: 10835

Abstract

Introduction: This study quantitatively evaluates a novel application of Self-Practice/Self-Reflection (SP/SR) to CBT therapists from minoritised ethnic backgrounds.

Aims: The primary aims of the study were to explore the impact of the SP/SR programme on therapists' skills in working with ethnicity in their clinical practice, their ethnic identity development, as well as on their perceived levels of personal and professional wellbeing. A secondary aim was to consider if any impacts were maintained following the completion of the programme.

Methods: This study adopted a multiple baseline single case experimental design to explore the overall and individual impacts of the programme, across baseline, SP/SR and follow-up phases. Participants were CBT therapists from minoritised ethnic backgrounds, and the outcomes of six participants who completed the programme are presented. Measures were developed and adapted for the purpose of this evaluation and weekly outcomes were collected. Outcomes were analysed using visual and statistical analysis.

Results: The results from this study suggested that overall, participants appeared to show increases in level and positive trends from the baseline to the SP/SR phase, however, these were only significant in the cases of some participants across outcomes. Significant improvements across three baseline conditions were only made in the skills to identify and address similarities and differences in ethnicity outcome, demonstrating a functional relationship. Outcomes from the follow-up phase presented a more mixed mixture.

Conclusions: The study gives some support for the impact of the SP/SR programme in developing therapist skills in working with ethnicity, as well as highlighting differential outcomes for participants related to levels of experience and engagement. The findings from

this study have possible implications for the personal and professional development of ethnically minoritised therapists, as well as future quantitative SP/SR literature.

Introduction

Self-Practice/Self-Reflection (SP/SR) is one evidenced therapist training methodology that has been used extensively within Cognitive Behavioural Therapy (CBT) training and professional development (Bennett-Levy et al., 2001, 2003). It is based on the principle of experiencing CBT "from the inside", where therapists practise CBT methods and techniques on themselves (self-practice), following which they engage in a formal process of reflection on the experience (self-reflection). It has been defined as "a formal self-experiential training process over an extended period of time, following through on real-life issues and developing reflective skills as a bridge between personal impact of the therapeutic techniques and implications for the therapist role" (Bennett-Levy & Haarhoff, 2019, p.383). Therefore, SP/SR can be seen as an integrative methodology, that falls somewhere in the intersection between more traditional forms of CBT training (for example, didactic teaching or roleplays) and types of personal practice (for example, personal therapy or meditation, Bennett-Levy, 2019; Bennett-Levy & Finlay-Jones, 2018; Bennett-Levy & Haarhoff, 2019; Bennett-Levy & Lee, 2014). It has been widely implemented in different formats and with a range of professionals across different career stages (Bennett-Levy et al., 2001, 2003; Bennett-Levy et al., 2015; Chaddock et al., 2014; Davis et al., 2014; Thwaites et al., 2017). It is also increasingly being integrated into professional training courses (Thwaites, et al., 2014).

SP/SR is underpinned by a model of therapist skill development, known as the Declarative-Procedural-Reflective (DPR) model, which was developed in parallel by Bennett-Levy (2006). This model proposes three implicated systems: a declarative system, a procedural system and a reflective system. The declarative system is understood to be the store of knowledge or the "what" of therapy, including conceptual knowledge, interpersonal knowledge and technical knowledge. The procedural system is concerned with the "how" and

"when" of therapy, where declarative knowledge is applied in practice. Finally, the reflective system is involved in the evaluation of declarative knowledge and procedural skills, supporting the refinement and development of skills, and is commonly referred to as the "engine" of skill development (Bennett-Levy, Thwaites, et al., 2009). The DPR model also distinguishes between the personal self and the therapist self, which are seen to be distinct but overlapping, and influence skill development (Bennett-Levy, 2006; Bennett-Levy & Haarhoff, 2019). Therefore, SP/SR as a methodology is seen to work across these three systems in developing therapist skills, where the experiential and reflective elements are seen to be particularly key in developing procedural and reflective skills (Bennett-Levy, McManus, et al., 2009). The DPR model has also been further extended to describe a Personal Practice (PP) model, which outlines how SP/SR and other forms of personal practice are related to therapist skilfulness (Bennett-Levy & Finlay-Jones, 2018). A key addition in the PP model is the emphasis on a "reflective bridge", which serves as a link between personal self-reflection and therapist self-reflection, and the process of transitioning between the two has possible outcomes such as enhanced self-awareness, personal development, and enhanced reflective and conceptual/technical and interpersonal beliefs and skills (Bennett-Levy & Finlay-Jones, 2018).

To date, there are a growing number of research studies that have evaluated the impact and experience of participating in formal SP/SR programmes. One of the primary outcomes, connected to the central aims of SP/SR, has been in relation to skill development, and studies have generally reported positive outcomes in relation to declarative knowledge, and procedural and reflective skills (Gale & Schröder, 2014; Thwaites et al., 2014). Specifically, participants have described improvements in the understanding of the CBT model (Bennett-Levy et al., 2001; Haarhoff et al., 2011); improvements in specific technical skills (Bennett-Levy, 2003; Chaddock et al., 2014; Davis et al., 2014); as well as enhanced

interpersonal skills (Davis et al., 2014; Thwaites et al., 2017). In addition to skills, studies and reviews have also reported outcomes relating to personal and professional development, where greater self-awareness is noted and SP/SR is also seen as an effective tool for personal change (Chigwedere et al., 2021; Fraser & Wilson, 2010; Gale & Schröder, 2014; Scott et al., 2020). These findings have also contributed to more recent conceptualisations of SP/SR as a wellbeing intervention, where greater wellbeing and reduced levels of burnout are documented (Bennett-Levy et al., 2015; Pakenham, 2015; Scott et al., 2020). However, it is important to note that individuals have been found to experience differential levels of benefit from SP/SR, with some people experiencing some negative effects (Bennett-Levy & Lee, 2014; Chaddock et al., 2014; Gale & Schröder, 2014). In addition, the research base around SP/SR is dominated by qualitative studies, with a need for greater, and more robust quantitative evaluation (Haarhoff & Farrand, 2012; McGillivray et al., 2015; Thwaites et al., 2014).

Despite the growing use of SP/SR in relation to the development of a range of generic and CBT-specific skills, to the author's knowledge, there is no existing programme that has explicitly addressed the development of therapist cultural competence. However, cultural competence and the provision of culturally responsive CBT are regarded as key competencies for CBT practitioners in the UK, as set out by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) Core Curriculum and Minimum Training Standards for practitioners (BABCP, 2021, 2022). This is also highlighted in a number of recommended practice guidelines, such as the Increasing Access to Psychological Therapies (IAPT) Black, Asian and Minority Ethnic Service User Positive Practice Guide (Beck et al., 2019). The provision of culturally competent and responsive CBT is a critical issue within CBT practice, where the acceptability of the approach to people from minoritised ethnic backgrounds has repeatedly been called into question, given its Eurocentric underpinnings and research base

(Hays, 2019; Hays and Iwamasa, 2006; Naeem, 2019; Rathod et al., 2015; Rathod et al., 2019). Further, significant issues around access to services, and systemic and structural barriers to care are noted, particularly within the UK's IAPT programme, which is the main provider of psychological therapies and of which CBT is the predominant approach (Baker, 2018; Baker & Kirk-Wade, 2023; Beck & Naz, 2019; Harwood et al., 2021; Lawton et al., 2021; Naz et al., 2019). There is a clear call from service users and practitioners for CBT provision in the UK to more explicitly consider ethnicity and culture within therapy (Faheem, 2023; Jameel et al., 2022; Mir et al., 2019; Prajapati & Liebling, 2022).

However, some key issues are highlighted within the CBT and wider cultural competence literature: first, despite the inclusion of cultural competence within CBT training standards, it is unclear how this is translated into teaching and implemented across training courses (Bassey & Melluish, 2012). Secondly, there is a significant training gap that is reported by practitioners, where they suggest that professional training courses do not sufficiently address the development of cultural competence (Bassey & Melluish, 2012; Benuto et al., 2019; Faheem, 2023b; Hakim et al., 2019). It is further emphasised that initiatives that seek to develop cultural competence focus more greatly on developing cultural knowledge, with self-reflection and skill development often neglected (Bassey & Melluish, 2012; Benuto et al., 2019; Faheem, 2023a; Haque et al., 2021; Naz et al., 2019). A third identified issue is the overwhelming focus of the cultural competence literature on the practice of White clinicians working with service users from minoritised ethnicities. Therefore, the unique training needs and experiences of therapists from minoritised ethnicities are often left out, despite there being a clearly articulated desire from therapists for their own ethnicity to be considered within their practice (Faheem, 2023; Haque et al., 2021; Kadaba et al., 2022; Sue & Sue, 2015).

One recent theoretical paper by Churchard (2022) has explored what the application of the DPR model to the development of cultural competence skills in White therapists could look like. In this paper, he posits that the barriers that White therapists may face in the development of skills to work with service users from minoritised ethnic backgrounds may relate to insufficient declarative knowledge around the experiences and issues related to being from a minoritised ethnicity; under-developed procedural skills in working with these groups, for example, exploring experiences of racism within therapy; and an overloaded reflective system, including cognitive emotional and situational barriers which may inhibit reflection, which is influenced by personal attitudes and experiences, for example, a colour-blind attitude. This adaptation is represented in Figure 2. In order to address these barriers, Churchard (2022) suggests areas for remedial action, including improving White therapists' knowledge about issues relating to ethnicity, gaining more experience in working with ethnically diverse service users, and having reflective spaces to recognise and address unhelpful ways of thinking and areas of bias.

Figure 1.

The application of the DPR model to develop cultural competence skills in white therapists (Churchard, 2022, permission from author received).

(Image removed due to copyright)

The above application of the DPR model to the development of therapist skills in working with ethnicity has not been extended to therapists who are from minoritised ethnic backgrounds. However, the general success of the SP/SR methodology in developing therapist skills may lend itself well to the development of cultural competence. In particular, the use of SP/SR in the development of procedural and reflective skills may be helpful . For example, practicing culturally responsive CBT techniques on oneself through self-practice (like completing a CBT formulation with the explicit consideration of ethnic identity or identifying strengths associated with ethnic identity), and then subsequently working through reflective questions on the experience of practicing these techniques and the implications of this for clinical practice (like how and when it may be incorporated into therapy) may support therapists to develop their skills in this area. Therefore, it is possible that the mechanisms that

underlie how more general skills are developed through SP/SR (like conceptual knowledge, procedural skills, interpersonal and reflective skills), as explained by the DPR and PP models, may also support the development of skills in working with ethnicity within clinical practice. In addition, the explicit bridging of the personal and therapist selves may offer therapists from minoritised ethnicities a unique opportunity to explore the personal and professional impact of their ethnicity and to develop a positive sense of their ethnic identity (for example, through developing a timeline of their ethnic identity or identifying strengths associated with their own ethnic identity). A positive ethnic identity is understood to be a likely protective factor for ethnically minoritised individuals against the impacts of racism (Chang, 2022; Neblett Jr. et al., 2012; Williams, Kanter et al., 2020; Williams, Rouleau, et al., 2020, Williams et al., 2022; Umana Taylor, 2011). Therefore, such a programme may support both the ethnic identity development and wellbeing of this group.

A novel SP/SR programme for CBT therapists from minoritised ethnic backgrounds was recently developed with the aim of providing therapists with a supportive space to explore their ethnic identity and its impact on their practice, as well as to develop their skills in working with ethnicity (Churchard & Thwaites, 2022). A full description of the programme and its delivery is provided in the methods section of this paper. The aim of this empirical paper was to quantitatively evaluate this SP/SR programme, using a multiple baselines single case experimental design. This evaluation was completed alongside a qualitative evaluation of the programme (Malik, 2023).

The primary aims of the evaluation were to explore the impact of the programme on:

1. Therapists' self-rated skill in working with ethnicity within their clinical practice.
2. The ethnic identity development of therapists themselves, particularly around the exploration, resolution and affect associated with their ethnic identities.

3. The wellbeing of therapists in relation to their professional and personal selves.

A secondary aim was to consider if any impacts were maintained following the completion of the programme.

This research was largely exploratory in nature, given it was a novel adaptation of SP/SR. However, in light of the existing research around SP/SR and the intended aims of the programme, it was hypothesised that the intervention would have positive impacts on skill development, ethnic identity development and wellbeing.

Method

Participants

Participants were qualified CBT therapists who self-identified as being from a minoritised ethnic background. This referred to all ethnic groups other than the White British group, so therapists from minoritised White ethnic groups such as Roma and Irish Travellers also met the criteria for participation in the programme (Law Society, 2023). They were recruited via advertisement on social media platforms, such as Twitter, as well as via a presentation at the European Association for Behavioural and Cognitive Therapies (EABCT) Annual Conference in September 2021. Due to initial low recruitment, a further strategy of advertising the study via email to qualified CBT therapists registered with the BABCP was taken. The following inclusion and exclusion criteria were adopted:

Inclusion:

- CBT Therapists with full or provisional accreditation from the BABCP.
- Identifying as being from a minoritised ethnic background.
- Living within the UK.

- Working at least one day a week in clinical practice, as the programme involved reflecting on ongoing clinical work and applying techniques and skills in clinical practice.

Exclusion:

- Engagement in a CBT training programme or in personal therapy for the duration of the programme, as they could present as possible confounds to the research.
- Participants for whom the programme material may be too emotionally live or sensitive, for example, due to recent experiences of racism or discrimination. This was left up to each participant's discretion.

Ten participants were initially recruited to the programme, however, one participant opted out of the programme early on due to external commitments. A final group of nine participants began the programme in May 2022.

The group consisted of seven female and two male therapists. Four of the group were between 25-34 years, three were between 35-44, one between 45-54 and one between 55-64. Participants ranged in the number of years that they had worked as a qualified CBT therapist, from two months to 12 years (as shown in Table 1). It was understood during recruitment that most participants worked in the National Health Service (NHS), with some participants practicing privately. However, this information is anecdotal and was not collected as a part of the participant demographic information.

In addition to the above demographic information, participants also provided contextual information as to the diversity of the staff teams and service users they worked with, as well as experiences of racism and discrimination in the workplace. This information was collected with the aim of understanding the wider context within which participants were practicing. As can be seen in Table 1, most participants answered that the staff teams they worked within were "A little diverse". In contrast, there was more of a range within the

diversity of service user groups participants worked with, where most participants stated they were “Moderately Diverse” to “Very Diverse”. Of note, the six participants who answered the questions related to experiences of racism and microaggressions all reported such experiences within their current workplaces and within therapeutic work with service users.

Table 1
Breakdown of participant demographic and contextual information.

Participant	Age Bracket	Gender (self-identified)	Ethnicity (self-identified)	Time practising as CBT Therapist	Diversity of staff team currently working in	Diversity of service user group within current clinical role	Experiences of racism or microaggressions within current workplace	Experiences of racism or microaggressions in therapeutic work with service users
Completers								
A	25-34	Female	Iranian	10 years	A little diverse	Not at all diverse	Yes, occasionally.	Yes, occasionally.
B	35-44	Female	Black British - Ghanaian	6 years	A little diverse	Very diverse	Yes, however, rarely.	Yes, however, rarely.
C	25-34	Female	British Pakistani	4 years	A little diverse	Moderately diverse	Yes, however, rarely.	Yes, however, rarely.
D	25-34	Male	Mixed - Filipino and Spanish	2 months	Very diverse	Moderately diverse	Yes, however, rarely.	Yes, occasionally.
E	35-44	Female	Black British African	4 years	Not at all diverse	Moderately diverse	Yes, very frequently.	Yes, frequently.

F	25-34	Female	Pakistani	2.5 years	A little diverse	Extremely diverse	Yes, occasionally.	Yes, however, rarely.
Non-completers								
G	55-64	Female	Black African	12 years	A little diverse	A little diverse	Yes, occasionally.	Yes, occasionally.
H	45-54	Male	African	12 years	A little diverse	A little diverse	Yes, however, rarely.	Yes, however, rarely.
I	35-44	Female	Black British Caribbean	2 years	Moderately diverse	Moderately diverse		

Two participants dropped out of the programme by September 2022 (following Module 6 of the programme). A third participant did not complete the programme due to health issues. Six participants completed the full programme and related evaluations. Therefore, the results presented in this paper will consider those of the six completers.

The current SP/SR programme

This SP/SR programme (Churchard & Thwaites, 2022) was developed specifically for CBT therapists from minoritised ethnic backgrounds with the aim that it would offer therapists a safe and supportive space to explore their ethnic identity and consider the personal impact, as well as any implications on their clinical practice. Therefore, it was hoped that the programme would support therapists to develop a positive sense of their own ethnic identity, while also supporting them to develop their skills in working with ethnicity within their practice, particularly, with service users who are also from minoritised ethnic backgrounds.

The programme consisted of a workbook with nine modules, which guided participants through a series of self-practice tasks and related self-reflection questions (as shown in Table 2). Participants were also invited to join a facilitated group reflective session every fortnight, on completion of each module. The modules drew upon a CBT-approach to support participants to explore their own ethnic background, placing a particular emphasis on strengths associated with ethnic identity, while also recognising and addressing challenges and experiences of racism and discrimination. Examples of the self-practice tasks included the completion of a cultural genogram, creating an ethnic identity timeline, and developing a longitudinal formulation around being from a minoritised ethnic background and its influence on participants as therapists. The related self-reflection questions encouraged participants to reflect on the process of completing these tasks and exercises, the impacts on them

personally, and crucially, any implications on their clinical practice (Modules 1 and 6 shown as examples in Appendix D).

Table 2
SP/SR programme modules

Module	Title
1	Identifying a Challenging Problem
2	Creating a Cross-sectional Formulation and Goal setting
3	Creating a Genogram
4	Your Personal Experience of Coming from a Minoritised Ethnicity
5	Developing a Longitudinal Formulation and Returning to Goals
6	Developing Strengths
7	Exploring Challenges and Looking After Yourself
8	Adapting CBT Change Techniques to Address Challenges
9	Reviewing the Programme and Thinking About Next Steps

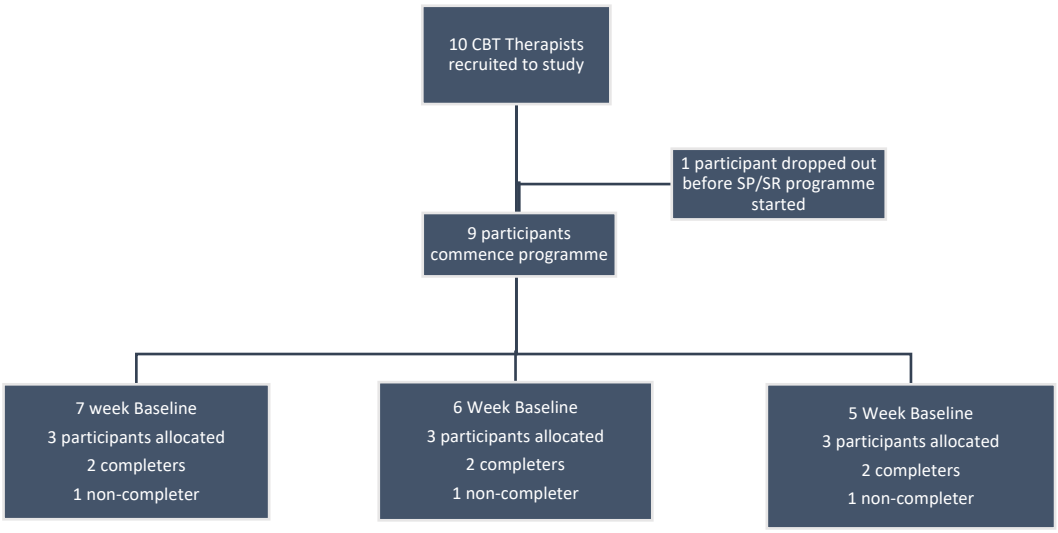
Design

An ABC multiple baseline single case experimental design (SCED) was chosen. Multiple baseline SCEDs are typically used in cases where intervention effects are expected to be sustained, and therefore, effects are replicated across participants, settings or behaviours (Krasny-Pacini & Evans, 2018). This study design allowed for the evaluation of individual participant outcomes, as well for making inferences about the overall impact of the SP/SR programme.

Data were collected across three experimental phases: baseline (A), SP/SR (B) and follow-up (C) phases. The length of the baseline phase was five to seven weeks, the intervention phase was 19 weeks, and the follow-up phase was five weeks. It was planned for outcome data to be collected weekly, therefore a minimum phase length of five weeks was set, to allow for sufficient data points to be collected. Five data points per phase are recommended, however, a minimum of three data points per phase was deemed acceptable for inclusion in this study (Kratochwill et al., 2010, 2013; Lobo et al., 2017).

As there need to be at least three demonstrations of an effect within a SCED, three baseline conditions were chosen varying in lengths, that is, seven, six and five weeks (Kratochwill et al., 2010, 2013). The beginning of the baseline period was staggered in this study.. Participants were randomly allocated to each of the three baseline conditions, with three participants in each condition (as shown in Figure 2).

Figure 2
Participant allocation and attrition diagram.



Measures

Outcomes were considered in relation to three main areas: therapist skill in working with ethnicity, ethnic identity development and wellbeing. They were completed by participants weekly, via an online survey tool. Due to the frequency of data collection, it was aimed for outcome measures to be brief and easy to complete, therefore measures were either developed or adapted for the purpose of this evaluation. This is described in detail below.

The outcome measures were reviewed by the research team and an expert reference group, to assess their suitability and safety for use in this study. The full outcome questionnaire is included in Appendix G.

Therapist Skill in Working with Ethnic Identity

This was one of the primary outcomes chosen, given the aims of the programme and the research around SP/SR in therapist skill development. However, there were no suitable existing validated measures examining therapist skills in working with ethnicity. Therefore, a set of skill-related outcomes were developed by the researcher for this study, which included 10 outcome questions. These skill outcomes largely related to procedural and reflective skills as set out by the DPR model (Bennett-Levy, 2016) and were informed by ideas around the provision of effective transcultural CBT (Beck, 2016), both of which were key references in the development of the programme.

The 10 skills outcomes broadly related to technical skills, such as skills in exploring ethnicity and including this within formulations (five questions), reflective skills, such as skills in managing personal resonances and addressing ethnic similarities and differences with clients (three questions), and supervision skills, such as the skills to bring discussions related to ethnicity within one's own supervision or as a supervisor (two questions).

Participants were asked to self-rate their level of skill in relation to each outcome on a scale of 0 (No skill) to 100 (Highly Expert).

An example of a skills outcome is given below:

Over the last week:

I have the skills to talk about and explore my client's ethnic identity in sessions

0----------25----------50----------75----------100

No skills Novice Competent Proficient Highly Expert

Ethnic Identity Development

Ethnic identity is defined as "the identity that develops as a function of one's ethnic group membership…Ethnic identity is conceptualised as a component of one's overall identity, and will vary in its salience across individuals" (Umana Taylor, 2011). A central aim of the SP/SR programme was to provide a supportive space for therapists to explore their own ethnic identity, with a particular focus on developing strengths associated with this. As described in the introduction, there is a significant body of research that highlights the protective role of a positive sense of ethnic identity for people from minoritised ethnic backgrounds, and a number of related interventions have focussed on ethnic identity development (Chang, 2022; Neblett Jr. et al., 2012; Williams, Kanter et al., 2020; Williams, Rouleau, et al., 2020, Williams et al., 2022; Umana Taylor, 2011). Therefore, the ethnic identity development of the therapists themselves was chosen as another key outcome.

The Ethnic Identity Development Scale (EIS, Umana-Taylor et al., 2004) was adapted for use in this study, which considers three components of ethnic identity development: the degree to which someone has explored their ethnicity (exploration), the degree to which they have resolved what their ethnic identity means to them (resolution), and the affect associated with that resolution (valence). The EIS is a validated and reliable measure of ethnic identity development (α=.84-.89, Umana-Taylor et al., 2004).

An outcome question relating to each component of ethnic identity from the EIS was selected and adapted for use in this study. Participants completed weekly self-ratings related to each of these three measures, providing scores on a scale of 0 to 100. Higher scores indicated a greater degree of exploration and resolution and a more positive sense of ethnic identity. Each outcome was evaluated separately.

The three ethnic identity development outcomes are given below:

In relation to the last week, how well do the following statements describe you:

I have explored aspects of my ethnic identity (Exploration)

0----------25----------50----------75----------100
Not well at all Slightly well Moderately well Very well Extremely well

I have had a clear sense of what my ethnicity means to me (Resolution)

0----------25----------50----------75----------100
Not well at all Slightly well Moderately well Very well Extremely well

Over the last week, how have you felt in relation to your ethnic identity:

In relation to my ethnic identity, I have felt (Affect)

0----------25----------50----------75----------100
Completely negative Quite negative Neutral Quite positive Completely positive

Wellbeing

There is some emerging evidence of the role of SP/SR in improving the wellbeing of therapists (Bennett-Levy et al., 2015; Pakenham, 2015; Scott et al., 2020). Therefore, this was also included as an outcome, with wellbeing was divided into 'Personal Wellbeing' and 'Therapist Wellbeing', as distinguished by the DPR model (Bennett-Levy, 2006).

A simple visual analogue style rating scale was developed by the researcher to measure both wellbeing outcomes. The scale ranged from 0 to 100, and participants provided their respective personal and therapist wellbeing ratings each week.

The two wellbeing outcomes are given below:

Over the last week, how would you rate:

Your personal wellbeing

0----------25----------50----------75----------100

Poor Wellbeing Fair Wellbeing Good Wellbeing Very Good Wellbeing Excellent Wellbeing

Your wellbeing as a therapist

0----------25----------50----------75----------100

Poor Wellbeing Fair Wellbeing Good Wellbeing Very Good Wellbeing Excellent Wellbeing

Procedure

On signing up to participate in the SP/SR programme, participants were randomly allocated to one of the three baseline conditions. At the beginning of the baseline phase, participants were invited to create a unique identifier, which was used to record all subsequent outcome data, alongside completing an initial questionnaire asking for demographic and contextual information. Participants were asked to complete the outcome questionnaire each week, providing self-ratings on the given skills, ethnic identity development and wellbeing measures. This was done across the baseline, SP/SR and follow-up phases, which was over the course of 31 weeks. As a part of these questionnaires, participants also provided information on the number of service users from a minoritised ethnic background with whom they worked with that week, and the amount of time they spent on the SP/SR programme that week.

During the SP/SR phase, participants worked through each of the nine programme modules independently, with a period of two weeks allocated to each module. On the completion of each module, participants were invited to join a fortnightly reflective group,

which was facilitated by the two programme authors (Dr Alasdair Churchard and Dr Richard Thwaites) and a third facilitator (Leila Lawton), an experienced CBT therapist with expertise in transcultural and anti-oppressive practice. The purpose of the reflective group was to offer participants an opportunity to come together and reflect on the process of completing the programme, as well as a facilitated peer support space to consider the impact of ethnicity within their practice. These group spaces were run online. The facilitators also received their own supervision around the running of this space.

After the completion of the SP/SR programme and the five-week follow-up period in which participants continued to complete weekly outcomes, they were invited to participate in post-programme interviews with the project co-researcher (Zara Malik). These interviews aimed to explore participants' experiences of the SP/SR programme and the implications of the programme on their ethnic and cultural identity. These interviews were evaluated as a part of Zara Malik's thesis project, which formed the qualitative evaluation of the SP/SR programme (Malik, 2023).

Ethics

Ethical approval for the SP/SR programme and the related analyses was granted by the UCL Research Ethics Committee (Committee Approval ID Number: 22167/001, as in Appendix C).

Prior to the programme, potential participants were invited to a series of information sessions, where detailed information about the programme was provided, and enabled an opportunity to meet the facilitators and research team, as well as to ask questions about the programme. Participants were also provided detailed information sheets outlining the programme, evaluations, possible risks and data protection information (as in Appendix E). Informed consent was received from each participant before beginning the programme. Participants

were informed of their right to withdraw from the programme and research at any time (as in Appendix F).

Due to the sensitive content of the programme and evaluations, participants were encouraged to create safety plans at the beginning of the programme and were invited to contact programme facilitators in case of any concerns. An expert reference group of three CBT therapists/clinical psychologists from minoritised ethnic backgrounds were also consulted on the programme and evaluation materials.

As personal data were collected from participants as a part of this project, strict data protection procedures were followed and data was pseudonymised and stored securely by the researchers in line with the Data Protection Act (2018).

Data Analysis

Visual analysis is the primary analysis for SCED data. The What Works Clearinghouse (WWC, Kratochwill et al. 2010) process for conducting a visual analysis was used, which examines (a) changes in level, (b) changes in trend, (c) changes in variability, (d) immediacy of change, (e) overlap between data in adjacent phases, and (f) consistency across like phases when determining a functional relationship.

For each variable, data was first visually inspected, following which statistical analyses of baseline stability and non-overlap data were completed. Tau-U was the chosen statistical analysis, which is a nonparametric technique for measuring data non-overlap between phases of data and is one of the more robust existing methods of analysing SCED data and allows the correction of baseline trend if indicated (Parker et al., 2011). To create a systematic process for conducting the visual and statistical analysis, the table in Appendix H was used to assist the analysis for each outcome variable. Missing data were retained in the analysis.

The analysis was conducted in two stages: the first stage of the analysis explored whether the SP/SR programme had an effect on each of the outcome variables, therefore baseline and intervention phases were compared for the six completers. Following this, the second stage of the analysis examined if these effects were sustained at follow-up for the three participants who completed sufficient data, therefore a comparison of the intervention and follow-up phase was done.

Data was graphed in Excel. In addition, two online programmes were used to support the visual and statistical: the single case research Tau-U calculator (Vannest et al., 2016) and the SCDA shiny web app (De et al., 2020).

Results

A summary of contextual information provided weekly by participants is presented first. Visual and statistical analyses were conducted on the weekly outcome data provided by participants to explore the overall and individual effects of the SP/SR programme on skill development, ethnic identity development and wellbeing. Although outcomes were considered within these three areas, each outcome item was analysed independently. Across all measures, higher self-ratings were associated with improved outcomes.

The results are presented for the six participants who completed the SP/SR programme; however, follow-up data was only considered for participants A, C and E because they were the only participants who provided sufficient follow-up data. For ease of presentation, only linear trends across outcomes have been presented in this section. The visual plots of the raw data for each outcome are presented in Appendix J.

In this thesis, of the 15 outcome variables that were completed by participants, the results of 12 are presented below, as they were directly addressed by the SP/SR programme

(7 skills outcomes, 3 ethnic identity outcomes and 2 wellbeing outcomes). The results of the remaining three skills outcomes, relating to making culturally sensitive adaptations to CBT, considering ethnicity within one's own supervision, as well as a supervisor, are included in Appendix K. The findings from the three outcomes suggest an overall increase in level and a positive trend from baseline to the SP/SR phase, with only some participants showing significant improvements and none being replicated across all three baseline conditions. In addition, there was not sufficient data collected for the skills outcome relating to being a supervisor, as only three participants were supervisors and this data could was only collected across two baseline conditions.

Contextual information

Participants provided weekly information on the number of service users they saw who were from minoritised ethnic backgrounds, and the amount of time they spent on the SP/SR programme each week. The time spent on SP/SR programme was calculated only for the SP/SR and follow-up phases. This information is summarised in Table 3.

Overall, it appeared that participants varied in the number of minoritised ethnic service users they saw each week, with participants B, C and D seeing a greater number of service users from these groups. There was also notable variation in the amount of time spent weekly on the SP/SR programme, both within and across participants. Participants E, F, D and A, on average, spent the most time on the SP/SR programme.

Participants were also able to provide additional contextual information, if relevant, to locate their ratings for each week. Examples of contextual information included illness, significant life events and global/political events. Full details of this are given in Appendix I.

Table 3
Weekly number of service users from minoritised ethnic backgrounds and time spent on SP/SR programme.

Participant	Number service users from minoritised ethnic backgrounds seen weekly		Time spent on SP/SR programme each week (in minutes)	
	Median	**Range**	**Average**	**Range**
A	2	0 - 5	28 minutes	0 – 70 minutes
B	4	0 - 7	20.71 minutes	0 – 30 minutes
C	4	0 - 7	19.58 minutes	0 – 90 minutes
D	5	0 - 10	31.92 minutes	0 – 90 minutes
E	1	0 - 6	69.50 minutes	0 – 120 minutes
F	1	0 - 5	33.85 minutes	0 – 90 minutes

Skills in working with ethnicity

For skills in working with ethnicity, seven self-rated outcomes were considered. Although each of these outcomes was analysed separately, for ease of presentation, these are shown within two broad categories: technical skills (skills in exploring ethnicity; skills in including ethnicity within formulations; skills in addressing difficulties related to service user ethnicity; and skills in integrating strengths related to service user ethnicity) and reflective skills (skills to identify, sit with and manage personal resonances; skills to address own ethnic similarities and differences with those of service users'; and skills to identify my own biases related to ethnicity).

The related linear trends and statistical analyses are shown below in Figures 3 and 4, and Tables 4, 5, 6 and 7.

Technical skills

Participants showed varying baseline trends across the four technical skill outcomes. The statistical analysis showed the baseline trends were significant in some cases, therefore baseline corrections were applied to account for any impacts of baseline trends (as seen in Table 5).

The visual analysis of all four outcomes generally showed high degrees of variability, particularly within the SP/SR phase. All participants showed an increase in level from the baseline to the SP/SR phase on outcomes relating to skills in exploring ethnicity and including this within formulations. For the outcomes relating to addressing difficulties related to ethnicity and integrating strengths, five out of six participants showed an increase in level, with Participants E and B showing small decreases in level respectively. This is also demonstrated by the change in mean score between the baseline and SP/SR phase (as in Table 4). Participants generally appeared to show an increasing trend in the SP/SR phase across all four technical skills. The subsequent statistical analysis showed some differing findings across the different outcomes (as in Table 5). Two participants appeared to make significant improvements during the SP/SR phase in the skills related to exploring ethnicity and integrating strengths outcomes, and one participant in the addressing difficulties related to ethnicity outcome. Most notably, Participant D appeared to show significant improvements across all three outcomes. Interestingly, none of the participants showed significant improvements in skills related to including ethnicity within formulations. Where improvements were significant, these were only replicated across a maximum of two baseline conditions.

From the SP/SR to the follow-up phase, Participants C and E generally appeared to show an increase in level and an increasing follow-up trend across all four technical skills outcomes. In particular, Participant E appeared to make significant gains within the follow-up

phase across all four outcomes, with Participant C doing so on the skills in addressing difficulties related to ethnicity outcome. In contrast, Participant A appeared to show a decrease in level and a decreasing follow-up trend, however these were not significant for any of the outcomes. Therefore, any improvements made during the intervention phase were generally maintained in the follow-up phase across all three baseline conditions.

Therefore, in exploring the effects of the SP/SR programme on the four technical skills outcomes, it appeared that most participants showed an increasing level and trend in the SP/SR phase, however these were only significant in some cases, with Participant D showing most consistent improvements across outcomes. These improvements were also not replicated across all three baseline conditions for any of the above outcomes, which is a requirement to demonstrate a functional relationship in a multiple baselines SCED. Therefore, in summary it cannot be concluded that the improvements in technical skills were as a result of the SP/SR programme. However, it appeared that some participants appeared to make significant gains within the follow-up phase and generally, and improvements appeared to be maintained after the end of the programme.

Figure 3

Linear trend lines for technical skill outcome

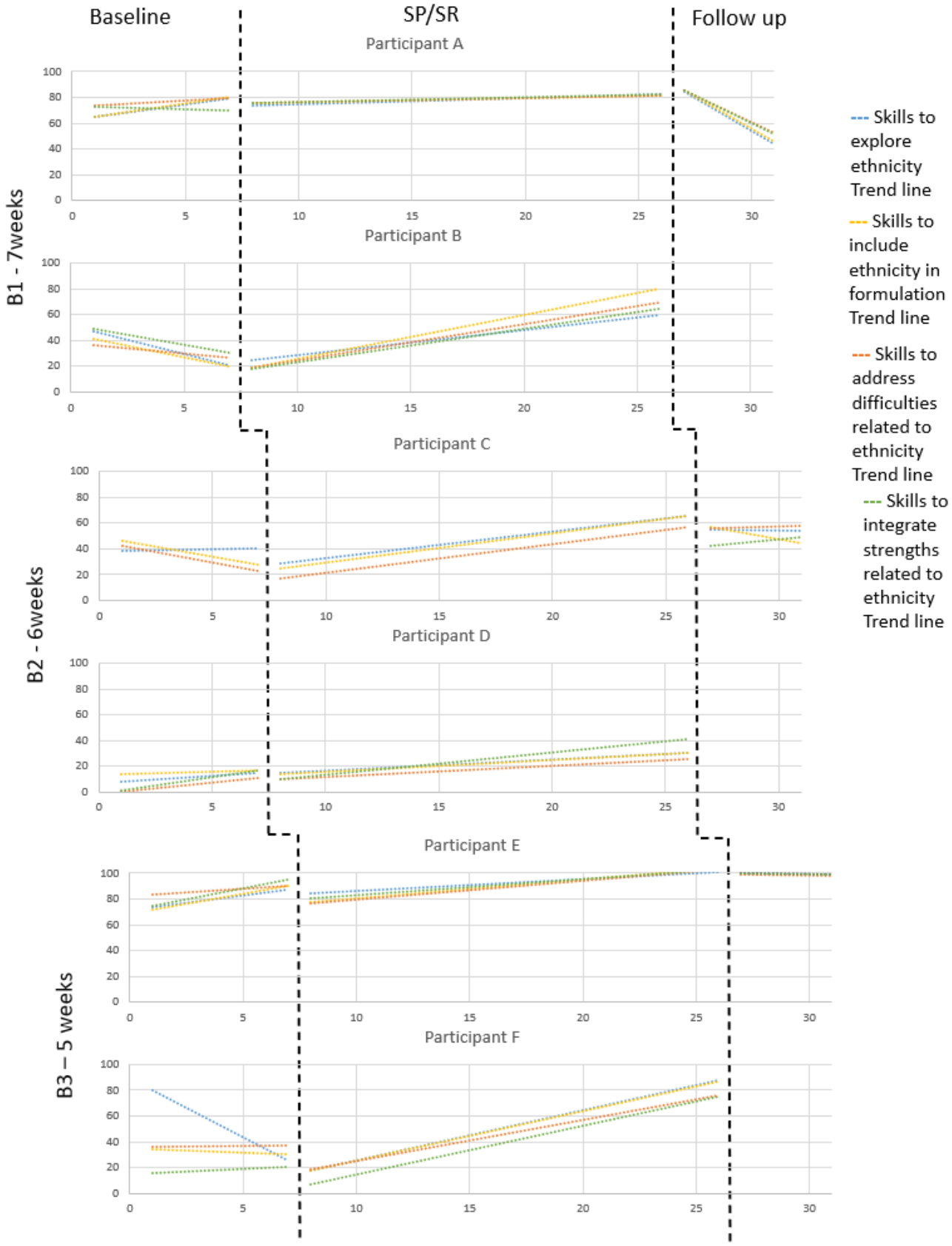


Table 4

Mean and standard deviation for baseline, intervention and follow-up phases for the technical skill outcomes.

Participant	Explore Ethnicity Mean (SD)			Formulation Mean (SD)			Address Difficulties Mean (SD)			Incorporate Strengths Mean (SD)		
	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up
A (B1)	72.43 (6.55)	78.27 (3.79)	64.00 (16.88)	72.86 (6.89)	78.47 (3.20)	65.40 (16.16)	76.43 (3.99)	78.93 (2.71)	68.80 (15.35)	70.86 (3.72)	79.13 (2.95)	68.40 (14.99)
B (B1)	34.60 (15.90)	39.17 (14.77)	-	31.40 (11.87)	44.67 (17.03)	-	31.80 (12.70)	39.83 (16.74)	-	40.40 (12.14)	37.17 (13.01)	-
C (B2)	39.33 (6.50)	48.00 (15.55)	54.60 (2.51)	35.50 (12.53)	46.39 (14.63)	52.50 (7.07)	30.83 (14.54)	38.28 (14.58)	57.20 (8.56)	34.83 (13.35)	36.50 (14.01)	46.00 (4.47)
D (B2)	12.17 (2.48)	20.20 (5.27)	-	15.83 (2.64)	20.20 (5.43)	-	6.33 (3.98)	15.30 (5.25)	-	10.50 (7.29)	21.00 (8.62)	-
E (B3)	83.00 (5.05)	91.33 (6.49)	99.20 (0.84)	83.80 (5.63)	88.67 (10.25)	99.25 (0.84)	88.00 (2.65)	87.93 (10.65)	99.00 (0.71)	88.60 (6.27)	89.80 (8.48)	99.20 (0.84)
F (B3)	43.50 (16.84)	52.00 (27.06)	-	31.75 (6.85)	51.55 (25.38)	-	37.00 (5.60)	47.00 (24.67)	-	19.00 (12.00)	40.27 (25.29)	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

Table 5

Tau-U analysis of baseline trend, baseline SP/SR comparison and SP/SR follow-up comparison for technical skill outcomes

Participant	Explore Ethnicity			Formulation			Address Difficulties			Integrating Strengths		
	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)
A (B1)	0.714+	0.438	-0.440	0.714+	0.371	-0.373	0.429	0.352	-0.240	-0.048	0.962*	0.360
B (B1)	-0.500	0.233	-	-0.600	0.600	-	-0.200	0.367	-	0.100	0.067	-
C (B2)	-0.067	0.315	0.289	-0.467	0.398	0.133	-0.333	0.306	0.744*	-0.067	0.028	0.378
D (B2)	0.733+	0.717*	-	0.267	0.450	-	0.800+	0.733*	-	0.533	0.633*	-
E (B3)	0.500	0.707*	0.960*	0.900+	0.373	0.960*	0.500	0.133	0.853*	0.800+	0.067	0.760*
F (B3)	-1.000+	0.409	-	0	0.432	-	0	0.250	-	0.167	0.546	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

*Significant change ($p \leq 0.05$)

+ Baseline correction applied

Reflective Skills

Participants showed varying baseline trends across the three reflective skills outcomes. The statistical analysis showed these trends were significant for some participants, therefore baseline corrections were applied to account for any impacts of baseline trends (as seen in Table 7).

The visual analysis across the three outcomes generally showed high degrees of variability, again most notable during the SP/SR phase. All participants showed an increase in level in the SP/SR phase on skills related to managing personal resonances, and five out of six participants showed the same on the remaining two reflective outcomes. This is also demonstrated by the change in mean score between the baseline and SP/SR phase (as in Table 6). All participants showed an increasing SP/SR phase trend across all three outcomes. The associated statistical analysis revealed that only Participant A showed a significant improvement in skills relating to managing personal resonances and identifying their own biases. On a different note, Participants A, D and F showed significant increases in their ratings of skills related to addressing their own ethnic similarities and differences, which crucially was replicated across the three different baseline conditions.

Comparing the SP/SR and follow-up phases, Participants C and E generally showed an increase in level and, in most cases, showed an increasing follow-up phase trend across the reflective skills. These improvements in the follow-up phase were significant for Participant E for all three skills. Similar to the technical skills, Participant A appeared to show a decrease in level and a downward trend in the follow-up phase, however these were not significant for any of the outcomes. Again, improvements made during the SP/SR phase were generally maintained in the follow-up phase across all three baseline conditions.

Therefore, looking at the effects of the SP/SR programme on the three reflective skills outcomes, it appeared that almost all participants showed an increasing level and trend in the

SP/SR phase. Some participants appeared to show significant improvements in their skills ratings during the SP/SR programme, which was replicated across all three baselines on the skills outcome relating to addressing own ethnic similarities and differences with that of service users'. Therefore, for this outcome, an improvement in skills can be attributed to the SP/SR programme. In addition, it appeared that improvements in skills ratings made during the SP/SR phase were generally maintained after the end of the intervention, with Participant E making further gains during this period.

Figure 4

Linear trend lines for reflective skill outcomes.

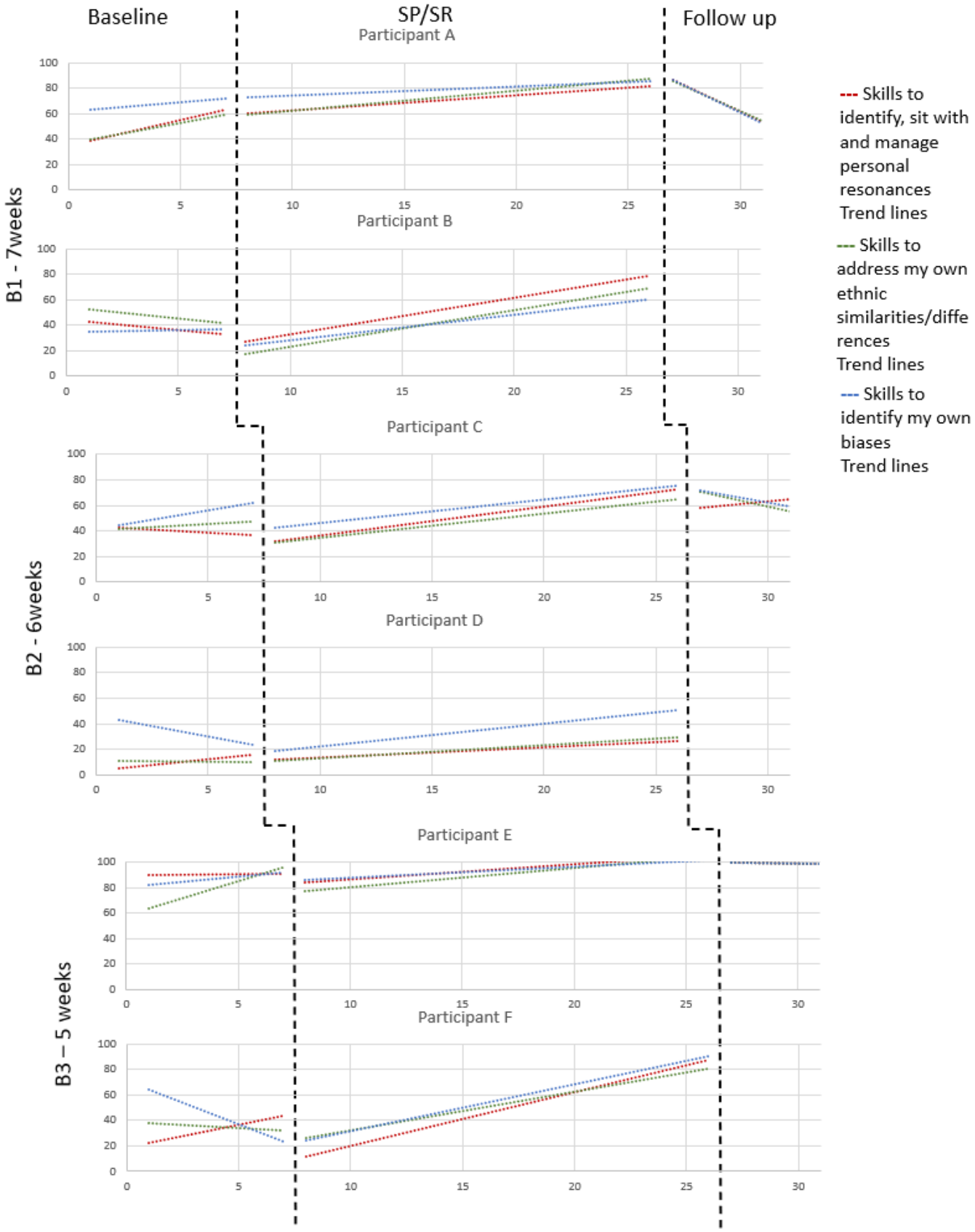


Table 6

Mean and standard deviation for baseline, intervention and follow-up phases for the reflective skill outcomes.

Participant	Personal Resonances Mean (SD)			Address Similarities/Differences Mean (SD)			Identify Own Biases Mean (SD)		
	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up
A (B1)	51.00 (9.50)	70.67 (9.68)	70.20 (15.30)	49.43 (8.38)	73.07 (12.18)	69.60 (13.83)	67.71 (8.73)	79.27 (6.10)	69.60 (16.62)
B (B1)	37.25 (7.68)	48.67 (17.63)	-	47.60 (13.67)	38.83 (15.77)	-	35.80 (11.01)	39.33 (9.91)	-
C (B2)	39.00 (18.47)	52.94 (17.45)	61.40 (6.07)	44.83 (11.53)	48.89 (16.53)	63.00 (6.71)	54.33 (12.09)	59.78 (12.41)	65.60 (5.32)
D (B2)	13.00 (2.45)	16.90 (4.95)	-	11.17 (3.43)	17.40 (5.56)	-	31.83 (10.11)	29.80 (10.05)	-
E (B3)	90.60 (3.97)	91.31 (7.22)	99.40 (0.89)	84.60 (8.65)	89.07 (10.25)	99.20 (0.84)	88.40 (4.28)	92.79 (6.07)	99.40 (0.89)
F (B3)	37.00 (7.30)	59.00 (28.03)	-	34.25 (7.93)	52.82 (23.19)	-	36.75 (17.91)	57.00 (27.46)	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

Table 7

Tau-U analysis of baseline trend, baseline SP/SR comparison and SP/SR follow-up comparison for the reflective skill outcomes.

Participant	Personal Resonances			Address Similarities/Differences			Identify Own Biases		
	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)
A (B1)	0.857+	0.686*	0.133	0.714+	0.714*	-0.160	-0.143	0.800*	-0.267
B (B1)	-0.333	0.667	-	-0.100	-0.333	-	0.100	0.167	-
C (B2)	0.067	0.454	0.256	0.067	0.213	0.5111	0.267	0.287	0.300
D (B2)	0.833	0.475	-	-0.267	0.783*	-	-0.267	-0.133	-
E (B3)	0.100	0.262	0.785*	1+	0.240	0.760*	0.300	0.486	0.771*
F (B3)	0.667	0.273	-	0.333	0.659*	-	-0.667	0.455	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

*Significant change ($p \leq 0.05$)

+ Baseline correction applied

Ethnic Identity Development

For ethnic identity development, self-rated outcomes were considered in relation to exploration of ethnic identity, resolution and valence related to ethnic identity. The visual and statistical analyses are shown below in Figure 5 and Tables 8 and 9.

Across all three ethnic identity development outcomes, although some participants showed increasing baseline trends, statistical analysis revealed that none of these trends were significant, therefore no baseline corrections were applied (Table 9).

There was generally some degree of variability across baseline and SP/SR phases for all participants across all three ethnic identity outcomes. All participants showed an increase in level from the baseline to intervention phase across all three outcomes, with the exception of Participant C, who showed a slight decrease in level for valence related to their ethnic identity. This is also demonstrated by the change in mean score between the baseline and SP/SR phase (as in Table 8). These changes appeared gradual across the three outcomes. Related to this, all participants with the exception of Participant C also showed an increasing SP/SR trend across all three outcomes, which was the desired trend direction. Participant C showed a decreasing intervention trend on valence related to ethnic identity, indicating a more negative view of their ethnic identity as the SP/SR programme progressed, however this reduction was not statistically significant. Of the five participants that appeared to show improving outcomes as per the visual analysis, the statistical analysis indicated that this was significantly improved during the SP/SR phase for participants A, E and F for exploration of ethnic identity, participants A and F for resolution related to ethnic identity, and participants E and F for valence related to ethnic identity. However, in all cases, these improvements were only replicated across two baseline conditions.

From the SP/SR to the follow-up phase, visual analysis indicated an increase in level for Participants A and E, who also showed an increasing trend in the follow-up phase across

all three outcomes. In contrast, Participant C showed an overall reduction in level and a decreasing follow-up trend for the three outcomes. The associated statistical analysis (as in Table 9) suggested that for Participant E, there was a further significant increase in exploration and resolution ratings in the follow-up phase. For Participant C, although there was a reduction in scores across all three outcomes, this was only statistically significant for resolution related to ethnic identity. The follow-up phase findings appear to be mixed across the three baseline conditions.

Therefore, in exploring the effects of the SP/SR programme on the three ethnic identity development outcomes, it appeared that five out of six participants showed an increasing level and trend across ethnic identity exploration, resolution and valence. However, these improvements were only significant for Participants A, E and F and none of these effects were replicated across all three baseline conditions, which is a requirement to demonstrate a functional relationship in a multiple baselines SCED. Therefore, it cannot be concluded that these improvements were as a result of the SP/SR programme. In addition, the findings in the follow-up phase appear to be mixed across baseline conditions. While two participants appeared to make further gains after the conclusion of the SP/SR programme, these were not maintained for Participant C, with a significant reduction in resolution related to their ethnic identity.

Figure 5

Linear trend lines for ethnic identity development outcomes.

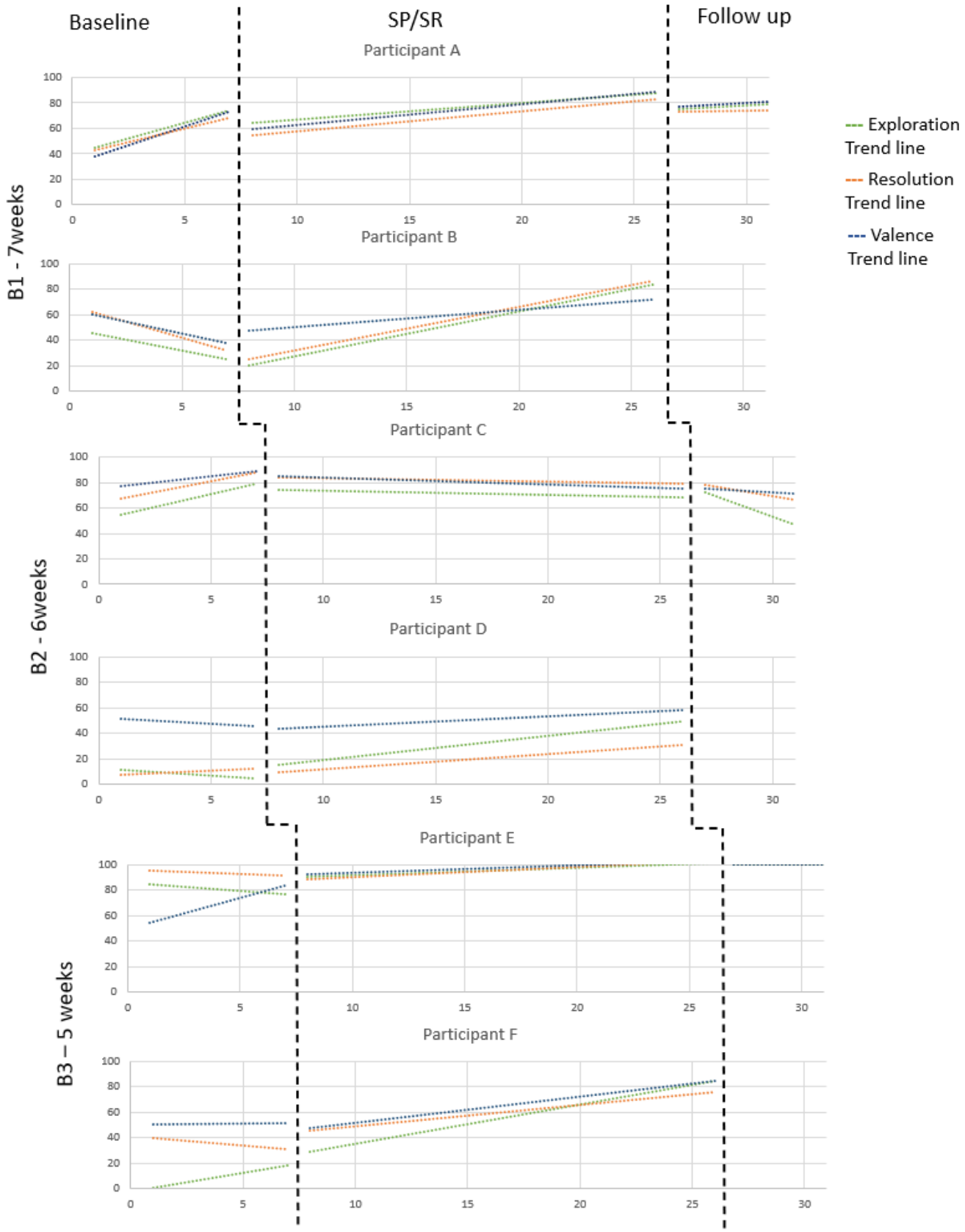


Table 8

Mean and standard deviation for baseline, intervention and follow-up phases for the ethnic identity development outcomes.

Participant	Exploration Mean (SD)			Resolution Mean (SD)			Valence Mean (SD)		
	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up
A (B1)	59.29 (15.25)	75.93 (9.16)	76.80 (9.36)	55.57 (15.38)	74.00 (10.70)	79.00 (6.44)	55.14 (17.03)	68.47 (16.48)	74.00 (5.48)
B (B1)	37.00 (10.30)	46.50 (16.36)	-	48.40 (13.90)	50.67 (22.15)	-	50 (14.71)	58.00 (10.06)	-
C (B2)	68.83 (9.17)	71.37 (13.50)	59.60 (11.08)	79.00 (9.06)	81.32 (7.06)	72.20 (4.60)	83.67 (5.39)	80.26 (6.33)	73.60 (6.62)
D (B2)	6.25 (6.29)	29.10 (22.24)	-	10.33 (3.27)	17.91 (9.66)	-	47.50 (4.18)	49.55 (16.04)	-
E (B3)	79.40 (20.76)	95.07 (3.95)	100.00 (0.00)	93.00 (3.46)	95.13 (5.36)	100.00 (0.00)	74.20 (16.33)	96.93 (4.89)	100.00 (0.00)
F (B3)	12.50 (9.47)	55.82 (22.16)	-	33.75 (11.73)	60.18 (14.78)	-	50.75 (0.96)	66.00 (13.65)	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

Table 9

Tau-U analysis of baseline trend, baseline SP/SR comparison and SP/SR follow-up comparison for the ethnic identity development outcomes.

Participant	Exploration			Resolution			Valence		
	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)
A (B1)	0.476	0.676*	0.013	0.571	0.705*	0.293	0.333	0.419	0.173
B (B1)	-0.667	0.333	-	-0.800	0.300	-	-0.700	0.233	-
C (B2)	0.600	0.254	-0.516	0.333	0.219	-0.684*	0.600	-0.316	-0.579
D (B2)	-0.500	0.625	-	0.400	0.530	-	-0.333	0.061	-
E (B3)	0	0.707*	0.867*	-0.300	0.347	0.600*	0.600	0.933*	0.467
F (B3)	0.333	1*	-	-0.333	0.909*	-	0.167	0.705*	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

*Significant change ($p \leq 0.05$)

Wellbeing

Personal and therapist wellbeing were considered. The visual and statistical analysis are shown in Figure 6 and Tables 10 and 11.

For both personal and therapist wellbeing, despite some participants showing an increasing baseline trend, none of these were found to be statistically significant in the Tau-U analysis, therefore no baseline corrections were applied (Table 11).

There were generally high levels of variability for both wellbeing outcomes, and in the case of personal wellbeing, variability reduced from baseline to the SP/SR phase for most participants. From the baseline to the SP/SR phase, the level increased for most participants across both personal and therapist wellbeing, with the exception of Participant B, whose level reduced on both, and Participant F, whose level reduced on personal wellbeing. This is also demonstrated by the change in mean score between the baseline and SP/SR phase (as in Table 10). Five out of the six participants also showed increasing SP/SR phase trends on both outcomes. The Tau-U comparison of the baseline and SP/SR phases showed differing results for personal and therapist wellbeing outcomes. For personal wellbeing, only Participant E appeared to show a significant improvement in wellbeing scores during the SP/SR programme. In contrast, for therapist wellbeing, Participants A, E and F showed a significant increase in wellbeing scores during this phase. However, these improvements in therapist wellbeing were only replicated across two baseline conditions.

For the SP/SR to follow-up phase comparison, the visual analysis appeared to show a mixed pattern. Participants A and E showed a further increase in level and trend in the follow-up phase, with these gains being statistically significant in the case of participant E for both personal and therapist wellbeing. Conversely, participant C showed a reduction in level and trend for both personal and therapist wellbeing in the follow-up phase, with a significant reduction in therapist wellbeing ratings.

Therefore, for personal and therapist wellbeing, the SP/SR programme appeared to have slightly differential effects. While the majority of participants appeared to show an increase in mean wellbeing ratings and increasing trends in the SP/SR phase across both personal and therapist wellbeing, a greater number of participants appeared to experience significant improvements in therapist wellbeing during the SP/SR programme. However, improvements in wellbeing outcomes were not replicated across all three baseline conditions, therefore overall conclusions cannot be drawn about the effect of the SP/SR programme on wellbeing. Further, improvements made during the SP/SR phase were only maintained in the follow-up phase in the case of two participants.

Figure 6

Linear trend lines for wellbeing outcomes.

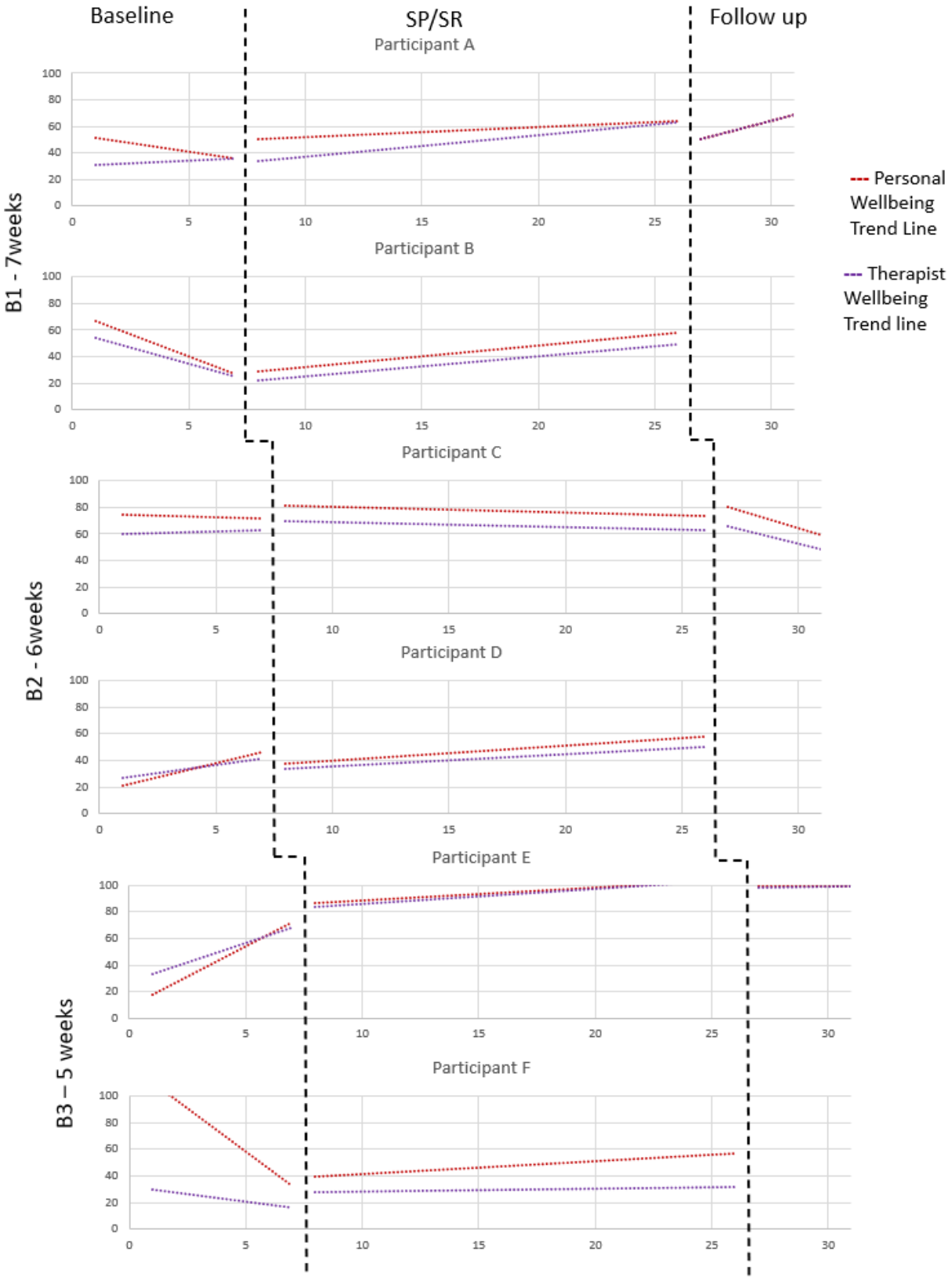


Table 10

Mean and standard deviation for baseline, intervention and follow-up phases for the wellbeing outcomes.

Participant	Personal Wellbeing Mean (SD)			Therapist Wellbeing (SD)		
	Baseline	Intervention	Follow-up	Baseline	Intervention	Follow-up
A (B1)	43.14 (18.89)	56.93 (13.86)	59.60 (14.77)	33.29 (15.68)	48.40 (13.11)	59.80 (14.39)
B (B1)	48.67 (17.08)	41.00 (9.63)	-	40.60 (14.24)	33.33 (11.52)	-
C (B2)	72.83 (4.36)	77.26 (7.38)	69.60 (8.65)	61.60 (2.41)	66.37 (7.40)	56.80 (7.66)
D (B2)	35.83 (27.46)	45.27 (18.30)	-	36.00 (23.56)	39.50 (19.92)	-
E (B3)	54.00 (31.50)	93.73 (6.57)	99.20 (1.79)	56.80 (22.88)	92.07 (6.75)	98.80 (1.79)
F (B3)	58.75 (27.11)	48.00 (16.17)	-	20.50 (4.39)	29.73 (9.47)	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

Table 11

Tau-U analysis of baseline trend, baseline SP/SR comparison and SP/SR follow-up comparison for the wellbeing outcomes.

Participant	Personal Wellbeing			Therapist Wellbeing		
	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow-up (Tau-U)
A (B1)	-0.143	0.438	0.093	0.095	0.581*	0.493
B (B1)	-0.533	-0.472	-	-0.500	-0.333	-
C (B2)	-0.200	0.386	-0.516	0.200	0.474	-0.674*
D (B2)	0.200	0.364	-	0.100	0.180	-
E (B3)	0.600	0.973*	0.693*	0.600	1.000*	0.653*
F (B3)	-0.667	-0.250	-	-0.667	0.682*	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

*Significant change ($p \leq 0.05$)

Discussion

This empirical paper describes the evaluation of a novel SP/SR programme for CBT therapists from minoritised ethnic backgrounds, using a multiple baselines single case experimental design. SP/SR has not previously been adapted to develop the cultural competence of therapists and this is also the first SP/SR programme that has explicitly focussed on the ethnic identity of therapists. The aim of the SP/SR programme was to provide therapists with space to explore their ethnic identity, and its personal and professional impact, as well as an opportunity to develop their skills in working clinically with the ethnic identity of service users. It was also hoped that the programme would promote the wellbeing of therapists. Therefore, the findings from this evaluation sought to add to the research base around cultural competence, as well as to the personal and professional development of therapists from minoritised ethnic backgrounds. This research also aimed to expand the quantitative literature around SP/SR.

The primary aim of this evaluation was to explore the impacts of the programme on therapists' self-rated skill in working with ethnicity in their clinical practice, their ethnic identity development, and personal and therapist wellbeing. The discussion for each is presented below:

Therapist skill in working with ethnicity

The results of this evaluation indicate that, overall, over the course of the SP/SR programme, most participants appeared to show improvements across the seven skills outcomes, with observed increases in level and trend during the SP/SR phase. These improvements in skills ratings were significant in the case of some participants, with the greatest number of participants showing significant improvements for the skills to identify

and address similarities and differences in ethnicity outcome (3 participants), followed by the skills to explore ethnicity (2 participants) and skills to integrate strengths related to ethnicity outcomes (2 participants). However, significant improvements were only replicated across the three baseline conditions for the skills to identify and address similarities and differences in ethnicity outcome, therefore, we can only conclude that improvements were as a result of the SP/SR programme for this outcome. It is possible that the SP/SR programme had the greatest impact on the skills to explore and address similarities and differences in ethnicity outcome as it considers the ethnic identity of therapists as it relates to that of service users, which is something that is often lacking within traditional cultural competence training (Faheem, 2023a) and might be specifically targeted by an SP/SR training methodology and the current intervention. It may also be possible that the engagement of the reflective bridge between the personal and therapist selves, through the self-practice exercises and related reflective questions contained in the programme, may have had a particular impact on this outcome (Bennett-Levy & Finlay-Jones, 2018).

In contrast, none of the participants appeared to show significant improvements in skills related to including ethnicity within formulations. This finding is particularly surprising, given that two of the modules of the SP/SR programme focussed on developing CBT formulations incorporating ethnicity/ethnic identity. It is difficult to ascertain why this might be from the quantitative data collected in this study.

Ethnic Identity Development

Similar to the skills outcomes, most participants appeared to show increasing levels and trends in relation to the three ethnic identity development outcomes during the SP/SR phase, however, these were only significant in the cases of some participants, with the greatest number of participants showing significant improvements on the outcome related to

the exploration of their ethnic identity (3 participants). Although three participants showed significant gains on this outcome during the course of the programme, this was not replicated across the three baseline conditions, and therefore, it is difficult to draw definite conclusions that improvements were as a result of the SP/SR programme.

It is interesting that, of the three ethnic identity development outcomes, there was a greater impact of the programme on the exploration component than on the resolution and valence components. Some models of ethnic identity development highlight the importance of exploration (Phinney, 1993; Phinney & Ong, 2007), therefore it may be that the current SP/SR programme offered therapists an important opportunity for exploration. This is also consistent with assertions from the CBT and related cultural competence literature, which highlights a need for therapists to have spaces to explore their own ethnicity and its implications on their practice (Faheem, 2023a; Haque et al., 2021; Naz, 2021).

Wellbeing

The majority of participants appeared to show increasing levels and trends in the ratings of their personal and therapist wellbeing. However, it appeared that more participants experienced a significant benefit for wellbeing related to their therapist selves (3 participants), than personal selves (1 participant). Considering these findings within the DPR and PP models (Bennett-Levy, 2006; Bennett-Levy & Finlay-Jones, 2018), it is possible that more people engaged in the SP/SR programme on the level of their therapist self, and so greater benefit was experienced related to this outcome. In addition, lower personal wellbeing ratings could be accounted for by personal events that participants highlighted when contextualising their weekly ratings (Appendix I), including reports of bereavement and illness that would understandably have impacted on perceived levels of personal wellbeing.

Therefore, looking at the overall impacts of the SP/SR programme on the three outcome areas, there appeared to be some evidence that the programme led to improvements in therapist reflective skill, specifically in relation to identifying and addressing similarities and differences in ethnicity outcome with service users. There also appeared to be a general increase in level and trend across outcomes during the course of the programme, however, these were not significantly improved in all cases. These findings may suggest that although participation in the programme was beginning to have a positive impact on the different outcome areas, skills in working with ethnicity, ethnic identity development and wellbeing are all dynamic factors, and change is often a longer or even life-long process. This is highlighted in particular within the cultural competence and ethnic identity development literature, where specific training programmes or interventions may just offer a starting point in a continuous journey of development (Benuto et al., 2019; Curtis et al, 2019; Haque et al., 2021; Maehler, 2021). Importantly, it appeared that none of the participants experienced any significant negative impacts as a result of this SP/SR programme during the course of the intervention.

A secondary aim of this study was to consider if any impacts of the programme were maintained after the completion of the programme. The findings from the comparison of the SP/SR and follow-up phases presented some mixed evidence, where improvements were maintained for two of three participants, with Participant E, in particular, making further gains across most outcomes. It may be that the follow-up phase offered a period of consolidation for Participant E, allowing for further gains to be made. In contrast, Participant C appeared to show some deterioration at follow-up, with a significant reduction in resolution related to their ethnic identity and in levels of therapist wellbeing. It is possible that a greater consideration of ethnic identity during the course of the SP/SR programme, which included a consideration of negative experiences and experiences of discrimination related to ethnic

identity, may have led to a reduced sense of resolution. It is also possible that these reductions reflect unknown factors outside of the SP/SR programme.

Individual Impacts of the SP/SR Programme

The multiple baselines SCED design also allowed for the consideration of individual outcomes related to this programme. A key finding from this evaluation is that different participants appeared to experience differential impacts and levels of benefit from the SP/SR programme. Participant D seemed to experience the greatest level of benefit related to the technical skills outcomes, showing significant improvements in skills related to exploring the ethnicity of service users, incorporating strengths and addressing difficulties related to ethnicity within their clinical practice. In contrast, it appeared that Participants A, E and F experienced the greatest benefit from the programme overall, showing significant improvements related to reflective skills, ethnic identity development and therapist wellbeing outcomes. Looking at the participant demographic and contextual information, it appeared that Participant D had the least clinical experience of the group, being the most recently qualified, while Participants A, E and F had varying lengths of experience, ranging from 2.5 to 10 years. Therefore, it is possible that the impact of the programme on the development of more concrete, technical skills was experienced by the novice therapist, with the more experienced therapists experienced some benefits related to reflective skills, their own ethnic identity development and therapist wellbeing. Similar findings have been reported in other SP/SR studies, where declarative information and procedural skills are enhanced for novice therapists, and skill refinement as well as personal and professional benefits are experienced by experienced therapists (Bennett-Levy, 2006; Bennett-Levy & Haarhoff; 2019; Thwaites et al., 2014).

In addition, it appeared that Participants A, D, E and F also spent the greatest amount of time on the SP/SR programme. Therefore, it is likely that their level of engagement in the SP/SR programme led to them experiencing the greatest levels of benefit. These findings are supported by existing SP/SR research which sets out differential impacts of SP/SR programmes for individuals, with engagement being a central factor related to outcome (Bennett-Levy & Lee, 2014; Chaddock et al., 2014). Bennett-Levy and Lee (2014) propose a model outlining the factors that influence engagement and experience of benefit from SP/SR, which include: course structure and requirements, expectation of benefit, available personal resources, feelings of safety with the process, and group processes. Although difficult to conclude for certain, it is likely that these factors impacted on participants' experiences and outcomes related to the current programme, particularly given the focus of the programme on ethnicity/ethnic identity.

The findings from this study have mainly been considered within the existing SP/SR literature. It would appear that the current findings appear more conservative than previous studies that have explored the impact of SP/SR on therapist skill, personal and professional development and wellbeing. However, this may be explained by the focus of the current intervention on the development of skills related to working with ethnicity in clinical practice, which has not previously been a target of SP/SR. Furthermore, the majority of studies that have evaluated the impacts of SP/SR have been qualitative and there are significant methodological limitations with the few existing quantitative studies examining SP/SR (McGillivray et al., 2015), so it is difficult to adequately situate these findings within the literature. The overall findings in this study seem to align more with the cultural competence literature, where a more mixed picture of training interventions is presented (Bentley et al., 2008; Clegg et al., 2016; Jongen et al., 2018; Truong et al., 2014). However, again it is hard to fully interpret these findings within the wider literature, as this is the first

study to use an SP/SR methodology to develop therapist skill in working with ethnic diversity and existing studies vary greatly in their methods of training (Bentley et al, 2008; Truong et al., 2014).

Strengths

This paper describes an initial attempt to evaluate quantitatively a novel SP/SR programme for therapists from minoritised ethnic backgrounds. Therefore, the findings from this evaluation seek to add to the needed quantitative research base around SP/SR, as well as to the literature around cultural competence, and the personal and professional development of therapists from minoritised ethnic backgrounds. The experiences and development of therapists from minoritised ethnic backgrounds remain incredibly under-researched areas (Kadaba et al., 2022; Sue & Sue, 2015), therefore the focus of the current evaluation on these areas could be important in furthering our understanding of the unique needs of this group of therapists.

Another strength of this study is the multiple baselines SCED design, which was applied rigorously following the WWC standards (Kratochwill et al. 2010) and which allowed for the exploration of both overall and individual outcomes. The visual analysis of graphed data was done systematically and the most robust, available statistical methods for analysing SCED data were also used in this study (Parker et al., 2011). Therefore, the design of this study extends previous attempts to apply this type of design to the quantitative evaluation of SP/SR offering a more robust design and analysis protocol.

Limitations

One of the main limitations of this research project, being a purely quantitative evaluation, is that is it difficult to fully contextualise these findings as it relates to this group

of therapists and to generalise these findings more widely. While some of the findings can be understood within the demographic and background information provided by participants, it is difficult to draw conclusions around experiences of the programme, perceived benefits, and possible underlying mechanisms of change. The purely quantitative data also makes it difficult to know if the hypothesised mechanisms of change within the programme are reflected in the findings from this study, . Therefore, it will be important to interpret these findings alongside the qualitative evaluation of this programme (Malik, 2023), which will likely give a fuller picture of the impact and outcome, as described by the participants. The qualitative evaluation would also provide further information about the experiences of participants who dropped out of the programme, which is not captured in this study. This will be crucial in any further developments to the programme.

A second limitation of this study is around the outcomes and related measurements. This evaluation relied on the use of unstandardised, adapted and self-rated outcomes. While this is not uncommon within SCED, SP/SR and cultural competence research (Jongen et al., 2018; Krasny-Pacini & Evans, 2018; McGillivray et al., 2015), they present some key issues. First of all, apart from the ethnic identity development outcomes, which were adapted from a validated measure, it is hard to know if the skills and wellbeing outcomes were actually measuring the constructs they sought to measure. Secondly, self-ratings are subjective and susceptible to reporting biases, and may not reflect true levels of outcomes. These issues may provide some possible confounds in the findings, where for example, measures asking about perceived level of skill may have actually reflected perceived levels of confidence in working with ethnicity. Naz and colleagues (2019) reference the overlap between the lack of confidence and the skills gap in working with ethnicity in clinical practice. There was also high degrees of variability in the weekly ratings provided which may have likely impacted on the overall findings of this project.

Finally, the current SP/SR intervention is pitched at the level of the individual therapist. However, it is increasingly acknowledged that change at the individual level is insufficient in bringing about transformative and lasting change for both therapists and service users from minoritised ethnic backgrounds, and there is more that needs to be done at a structural and institutional level (Beck & Naz, 2019; Lawton et al., 2021; Naz et al., 2019). For example, the need for community engagement in the development and design of services. Related to this, some authors have argued for going beyond the ideas of developing cultural competence, and instead, promoting cultural safety, which taps into some of these more structural changes (Curtis et al., 2019). Curtis and colleagues (2019) recommend a definition of cultural safety, which promotes the 'critical consciousness' of healthcare professionals and organisations to reduce bias and strive for equity. Therefore, while interventions at the individual level may be experienced as beneficial, it is crucial for these to come alongside wider change.

Implications and Future Directions

As stated in the introduction of this paper, therapists from minoritised ethnic backgrounds express a clear need for cultural competence initiatives to address their unique training needs, as well as for access to spaces to consider their own ethnicity within their practice. Related to the above, this study has a number of important implications for clinical practice and research:

1. The findings from this study provide some initial support for the use of SP/SR as a methodology for developing therapist reflective skill in working clinically with ethnicity, for therapists from minoritised ethnic backgrounds. Increasing trends were also documented across skills outcomes more broadly. Therefore, it might be that this programme offers a novel and practical way of developing therapist skills

(particularly reflective skills) and consideration may be given to integrating a similar approach within existing CBT professional training programmes where there has been comparatively less of a focus of the development of technical and reflective skills related to cultural competence (Bassey & Melluish, 2012; Naz et al., 2019).

2. The current SP/SR programme and the findings of this evaluation also adds to existing initiatives that aim to support the personal and professional development of therapists from minoritised ethnic backgrounds. Participation in an experiential programme, such as SP/SR, appears to have some positive impacts to this end, where increasing trends in scores related to the ethnic identity development and wellbeing of therapists have been observed. The same or similar initiatives may be considered within professional training and/or service-specific contexts.
3. The findings from this research also provide further support to the assertion that SP/SR programmes have differential impacts for individuals, depending on their level of experience as well as on their levels of engagement with SP/SR. This may support the development of further iterations of the current programme or other similar initiatives, where a greater focus on technical skill development may be more supportive for novice therapists, while programmes aimed at more experienced therapists may place a greater emphasis on reflective skills, and personal and professional development. As suggested by previous studies (Chaddock et al., 2014), better orientation to the programme and a clear setting of expectations around impact and level of commitment may also support with engagement in future studies.
4. The current research methodology may also be replicated and extended in future attempts to quantitatively evaluate SP/SR programmes, where there is a lack of good quality empirical research (Bennett-Levy, 2019).

5. From the outset, co-production has been a key part of the development of this programme and the related evaluations, with the consultation of an expert reference group at each stage. Highlighting the voices and experiences of therapists from minoritised ethnic backgrounds is crucial in future work. As the first-hand accounts of participants are not captured within the current study, it is important that these findings are considered alongside the quantitative evaluation of the programme (Malik, 2023). There are also plans for the individual accounts of some of the participants to be published in an article, as well as at the upcoming 2023 BABCP Conference.

As this is the first SP/SP programme and evaluation of its kind, it would be important for further evaluations to take place, addressing the limitations of the current study. In particular, it would be important for future studies to address the limitations around the measurement of outcomes, where the validation of simple measures prior to use in this study would be helpful. Specifically related to the skills outcomes, it could be helpful to measure perceived confidence alongside perceived skill to delineate the two constructs. Adopting a mixed methods analysis may also be helpful in future evaluations, where the mechanisms of change may be examined in greater detail.

In addition, while the DPR model has been applied to the development of the cultural competence of White therapists (Churchard, 2022), this has, so far, not been extended to the development of similar skills for therapists from minoritised ethnic backgrounds. Although aspects of the DPR and PP model (Bennett-Levy, 2005; Bennett-Levy & Finlay-Jones, 2018) have been applied to interpret the current findings and their implications, it would be important for a comprehensive theoretical model to be developed. It is hoped that the qualitative (Malik, 2023) and current quantitative evaluation of this SP/SR programme may inform this model, which may guide further research (McGillivray et al., 2015).

Conclusion

In sum, there is initial evidence for the impact of this novel SP/SR programme for therapists from minoritised ethnic backgrounds in developing skills in identifying and addressing similarities and differences in ethnicity with that of service users within clinical practice, with overall positive trends in additional outcomes related to developing skills in working with ethnicity, ethnic identity development and wellbeing. The differential impact of the programme on participants can also be demonstrated in this study, with some experiencing greater benefits than others. These findings may have important implications for the personal and professional development of therapists from minoritised ethnic backgrounds within CBT professional training courses and service-specific contexts, as well as for future quantitative research around SP/SR.

References

Baker, C. (2018). Mental Health Statistics for England: prevalence, services and funding. UK Parliament. http://allcatsrgrey.org.uk/wp/download/public_health/mental_health/SN06988-1.pdf

Baker, C & Kir-Wade, E. (2023). Mental health statistics: prevalence, services and funding in England. UK Parliament. https://commonslibrary.parliament.uk/research-briefings/sn06988/.

Bassey, S., & Melluish, S. (2012). Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: A template analysis focus study. *Counselling Psychology Quarterly*, *25*(3), 223–238. https://doi.org/10.1080/09515070.2012.711528

Beck, A. (2016). *Transcultural cognitive behaviour therapy for anxiety and depression: A practical guide.* Routledge.

Beck, A., & Naz, S. (2019). The need for service change and community outreach work to support trans-cultural cognitive behaviour therapy with Black and Minority Ethnic communities. *The Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X18000016

Beck, A., Naz, S., Brooks, M. and Jankowska, M. (2019). Black, Asian and Minority Ethnic Service User Positive Practice Guide.

Bennett-Levy, J. (2006). Therapist Skills: A Cognitive Model of their Acquisition and Refinement. *Behavioural and Cognitive Psychotherapy*, *34*(1), 57–78. https://doi.org/10.1017/S1352465805002420

Bennett-Levy, J. (2019). Why therapists should walk the talk: The theoretical and empirical case for personal practice in therapist training and professional development. *Journal*

of Behavior Therapy and Experimental Psychiatry, *62*, 133–145. https://doi.org/10.1016/j.jbtep.2018.08.004

Bennett-Levy, J., & Finlay-Jones, A. (2018). The role of personal practice in therapist skill development: A model to guide therapists, educators, supervisors and researchers. *Cognitive Behaviour Therapy*, *47*(3), 185–205. https://doi.org/10.1080/16506073.2018.1434678

Bennett-Levy, J., & Haarhoff, B. (2019). Why therapists need to take a good look at themselves. In S. Dimidjian (Eds.), *Evidence-based practice in action: Bridging clinical science and intervention (pp. 380-394).* The Guildford Press.

Bennett-Levy, J., & Lee, N. K. (2014). Self-Practice and Self-Reflection in Cognitive Behaviour Therapy Training: What Factors Influence Trainees' Engagement and Experience of Benefit? *Behavioural and Cognitive Psychotherapy*, *42*(1), 48–64. https://doi.org/10.1017/S1352465812000781

Bennett-Levy, J., McManus, F., Westling, B. E., & Fennell, M. (2009). Acquiring and Refining CBT Skills and Competencies: Which Training Methods are Perceived to be Most Effective? *Behavioural and Cognitive Psychotherapy*, *37*(5), 571–583. https://doi.org/10.1017/S1352465809990270

Bennett-Levy, J., Lee, N., Travers, K., Pohlman, S., & Hamernik, E. (2003). Cognitive therapy from the inside: Enhancing therapist skills through practising what we preach. Behavioural and Cognitive Psychotherapy, 31, 145–163. doi:10.1017/S1352465803002029

Bennett-Levy, J., Thwaites, R., Chaddock, A., & Davis, M. (2009). Reflective Practice in Cognitive Behavioural Therapy: The Engine of Lifelong Learning. In R. Dallos, & J. Stedmon (Eds.), *Reflective Practice in Psychotherapy and Counselling* (pp. 115-135). New York: Open University Press.

Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H. (2015). *Experiencing CBT from the inside out: A self-practice/self-reflection workbook for therapists*. New York: Guilford Press.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, *29*(2), 203–220. https://doi.org/10.1017/S1352465801002077

Bennett-Levy, J., Wilson, S., Nelson, J., Rotumah, D., Ryan, K., Budden, W., Stirling, J., & Beale, D. (2015). Spontaneous Self-Practice of Cognitive Behavioural Therapy (CBT) by Aboriginal Counsellors During and Following CBT Training: A Retrospective Analysis of Facilitating Conditions and Impact. *Australian Psychologist*, *50*, 329–334. https://doi.org/10.1111/ap.12154

Bentley, P., Jovanovic, A., & Sharma, P. (2008). Cultural diversity training for UK healthcare professionals: A comprehensive nationwide cross-sectional survey. *Clinical Medicine (London, England)*, *8*(5), 493–497. https://doi.org/10.7861/clinmedicine.8-5-493

Benuto, L. T., Singer, J., Newlands, R. T., & Casas, J. B. (2019). Training culturally competent psychologists: Where are we and where do we need to go? *Training and Education in Professional Psychology*, *13*(1), 56–63. https://doi.org/10.1037/tep0000214

British Association for Behavioural and Cognitive Psychotherapies (BABCP) (2021). Core Curriculum. https://babcp.com/Portals/0/Files/About/Core%20Curriculum%20Jul%202022.pdf?ver=2023-05-11-145433-467

British Association for Behavioural and Cognitive Psychotherapies (BABCP) (2022). Minimum Training Standards.

https://babcp.com/Portals/0/Files/About/Minimum%20Training%20Standards%201222.pdf?ver=2022-12-15-155902-380

Chaddock, A., Thwaites, R., Bennett-Levy, J., & Freeston, M. H. (2014). Understanding individual differences in response to Self-Practice and Self-Reflection (SP/SR) during CBT training. *The Cognitive Behaviour Therapist*, *7*, e14. https://doi.org/10.1017/S1754470X14000142

Chang, Y. Y. (2022). *Asian Canadian therapists' experience and coping with racial microaggression: A qualitative examination with interpretative phenomenological [*Doctoral dissertation, University of Windsor]. Electronic Theses and Dissertations. https://scholar.uwindsor.ca/cgi/viewcontent.cgi?article=9696&context=etd

Chigwedere, C., Bennett-Levy, J., Fitzmaurice, B., & Donohoe, G. (2021). Personal practice in counselling and CBT trainees: The self-perceived impact of personal therapy and self-practice/self-reflection on personal and professional development. *Cognitive Behaviour Therapy*, *50*(5), 422–438. https://doi.org/10.1080/16506073.2020.1846608

Churchard, A. (2022). How can psychotherapists improve their practice with service users from minoritised ethnicities? An application of the Declarative-Procedural-Reflective (DPR) model of clinical skill development. *The Cognitive Behaviour Therapist*, *15*, e1. https://doi.org/10.1017/S1754470X21000386

Churchard, A. & Thwaites, R. (2022). A Self-Practice / Self-Reflection (SP/SR) Programme for CBT Therapists from Minoritised Ethnicities. [Unpublished manuscript].

Clegg, S., Heywood-Everett, S., & Siddiqi, N. (2016). A review of cultural competence training in UK mental health settings. *British Journal of Mental Health Nursing*, *5*(4), 176–183. https://doi.org/10.12968/bjmh.2016.5.4.176

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Data Protection Act (2018). UK public general acts c.12. https://www.legislation.gov.uk/ukpga/2018/12/contents

Davis, M. L., Thwaites, R., Freeston, M. H., & Bennett-Levy, J. (2014). A Measurable Impact of a Self-Practice/Self-Reflection Programme on the Therapeutic Skills of Experienced Cognitive-Behavioural Therapists: Self-Practice/Self-Reflection Enhances Skill in Experienced CBT Therapists. *Clinical Psychology & Psychotherapy*, *22*(2), 176–184. https://doi.org/10.1002/cpp.1884

De , T.K., Michiels, B., Vlaeyen, J.W.S., & Onghena, P. (2020). Shiny SCDA [Computer software]. Retrieved from https://ppw.kuleuven.be/mesrg/software-and-apps/shiny-scda

Faheem, A. (2023a). 'It's been quite a poor show' – exploring whether practitioners working for Improving Access to Psychological Therapies (IAPT) services are culturally competent to deal with the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist*, *16*, e6. https://doi.org/10.1017/S1754470X22000642

Faheem, A. (2023b). 'Not a cure, but helpful' – exploring the suitability of evidence-based psychological interventions to the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist*, *16*, e4. https://doi.org/10.1017/S1754470X22000599

Fraser, N., & Wilson, J. (2010). Self-case study as a catalyst for personal development in cognitive therapy training. *The Cognitive Behaviour Therapist*, 3, 107–116. doi:10.1017/S1754470X10000097

Gale, C., & Schröder, T. (2014). Experiences of self-practice/self-reflection in cognitive behavioural therapy: A meta-synthesis of qualitative studies. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*(4), 373–392. https://doi.org/10.1111/papt.12026

Haarhoff, B., & Farrand, P. A. (2012). Reflective and self-evaluative practice in CBT. In W. Dryden & R. Branch (Eds.). *The CBT Handbook* (pp. 475-492). Sage.

Haarhoff, B., Gibson, K., & Flett, R. (2011). Improving the quality of cognitive behaviour therapy case conceptualization: The role of self-practice/self-reflection. *Behavioural and Cognitive Psychotherapy*, **39**, 323– 339. doi:10.1017/S1352465810000871

Hakim, N., Thompson, A., & Coleman-Oluwabusola, G. (2019). An evaluation of the transition from BAME community mental health worker to IAPT low intensity psychological wellbeing practitioner. *The Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X18000296

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., Hall, J., MacCrimmon, S., Rimes, K. A., Woodhead, C., & Hatch, S. L. (2021). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*, 1–12. https://doi.org/10.1017/S0033291721002518

Haque, F., Thapa, B., & Kunorubwe, T. (2021). *Reflections on Cultural Competence Training in IAPT*. *49*, 18.

Hays, P. A. (2019). Introduction. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision (2nd ed.).* (pp. 3–24). American Psychological Association. https://doi.org/10.1037/0000119-001

Hays, P. A., & Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. American Psychological Association.

Jameel, S., Munivenkatappa, M., Arumugham, S. S., & Thennarasu, K. (2022). Cultural adaptation of cognitive behaviour therapy for depression: A qualitative study exploring views of patients and practitioners from India. *The Cognitive Behaviour Therapist*, *15*, e16. https://doi.org/10.1017/S1754470X22000137

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: A systematic scoping review. *BMC Health Services Research*, *18*(1), 232. https://doi.org/10.1186/s12913-018-3001-5

Kadaba, M. L., Chow, J. S., & Briscoe-Smith, A. (2022). Recommendations for Creating and Teaching a Graduate Psychology Course Exclusively for Black, Indigenous, and People of Color Students. *Teaching of Psychology*, 00986283211070012. https://doi.org/10.1177/00986283211070012

Krasny-Pacini, A., & Evans, J. (2018). Single-case experimental designs to assess intervention effectiveness in rehabilitation: A practical guide. *Annals of Physical and Rehabilitation Medicine*, *61*(3), 164–179. https://doi.org/10.1016/j.rehab.2017.12.002

Kratochwill T. R., Hitchcock J., Horner R. H., Levin J. R., Odom S. L., Rindskopf D., Shadish W. R. M. (2010). *Single case designs technical documentation* Retrieved from http://ies.ed.gov/ncee/wwc/pdf/wwc_scd.pdf

Kratochwill, T. R., Hitchcock, J. H., Horner, R. H., Levin, J. R., Odom, S. L., Rindskopf, D. M., & Shadish, W. R. (2013). Single-Case Intervention Research Design Standards. *Remedial and Special Education*, *34*(1), 26–38. https://doi.org/10.1177/0741932512452794

The Law Society (2023, February 24). A guide to race and ethnicity terminology and language. https://www.lawsociety.org.uk/topics/ethnic-minority-lawyers/a-guide-to-race-and-ethnicity-terminology-and-language

Lawton, L., McRae, M., & Gordon, L. (2021). Frontline yet at the back of the queue – improving access and adaptations to CBT for Black African and Caribbean communities. *The Cognitive Behaviour Therapist*, *14*, e30. https://doi.org/10.1017/S1754470X21000271

Lobo, M. A., Moeyaert, M., Cunha, A. B., & Babik, I. (2017). Single-Case Design, Analysis, and Quality Assessment for Intervention Research. *Journal of Neurologic Physical Therapy : JNPT*, *41*(3), 187–197. https://doi.org/10.1097/NPT.0000000000000187

Maehler, D. B. (2022). Determinants of ethnic identity development in adulthood: A longitudinal study. *British Journal of Developmental Psychology*, *40*(1), 46–72. https://doi.org/10.1111/bjdp.12384

Malik, Z. (2023). Untitled DClinPsy thesis [Unpublished thesis]. University College London.

McGillivray, J., Gurtman, C., Boganin, C., & Sheen, J. (2015). Self-Practice and Self-Reflection in Training of Psychological Interventions and Therapist Skills Development: A Qualitative Meta-Synthesis Review. *Australian Psychologist*, *50*(6), 434–444. https://doi.org/10.1111/ap.12158

Mir, G., Ghani, R., Meer, S., & Hussain, G. (2019). Delivering a culturally adapted therapy for Muslim clients with depression. *The Cognitive Behaviour Therapist*, *12*, e26. https://doi.org/10.1017/S1754470X19000059

Naeem, F. (2019). Cultural adaptations of CBT: A summary and discussion of the Special Issue on Cultural Adaptation of CBT. *The Cognitive Behaviour Therapist*, *12*, e40. https://doi.org/10.1017/S1754470X19000278

Naz, S. (2021). Where am I really from? *CBT Today*, 49 (1), p28.

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *The Cognitive Behaviour Therapist*, *12*, e22. https://doi.org/10.1017/S1754470X19000060

Neblett Jr., E. W., Rivas-Drake, D., & Umaña-Taylor, A. J. (2012). The Promise of Racial and Ethnic Protective Factors in Promoting Ethnic Minority Youth Development. *Child Development Perspectives*, *6*(3), 295–303. https://doi.org/10.1111/j.1750-8606.2012.00239.x

Pakenham, K. I. (2015). Effects of Acceptance and Commitment Therapy (ACT) Training on Clinical Psychology Trainee Stress, Therapist Skills and Attributes, and ACT Processes. *Clinical Psychology & Psychotherapy*, *22*(6), 647–655. https://doi.org/10.1002/cpp.1924

Parker RI, Vannest KJ, Davis JL, Sauber SB (2011). Combining nonoverlap and trend for single-case research: Tau-U. Behavior Therapy 42, 284–299.

Phinney, J. S. (1993). A three-stage model of ethnic identity development in adolescence. In M. E. Bernal & G. P. Knight (Eds.), Ethnic identity: Formation and transmission among Hispanics and other minorities (pp. 61-79). New York: State University of New York Press.

Phinney, J.S., Ong, A.D., (2007). Conceptualization and measurement of ethnic identity: Current status and future directions. Journal of Counseling Psychology, 54, 271-281. DOI: 10.1037/0022-0167.54.3.271

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. https://doi.org/10.1007/s40615-021-00993-x

Rathod, S., Kingdon, D., Pinninti, N., Turkington, D., & Phiri, P. (2015). *Cultural Adaptation of CBT for Serious Mental Illness: A Guide for Training and Practice*. John Wiley & Sons, Ltd.

Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, *12*, e10. https://doi.org/10.1017/S1754470X18000247

Scott, J., Yap, K., Bunch, K., Haarhoff, B., Perry, H., & Bennett-Levy, J. (2020). Should personal practice be part of cognitive behaviour therapy training? Results from two self-practice/self-reflection cohort control pilot studies. *Clinical Psychology & Psychotherapy*, *28*(1), 150–158. https://doi.org/10.1002/cpp.2497

Sue, & Sue, D. (2015). *Counseling the culturally diverse: theory and practice* (7th ed). Wiley.

Thwaites, R., Bennett-Levy, J., Cairns, L., Lowrie, R., Robinson[1], A., Haarhoff, B., Lockhart[1], L., & Perry, H. (2017). Self-practice/self-reflection (SP/SR) as a training strategy to enhance therapeutic empathy in low intensity CBT practitioners. *New Zealand Journal of Psychology*, *46*, 63–70.

Thwaites, R., Bennett-Levy, J., Davis, M., & Chaddock, A. (2014). Using self-practice and self-reflection (SP/SR) to enhance CBT competence and metacompetence. In A. Whittington & N. Grey (Eds.), *How to become a more effective CBT therapist: Mastering metacompetence in clinical practice* (pp. 241–254). Wiley Blackwell.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, *14*(1), 99. https://doi.org/10.1186/1472-6963-14-99

Umaña-Taylor, A. J. (2011). Ethnic identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 791–801). Springer Science + Business Media. https://doi-org.libproxy.ucl.ac.uk/10.1007/978-1-4419-7988-9_33

Umaña-Taylor, A. J., Yazedjian, A., & Bámaca-Gómez, M. (2004). Developing the Ethnic Identity Scale Using Eriksonian and Social Identity Perspectives. Identity (Mahwah, N.J.), 4(1), 9–38. https://doi.org/10.1207/S1532706XID0401_2

Vannest, K.J., Parker, R.I., Gonen, O., & Adiguzel, T. (2016). Single Case Research: web based calculators for SCR analysis. (Version 2.0) [Web-based application]. College Station, TX: Texas A&M University. Retrieved Saturday 10th June 2023. Available from singlecaseresearch.org

Williams, M. T., Kanter, J. W., Peña, A., Ching, T. H. W., & Oshin, L. (2020). Reducing microaggressions and promoting interracial connection: The racial harmony workshop. *Journal of Contextual Behavioral Science*, *16*, 153–161. https://doi.org/10.1016/j.jcbs.2020.04.008

Williams, M. T., Holmes, S., Zare, M., Haeny, A., & Faber, S. (2022). An Evidence-Based Approach for Treating Stress and Trauma due to Racism. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2022.07.001

Williams, M. T., Rouleau, T. M., La Torre, J. T., & Sharif, N. (2020). Cultural competency in the treatment of obsessive-compulsive disorder: Practitioner guidelines. *The Cognitive Behaviour Therapist*, *13*, e48. https://doi.org/10.1017/S1754470X20000501

Part Three: Critical Appraisal

Word Count: 3373

Introduction

This critical appraisal will consider my experiences and reflections on the process of embarking on this research project. It will begin by setting out my interest in the research area, following which it will consider, in detail, my reflections on the research design and analysis. The appraisal will then describe the development of the outcome measures used in the evaluation, including the dilemmas that came up. Finally, I will reflect on my positionality within this research project and its impact on the research process.

My interest in the research area

Before joining this research project, I was unfamiliar with SP/SR and its use as a therapist training methodology. However, I was drawn to this area for two main reasons:

First, I was very interested in the fact that this project involved an intervention for therapists from minoritised ethnic backgrounds. Prior to training, I worked as an Assistant Psychologist in a Staff Support team, where a part of my role involved co-facilitating reflective and supportive spaces for staff teams impacted by significant incidents. I continued in this role through the beginning of the COVID-19 pandemic, which added a different level of challenge for front-line staff teams and the early impacts of the pandemic on the NHS were already clear. It was apparent that services across the Trust were incredibly under-resourced, where high levels of burnout were being reported by staff, however, unfortunately, very little was changing in the way of support for them. In addition, it was clear that staff from minoritised ethnic backgrounds were being disproportionately negatively impacted in the workplace, as has been corroborated by recent research (Chaudhry et al., 2020; Jesuthasan et al., 2021; NHS England, 2022). This fact was brought to light in a new way following the murder of George Floyd and the subsequent Black Lives Matter movement in 2020, which prompted a number of important and long overdue conversations around the experiences of

minoritised and marginalised staff within the Trust. Bearing witness to these stories and experiences, alongside my time in this role more generally, fostered my interest in staff support initiatives, particularly those for marginalised staff groups.

Secondly, I was also drawn to the idea of the programme itself, which aimed to provide therapists with a space to explore and reflect on their ethnic identity over time, with a particular focus on strengths associated with ethnicity. In previous clinical roles and placements, my experience has been that the ethnic and cultural backgrounds of service users are often unconsidered within clinical practice, and when they are thought about, they are often approached with a negative frame. This is consistently reported by service users and practitioners as a common experience and is also highlighted within the CBT literature (Faheem, 2023; Hays, 2019; Spalding et al., 2019). Therefore, I valued that the programme took a predominantly strengths-based approach to ethnicity, while simultaneously acknowledging and holding space for the more challenging experiences that people from minoritised ethnic backgrounds are faced with. Crucially, these experiences were framed within the wider contexts of structural racism, and the influential processes of power and privilege, including how they play out on a global scale. The exploration of ethnic identity also held personal resonances for me, where my own relationship with my ethnicity has changed over time. Growing up in India and then moving to the UK as an adult, I had to learn to negotiate my new identity as someone from a minoritised ethnic background, which brought with it different understandings and implications for my experiences. For me, this has prompted reflection on the impacts of colonialism and racism, including my own internalised racism, where I am continuing to navigate my position and the accompanying thoughts and emotions that it brings.

Reflections on the research design and analysis protocol

It was planned for this evaluation to adopt a SCED design, given its use in previous quantitative SP/SR studies. In addition, as this was a novel adaptation of SP/SR, such a design allowed for the study of both individual and overall impacts of the programme. However, SCED as a research design and methodology was something I was completely new to, and therefore, when drawing up my initial research proposal, I used existing single-case SP/SR studies to guide my research design (e.g. Chaddock et al., 2014). However, at that stage, the proposal reviewer highlighted some key issues around refining my research design, as well as looking beyond just the use of visual analysis. This prompted me to do extensive research into the existing literature and practical guidelines around SCED, to develop my own understanding of the types of SCED designs and the existing best-practice guidance around conducting the associated visual and statistical analyses. My initial research into the area helped me to fine-tune my design, choosing a multiple-baseline design with sufficient baseline conditions and data points in each phase. However, it also presented some additional challenges as described below.

Firstly, I found that SCEDs were predominantly used in behavioural and rehabilitation research (Krasny-Pacini & Evans, 2018), so it was more difficult to find their application to studying other types of interventions. Secondly, while the field of SCEDs had developed since its initial inception, there still appeared to be some inconsistencies in guidance around the application of the design and analyses, in particular, around carrying out visual analyses. One recent paper by Wolfe and McCammon (2022) describes the variability in how visual analysis is taught and carried out. Finally, it was difficult to find a consensus within guidance papers around the best statistical analyses for SCED designs, with different studies taking different approaches to incorporating statistical tests (Krasny-Pacini & Evans, 2018; Lobo et al., 2017).

Unfortunately, there was a lack of expertise in this area within our research team, as well as within the wider UCL course, so it was difficult to navigate some of these challenges and make informed choices around our design and analysis protocol. I personally found it very hard to know if I was on the right track with my design and protocol.

Therefore, our first step was to seek guidance from external consultants with expertise in SCED designs. We reached out to two clinical psychologists, Dr Chris Gaskell and Dr Steve Kellett, who had extensive experience in SCED research and specifically its application to practice-based research and therapeutic interventions. They were very kind in offering time to meet with me and my internal supervisor, Dr Henry Clements, to review our design and planned analysis protocol. This meeting was very helpful in refining aspects of my analysis and plans for presenting my results, as well as in having a space to ask specific advice about SCEDs in their application to our study. This meeting also offered some reassurance that we were generally approaching the design and analysis in a suitable way. In addition to the feedback and advice that was received during this meeting, I also found it helpful to draw on a few recent intervention papers that used multiple baseline SCED designs (Thomson et al., 2017; Willson et al., 2016). These papers were particularly helpful in helping me to select an appropriate and robust statistical analysis, as well as gave me ideas on how to present my data and report my results. When conducting my analysis, I also found it very helpful to develop a visual analysis table (as in Appendix G), which allowed me to systematically carry out the visual analysis and consider these findings in relation to my statistical analysis. Wolfe and colleagues (2019) similarly highlight the need for systematic protocols in conducting visual analysis.

Therefore, in taking these steps, we were able to reach a robust research design and analysis, which may be helpful in informing future attempts to quantitatively evaluate SP/SR.

The development of outcome measures

A key part of the research process in this evaluation involved the development of the outcome measures. The outcome areas that we chose were informed by existing research around SP/SR, particularly on its impact on skill development and wellbeing (Bennett-Levy & Haarhoff, 2019). Therefore, we were interested in whether this current adaptation of SP/SR would have similar impacts on therapist skill in working with ethnicity within their clinical practice and on their perceived levels of wellbeing. Further, as one of the main aims of the programme was to offer therapists a supportive space to explore their own ethnic identity through the experiential exercises included within the programme, particularly incorporating strengths, it was thought that the programme may support therapists in their ethnic identity development.

I initially started by reviewing existing measures for their suitability for use in our evaluation and considered a number of measures related to each outcome area, which is described in more detail below. However, there were a few important factors that guided decision-making around outcome measure selection. Firstly, given that SCED research involved the repeated measurement of outcomes over time, it was important to find measures that were simple enough to be administered and completed by participants weekly. Secondly, as we intended to recruit participants from different minoritised ethnic backgrounds, it was important for measures related to ethnic identity to capture this for different ethnic groups. Finally, we also needed measures that were therapist or self-rated, as it was planned for participants to be providing ratings themselves.

Unfortunately, I encountered two key issues: either there were no available measures relating to an outcome area we were interested in, or existing measures were not appropriate for use in our study, due to their length or potential for regular administration. Therefore, as a research team, we decided to develop new measures or adapt existing measures for this study.

This is not an uncommon practice in SCED research (Krasny-Pacini & Evans, 2018). The process of developing measures for each outcome area is described below, highlighting specific issues that were encountered for each:

Therapist skill in working with ethnicity

Unfortunately, there appeared to be no existing measures that considered therapist skills in working with ethnic identity in clinical practice. This was not surprising given its specific focus, so I looked to the wider cultural competence literature. I considered the use of the Cultural Humility Scale (Hook et al., 2013) and the Therapist Cultural Competence Scale (Perez-Rojas et al., 2019), however both measures were service-user-rated and also less concerned with specific skills related to working cross-culturally.

In developing our own measure of therapist skill in working with ethnicity, we were interested in capturing the practical aspects of transcultural work from assessment to intervention, as well as giving consideration to the reflective skills that are involved, where the identity, position and awareness therapists were considered alongside that of the client. These ideas are summarised by Beck (2016) and were also informed by the consideration of the person of the therapist, as described by the DPR model (Bennett-Levy, 2006). Therefore, these two references formed the basis of the development of the therapist skill outcomes.

Ethnic identity development

There appeared to be a few measures and models that considered ethnic or racial identity development, such as the Ethnic Identity Scale (Umana-Taylor et al., 2004), the Cross Ethnic-Racial Identity Scale (CERIS, Worrell et al., 2019), as well as the Racial and Cultural Identity Development Model (Sue & Sue, 2015). However, the CERIS appeared specific to an American demographic. On the other hand, the Racial and Cultural Identity

Development Model did not have a related measure and it was agreed that adapting a stage-based model into a measure risked losing the fluidity that may capture an individual's relationship with their ethnic identity. Therefore, the EIS was selected as being the most suitable of the measures.

The EIS was available in a full (17 questions) and a brief version (9 questions, Douglass & Umana-Taylor, 2015), however it was felt that both were still too long for repeated use. Therefore, we decided on selecting a single question relating to each of the constructs that the EIS separated ethnic identity development into, namely, exploration, resolution and valence (Umana-Taylor et al., 2004). Further, it was felt that the existing exploration statements (e.g. “I have experienced things that reflect my ethnicity, such as eating food, listening to music, and watching movies” and ” I have learned about my ethnicity by doing things such as reading, searching the internet, or keeping up with current events”), seemed to ask more surface-level questions about someone’s ethnicity and culture, where ethnicity and culture are also reflected in deeper ways, such as in communication styles and ways of relating to others (Hall, 1976). Therefore, this question was revised to “I have explored aspects of my ethnic identity”, to encompass all of these ideas.

Wellbeing

Widely used wellbeing measures, such as the Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS, Tennant et al., 2007) were considered for use in this study. However, similar to the measures above, such measures deemed to be too long for repeated measurement. Instead, it was felt that a simple, visual analogue-style measure of wellbeing would be more appropriate. I drew on the Outcome Rating Scale (ORS, Miller et al., 2003) to develop the current wellbeing measures, which I had previously found to be a helpful and easy-to-administer measure in clinical work with children and young people. As the DPR

model (Bennett-Levy, 2006) also distinguishes between the personal and professional selves of the therapist, which are seen to be distinct but overlapping, it was felt that it would be important separately to capture these aspects of the participants' wellbeing, which may be different and may also be differentially impacted by the current programme.

Given that we were using un-validated or significantly adapted measures, it was agreed that each outcome would be evaluated separately, rather than pooling scores across outcomes to give overall measures of skill development, ethnic identity development and wellbeing. Further, it was also decided to score outcomes on a scale of 0-100, providing anchor points for participants to give ratings, to enable us to capture more subtle changes as well as to minimise the chances of floor or ceiling effects. We also decided it would likely be helpful for participants if all the rating scales were kept consistent. Finally, the full set of outcome measures were reviewed by an Expert Reference Group (ERG), for their safety and suitability for use in the study. The ERG was made up of three qualified CBT therapists and clinical psychologists, who were from minoritised ethnic backgrounds and also had significant experience of transcultural and anti-oppressive practice. The ERG were invaluable in providing suggestions and guidance, that supported me to further refine these measures. For me, the inclusion of an ERG and their input into the project highlighted the importance of co-production, specifically in research and practice that seeks to improve provision for people from marginalised and minoritised groups. It will be crucial for the views and experiences of participants in this programme to shape future developments within the current programme and may also be helpful in informing wider initiatives that aim to support the development of therapists from minoritised ethnic backgrounds.

On reflection, I think we selected too many outcome measures in this evaluation, where it would have been more helpful to home in on specific outcomes that were hypothesised to be influenced by the programme. This is partially reflected in my decision to

present only seven of the 10 skills outcomes in the results section. Given the time constraints of it being a DClinPsy project, it was not possible to give time to validating the measures we developed to ensure that they were indeed measuring what they set out to measure. In addition, as the measures were all self-rated, they are limited in reflecting subjective change. However, given these limitations, it was important that an attempt was made to quantitatively evaluate this novel programme and understand any impacts that it may have had for the participants. Bennett-Levy (2019) reflects on this dilemma in a recent paper, where he poses two choices: either we are bound by scientism, where the absence of gold-standard research around personal practice methods like SP/SR limits their future use; or we recognise the challenge of research in this area, where we strive to research the value of these methods while simultaneously improving our methods to measure their impact.

Reflections on my own positionality within the research project

While a reflexive stance is less common within quantitative literature, it has been important to consider my own positionality at different points within this research project.

Zara, the other trainee on this project, and I were involved since the early stages of the development of the programme, where we were invited to provide feedback on the content of the modules, alongside developing our individual research projects. While I valued being invited to contribute to these different aspects of the programme and evaluations, it meant that I was approaching it in both the role of a researcher, as well as in a more personal capacity, drawing on my own identity and experiences, in my hopes and expectations for the project.

As described in the first section of the appraisal, I was drawn to this research because of my previous personal and professional experiences, and therefore it was an area I felt very passionately about. Zara and I were also heavily involved in the recruitment of participants

and had an opportunity to meet a number of therapists who were interested in the programme, hearing their motivations to participate in the programme and also their experiences of navigating challenges in their professional contexts. Our involvement in the programme development and recruitment left me feeling very connected to the programme material and participants, and I was motivated to do their stories justice within these evaluations. These feelings were fuelled when undertaking research for my CI, which involved reading about issues of access and acceptability for service users from minoritised ethnicities, as well as encountering the real absence of the voices and experiences of therapists from these groups within the literature (Faheem 2023; Lawton et al., 2021; Naz, 2021; Spalding et al., 2019).

As I moved further along the research process, I became more focused on the data collection and analysis elements. The programme had also commenced at this point, where I no longer had contact with the participants, and it was also agreed that Zara and I would not be provided with regular feedback on the progress of the programme to reduce any bias within our evaluations. Tracking and recording the weekly outcomes, I noticed I was feeling more disconnected from the spirit of this research, with the experiences of the participants being reduced to numbers within my evaluation. This is something that I continued to find difficult to reconcile as I moved into the final stages of the research process, where it was difficult to make sense of the real impacts that this programme may have had for participants, where my data was limited in providing context and experiential information.

Throughout this project, it has been important to balance my personal position with my position as a researcher, where both had important implications for the research. In writing up this project, I have also similarly had to balance being as objective as possible and accurately presenting my findings, while also recognising the impacts and implications that may not be fully captured by this type of research. I have also found it incredibly valuable to

consistently reflect on my changing position within this project, which is something that I am grateful to have had the space for with an external supervisor, Carla Quan-Soon.

Conclusion

I am grateful to have had the opportunity to carry out this research, which has concurrently been rewarding and challenging. This project has developed my research skills, particularly in previously unfamiliar areas like SCED research, and has supported me to consider the opportunities and challenges that developing tailored outcome measures can present. Working on this project has also played a crucial role in supporting my understanding of the existing literature and status of culturally responsive practice, as well as acknowledging the importance of change taking place at every level to improve the care and experiences of people who are minoritised within health and care services. This commitment to culturally responsive and anti-oppressive practice is something I hope to carry forward in my practice and research in the future.

References

Beck, A. (2016). *Transcultural cognitive behaviour therapy for anxiety and depression: A practical guide.* Routledge.

Bennett-Levy, J. (2006). Therapist Skills: A Cognitive Model of their Acquisition and Refinement. *Behavioural and Cognitive Psychotherapy*, *34*(1), 57–78. https://doi.org/10.1017/S1352465805002420

Bennett-Levy. J. (2019). Why therapists should walk the talk: The theoretical and empirical case for personal practice in therapist training and professional development. *Journal of Behavior Therapy and Experimental Psychiatry*, *62*, 133–145. https://doi.org/10.1016/j.jbtep.2018.08.004

Bennett-Levy, J., & Haarhoff, B. (2019). Why therapists need to take a good look at themselves. In S. Dimidjian (Eds.), *Evidence-based practice in action: Bridging clinical science and intervention (pp. 380-394).* The Guildford Press.

Chaddock, A., Thwaites, R., Bennett-Levy, J., & Freeston, M. H. (2014). Understanding individual differences in response to Self-Practice and Self-Reflection (SP/SR) during CBT training. *The Cognitive Behaviour Therapist*, *7*, e14. https://doi.org/10.1017/S1754470X14000142

Chaudhry, F. B., Raza, S., Raja, K. Z., & Ahmad, U. (2020). COVID 19 and BAME health care staff: Wrong place at the wrong time. *Journal of Global Health*, *10*(2). doi: 10.7189/jogh.10.020358

Douglass, S., & Umaña-Taylor, A. J. (2015). A brief form of the Ethnic Identity Scale: Development and empirical validation. *Identity: An International Journal of Theory and Research, 15*(1), 48–65. https://doi-org.libproxy.ucl.ac.uk/10.1080/15283488.2014.989442

Faheem, A. (2023). 'Not a cure, but helpful' – exploring the suitability of evidence-based psychological interventions to the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist*, *16*, e4. https://doi.org/10.1017/S1754470X22000599

Hall, E.T. (1976). *Beyond Culture*. Anchor Books/Doubleday.

Hays, P. A. (2019). Introduction. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision (2nd ed.).* (pp. 3–24). American Psychological Association. https://doi.org/10.1037/0000119-001

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of counseling psychology*, *60*(3), 353.

Jesuthasan, J., Powell, R. A., Burmester, V., & Nicholls, D. (2021). 'We weren't checked in on, nobody spoke to us': an exploratory qualitative analysis of two focus groups on the concerns of ethnic minority NHS staff during COVID-19. *BMJ open*, *11*(12), e053396.

Krasny-Pacini, A., & Evans, J. (2018). Single-case experimental designs to assess intervention effectiveness in rehabilitation: A practical guide. *Annals of Physical and Rehabilitation Medicine*, *61*(3), 164–179. https://doi.org/10.1016/j.rehab.2017.12.002

Lawton, L., McRae, M., & Gordon, L. (2021). Frontline yet at the back of the queue – improving access and adaptations to CBT for Black African and Caribbean communities. The Cognitive Behaviour Therapist, 14, e30. https://doi.org/10.1017/S1754470X21000271

Lobo, M. A., Moeyaert, M., Cunha, A. B., & Babik, I. (2017). Single-Case Design, Analysis, and Quality Assessment for Intervention Research. *Journal of Neurologic Physical Therapy : JNPT*, *41*(3), 187–197. https://doi.org/10.1097/NPT.0000000000000187

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, 2(2), 91-100.

NHS England. (2022). *NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts. https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/*

Naz, S. (2021). Where am I really from? *CBT Today, 49 (1), p28.*

Pérez-Rojas, A. E., Bartholomew, T. T., Lockard, A. J., & González, J. M. (2019). Development and initial validation of the Therapist Cultural Comfort Scale. *Journal of Counseling Psychology, 66*(5), 534–549. https://doi-org.libproxy.ucl.ac.uk/10.1037/cou0000344

Spalding, B., Grove, J., & Rolfe, A. (2019). An exploration of Black, Asian and Minority Ethnic counsellors' experiences of working with White clients. *Counselling and Psychotherapy Research*, *19*(1), 75–82. https://doi.org/10.1002/capr.12194

Sue, & Sue, D. (2015). *Counseling the culturally diverse: theory and practice* (7th ed). Wiley.

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Development and UK validation. Health and Quality of Life Outcomes, 5, Article 63. https://doi-org.libproxy.ucl.ac.uk/10.1186/1477-7525-5-63

Thomson, C., Wilson, R., Collerton, D., Freeston, M., & Dudley, R. (2017). Cognitive behavioural therapy for visual hallucinations: an investigation using a single-case experimental design. Cognitive Behaviour Therapist, 10. https://doi.org/10.1017/S1754470X17000174

Umaña-Taylor, A. J., Yazedjian, A., & Bámaca-Gómez, M. (2004). Developing the Ethnic Identity Scale Using Eriksonian and Social Identity Perspectives. Identity (Mahwah, N.J.), 4(1), 9–38. https://doi.org/10.1207/S1532706XID0401_2

Willson, R., Veale, D., & Freeston, M. (2016). Imagery Rescripting for Body Dysmorphic Disorder: A Multiple-Baseline Single-Case Experimental Design. *Behavior therapy*, *47*(2), 248–261. https://doi.org/10.1016/j.beth.2015.08.006

Wolfe, K., Barton, E. E., & Meadan, H. (2019). Systematic Protocols for the Visual Analysis of Single-Case Research Data. *Behavior Analysis in Practice*, *12*(2), 491–502. https://doi.org/10.1007/s40617-019-00336-7

Wolfe, K., & McCammon, M. N. (2022). The Analysis of Single-Case Research Data: Current Instructional Practices. *Journal of Behavioral Education*, *31*(1), 28–42. https://doi.org/10.1007/s10864-020-09403-4

Worrell, F. C., Mendoza-Denton, R., & Wang, A. (2019). Introducing a New Assessment Tool for Measuring Ethnic-Racial Identity: The Cross Ethnic-Racial Identity Scale–Adult (CERIS-A). *Assessment (Odessa, Fla.),* 26(3), 404–418. https://doi.org/10.1177/1073191117698756

Appendices

Appendix A
Outlining Each Trainee's Contribution to the Joint Research Project

This thesis is one of two projects that evaluated the novel SP/SR programme for therapists from minoritised ethnic backgrounds. The other project was carried out by Zara Malik, also a final year trainee clinical psychologist at UCL.

While the current project involved a quantitative evaluation, using a multiple baselines single case experimental design, Zara's project involved the qualitative evaluation of participants' experiences of the programme and any personal and professional implications. Qualitative data was collected using post-programme interviews with participants and was analysed using a reflexive thematic analysis.

Zara and I both provided feedback on the design and content of the programme. We also jointly applied for UCL Ethics for the programme and evaluations and jointly developed participant materials, such as information sheets, consent forms and advertisement material. We were also jointly involved in the recruitment of participants to the study, alongside the wider research team.

We each designed our own evaluations, providing feedback on each other's projects alongside the wider research team. We also collected and analysed our data independently, and the write-up of each of our theses was also done independently of each other.

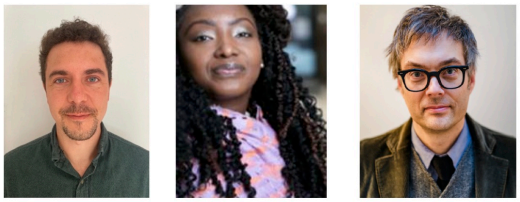
Appendix B
Advertising material

UCL Ethics ID 22167/001

SELF-PRACTICE/SELF-REFLECTION PROGRAMME FOR CBT THERAPISTS FROM MINORITISED ETHNICITIES

Recruitment closing on Thursday the 12th of May 2022. Please contact the team by this date.

We are a group of researchers from psychological professions who believe that more needs to be done to support therapists from minoritised ethnicities. Therefore, we are looking for CBT Therapists from minoritised ethnicities to take part in a new Self-Practice/Self-Reflection programme to explore how their ethnic identity may relate to their clinical practice as a therapist, in a safe and supportive space.



Facilitators: Dr Alasdair Churchard (Clinical Psychologist, Leila Lawton (Cognitive Behavioural Psychotherapist) and Dr Richard Thwaites (Consultant Clinical Psychologist)

Researchers: Zara Malik, Sakshi Shetty Chowdhury (Trainee Clinical Psychologists) and Dr Henry Clements (Clinical Psychologist and Clinical Director, UCL DClinPsy)

What your participation in the programme would involve:

- Working through 9 modules that involve you reflecting on the links between your ethnic identity and your clinical practice, over approximately 18 weeks (estimated May to September 2022)
- Attending an online reflective group space every fortnight with other CBT Therapists from minoritised ethnicities to reflect on your experience of completing the modules.
- Helping us evaluate the programme by answering a short series of questions on a weekly basis and completing one interview after the programme.

You can you get involved if you:

- Identify yourself as being from a minority ethnic background.
- Have provisional or full accreditation with the BABCP.
- Are currently practising as a CBT Therapist in the UK.

Potential benefits of participating:

- We hope this will be a supportive and reflective space for therapists to consider how their specific cultural context and background, as well as the the strengths and challenges of being from a minoritised ethnicity, may relate to their clinical practice.
- We hope that gaining your perspectives of the programme will further an understanding of therapists' experiences of being from a minoritised ethnicity and ways in which they can be supported.

If you would like to find out more about participating in this programme, we are able to arrange an individual meeting with you at a time that is convenient. **Please contact Zara Malik (zara.malik.20@ucl.ac.uk) or Richard Thwaites (richard.thwaites@cntw.nhs.uk), if this is something you would be interested in.**

Any personal information collected as part of the research will be processed in accordance with relevant data protection legislation.

Appendix C
UCL Notification of Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

9th March 2022

Dr Henry Clements
Research Department of Clinical, Educational and Health Psychology
UCL

Cc: Zara Malik & Sakshi Chowdhury

Dear Dr Clements

Notification of Ethics Approval with Provisos
Project ID/Title: 22167/001: Self-Practice/Self-Reflection programme for CBT Therapists from minoritised ethnicities

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **9th September 2023.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form' https://www.ucl.ac.uk/research-ethics/responsibilities-after-approval

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol.

The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research;
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

Professor Lynn Ang
Joint Chair, UCL Research Ethics Committee

Appendix D
Modules 1 and 6 of SP/SR Programme for CBT Therapists from Minoritised Ethnicities
[Not to be shared or reproduced without the permission of Alasdair Churchard]

Module 1: Identifying a Challenging Problem

Introduction

You are now ready to begin this SP/SR programme. We are going to start by identifying a focus for the programme, so we can formulate the issue and set goals. We are making the explicit assumption that your ethnic background affects your experience in your clinical role in many different ways. Similarly to therapy one key task is to make sure that there is a clear focus, so in this module we will guide you to identify what in particular you would like to work on in this programme.

Exercise: Identifying My Challenging Problem for the SP/SR Programme

Coming from a minoritised ethnicity will probably have affected your life in multiple areas, both personal and professional. This programme is written specifically for you as a CBT therapist from a minoritised ethnicity, and as such our hope is that it will support you in your clinical role. We have created this programme so you can develop your skills in working with issues surrounding ethnic diversity within a CBT framework, but also to open up a reflective space to consider what emotions come up for you in this context and how to best work with those emotions. We are aware that CBT programmes and most other formal mental health trainings have not routinely included this within training and individuals are likely to have had varied experiences of supervision on this area. There is no assumption on our part that CBT therapists should feel competent in this area nor implied criticism if they do not, as this is likely to be a reflection of the wider system.

There may be many areas of your clinical role where your ethnic identity is relevant. In the below exercise we will ask you to consider your confidence in these various areas, as this will guide you to which area is most appropriate to work on in this programme. Working with issues surrounding ethnicity will probably bring up personal reactions and emotions on your part, so it is important that whatever you work on triggers sufficient emotion that the programme is meaningful, but not so much that the programme will feel overwhelming or unmanageable. We think that one key consideration here is how confident you feel in the various areas of your clinical role, as lower levels of confidence will lead to the work feeling more challenging and to higher levels of emotion. In order to trigger the right amount of emotion we would encourage you to think about working on an area where you have some level of confidence, but where you still feel unsure and where difficult emotions can arise as a result.

Another factor to consider is whether you pick an area where you have experienced racist abuse or microaggressions while carrying out your clinical role (see the box below for more information about what a microaggression is). These experiences will naturally trigger higher levels of emotion, so it is important to consider whether focussing on this will lead to this SP/SR programme feeling overwhelming. As you will see from the table below (on page 19) there are multiple areas you can focus on which should not be related to the experience of racism (e.g. raising ethnicity as an issue with clients from minoritised ethnicities), so do consider carefully whether it would be safer and better for you to focus on one of these other areas.

WHAT IS A MICROAGGRESSION?

A microaggression is a 'relatively minor insulting event made disproportionately harmful by being part of an oppressive pattern of similar insults' (Rini, 2018, p. 332). One example could be a British person from a minoritised ethnicity being asked "Where are you from?", with the implication being that as they are not white they cannot really be from Britain. The use of the word 'micro' may unfortunately suggest that these are not of great importance, but of course they can be deeply hurtful. This youtube video gives an accessible description of what microaggressions are.

As we stated in the guidance chapter being on the receiving end of racist abuse or microaggressions is unacceptable and it should not be up to you to resolve this situation. Do look at the guidance chapter again to see what support you should be entitled to from your organisation. However, the nature of racism is that it can be difficult to work out how to respond at a personal level, and you may also not have had much space in your clinical role to think about the impact of these experiences. If you did want to address the experience of racist abuse or microaggressions in this programme we would suggest that you use this space to think about your preferred way of responding to these experiences. It may also be helpful to share how this has affected you in the context of a supportive group. If you do choose to work on experiences of racism, our message will always be that it is not up to you to learn to live with these experiences. Our focus will rather be on supporting you to find your preferred way to deal with these experiences and their effects.
When completing this exercise we suggest the following:

1. Find a quiet space for yourself for this exercise.

2. Look through the below table (om page 13), which shows a range of areas in your clinical role where your ethnic identity may be a factor. It also shows the types of challenges therapists may face in these areas. When looking through this consider what area feels most salient to you in terms of your confidence levels. Remember that we are suggesting that you pick an area where you have some degree of confidence, but you do still feel unsure.

It may be that something comes up for you which is not in the table and it is not intended to give a complete list of examples. We are aware that many difficult areas might be either the result of the system/context or at least an interaction with the system or context. Ideally however, identifying a focus that is not purely due to the context would be most beneficial in terms of being able to make changes. So for example if you are experiencing regular racist incidents within a work setting, SP/SR is not going to be able to change the system (even if it can help you identify some ways you can challenge this rather than internalise this).

Table: Areas in your Clinical Role where your Ethnic Identity may be a Factor

Area	**Examples of challenges therapists may face**
Lack of confidence in raising ethnicity with clients from minoritised ethnicities	• When working with clients from minoritised ethnicities I do not consistently raise ethnicity as an issue • I only feel confident about raising ethnicity with clients from my own ethnic background
Able to raise ethnicity as an issue, but lack skills in assessment (including asking about experiences of racism), or formulation, or intervention	• I can raise ethnicity as an issue in assessment, but I am not sure how to bring this into CBT formulations or interventions • I shy away from asking about experiences of racism
Unsure how to respond when experiencing racist abuse and/or microaggressions from clients during therapeutic work	• I experience explicit racism and/or microaggressions from clients during therapeutic work and feel unsure how to respond
Difficulties in role as supervisor	• I do not feel confident about raising ethnicity as an issue in supervision, either when discussing work with clients or supervisees' own personal ethnic backgrounds • I experience explicit racism and/or microaggressions from my supervisees and feel unsure how to respond
Difficulties in role as supervisee	• I do not feel confident about raising clients' ethnicity or my own within my own clinical supervision. • I experience explicit racism and/or microaggressions from my supervisor and feel unsure how to respond
Difficulties in wider service discussions of ethnicity and culture	• I feel confident in working with issues of ethnicity in therapy with clients, but I feel anxious about raising ethnicity as an issue within the broader service • I experience explicit racism and/or microaggressions from my colleagues and feel unsure how to respond

Having identified the general area you would like to work on, think to a time in your clinical role when this situation arose and an emotional reaction was evoked. You might particularly want to think about what effect this had on how you carried out the relevant clinical tasks, and also the impact this had in terms of personal reactions and emotions. List any situations that come up for you in the box below.

CHALLENGING SITUATIONS 

3. Looking at the situations identified in the above box, which one would you like to focus on in this SP/SR programme? Use levels of emotion as a guide: the situation should be associated with a reasonably strong emotional response, for example anxiety, anger, or general distress. However it is best to not pick a situation where the emotion is so strong that it is overwhelming. As a guide we suggest emotions in the range of 50-80%. Having decided this write down details of the challenging situation in the box below.

MY CHALLENGING SITUATION 

Creating a Measure of Change: The Visual Analogue Scale

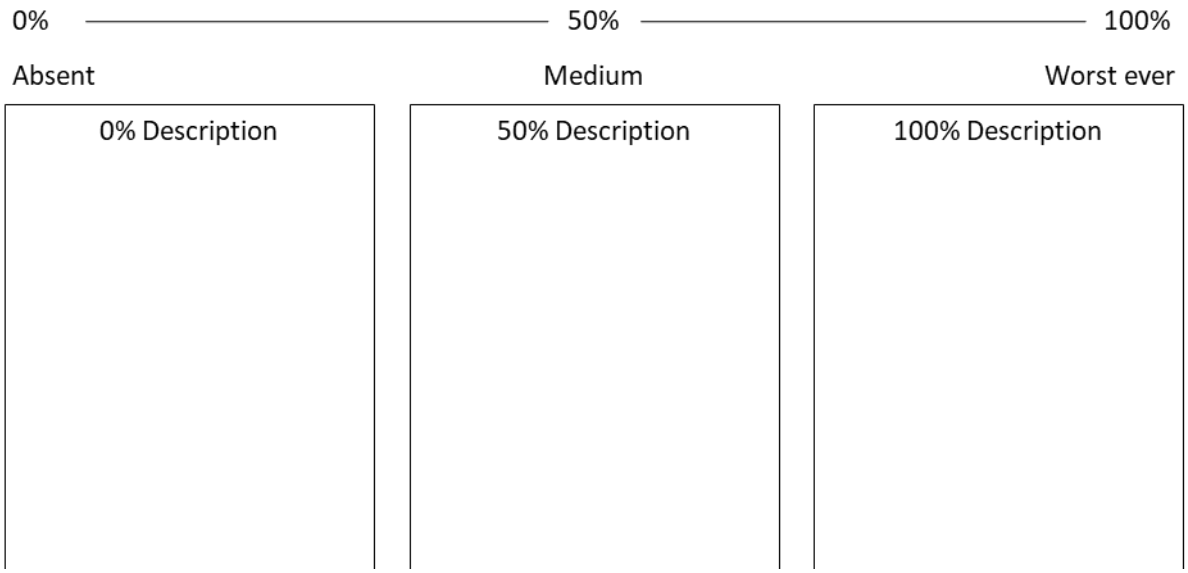
Now that you have identified a challenging situation, the next step is to create a visual analogue scale (VAS). You can think of this like a ruler which allows you to measure how much you experience the difficult emotion related to the challenging situation. Using the VAS on repeated occasions is a straightforward method to see how the emotion changes over time.

When you create the VAS it needs to go from 0-100%. For example, if the emotion you were rating was anxiety, 0% would equal no anxiety at all and 100% would equal the most anxiety you have ever experienced. In order to develop this it is helpful to give three ratings of the difficult emotion. Firstly, we will ask you to write down when the emotion was at its worst, and this will be the 100% rating. Secondly we will ask you to describe when the emotion was at 50%, and finally when the emotion was at 0%. Doing this creates 'anchor points' and can help with the process of rating as you continue to use the VAS over the course of this programme.

Exercise: Creating a Visual Analogue Scale 

It is now time for you to develop your own VAS. Fill in the challenging situation at the top, then describe how the anxiety feels at 0%, 50% and 100%. Finally make a mark on the line to indicate how much you experience that emotion at present (or when the situation most recently happened).

My challenging situation:……



Self-reflection 

You have now completed the self-practice part of Module 1, so this section is where you reflect on the experience of doing these exercises. We have some suggestions about how best to approach these reflections in the guidance chapter at the start of this programme which you may want to look at again before answering the questions below.

- What effect did doing the self-practice exercises have on you? Were they easy or hard to engage with, and did you notice any stronger emotions, thoughts, or physical sensations while you were doing them?

- How did you find thinking about your ethnic identity in relation to your clinical role? Did any particularly strong emotions come up, and if so do you think that these emotions will be manageable within this programme? If not, what would help to make the programme manageable and not overwhelming?

- Based on the self-practice exercises what are your thoughts about how a client might find the process of identifying a focus at the start of therapy? Would this change how you might approach this with clients, and if so how would you do things differently?

- Has anything else come up for you while completing this module, in particular in relation to your ethnic identity, that you would like to reflect more about over the next week?

Module 6: Developing Strengths

Introduction

In the last module we asked you start active work on the goals you had previously identified. In this and the following modules we will explore and address how working towards these goals has affected you, both in terms of drawing on strengths but also addressing any challenges that have come up.

The goals you developed are related to your ethnic identity, so we are assuming that as you work on these goals thoughts and emotions related to your ethnicity will arise. The interventions in this and the following modules are focussed around addressing those personally resonant thoughts and emotions. It may be that as you have found working towards your goals to be a positive experience. That is very good if so and we will use this module to build on this positive experience, as well as to see if we can make explicit links between progress and strengths you have identified in previous modules.

You may however have found that working towards goals has brought up more challenging thoughts and emotions and the idea of building on strengths feels some distance from your experience. The next module will focus on addressing challenges, but in this module we would encourage you to explore working with strengths. We have designed this so it should be possible for you to explore strengths related to your ethnic identity, even if it has been difficult to connect with these on a personal level so far.

In this module you will therefore explore how working towards your goals has affected you, looking specifically at whether this allows you to connect more fully with strengths associated with your ethnic identity.

Exercise 1: Identifying Experiences of Strengths While Working Towards Goals

In the last module we asked you to keep a record of what you experienced as you worked towards your goals. It would be helpful if you have this to hand as you go through this exercise.

Looking at this record, what do you notice about how working on these goals affected you? Did it bring up any positive thoughts, feelings, and behaviours?

Working towards your goals may have been a positive experience where things went well (however this will not be everyone's experience, so do not feel like this should be the case for you). If this is where you are at, then we would like to build on this. We will do this by exploring whether progress you have made can be supported by drawing on strengths associated with your ethnic identity.

For the rest of the module, it would be helpful to have your longitudinal formulation to hand, as this will support you to make links between your current experience and strengths you have already identified. Also, as we have stated before it may be difficult to identify strengths. Do not worry if this is how it feels for you: finding it difficult to see strengths is probably related to systemic societal factors which emphasise deficits associated with coming from a minoritised ethnicity.

It may seem somewhat unfamiliar to draw on strengths in such an explicit way, as this is not a standard part of many CBT interventions. A first step therefore is to identify if any strengths related to your ethnic identity have come up while you have been working towards your goals. The table below includes some prompts, along with space for you to fill out your own experience:

Table for Exercise 1: Identifying my Strengths 

Potential areas of strength which may have come up while you were working towards your goals	**Prompts**	**My experience of this as I worked towards my personal goals**
Using perspectives, metaphors and images from your culture to guide yourself	As you have worked towards your goals, has anything you have had passed down to you from your culture become more salient? This might be particular ways of looking at the world, drawing on the specific perspective which will come from your ethnic background.	
Feeling an increased sense of belonging	As you work towards your goals and think more about your ethnic identity, this may contribute towards you having more of a sense of belonging. It may be that you find yourself having new conversations with family members about your family's ethnic identity(/ies) and that you experience a greater sense of connection to your ethnic identity. This may also come out in your interests outside of work, for instance the media and arts (e.g. books, music, film, TV etc) you consume. Did working towards your goals bring up any thoughts, feelings, or behaviours related to a sense of belonging?	
Demonstrating solidarity against racism	We would argue that doing any kind of active work around ethnicity shows an anti-racist stance. Clients or colleagues may value you taking an active role in this and this may support them to take action themselves. Did working towards your goals help you to connect with this anti-racist stance?	
Resilience developed as a result of ethnic identity	Working towards your goals may have brought you into contact with racism and prejudice. It is important to look after yourself when you are doing this work, so are there any aspects of your ethnic identity which encourage resilience and which can be drawn upon to help to manage experiences of	

Potential areas of strength which may have come up while you were working towards your goals	**Prompts**	**My experience of this as I worked towards my personal goals**
	racism and prejudice? You might think here about yourself but also what you have learnt from your family about how to cope with this very difficult issue.	
Seeing your ethnic identity as valuable	Given the existence of systemic racism all too often minoritised ethnicities can have their identity portrayed as simply associated with negatives. Did working towards your goals give you a sense of your ethnic identity as valuable and a source of strength?	
Seeing ethnicity as an important area for clinicians to address	This may seem obvious (and after all this idea is the basis of this entire SP/SR programme), but all too often ethnicity will not be addressed by clinicians. Did working towards your goals give you a greater appreciation of why matters related to ethnicity could be important to address in your clinical role?	

Exercise 2: Building on Strengths Associated with Your Ethnic Identity

Having completed the above table, we are now in a position to do active work to build on any strengths you identified.

You may however have found it difficult to complete the table and to identify strengths. Do not worry if that is the case. As we stated above our view is that systemic racism emphasises deficits associated with the identities of minoritised ethnicities, and that finding it difficult to identify strengths shows the power of systemic racism rather than any shortcoming on your part. It may also be that strengths relate to less visible aspects of culture such as attitudes to ageing, approaches to marriage, decision making, and problem solving. Looking again at the culture iceberg model we previously mentioned in module three may be helpful here.

We would encourage you to use this exercise to build on any strengths you have identified, no matter how tentatively. However, if this feels too challenging then there is also the option to use this exercise to explore strengths related to your ethnic identity in general. A significant body of research (for more information see Sue et al., 2019) shows that a positive sense of ethnic identity has many beneficial effects on the individual. Connecting with this positive sense of identity may support you in the rest of this programme even if it does not seem to immediately directly relate to your goals.

If you are using this exercise to explore strengths related to your ethnic identity in general (rather than building on a strength you identified in exercise one of this module), then the below bullet points give some suggestions for activities you could try out:

- **Connecting with positive representations of your ethnicity.** There are many more positive representations of the experience of coming from a minoritised ethnicity. One recent example is the Small Axe series by the Black British director Steve McQueen, and the recent Being… series from the BBC about diverse religious faiths also shows the positives that come with a variety of different ethnic identities. It may be helpful for you to explore this in print, on TV or film, or in music.
- **Finding out more about the history of your ethnicity.** Finding out more about the historical experiences of your ethnic community can lead to you becoming aware of strengths which had not previously been brought to your attention. An accessible example of this is: https://www.theguardian.com/tv-and-radio/2020/sep/28/this-mornings-alison-hammond-i-had-to-educate-myself-on-black-history. Given time constraints it would probably be easier for you to watch a film or TV programme about this, but there are many books available on the history of minoritised ethnicities.
- **Having a conversation with family members about your ethnicity.** Talking with family members about their experience may lead to new and helpful conversations about what it means to be from a minoritised ethnicity.
- **Engaging in a cultural practice associated with your ethnicity.** There are a huge range of practices associated with the cultures of minoritised ethnicities. These include

religious and spiritual practices, cooking, dance, physical disciplines such as Tai Chi, music, crafts and many other activities besides.

INTERSECTIONALITY AND STRENGTHS

In module four we encouraged you to think about how other aspects of your identity (e.g. gender, class, sexual orientation, etc) related to your ethnicity. These other parts of your identity will impact on the types of strengths you identify: for instance a working class Muslim woman or a gay black man might have quite specific strengths they could connect with. When exploring strengths related to intersectionality the above bullet points will still apply, but it might be helpful to focus down on to activities which more closely relate to your particular identity (e.g. finding out more about the history of people with a similar identity to you in the UK).

This exercise will follow the format of an exploratory behavioural experiment. We would ask you to take the following steps:

1. If you are building on a strength you identified in exercise one of this module, look at the first table in this module and identify either the clearest or most personally meaningful strength.
    a. OR if you are using this exercise to explore strengths related to your ethnic identity in general look at the bullet points listed immediately above and choose which particular strength you would like to explore.
2. Write down the strength you have chosen into the first column of the behavioural experiments record below. Then fill out the next column ('Experiment to explore and develop strength further'). The above bullet points give some suggestions as to specific activities to engage in to connect with strengths.
3. Carry out the experiment and fill out the last two columns. In the final column ('What I learned') think specifically about how you could draw on this strength as you continue to work towards your goals over the remainder of this programme.

Table for Exercise 2: Building on Strengths Associated with Your Ethnic Identity 

Strength associated with my ethnic identity	**Experiment to explore and develop strength further**	**Outcome**	**What I learned**
What strengths associated with your ethnic identity have you become more aware of, while you have been working towards your goals? Pick the clearest or more personally meaningful one for you. If this has been difficult pick a strength to explore from the above bullet points.	What could you do to build on this strength? Are there activities you could engage with, people you could talk to, or actions you could take to support you to do this? The bullet points above may provide some helpful ideas about specific activities to engage in. As you plan this what thoughts and feelings come up?	What happened when you carried out the experiment? What did you observe in terms of thoughts, feelings, behaviour, bodily sensations? Were there any difficulties? Does the outcome fit with your prediction?	What have you learnt about this strength? Could you draw on this in future in your clinical role? Does this affect how you will approach your goals over the remainder of this programme?

Self-reflection 

- What did you notice when you explored strengths associated with your ethnic identity?

- This is the first intervention module, so what do you think about focussing on strengths rather than challenges at the beginning of the intervention?

- Could you bring strengths into your work with service users from minoritised ethnicities? If so how could you do this?

- A strengths focus can be useful as well with clients whose ethnicity is white British. Would you like to bring strengths more into your general clinical work, and if so how could you do this?

- Has reflecting on your strengths changed how you see yourself personally or professionally?

- Is there anything you would like to do to develop the strengths you identified further?

Appendix E
Participant Information Sheet

UCL Research Ethics Committee Approval ID Number: 22167/001

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Project Title: Self-Practice/Self-Reflection programme for CBT therapists from minoritised ethnicities
Department: Research Department of Clinical, Educational and Health Psychology

Name of the Researchers: Zara Malik and Sakshi Shetty Chowdhury (Trainee Clinical Psychologists)
Name of the Principal Researcher: Dr Henry Clements (Clinical Director and Associate Professor, UCL Doctorate in Clinical Psychology)

Zara Malik: zara.malik.20@ucl.ac.uk
Sakshi Shetty Chowdhury: Sakshi.chowdhury.20@ucl.ac.uk

You are being invited to take part in a research study, which is being done as a part of the above researcher's Doctorate in Clinical Psychology thesis project. Before you decide to take part in this study it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. We can be contacted using the above email addresses if there is anything that is not clear or if you would like more information.

Please take time to decide whether you wish to take part.

Purpose of the study

There are a growing number of psychological therapists that identify as being from a minoritised ethnicity as the NHS aims to diversify their workforce. However, being a therapist from a minoritised ethnicity can come with some challenges because there has been historical and ongoing racial and ethnic prejudice, discrimination, and injustice. This novel programme aims to provide a space for therapists to reflect on their experiences, challenges and strengths of being from a minoritised ethnicity and to consider how this may relate to their clinical practice.

The programme follows a Self-Practice/Self-Reflection (SP/SR) format. SP/SR is a programme designed to assist therapists in learning therapeutic techniques 'from the inside', increase therapy skill and importantly give them a chance to engage in self-care. We hope that by adapting traditional SP/SR programmes, we will enable a safe and supportive space for you to explore how your ethnic identity might relate to your clinical role. We also hope that this will give you a chance to further develop your therapeutic skills in working with clients from minoritised ethnicities.

This programme will be delivered via a workbook comprising 9 modules of information, self-directed practice and reflective tasks, alongside bi-weekly reflective sessions, led by three experienced facilitators: Dr Alasdair Churchard (Clinical Psychologist), Leila Lawton (Cognitive Behavioural Psychotherapist) and Dr Richard Thwaites (Consultant Clinical Psychologist.

As this is a novel programme, we will evaluate the impact and experience of participating in this programme. Specifically, Zara Malik and Sakshi Shetty Chowdhury (UCL Trainee Clinical Psychologists) will be carrying out this evaluation as a part of their Doctorate in Clinical Psychology (DClinPsy) research.

This project is being supervised by Dr Henry Clements (Associate Professor and Clinical Director, UCL DClinPsy), who is also the named Principal Investigator (PI) for this project.

Can I take part?

As this programme is for CBT therapists from minoritised ethnicities, we ask that people are provisionally or fully accredited as a CBT Therapist from the BABCP and are in regular clinical practice. We ask that people identify themselves as being from a minoritised ethnic background.

It is important that we ensure this programme is as safe and useful as possible for you, therefore we ask you not to participate if you feel you are undergoing a high degree of stress. Additionally, so that we can evaluate the effectiveness of the programme, it is important that we reduce things that may influence people's experiences and outcomes in relation to the programme. Therefore, we also ask you not to participate if you are undergoing psychological therapy or any major professional development courses or formal programmes exploring your ethnic identity.

How do I take part?

If you would like to participate in this programme, please email Zara Malik to register you interest (zara.malik.20@ucl.ac.uk) from Thursday the 14th of April. You will be invited to complete a study consent form and be informed of the next steps of the programme.

If we receive high levels of interest in this programme, the first 15 people to contact the researcher Zara Malik via email to express an interest in participating in the programme will be invited to participate and offered an opportunity to ask any further questions they may have about the study or the consent form. A waiting list will be formed after the first 15 participants and ordered on a first come first served basis. If a potential participant decides not to take part, or if Zara does not hear back from them within 1 week, the next person on the waiting list will be contacted. Once 15 people have fully consented to take part, the remaining people that expressed an interest will be emailed to let them know they have not secured a place on the programme and to thank them for their interest in taking part.

Do I have to take part?

You do not have to take part and you can also withdraw at any stage without giving a reason and without any negative consequences. If you wish to withdraw then please speak to the programme facilitators.
However, with your consent (as indicated on the study consent form) you may still be invited to participate in an interview about your experience of the programme. You can choose whether or not you would like to complete this interview when invited.

If you choose to withdraw from the study, all of your data will be subsequently withdrawn from the study.

Facilitator contact details:
Dr Alasdair Churchard: alasdair.churchard@oxfordhealth.nhs.uk
Leila Lawton: leila.lawton@slam.nhs.uk
Dr Richard Thwaites: richard.thwaites@cntw.nhs.uk

What will happen if I take part?
If you take part in the programme, you will be invited to orientation and safety planning sessions where you will meet the programme facilitators, researchers and other participants in the programme. You will also be provided with the SP/SR workbook, which contains nine modules in total. Personal data will be collected as a part of this research. During the orientation session, you will also be invited to complete a questionnaire asking for details of your age group, ethnicity, gender, diversity of your workplaces, as well as number of years qualified as a CBT Therapist. This will be done using Qualtrics, a web-based survey tool.

You will be guided to complete a module every two weeks, following which you will be invited to join a reflective session with the programme facilitators (Dr Alasdair Churchard, Leila Lawton and Dr Richard Thwaites) and other group participants to share experiences of completing the module and reflections noted at the end of it. The group will consist of the same 12-15 people and will take place every two weeks, following each module.
The group sessions will be between May 2022 and October 2022. You are encouraged to attend all of the group sessions. Each group session will last one hour, and we suggest an additional hour and a half each week would be sufficient for you to work on the allocated module between the group sessions.

Throughout the programme, you will be asked to complete a series of questions which are designed to help evaluate the programme. The questions ask about your self-rated skill in working with people from minoritised ethnicities, as well as your beliefs around your own ethnicity and your personal and professional wellbeing. These questions are designed for you to complete weekly and take around 5 to 10 minutes to complete. You will also be asked to complete these measures for up to 7 weeks prior to the beginning of the programme (either 5, 6 or 7 weeks, depending on random allocation to baseline condition at orientation session), and for 5 weeks after the end of the programme. All measures will be collected using Qualtrics, and will be collected pseudonymously, using a unique code.

You will also be invited to participate in an interview after the completion of the programme to tell us about your experience of it. Zara Malik will contact you up to 2 weeks after the final session to arrange a suitable time for the interview, which will take place online using Zoom

video conferencing. Interviews are expected to last between 60 to 90 minutes and will mark the end of your participation in the research study. If for any reason you do not complete the programme, Zara Malik may contact you to check whether you would still like to be interviewed if you consent to this.

The interview will be audio recorded on a separate encrypted recording device, and the audio recording will be stored on the UCL N drive and will be transcribed by Zara Malik, using an approved transcribing software, Scrintal. Recordings will be identified only by a unique code and they will not be used for any purpose other than for the research study. Your name and any potentially identifying information will not be included anywhere in the transcript. We may quote you directly in the project write up. If this is done your anonymity will be preserved.
The interview data will be transcribed verbatim. The transcribed data will be evaluated using a robust method called 'Reflexive Thematic Analysis'. which aims to analyse and interpret patterns across the data and develop themes from these interpretations.

Safety during the programme:

You will be invited to create a Personal Safety Strategy during the initial orientation and safety planning group session. This plan will outline steps for you to take if you do become distressed during the course of the programme, for any reason.

If you need more help after having used this strategy the facilitators will be available to meet with you individually on up to two occasions. We hope this will be enough to manage any distress you feel, but if it is not then the facilitators may suggest discontinuing the SP/SR programme and think with you about what further support might be helpful. They will be available for a debrief session if you do decide to discontinue the programme.

Are there possible disadvantages and/or risks in taking part?
The programme is focused on your experience as a CBT therapist from a minoritised ethnicity, therefore we think it is inevitable that you will encounter some challenging personal material, for example related to racial prejudice. When more challenging material comes up, we want you to be confident that you will not feel overwhelmed, therefore strategies to manage any understandable distress will be identified in your own personal safeguard strategy. Nevertheless, before you begin the programme, we would encourage you to think about whether you are experiencing, or are likely to experience soon, any periods of high personal stress. If this is the case, then we would advise that now is not the right time to do this programme.
You may also find aspects of completing the questions and the interview distressing as we may ask for your experiences of 'race' and racism in relation to your job role. We encourage you to regularly complete the measures, however if something is too sensitive then you do not have to answer it**.** We want to understand your experience of the programme as much as possible, but you can choose not to discuss something at the interview and will be reminded of this before the interview begins. You will also be directed to your personal safety strategy during the interview, if needed.

This programme will involve around 30 hours of individual and group work over the course of 7 months.

What are the possible benefits of taking part?
There is a growing number of therapists from minoritised ethnic backgrounds in the UK. However, we believe there is a strong need for more support for therapists from minoritised ethnicities to consider how their ethnic identity might relate to their clinical role. Therefore, we hope this programme may provide a supportive and reflective space for you and the other participants to consider your specific cultural context and background, as well as the strengths and challenges of being from a minoritised ethnicity. We also hope that this will help you to develop your CBT skills when working with clients of all ethnicities.
We hope that gaining your perspective of the programme through the questionnaires and interview that you complete will further an understanding of CBT therapists' experiences of being from a minoritised ethnicity, and potentially indicate ways in which such therapists may be supported.

What if something goes wrong?
If you wish to raise a concern about the SP/SR programme, we would encourage you to contact the programme facilitators in the first instance (alasdair.churchard@oxfordhealth.nhs.uk; leila.lawton@slam.nhs.uk; richard.thwaites@cntw.nhs.uk).

However, if for any reason you feel unable to speak to the facilitators, please contact Henry Clements (Principal Investigator for the study) at henry.clements@ucl.ac.uk. He can also be contacted for any complaints related to the evaluation of the programme.

If you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk.

Will my taking part in this project be kept confidential?
The facilitators and participants in the group sessions of the programme will consent to keeping everything confidential to the group. The groups will be set up in a way that you will not have access to other participants' contact information unless you wish to share it. If you prefer, you may also choose an alternative name to display when you join the online group sessions via Zoom.

Contact information, including email addresses and home addresses (used to post a copy of the workbook) will be held securely by Zara Malik on an encrypted file on a secure UCL drive. Address information will be deleted as soon as the workbooks are sent in April/May before the programme starts. Email addresses will be held until the submission of the researchers' DClinPsy theses, anticipated to be in September 2023. You may also consent to your email being held for a further three years (September 2026), if you wish to receive copies of any publications resulting from this research.

All data collected during the programme, including demographic information, questionnaire and interview data will all be held against a unique code, thereby pseudonymising the data.

A key containing the code and the above demographic information will be stored securely as an encrypted zip file on the researcher's secure UCL drive. The quantitative questionnaires will be collated using this code via Qualtrics and all responses will be stored in an encrypted folder on secure UCL drives. The interviews will be recorded using an encrypted audio recording device and the recordings will be immediately transferred to Zara Malik's UCL N drive in an encrypted folder. The recordings will be subsequently deleted from the recording device. Zara will transcribe the recordings using an approved transcription software, Scrintal, and the audio file of each interview will be destroyed as soon as the interview has been transcribed, which will be within three weeks of the interview. All recordings will be deleted by June 2023. Any identifying or potentially identifying information will so far as possible be removed at the time of transcription.

Your personal identifiable information will be deleted once the researchers have passed the Doctorate in Clinical Psychology course (anticipated to be September 2023), such that the data is then fully anonymised. This data will be stored until we have written up and disseminated study findings which will be a maximum of 3 years (September 2026).

All personally identifiable information will be kept confidential within the research team.

Limits to confidentiality

If the programme facilitators or researchers have concerns that you are a risk to yourself or others, then the safety plan that you will have created at the beginning of the programme needs to be followed, which includes information about the relevant support services. In the unlikely event they may have to break confidentiality and let relevant others know, they will inform you if they are going to do this, unless they believe it will increase the risk or it is not possible to inform you.

What will happen to the results of the research project?

The write-up of this project will be part of our theses and published online. The project may be published in an academic journal. You will not be identifiable in any way from the write-up of the project. If you wish to receive a copy of any publications resulting from this research, please indicate your consent and provide us with a preferred email in the consent form.

Local Data Protection Privacy Notice

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in the UCL General Participant Privacy Notice which is available here.

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

Personal data will be sought in this research. As stated above, if you disclose identifying or potentially identifying information which constitutes personal data in your interview, this identifying or potentially identifying information will so far as possible be removed at the time of transcription.

The controller for this project will be University College London (UCL). UCL has appointed a Data Protection Officer who has oversight of UCL activities involving the processing of personal data. If you are concerned about how your personal data is being processed, or if you would like to discuss your rights in relation to personal data, please contact the UCL Data Protection Officer at data-protection@ucl.ac.uk. The UCL Data Protection Officer can also be contacted by telephoning +44 (0)20 7679 2000 or by writing to: University College London, Gower Street, London WC1E 6BT.

Personal data, or personal information, mean any information about an individual from which that person can be identified. It does not include data where an individual's identity has been removed (anonymous data). In this study, the lawful basis that will be used to process your personal data is 'Public task' for personal data. Personal data will be sought in this study for the purposes of the research.

Special category personal data means any personal data that reveal racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health (the physical or mental), sex life or sexual orientation, genetic or biometric data. In this study, the lawful basis for processing any special category personal data is for scientific and historical research or statistical purposes. Special category personal data will be sought in this study for the purposes of the research.

As stated above, you have the right to withdraw from the study at any time and to request that all your data are immediately destroyed.

The retention periods for data have been set out above.

Complaints
If you wish to complain about our use of personal data, please send an email with the details of your complaint to the UCL Data Protection Officer so that they can look into the issue and respond to you. Their email address is data-protection@ucl.ac.uk.

You also have the right to lodge a complaint with the Information Commissioner's Office (ICO) (the UK data protection regulator). For further information on your rights and how to complain to the ICO, please refer to the ICO website: https://ico.org.uk/

Ethical review of the study
The project has received ethical approval from UCL Research and Ethics Committee. UCL Research Ethics Committee Approval ID Number: 22167/001

Thank you for reading this information sheet and for considering taking part in this research study.

Appendix F
Participant Consent Form

CONSENT FORM FOR CBT THERAPISTS FROM MINORITISED ETHNIC BACKGROUNDS

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Self-Practice/Self-Reflection programme for CBT therapists from minoritised ethnicities

Department: Research Department of Clinical, Educational and Health Psychology

Name and Contact Details of the Researcher(s):
Zara Malik: zara.malik.20@ucl.ac.uk
Sakshi Shetty Chowdhury: sakshi.chowdhury.20@ucl.ac.uk

Name and Contact Details of the Principal Researcher:
Henry Clements: henry.clements@ucl.ac.uk

Name and Contact Details of the UCL Data Protection Officer:
Alexandra Potts: data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee: TBC

Project ID number: 22167/001

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction. I consent to participating in the SP/SR group programme for therapists from minoritised ethnic backgrounds. I consent to participating in the quantitative evaluation of the programme, which would involve completing weekly outcome measures. I consent to participating in post-programme interviews for the qualitative evaluation of the programme.	
2.	I understand that I can withdraw from the programme and evaluations at any point during the programme and without needing to provide any reason. If I wish to withdraw from the programme, I am aware that I will need to contact the SP/SR group facilitators (Richard Thwaites - richard.thwaites@cntw.nhs.uk, Alasdair Churchard - alasdair.churchard@oxfordhealth.nhs.uk) to inform them of this. I understand that if I withdraw from the programme, I may be contacted by the researchers to check whether I would still like to be interviewed about my experience of the programme.	
3.	I understand that my personal information *(gender, ethnicity, area of work, diversity of workplace, number of years qualified)* will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing. I understand that according to data protection legislation, 'research purposes' will be the lawful basis for processing special category data.	
4.	I understand that my personal data gathered in this study will be encrypted and stored securely on the UCL N: drive, which will be destroyed when the researchers have passed their Doctorate in Clinical Psychology course which is anticipated to be in September 2023. I understand that quantitative data that is collected weekly using Qualtrics will be pseudonymised using a unique identification number and this data will be destroyed by September 2023.	

	It will not be possible to identify me in any publications.	
5.	I consent to my interview being audio recorded and understand that the recordings will be stored on an encrypted folder in the UCL N: drive and destroyed within three weeks following transcription. All recordings will be deleted by June 2023. Any potentially identifiable information will so far as possible be removed at the time of transcription. The transcripts will also be destroyed when the researchers have passed their Doctorate in Clinical Psychology course which is anticipated to be in September 2023. I consent to audio recording of my interview.	
6.	I understand that an element of my participation in the SP/SR programme would be to take part in a reflective group session which will be every two weeks. As the group session will involve myself and other group members sharing their reflections on the SP/SR process, I am aware of the importance of confidentiality within the space, which will be set out during the initial sessions of the programme. I understand that confidentiality will be maintained by the facilitators as far as possible, unless they become concerned for mine or someone else's welfare during the programme, in which case they might need to inform relevant agencies. I will be made aware of this by the facilitators unless this is not possible, or it is deemed this might raise any risk.	
7.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the research. I understand that a safety plan will be drawn up at the beginning of the programme and that I will make use of this when needed. I am also aware that I can contact the group facilitators for up to two one-to-one sessions, if needed.	
8.	I understand the direct/indirect benefits of participating.	
9.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
10.	I understand that the information I have submitted may be published as a research study within an academic journal, as well as the findings being disseminated in other forums.	

11.	I understand that if I would like to receive a copy of any publications, my email address will be held by the researchers for up to three years after the end of the programme (September 2026) I wish to receive a copy of any written publications. Yes/No I would like any publications to be sent to this email address:	
12.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
13.	I hereby confirm that: I understand the exclusion criteria as detailed in the Information Sheet and explained to me by the researcher; and I meet the inclusion criteria; and I do not fall under the exclusion criteria.	
14.	I am aware of who I should contact if I wish to lodge a complaint.	

_____	_____	_____
Name of participant	Date	Signature
Researcher	Date	Signature

Appendix G
Full Demographic and Weekly Outcome Questionnaire

Demographic/Contextual information questionnaire

Thank you so much for completing the following questions as a part of the evaluation of the SP/SR programme for therapists from minoritised ethnic backgrounds. This initial questionnaire is for us to get some helpful demographic and contextual information.

Please create a unique ID code using the first three letters of the city in which you were born and the last four digits of your phone number. For example, for someone born in London with a phone number of 123456789, their unique ID would be LON6789.

This code will be used to collect all subsequent data in this study and all questionnaire and interview data will also be stored pseudonymously against this code.

Some definitions…

Throughout this programme and its evaluation, we will be using the terms ‘ethnicity’ and ‘minoritised ethnicity’.

Where we use the term ethnicity, we mean a group of people who share similar cultural experiences, religious practices, traditions, ancestry, language, dialect or national origins (for example, African-Caribbean, Indian, Irish). We use this term here instead of race, as this captures a broader range of shared identities as well as allows for greater nuance within this, however, we do understand that there will be multiples experiences within ethnic groups.

This programme and its evaluation are also particularly focussed on the experiences of individuals from minoritised ethnicities or people from minoritised ethnic backgrounds. By this, we mean people who are in an ethnic or racial minority within the UK, that is, people from ethnic groups other than White British. We are using the term “minoritised” as opposed to minority as we think that this acknowledges how people from backgrounds other than White British are made into a minority by social processes, such as racism. Other terms that are also used to refer to people of non-White British ethnicities are 'BAME' (Black, Asian and minority ethnic) and 'BME' (Black and minority ethnic).

Please answer the following demographic questions:

What age bracket are you in?
18-24
25-34
35-44
45-54
55-64
65 and over

What is your gender identity? (Free text box)

What is your ethnicity? (Free text box)

How many years have you been working as a CBT therapist for? (Free text box)
How would you rate the ethnic diversity within the staff team that you currently work in? Please answer this question based on the team(s) you work with directly/most closely.

Not at all diverse
A little diverse
Moderately diverse
Very diverse
Extremely diverse
I do not work in a team

How would you rate the ethnic diversity of the client group you have worked with in your current clinical role?

Not at all diverse
A little diverse
Moderately diverse
Very diverse
Extremely diverse

Unfortunately, we find ourselves in a society where issues of systemic racism are pervasive and individuals from minoritised ethnicities are often faced with experiences of racism and microaggressions.

We would like to understand a little more about your individual experiences of this, if any, within your clinical work as one of the central hopes of this programme is to offer a supportive and reflective space for therapists from minoritised ethnicities to make sense of some of these experiences within a safe group environment.

We do understand that this may be difficult information to share, so you may choose not to answer the following questions if you would prefer not to.

Have you experienced racism or microaggressions in your current workplace? If yes, how frequent would you say these experiences have been?

Yes, very frequently
Yes, frequently
Yes, occasionally
Yes, however, rarely
No, never

Have you experienced racism or microaggressions in your therapeutic work with clients? If yes, how frequent would you say these experiences have been?

Yes, very frequently
Yes, frequently
Yes, occasionally
Yes, however, rarely
No, never

Weekly questionnaire

Please enter the unique ID code that you generated at the beginning of the programme. This code was created using the first three letters of the city in which you were born and the last four digits of your phone number. For example, for someone born in London with a phone number of 123456789, their unique ID would be LON6789.

How many clients, if any, have you worked with this week who are from a minoritised ethnic background? (Free text)

How much time have you spent on the SP/SR programme this week? Please give an estimate in minutes.

Therapist Skill

We would like to ask you some questions in relation to your clinical work over the last week, both as a therapist and as a supervisor and/or supervisee.

All the responses that you provide will be used solely for the evaluation of this SP/SR programme and will not be used for other purposes, for example, to rate your skills as a clinician.

Please rate the following statements from 0 to 100, in relation to your perceived level of skill in considering ethnicity within your clinical role. While the following anchor points are given, please do use the whole scale from 0 to 100 to provide your self-rating.

Note: If you have not worked in a supervisory capacity, please mark "Not Applicable" for Question 10.

0----------25----------50----------75----------100
No skills Novice Competent Proficient Highly Expert

1. I have the skills to talk about and explore my client's ethnic identity in sessions

2. I have the skills to incorporate my client's ethnic identity and cultural context into formulations
3. I have the skills to adapt CBT interventions in a culturally sensitive way (e.g. thought challenging, behavioural activation)
4. In sessions, I have the skills needed to explicitly address difficulties related to my client's minoritised ethnic identity (e.g., microaggressions, experiences of discrimination)
5. I have the skills to identify, sit with and manage personal resonances that conversations around my clients' ethnicity bring up for me.
6. I have the skills to elicit and integrate my client's strengths that are related to their ethnic identity.
7. I have the skills to identify and address my own ethnic differences and/or similarities with my client in sessions
8. I have been aware of/been able to identify my own biases about my client's ethnic identity
9. As a supervisee, I have the skills to bring discussions and issues related to my own or my clients' ethnicity to supervision.
10. As a supervisor, I have the skills to create a space where my supervisee can bring in discussions and issues around their own or their client's ethnicity (NA option included)

Ethnic Identity Development
We would also like to ask you some questions in relation to your ethnic identity.

Please rate the following statements from 0 to 100, in relation to the following areas. While the following anchor points are given, please do use the whole scale from 0 to 100 to provide your self-rating.

In relation to the last week, how well do the following statements describe you:

I have explored aspects of my ethnic identity

I have a clear sense of what my ethnicity means to me

0----------25----------50----------75----------100
Not well at all Slightly well Moderately well Very well Extremely well

Over the last week, how have you felt in relation to your ethnic identity:

In relation to my ethnic identity, I have felt

0----------25----------50----------75----------100
Completely negative Quite negative Neutral Quite positive Completely positive

Wellbeing

Finally, we would like to ask you a few questions about your perceived wellbeing, both personally and as a therapist.

While there are a number of ways to understand and define wellbeing, we would consider wellbeing here to mean both how people feel (e.g. feeling happy and content) and how they function (e.g. having agency over their lives, having a sense of purpose and experiencing positive relationships).

Please rate the following statements from 0 to 100. While the following anchor points are given, please do use the whole scale from 0 to 100 to provide your self-rating.

Over the last week, how would you rate:

Your personal wellbeing

Your therapist wellbeing

0----------25----------50----------75----------100

Poor Wellbeing *Fair Wellbeing* *Good Wellbeing* *Very Good Wellbeing* *Excellent Wellbeing*

Is there any other information that you would like to provide that would help us to contextualise the ratings you have provided for this week (e.g. illness)? (Free text box).

Appendix H
Visual Analysis Tables

Variable –

	A	B	C	D	E	F
Baseline Level Trend Variability						
SP/SR Level Trend Variability						

Comparison Immediacy Overlap (stats) Consistency (across phases)						
Overall comments (3 demonstrations of effect) Magnitude of effect						

Variable –

	A	B	C	D	E	F
SP/SR Level Trend Variability						
Follow-up Level Trend Variability						
Comparison Immediacy						

Overlap (stats) Consistency (across phases)						
Overall comments (3 demonstrations of effect) Magnitude of effect						

Appendix I
Weekly Contextual information

Time point	Participant					
	A	B	C	D	E	F
Week1 *intro					illness	
Week 2	I have had covid, so a bit tired and worn out.	Relationship difficulties	I have been on A/L for the past week		ongoing recovery from a low immune system	
Week 3 *mod 1	I had some family news that made feel desperately sad for a few days.				illness	
Week 4				bereavement	illness	
Week 5 *mod 2	I was off work last week and on a break so a little different.	No		bereavement		
Week 6	I saw lots of family and friends, hence better wellbeing.					
Week 7 *mod3	I interviewed for a new job and was successful, this has boosted my mood as a therapist.	Not applicable				
Week 8						

Week 9 *mod4				**on holiday**		**I have been on leave and then training for the week**
Week 10	**I have had 2 weeks of annual leave so data is a bit different with client conatct.**					
Week 11 *mod 5		**Coming back from annual leave after summer break so not as many patients**				
Week 12			**I was on Annual Leave for this week**			
Week 13 *mod6	**I have a new job offer and that's boosted my mood in terms of wellbeing as a therapist.**					
Week 14	**preoccupied and sad about event in my home country.**					
Week 15 *mod 7						
Week 16				**On annual leave**	**shoulder injury**	
Week 17 *mod 8		**I have been on annual leave this week**				
Week 18						
Week 19 *mod 9			**Annual Leave this week**			
Follow up 1						

Follow up 2						
Follow up 3	**Consuming too much news and seeing so much violence in my home country has taken a bit of toll on my mood this week.**					
Follow up 4	**I've been on annual leave so feeling rested.**					
Follow up 5	**First week in the new role so I haven't had any clinical contact.**					**In process of leaving post so not many clients**

Appendix J
Visual plots for all outcomes

Figure 1
Visual plots for technical skills outcomes.

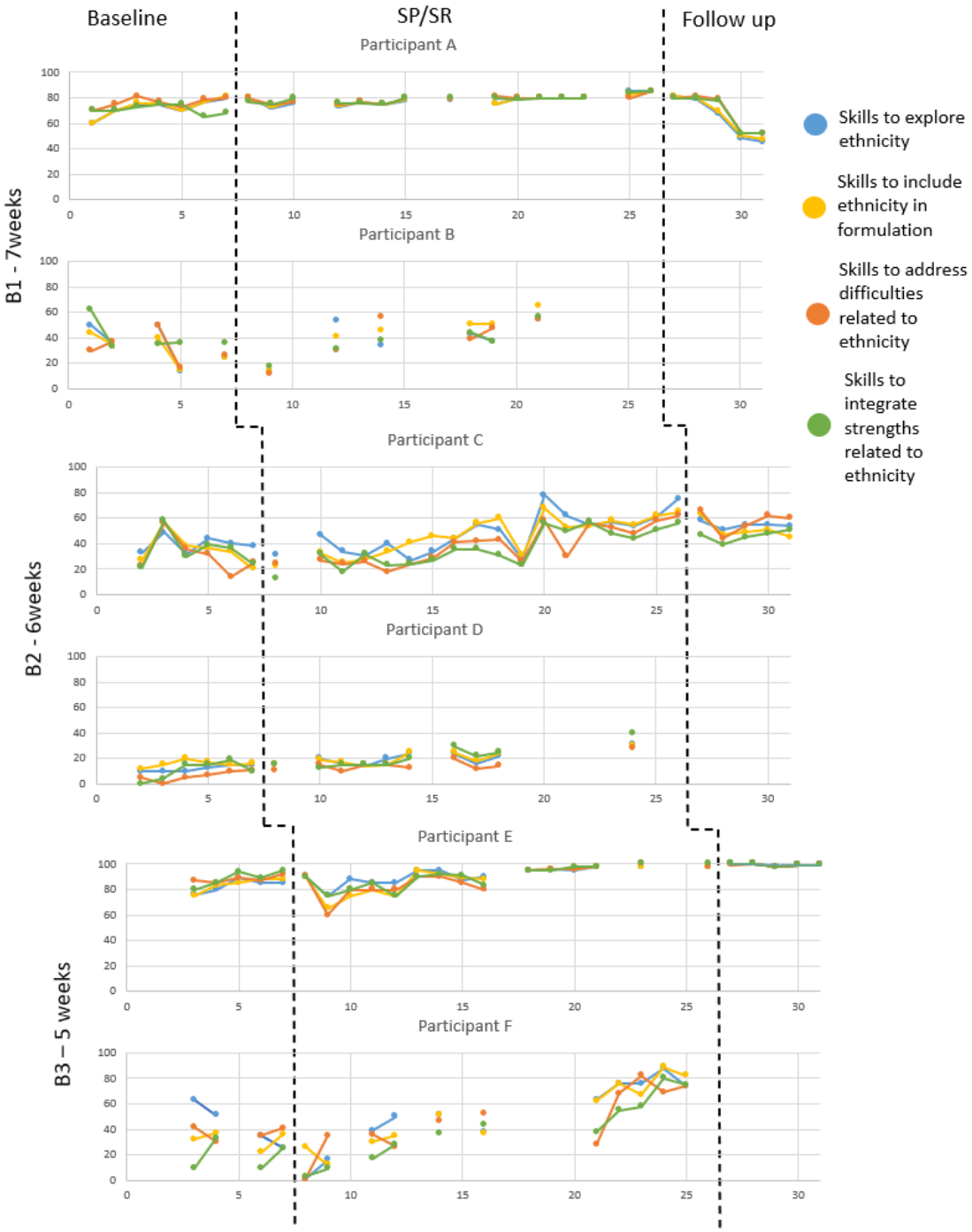


Figure 2

Visual plots for reflective skills outcomes.

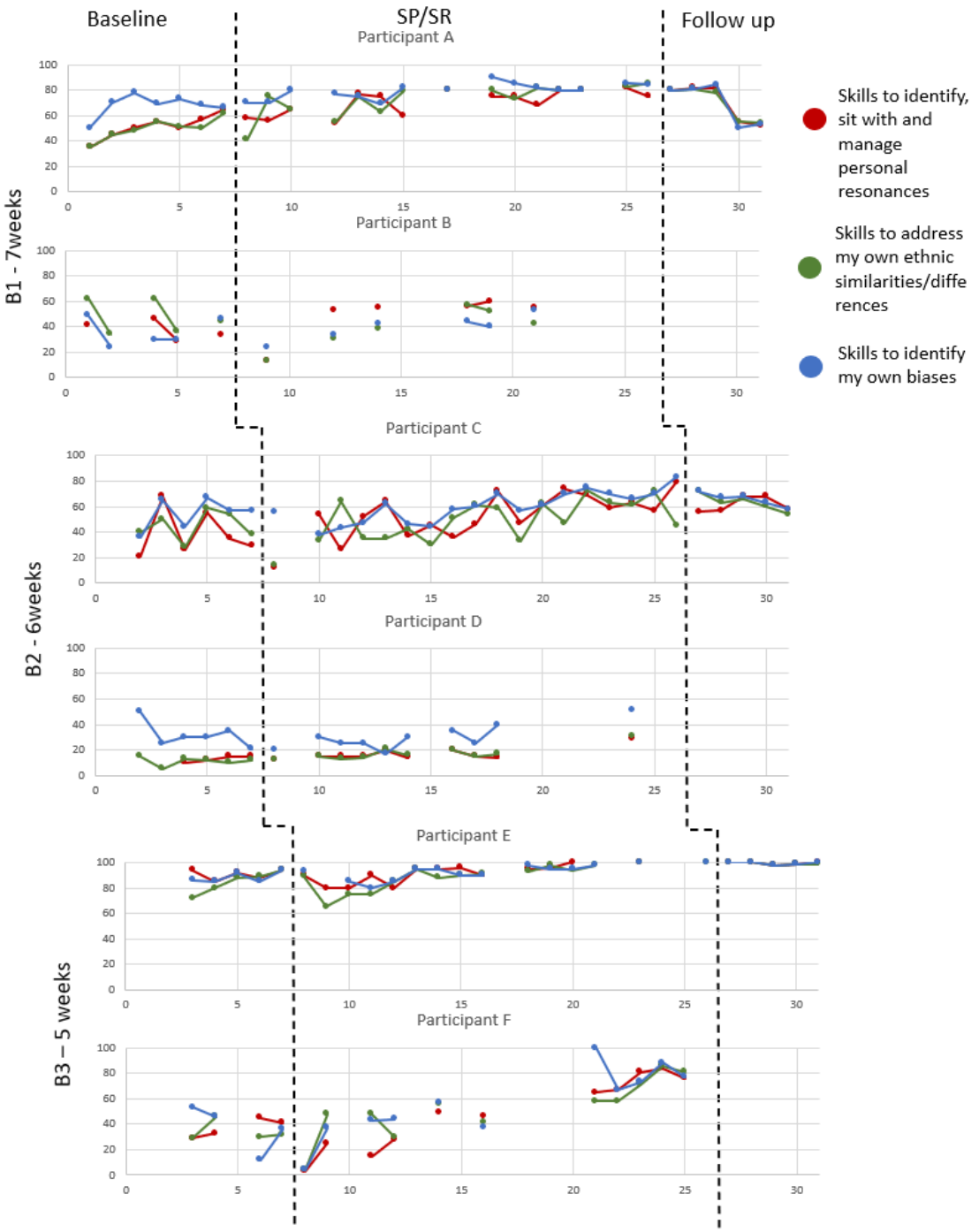


Figure 3

Visual plots for ethnic identity development outcomes.

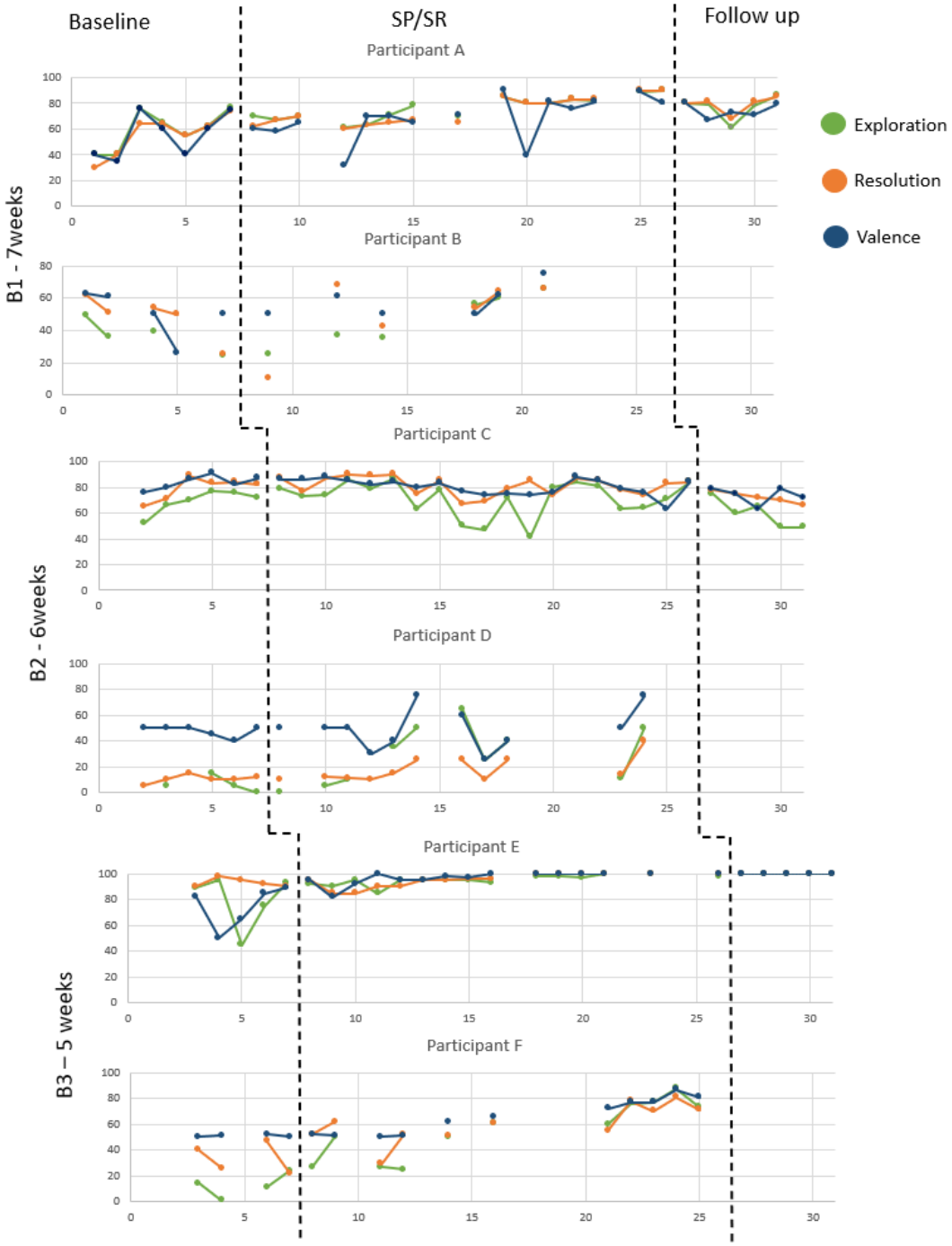
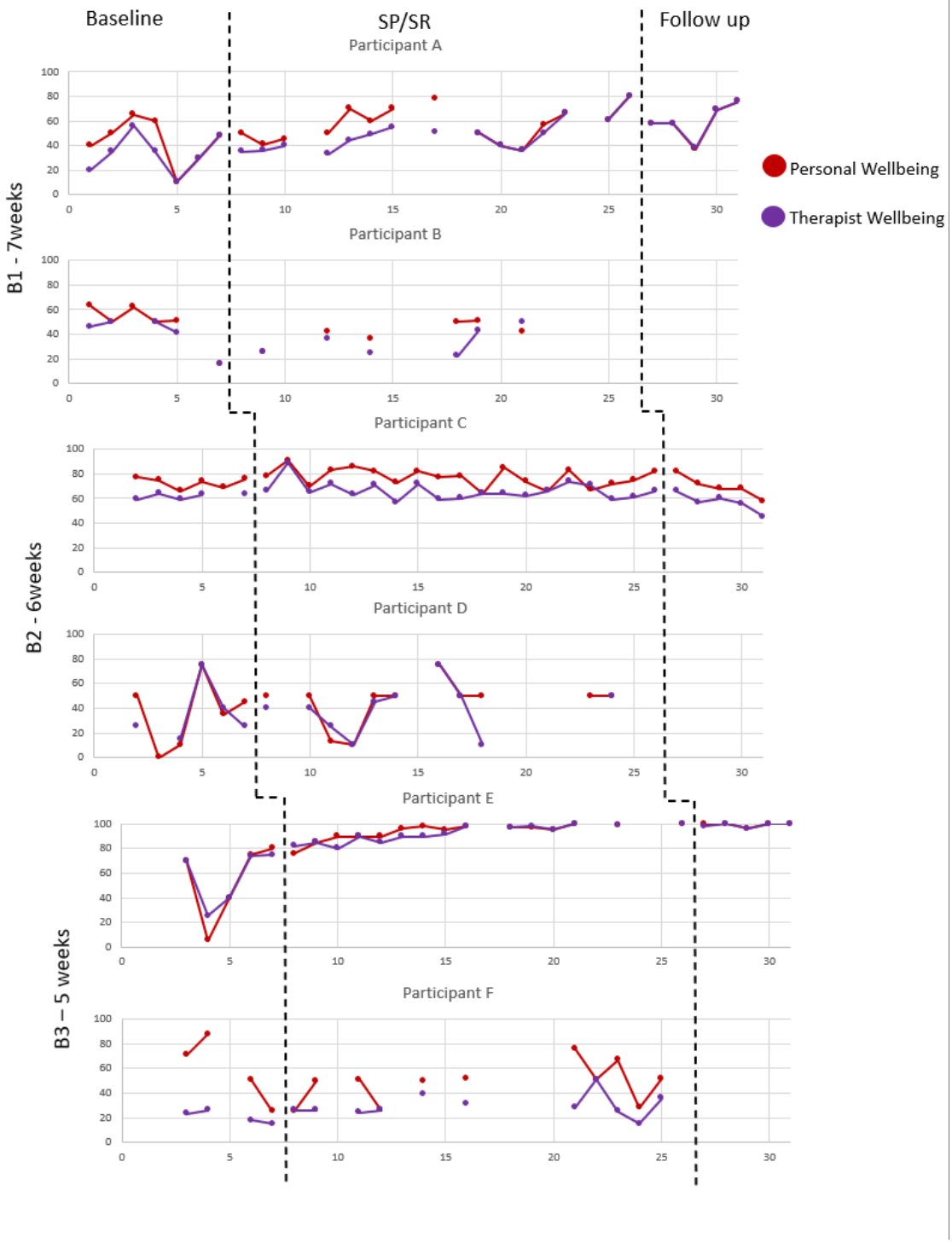


Figure 4
Visual plots for wellbeing outcomes.



Appendix K
Visual and Statistical Analysis for Remaining Outcomes

Figure 1

Visual plots and linear trend lines for remaining skills outcomes.

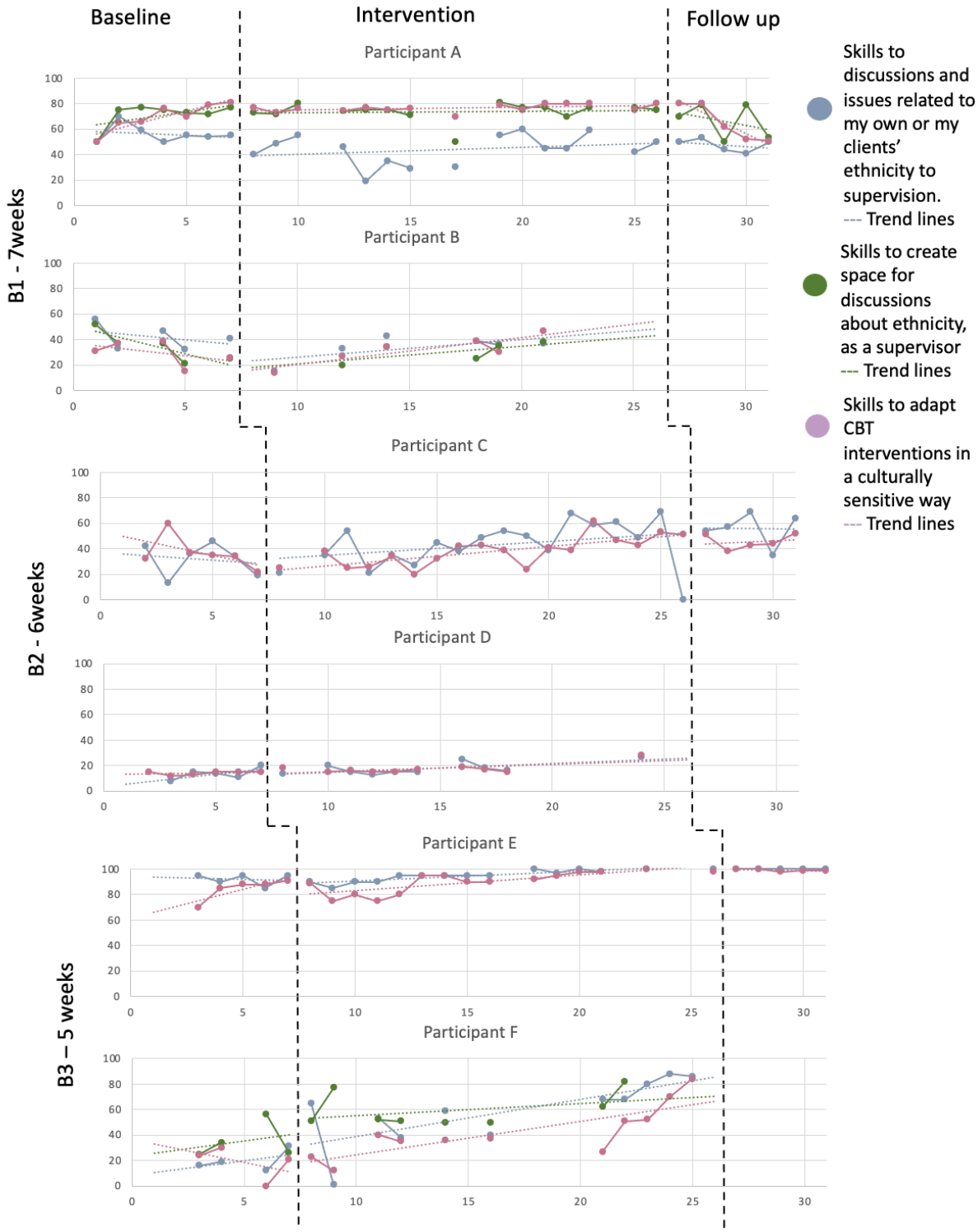


Table 1

Mean and standard deviation for baseline, intervention and follow-up phases for the remaining skills outcomes.

Participant	Adapt Interventions Mean (SD)			Own Supervision Mean (SD)			As Supervisor Mean (SD)		
	Baseline	Intervention	Follow up	Baseline	Intervention	Follow up	Baseline	Intervention	Follow up
A (B1)	69.57 (10.63)	76.47 (2.97)	65.00 (14.35)	56.14 (6.87)	43.93 (11.76)	47.60 (4.93)	71.29 (9.57)	73.60 (7.21)	66.20 (13.95)
B (B1)	29.60 (9.63)	31.83 (11.23)	-	41.80 (10.03)	33.83 (9.81)	-	34.40 (12.16)	30.40 (7.57)	-
C (B2)	36.67 (12.58)	38.00 (11.33)	45.60 (5.86)	31.67 (13.00)	43.00 (17.97)	55.80 (13.03)	-	-	-
D (B2)	14.17 (1.33)	17.50 (3.95)	-	13.60 (4.51)	17.80 (4.78)	-	-	-	-
E (B3)	84.40 (8.32)	90.00 (8.54)	99.20 (0.84)	92.00 (4.47)	95.00 (4.54)	100.00 (0.00)	-	-	-
F (B3)	18.75 (13.05)	42.45 (20.80)	-	19.50 (8.19)	58.73 (25.32)	-	35.25 (14.41)	59.38 (13.09)	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

Table 2

Tau-U analysis of baseline trend, baseline SP/SR comparison and SP/SR follow-up comparison for the remaining skills outcomes.

Participant	Adapt Interventions			Own Supervision			As Supervisor		
	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow up (Tau-U)	Baseline Trend (Tau-U)	Baseline vs SP/SR (Tau-U)	SP/SR vs Follow up (Tau-U)
A (B1)	0.905+	0.191	-0.307	-0.048	-0.610*	0.147	0.143	0.133	-0.227
B (B1)	-0.200	0.100	-	-0.400	-0.300	-	-0.700	-0.240	-
C (B2)	-0.467	0.185	0.467	-0.200	0.463	0.456	-	-	-
D (B2)	0.333	0.733*	-	0.400	0.500	-	-	-	-
E (B3)	0.900+	0.373	0.853*	-0.100	0.400	0.733*	-	-	-
F (B3)	-0.333	0.727*	-	0.333	0.818*	-	0.333	0.688*	-

B1 – Baseline 1; B2 – Baseline 2; B3 – Baseline 3

*Significant change ($p \leq 0.05$)

+ Baseline correction applied