

Portfolio Volume 1: Major Research Project

**Cultural Influences on Psychiatrists' Constructions of
Mental Health Problems: A Repertory Grid Study**

Mary Eno Addo

June 2018

Word count: 29,958

(Excluding tables, figures, references and appendices)

**Submitted to the University of Hertfordshire in partial fulfilment
of the degree of Doctor of Clinical Psychology**

Acknowledgements



I would like to dedicate my thesis to Isaac and Israel, who have both been a pillar of strength and support throughout this thesis and training process. Thank you for your constant encouragement, patience and sacrifices. WE took this journey together, as a team, and I am forever thankful that you were both by my side every step of the way.

I would like to say thank you to Emeritus Professor David Winter for guiding me through the world of Personal Construct Psychology and the use of repertory grid, for all his time, dedication, help and support. Thank you to Dr Keith Sullivan for his time, help and guidance on the statistical analysis.

I would like to thank Professor Suman Fernando and Professor Simon Dein for providing consultation to this research, for their time and encouragement.

Last and definitely not least, I would like to say a special thanks to all the Trainee Psychiatrists who participated in this research; without their valuable time and willingness to take part, this project would not have been possible.

Table of Contents

Abstract	8
Chapter 1: Introduction	9
1.1. Chapter Overview	9
1.2. Introduction to key definitions	10
1.2.1. Culture and ethnicity	10
1.2.2. Western and non-Western	11
1.3. Epistemological Position	12
1.4. Personal significance & experience that cultivated interest in the topic	15
1.5. Societal and cultural context of Psychiatry	15
1.5.1. Culture and Perspective-taking	16
1.5.2. Culturally-embedded empathy/ understanding	18
1.5.3. Concepts of mental health in different cultures	20
1.5.4. Implications of culture on mental health practice	22
1.5.4.1. Interaction between the client and the clinician in context of culture	22
1.5.4.2. Implications of difference in cultural perceptions	23
1.6. Systematic Literature Review	26
1.6.1. Search Strategy	26
1.6.2. Summary of findings and quality review	30
1.6.2.1. Clinicians' construction of clients from different cultural backgrounds	31
1.6.2.2. Clinicians' constructions of clients generally, in the the context of clinicians' constructions of significant people in their lives as well as themselves	44
1.7. Rationale for the current study	54
1.8. Research Aims	56
1.9. Research Hypotheses	57

Chapter 2: Methodology	60
2.1. Design	60
2.2. Participants and Recruitment	60
2.3. Description of participants	62
2.4. Measures	62
2.4.1. Repertory grid	62
2.4.2. Rationale for choosing repertory grid methodology	63
2.5. Procedure	64
2.5.1. Part one: Developing the supplied constructs	64
2.5.2. Part two: Repertory grid	65
2.6. Analysis of Repertory Grids	68
2.6.1. Grid measures extracted for analyses	68
2.6.2. IDIODRID (Grice, 2004)	68
2.6.3. GRIDSTAT (Bell, 2004b)	69
2.6.4. Content Analysis	81
2.6.5. Demographic Questionnaire	85
2.7. Data Collation and Analysis on SPSS	85
2.8. Ethical Considerations	86
2.9. Feedback	86
2.10. Service User Involvement	87
Chapter 3: Results	88
3.1. Section 1: Within-subject differences	89
3.1.1. Findings related to sub-hypotheses of hypothesis 1	89
3.1.2. Findings related to sub-hypotheses of hypothesis 2	106
3.2. Section 2: Between-subject differences	110
3.2.1. Findings related to sub-hypotheses of hypothesis 3	110
3.3. Section 3: Additional findings	118
3.3.1. Summary of analysis procedure	118
3.3.2. Findings related to correlations	118
3.4. Plots of elements in construct space derived from principle component	123
3.4.1. Understanding the plots	123

3.4.2. Case Example 1	123
3.4.2.1. Additional statistical finding related to case example 1	125
3.4.3. Case Example 2	126
3.4.3.1. Additional statistical finding related to case example 2	128
3.4.4. Case Example 3	129
3.4.4.1. Additional statistical finding related to case example 3	131
Chapter 4: Discussion	132
4.1 Overview of results in relation to hypotheses and relevance to empirical literature	132
4.2. Summary of additional findings	139
4.3. Case Examples	140
4.4. Clinical implications	143
4.4.1. Becoming aware of perceptions that influence practice	143
4.4.2. Identifying factors that can influences diagnoses and the treatment referral process	144
4.4.3. Enhancing cultural communication in mental health	145
4.4.4. Incorporating cultural awareness at training level	146
4.5. Consideration of the quality of the current study	147
4.5.1. Strengths	147
4.5.2. Limitations	149
4.6. Recommendations for further research	153
4.7. Conclusions	155
References	156
Appendices	175
Appendix A: Summary of the research in the systematic literature review	175
Appendix B: Quality appraisal of the research in the systematic literature review	207
Appendix C: Participant Information Sheet	217
Appendix D: Consent Form	219
Appendix E: Demographic Information	220
Appendix F: Example of the Repertory Grid	222

Appendix G: Debrief Information	223
Appendix H: Ethics Approval Notification	224
Appendix I: Quality appraisal of the current study	225

List of Tables and Figures

Table 1: Search Terms used in Systematic Literature Search	27
Table 2: Literature Search Inclusion and Exclusion Criteria	28
Table 3: Inclusion and exclusion criteria for recruiting Trainee Psychiatrists	60
Table 4: The supplied constructs for the repertory grid	65
Table 5: Grid measure for analyses and how they relate to the hypotheses	71
Table 6: CSPC categories and their hierarchical order	83
Table 7: Comparing salience of elements of clients of participants' own ethnicity and clients of other ethnicities	89
Table 8: Comparing the difficulty to understand clients of the participants' own ethnicity and clients of other ethnicities	90
Table 9: Comparing the distance of self (as now) from clients of the participants' own ethnicity and clients of other ethnicities	91
Table 10: Comparing the distance of ideal self from clients of the participants' own ethnicity and clients of other ethnicities	92
Table 11: Comparing the conflict associated with the construing of clients of the participants' own ethnicity and clients of other ethnicities	93
Table 12: Comparing the inability to apply personal constructs to clients of the participants' own ethnicity and clients of other ethnicities	94
Table 13: Comparing the inability to apply clients constructs to clients of the participants' own ethnicity and clients of other ethnicities	95
Table 14: Comparing the frequencies of the classification of constructs for clients of the participants' own ethnicity and clients of other ethnicities	96
Table 15: Comparing the distance of significant people in the participants life from clients of their own ethnicity and clients of other ethnicities	105
Table 16: Non-parametric test comparing the extent to which constructs discriminate between elements	106

Table 17: Frequency of each classification system for personal constructs and client constructs	107
Table 18: Comparing the inability to apply personal constructs to significant people and clients	108
Table 19: Comparing the inability to apply client constructs to significant people and clients	109
Table 20: Comparing participants from European and non-European backgrounds 'perception of clients of their own ethnicity and clients of the other ethnicities view of the presenting mental health problem mental health problem in spiritual or religious terms	110
Table 21: Comparing participants from European and non-European backgrounds 'perception of whether clients of their own ethnicity and clients of other ethnicities will consider they would benefit from religious or spiritual assistance	112
Table 22: Comparing participants from European and non-European backgrounds' perception of clients of their own ethnicity and clients of the other ethnicities view of the presenting mental health problem in biomedical or somatic terms	114
Table 23: Comparing participants from European and non-European backgrounds' perception of whether of clients of their own ethnicity and clients of other ethnicities will consider that they would benefit from psychotropic medication	115
Table 24: Comparing participants from European and non-European backgrounds' perception of clients of their own ethnicity and clients of the other ethnicities view of the presenting mental health problem in psychological terms	116
Table 25: Comparing participants from European and non-European backgrounds' perception of whether clients of their own ethnicity and clients of other ethnicities will consider that they would benefit from psychological intervention	117
Table 26: Correlations between demographic and grid variables	118
Table 27: Comparing participants from European and Non-European	125

backgrounds' inability to apply personal construct to clients of other ethnicity	
Table 28: Comparing participants from European, African and Asian backgrounds' regarding the extent to which they use personal construct to discriminate between elements	128
Table 29: Comparing participants from European, African and Asian backgrounds' inability to apply client construct to clients of other ethnicities	131
Figure 1: Systematic Literature Review Flow Chart	29
Figure 2: Self, ideal self and significant people contrasted with clients, regardless of ethnicity	123
Figure 3: Self, ideal self, significant people and clients of own ethnicity were contrasted with clients of other ethnicities	126
Figure 4: Self, ideal self, significant people and clients of European ethnic group (different ethnic group to the psychiatrist) were contrasted with clients of non-European ethnic groups (including those of the same ethnicity).	129

Abstract

Background: The literature suggests that people from different cultures make sense of their experiences in different ways, including how they understand mental health problems. Much of this research focused on how clients from different cultures understand their mental health problems. There are a few studies on clinicians' construal of clients. There appears to be a lack of research looking at how clinicians from various ethnicities construe clients from different ethnicities.

Aims: The research explored whether psychiatrists from different ethnicities have different ways of understanding clients of similar or different ethnic background to themselves. Additionally, differences in the ways in which psychiatrists from different ethnicities construe clients and people significant to them in their personal lives were explored.

Method: Using a cross-sectional approach, within subject and between-subject designs were employed. Seventeen Trainee Psychiatrists were recruited from various academic settings. Repertory grid technique was used to elicit significant people in the participant's life and clients they have worked with as well as constructs, on which all the elements were rated.

Results: The study showed that the participants did not find clients of the same ethnicity more meaningful, similar to themselves or easier to understand than the clients of a different ethnicity. However, it was found that the participants were more conflicted in their construing of clients of a different ethnicity. The case examples showed differences in the ways that psychiatrists from different ethnicities make sense of clients.

Conclusions: In a novel study that used repertory grid technique to explore an ethnically diverse group of psychiatrists' construing of clients, the findings highlight the implicit processes that can influence clinical practice when clinicians encounter clients from diverse ethnic backgrounds. In light of working cross-culturally as clinicians, the study addresses the need to acknowledge the impact of cultural differences; through reflection, consultation, and training.

Chapter 1: Introduction

“The language of the culture also reflects the stories of the culture. One word or simple phrasal labels often describe the story adequately enough in what we have termed culturally common stories. To some extent, the stories of a culture are observable by inspecting the vocabulary of that culture. Often entire stories are embodied in one very culture-specific word. The story words unique to a culture reveal cultural difference”

– Tell Me a Story: Narrative and Intelligence (Roger C. Schank, 1995; p. 149)

1.1. Chapter overview

This research focuses on exploring the systems that trainee psychiatrists from different ethnicities use in construing clients from different ethnic backgrounds as well as significant people in their lives. To start with, I will define some of the terminologies that will be used throughout this report and then state my epistemological position and personal experiences that inform this research. Subsequently, I will explore perspective-taking, empathy (and understanding), concepts of mental health, interaction between the clinician and the client as well as implications of difference in perceptions, in the context of culture. This will be followed by a systematic literature review that will be divided in two parts. The first part will focus on clinicians’ construction of clients who are of a different or similar ethnicity to the clinician. The second part will focus on how clinicians construe clients generally, in relation to significant people in their personal lives and themselves.

1.2. Introduction to key definitions

1.2.1. Culture and ethnicity

Culture is an important aspect of everyday life that plays a role in our view of ourselves and others as well as how we are viewed by others (Ji and Yap, 2016). There are many definitions of culture and the definition that will be applied for the purpose of this study will be that by Fernando (2014), who states that:

Whether referring to that of an individual or a group, culture is now seen as something that is dynamic and far from static – a flexible system of values and world views that people live by, and through which they define identities and negotiate their lives... and this is the main use of the term in the field of mental health. (p.12)

For the purpose of this research, ethnicity will be defined as the way in which people who share a similar cultural framework group themselves. In the last census in 2011, it was indicated that of the 56 million people living in England and Wales, 86% were White, 8% were Asian or Asian British and 3% were Black African/ Caribbean or Black British. Therefore in this study, the ethnicities that will be considered are the principal ones in the UK: White European descent, Black African/ Caribbean descent and Asian descent. These groups are chosen based on an interest in exploring their cultural understanding of mental health problems and not assuming that the vast sub-groups within these ethnicities have the same cultures or understanding of reality, values or thoughts. Of course, the understanding of mental health problems of individuals from similar cultures may differ due to the unique ways of interacting with the normative practices but what we aim to explore is the overall view (influenced by societal values) that is shared amongst specific groups of people within specific ethnicities.

1.2.2. Western and Non-Western

In this paper, reference to Western countries will encompass countries within Europe and North America whereas non-Western countries will include Asia and Africa. Culture is partly viewed dichotomously when referencing different countries: for example, Western countries are often viewed as individualist and non-Western countries are deemed as collectivist. The definition of collectivist and individualist is derived from Triandis' (2001) definition of these constructs, which is as follows:

In collectivist cultures people are interdependent within their in-groups (family, tribes, nation, etc.), give priority to the goals of their in-group, shape their behaviour primarily on the basis of in-group norms and behave in a communal way... People in collectivist cultures are especially concerned with relationships. (p. 909)

In individualist societies people are autonomous and independent from their in-groups; they give priority to their personal goals over the goals of their in-groups, they behave primarily on the basis of their attitudes rather than the norms of their in-groups, and exchange theory adequately predicts their social behavior. (p. 909)

It is important to note that this dichotomous way (collectivist and individualist) of viewing the world can be described as idealistic because in reality people may hold a mixed concept of personhood. For example, Spiro (1993) argues that 'a typology of the self and/ or its cultural conception which consists of only two types, Western and a non-Western, even if conceived as ideal types, is much too restrictive.' (p. 117). Additionally, Turner et al. (1994) suggested that people have variable ways of categorising themselves, which 'provides people with behavioural and psychological flexibility in that we are able to act both as individual persons and collectively and as different kinds of persons and collectivities on different occasions.'(p. 461). Therefore, it is not being assumed that people who come from

individualistic or collectivist cultures possess all of these respective traits (Triandis, 2001). Nonetheless, these socially validated categories and cultural patterns can shape how people perceive their world and the meanings they attach to events (Triandis, 1995; Turner et al., 1994).

In taking a critical stance, it should be said that using dichotomous terms such as ‘individualism and collectivism’ as well as ‘western and non-western’ can narrow the thinking around how people within these cultures differ and also the context that shapes how people behave. Even though the initial argument put forward appears to insinuate that collectivism and individualism are contraries, it is important to clearly highlight that these aspects of human behaviour can be established in all communities as everyone can function in this manner. Additionally, though these terms can help predict human behaviour on a worldwide scale, it should be said that within every culture there are people who may ‘tightly’ or ‘loosely’ follow norms of the specific culture or community within which they reside, therefore it can be argued that it is unreasonable to assume a global or generalised view of a group of people (Miller 2002). Additionally, it should be highlighted that studies (Inglehart & Welzel 2005; Schwartz, 2006) have suggested that people’s values (within cultures) can change over time, which can be due to factors such as socioeconomic developments (Inglehart & Baker, 2000). Therefore, it can be argued that people’s values in regard to concepts such as individualism and collectivism may not be stable over time.

1.3. Epistemological Position

Epistemologically, a personal constructivist position will be taken within this research. This is because the fundamental aspect of constructivism is that it takes into account how we maintain our constructs concerning the world around us and how that guides the actions we take (Neimeyer and Winter, 2007, p. 152). Constructivism does not aim to present absolute

truths or no truths but rather looks at how individuals and societies creatively generate realities and meanings that 'reflect' a viewpoint (Raskin, 2002, p. 2). Though the constructivist considers 'the existence of an external reality that is independent of the observer', it is argued that the observer only knows the 'independent reality... through their constructions of it' (Raskin, 2002, p.3).

Within a constructivist position, there is also the concept of 'personal constructivism' that is also referred to as personal construct theory or psychology (PCT; PCP) (Raskin, 2002).

Personal construct theory (PCT; Kelly, 1955), with its fundamental assumption of 'constructive alternativism' (Winter, 1996, p. 599; Kelly, 1955, 1991), offers a perspective from which an individual's construction of a situation is not necessarily the actual reality but rather the individual's own personal explanations and interpretation. Therefore, our interpretation of past events with comparable themes influences how future events are anticipated (Construction Corollary, Kelly, 1955). Thus, the way a person constructs events, though not fixed, will provide a basis for their predictions about the world and their actions.

According to Kelly, humans are active agents when it comes to processing the world around them. Similar to 'scientists', they are constantly hypothesising (Winter, 1996, p. 599) and 'seeking predictions' (Reynolds, 2013, p.77), with an anticipation and outlook towards prospective events in order to make meaning. Bannister and Fransella (1986) stated that:

...a person is in business to understand their own nature and the nature of the world and to test that understanding in terms of how it guides them and enables them to see into the immediate and long term future. (p. 8)

It is clear that personal construct psychology (PCP) places the person at the centre of their construction and interpretation of events around them. Therefore, whilst people with common background and experiences are likely to develop a similar construct system (as indicated in

the Commonality Corollary, Kelly, 1955), all people have unique ways of construing the world (as indicated in the Individuality Corollary, Kelly, 1955). Additionally, it has been suggested that constructs do not generalize to all events but rather they are constrained to the anticipation of restricted range of events (also referred to as the range of convenience as described in the Range Corollary, Kelly, 1955).

Though this epistemological stance does not view a person in terms of separate entities (disconnecting cognition, behaviour and emotions), there have been arguments that the personal construct model is akin to cognitive-behavioural models as it can be analytical and calculated (Raskin, 2002). Others have taken a more humanistic stance in their emphasis on the person's free will in actively creating their own meaning, highlighting 'personal agency and self-determination' (Epting and Leitner, 1992; Raskin, 2002, p. 5). Even so, a number of researchers within the field of PCP have argued an aspect of 'limited realism' within this theory in that some correspondence between the external reality and the person's constructs can be asserted, even if this is not clear cut (Raskin, 2002, p. 3).

According to Chiari and Nuzzo (1996b; Raskin, 2002), this suggests that PCP does not truly fit with constructivist theory. In line with this, Fransella (1995) points out that, 'if personal construct theory is allowed to be subsumed under the umbrella of constructivism as if it were nothing but constructivist, Kelly's philosophy may well survive, but his theory will sink without trace' (p. 131).

In acknowledging these conflicting viewpoints, I adopt a position that accepts that personal constructs (based on our own experiences) enable us to construe the world around us and act in accordance with our own theories as well as to predict impending events. Yet, I recognise that a constant construal (e.g. of illness) that corresponds with external forces may be viewed as reality, even if limited.

1.4. Personal significance and experience that cultivated interest in the topic

In embarking on my journey to becoming a psychologist, I was initially unaware of my own inherent views of mental health problems until I worked in a psychosis service, as an Assistant Psychologist. In providing psychological therapy to clients experiencing psychosis, I became aware that I, at times, wondered whether psychological and biomedical interventions were sufficient to promote recovery without spiritual assistance, especially for people of faith. Though this was an unspoken dilemma of mine in working with some clients, I never felt that there was space to professionally express these views as clients' spiritual experiences were often described within a non-spiritual concept.

I often wondered whether other clinicians experienced these dilemmas whereby their own inherent views, perhaps in the context of their culture, influenced how they perceived presenting problems in the professional context, and how this may influence the processes involved in conceptualisation, diagnosis and treatment. I wondered whether ethnic differences between clinicians as well as the ethnic difference between the clinician and the client may also play a role in our construction of clients.

Clinically, I became aware of the discrepancies in a range of cultures and how mental health is understood as well as the alternative treatments that some clients sought. This often seemed more salient in ethnic minority groups, though prevalent in majority ethnic groups. The next section will therefore look at the societal and cultural context in which mental health is understood.

1.5. Societal and cultural context of Psychiatry

Before considering the construction of clients by clinicians in the systematic literature review, it seems necessary to understand the societal and cultural context in which our understanding of ourselves and others is developed, adapted and maintained. The discussion

within this section will include culture and perspective-taking; culturally-embedded empathy and understanding; concepts of mental health in different cultures as well as the implications of culture on mental health practice.

1.5.1. Culture and Perspective-taking

There is evidence that suggests that in non-Western cultures there is a sense of interdependence in the way that the world is viewed, which is often contrasted with the individualistic ways of Western cultures (Mayer et al., 2012; Wu and Keysar 2007). It can be hypothesised that this way of viewing the world can influence the process of perspective-taking, when considering others around us. Wu and Keysar's (2007) study of 20 non-Asian Americans and 20 Chinese participating in a game that involved interaction between two individuals (participant and researcher) found that American participants fixated on the object concealed from the researcher significantly more than the Chinese participants. Despite knowing that the researcher could only see one object (unconcealed), the American participants were more likely to move the object that was concealed from the researcher's view. In contrast, the Chinese participants were able to identify the object the researcher had in mind and moved the object that was not concealed from the researcher's view. The study suggested that the Chinese participants had taken into consideration what the researcher could see in order to problem solve, whereas the American participants struggled with the task. This study highlighted that people from cultures that promote interdependency are more likely to be better at perspective-taking because they tend to attend to others. On the other hand, people from cultures that focus on independence tend to attend to the self.

It is important to note the relevance of Wu and Keysar's findings when considering how perspective-taking plays out within structures that aim to understand mental health. Fernando (1991; 2014) highlighted the variation in different cultures when it comes to understanding health and illness. Fernando (2014) postulated that:

In non-western holistic traditions, subjective and objective experiences are so intertwined and interposed one into the other that they cannot be separated. But a traditional western non-holistic approach would attribute ill-health to either an external cause or internal one, each seen as a separate entity. A holistic tradition promotes a sense of health as a harmonious balance between various forces in the person and/ or social context as opposed to seeing health as individualised sense of well-being. (p. 24-25)

It can be hypothesised that this idea of interaction of various forces, and the required mutual consideration of the other in resolving complexities, is more deep rooted in some cultures than others. As suggested by Fernando, it is perhaps necessary to consider the historical development of Western psychology that looked at the mind as an introspective entity that is separate from the behaviour (Moodley and Ocampo, 2014). It can be argued that people (including clinicians) in Western countries may view another's presentation of mental health problems as lying within the person, which reiterates the individualised way of viewing problems. For example, a biological perspective would regard the 'mental health disorder' (such as schizophrenia and depression) as a chemical imbalance in the individual's brain (Speerforck et al., 2014) and the most commonly used psychological model (CBT) for depression would describe the difficulty in terms of an interconnection between how the individual thinks, feels and behaves (Beck, 1967; 1972; 2002).

Though these advances in how mental health is perceived are helpful in understanding distress, it can be hypothesised that these ways of understanding mental health problems may not be concepts that can be easily applied when considering individuals from non-Western settings. For example, someone presenting with schizophrenia in a non-Western setting may attribute their illness to spirituality or religion, and thus may view the presenting difficulty as

an interplay between the self and a deity (Opare-Henaku and Utsey, 2017). Therefore, others have argued that within a non-Western context, ‘the satisfaction of the personal, relational and collective needs’ (Nelson and Prilleltensky, 2005, p. 56) when considering good health is highly valued (Moodley and Ocampo, 2014).

The implication here is not assuming that there is a homogenous ‘western’ and ‘non-Western’ set of ideas because doing so will be failing to take into consideration the heterogeneity that exists within cultural populations or cross-cultural overlaps and commonality. Additionally, the separation of the psychological functioning or behaviours of people into categories such as non-Western and Western can be said to be an idealistic way of viewing a group of people, which can perpetuate stereotypical ideas as well as minimise the variation in behaviour and functioning of people of a similar culture.

Additionally, with regard to Wu and Keysar’s (2007) study, it can be argued that this study only compares two cultures and as such it can be argued that it is biased to assume that individuals from these cultures are homogenous and have the same qualities. This can be said to be an oversimplification of how complex the concepts of culture are, especially given that people may apply customs and norms specific to various cultures in a very individualistic way. This is also problematic because the measure that aimed to capture independence and inter-dependence did not appear to take into consideration the self-construal of individuals within their own cultures. Miller (2002) highlighted the importance of including cultural understanding in these types of measures.

1.5.2. Culturally-embedded empathy/ understanding

The ability to understand another’s perspective can be said to be partly influenced by one’s empathetic response towards the other. The role an empathetic response plays during interaction with others’ can be said to enable the formation and maintenance of a relational bond. Others have argued that empathy allows us to be ‘psychologically in tune with others’

feelings and perspectives' (Chopik et al. 2016, p. 24). Chopik et al. (2016), exploring the idea of cross-cultural understanding of empathy, suggested that there may be a relationship between empathy and the way in which an individual may construe themselves as an 'interdependent part of a larger social group' (p.24).

Kirmayer (2008) highlighted that 'difference in cultural background or social position' (p. 458) between the client and the clinician can have an impact on the therapeutic alliance. This was said to be specifically related to the challenge that the clinician may face in empathising with the client, especially when the presenting 'psychopathology' is unfamiliar. Kirmayer (2008) argued that empathy can therefore be said to be 'a privileged way of understanding the psychological dynamics of another person by entering their psychology' (p. 459). However, it was also suggested that limitation of empathy in the clinic room can lead the clinician to experience the client as foreign (Kirmayer, 2008). According to Kirmayer (2008), in these cases, the clinician may draw on 'theories of psychopathology, including structural models and causal mechanisms' (p. 458) to help make sense of this novel experience. Though in some cases this may help increase empathy, it can be argued that it is likely that the empathetic response to the unusual presentation or individual may still be limited. This is because it can be hypothesised that the aspect of empathy that takes into consideration the viewpoint of another person may be partial as it can be difficult to fully understand a different point of view, especially if the client's own understanding is embroiled within their own culture. Nonetheless, Kirmayer (2008) suggested that the clinician can use 'imaginative elaboration (constructing scenarios to situate the other's actions and experience in their life context)' (p. 459). The question that comes to mind, when considering the aforementioned suggestion, is whether the clinician's imagination can be consistent with the client's construction of their experience (that might be influenced by their culture).

Despite the argument that cultural similarities and differences can influence empathetic response, it can be argued that in everyday practice there are many other factors that can have an impact on the client-clinician relationship. For example, Constonguay et al. (2006) highlighted that there has been empirical literature that argues that clients' behaviours such as 'avoidance' and 'interpersonal difficulty' (Constantino et al., 2002) as well as therapists' characteristics such as 'rigidity' and 'criticalness' (Ackerman & Hilsenroth, 2001) can negatively influence alliance between the clinician and client. On the other hand, Constonguay et al. (2006) suggested that factors such as the client's ability to be psychological minded and the therapist's warmth as well as flexibility can have a positive impact on the quality of the relationship.

1.5.3. Concepts of mental health in different cultures

There appears to be a range of explanations of mental health problems applied to causality, how the manifestation of the mental health problems is described (Olafsdottir & Pecosolido, 2011), approach to services and help seeking behaviour (Wynaden et al., 2005), choice of treatment that is understood to be acceptable (Fung & Wong, 2007) as well as maintenance of the presenting experience.

For many parts of African countries, people 'believe that the natural world is partly physical, but mostly spiritual and the occurrences in the spiritual world can manifest in the physical world' (Opare-Henaku and Utsey, 2017, p. 503). Gyekye (1995) described the sense of personhood as a 'psychophysical dualism', where the concepts of the body and spirit are said to go hand-in-hand. Kpanake (2018) asserts that there is an interconnection between the self, social world and spiritual elements. Additionally, Gyekye (1995) points out that a person is viewed as consisting of three key elements, which are the body (physical), the spirit (this includes the individual's personality and intellectual foundations) and the soul (viewed as the

source of life). Therefore, as suggested by Brautigam and Osei (1979), it can be said that these concepts of personhood play a significant role in the understanding and construction of mental health problems within African cultures.

Others have suggested that, like African traditions, Asian cultures also place emphasis on alternative explanations of mental health problems such as ‘supernatural forces’ (Yeung et al., 2017, p. 590) and spirituality (Laungani, 1999). Additionally, Fernando (2014) highlights that in the Chinese culture ‘illness is an imbalance between the *yin* and *yang* (two contemporary poles of energy)’ (p. 26). Therefore, one can assume that the co-existence of these features, which a person embodies, is crucial in their wellbeing. In regard to the view of mental health in other parts of Asia, Laungani (1999) pointed out that ‘the Indian mind may therefore resort to formulation where material and spiritual, physical and metaphysical, natural and supernatural explanations of phenomena co-exist with one another’ (p. 149). Therefore, Indian holistic medicine, such as the traditional Ayurveda, is used as a form of treatment to bring harmony between the individual, their body and their psyche (Fernando, 2014; Laungani, 1999)

Others have argued that in non-Western cultures that place much emphasis on holism (Fernando, 1991; 2014), it is common to view good mental health as a ‘balanced functioning of all components of the person’ (Opare-Henaku and Utsey, 2017, p. 504). Therefore, it can be hypothesised that the interventions that might be better received are ones that take into consideration the ‘whole being’ and that would include spirituality.

There is literature suggesting that the concept of ‘mental illness’ in European psychiatry seems to be very much embedded in a bio-medical model of illness (Fernando, 1991, 2010; Morrison, 2017), thus often lacking the idea of holism. Therefore, it comes with no surprise

that there, at times, exists a struggle to accommodate the ‘whole’ person within the concepts of Western psychiatry.

It can be hypothesised that the limited understanding of non-Western constructions of mental health problems can lead clinicians to attach adjectives in line with the Western understanding of distress to the mental health presentations of non-Western people. Others have argued that this can often pose problems such as unwarranted diagnosis or absence of diagnosis (Bassett and Baker, 2015). For the clinician encountering these unfamiliar expressions of mental health problems, it can be argued that this can provoke anxiety, especially when there is a lack of certainty. As such, it can be hypothesised that the client’s expression of mental health problems might be fitted within the clinician’s own frame of understanding. The process of using a Western understanding to make sense of a non-Western expression of experience can be predicted to lead to a limited opportunity to empathetically engage with the client’s cultural position.

1.5.4. Implication of culture on mental health practice

1.5.4.1. Interaction between the client and the clinician in context of culture

Culture and ethnicity appear to play an important role in the communication process between the client and the clinician. For example, a client from a different ethnicity to the clinician may be less expressive due to fear of misunderstanding (Schouten and Meeuwesen, 2006) and in some cases fear of racial profiling that can lead to discriminatory practices (Hwang, et al., 2008; Fernando, 1991; 2014). This can be particularly challenging when expression, appearance and disguise of the reported problem is embedded within one’s own culture (Hwang, *et al.*, 2008). As such, this can lead to inaccurate diagnosis of people from different cultures and ethnicities, especially when their problems are understood within a Western conceptualisation or construction (Fernando, 2014; Smedley et al., 2003).

It seems that the discrepancy in the understanding of mental health problems can also have an impact on the clients' and the clinicians' encounter. For example, a study conducted in New Zealand (Bush, et al., 2005) indicated significant cultural differences in the views of psychiatrists and the perceptions of people of Samoan descent, whereby the psychiatrists were perplexed by the Samoans' concept of relational self as well as the interconnection between spirituality and mental health.

Given that our society is becoming increasingly multicultural and multiracial, clinicians will inevitably encounter clients from different (or similar) cultural and ethnic backgrounds to themselves. Therefore, a mono-cultural approach cannot be used to treat a multi-cultural society (Sue and Sue, 1990). For the past two decades, there have been proposals that clinicians ought to become culturally competent (Bhui et al., 2007; Leavitt, 2002). However, the question is how can clinicians become culturally competent when conversations around race, ethnicity and culture can bring about discomfort (Bhui et al., 2012; Nolte, 2007).

The increasing literature on causes and preferred treatment(s) of mental health problems, mostly focuses on the cultural and ethnic background of the client and not that of the clinician. It is therefore becoming increasingly relevant that clinicians are aware of their own cultural identity and standpoint and recognise how their own beliefs (in part influenced by culture) may influence the interaction with clients and the understanding of the causes and treatment(s) of the presenting problem (Hwang, et al., 2008).

1.5.4.2. Implications of difference in cultural perceptions

Research evidence suggests that culture and ethnicity play an important role when informing the diagnosis and treatment of mental health problems (Alarcon, 2009). Most of the evidence is based on the clients' culture or ethnicity and how that influences their perception of the

causes of their mental health difficulties and the treatment options they may prefer (Ae-ngibise et al., 2010; Fernando, 2014; Hwang, et al., 2008).

Kleinman (1978), who proposed the explanatory model of illness, suggested that the client's understanding of their mental health problems is rooted within the social context and as such people from different cultural backgrounds may experience and interpret their problems differently. It appears that there is a disparity between different ethnicities when it comes to beliefs and explanations of mental health problems (Williams and Healy, 2001). For example, as previously mentioned, causes of mental health problems in Western countries seem to be grounded in a biomedical or 'somatopsychic' framework, whereas in other parts of the world, such as in Asia and Africa, mental health may be viewed holistically within the physical, social and spiritual background (Fernando, 2014). Therefore in the non-Western parts of the world people who do not attribute biomedical factors to their mental health difficulties may seek other treatment options such as seeing a religious figure or a spiritual healer (Fernando, 1991; 2014; Ae-ngibise et al., 2010).

In the 1980's, Kleinman (1988) and Fabrega (1987) were both in agreement that culture has an influence on the clinician's view of what is normal and what needs to be categorised as illness. Perhaps, ethnic and cultural similarities between the client and the clinician may elicit a more holistic view of the problem, whereas differences may lead to categorization of the illness or the stereotyping of what may be perceived as normal within a particular ethnic group.

Comino et al. (2001) pointed out that practitioners, such as GPs, may find it challenging to detect mental health problems in various ethnic minority groups or other cultures because of 'their implicit assumption of low prevalence of emotional disorders in some immigrant groups' (p.72). This may offer an explanation to the under-representation of some ethnic

groups, such as Asian clients, in mental health services (Chen et al., 2003). On the other hand, this statement can also be applied to the over-representation of African and African Caribbean clients diagnosed with schizophrenia (Hickling, et al., 1999).

It is worth taking into consideration cognitive theories that can offer some explanation for the potentially repeated diagnostic labels offered to clients from a specific background. One can hypothesise that in order to deconstruct the complex mental state presentation of a client from a different background, there may be some reliance on schemas (Abbe et al., 2009). It can be argued that this sense-making process can incorporate mentally running through past events to help inform what can be done in the present and anticipate the future. Therefore, if a clinician is familiar with a certain group of people, having a certain presentation, and being given a particular diagnosis, then it is possible that their personal construction (or schema) may influence the diagnosis given to the individual, in the context of their background. Thus, in addition to social context, there is a likelihood that experiences or decisions are influenced by what is learned ('conditioned response') and how that is represented cognitively ('schemas', 'personal constructs'). This includes how clinicians are trained and ways in which they are taught to make sense of the presenting difficulties of others.

It is therefore important to highlight the usefulness of familiarity of the context in which the client's distress may manifest itself. In relation to the function of familiarity in practice, a study by Hickling et al. (1999) found that, to some degree, there was a discrepancy between a Jamaican psychiatrist and a British psychiatrist in regard to the diagnosis of schizophrenia given to clients from a black ethnic minority group. The study indicated that the Jamaican psychiatrist had access to information that enabled him to place the symptoms expressed by the clients' 'into their cultural context' prior to the diagnosis (Hickling et al., 1999, p. 284).

1.6. Systematic Literature Review

The literature discussed so far highlights that there are some discrepancies in how mental health is understood in different cultures. However, it emerges that this can be a challenge for clinicians who work within models that may not fit within the alternative explanations that clients may present with. This can lead to uncertainties within practice and often addressing these uncertainties means applying the (familiar) biomedical model. Though the biomedical model provides a structure that assumes universal treatment for all clients, this can have implications in clinical practice regarding how the presenting problems of clients of diverse ethnic backgrounds are adequately addressed. The literature thus far offers some explanations of how clients and lay people make sense of their mental health experience, but does not offer much explanation of how clinicians make sense of clients whom they see and their understanding of some of the issues these clients present with.

In the next section, I shall present a systematic literature review of studies that consider clinicians' construction of clients and how clinicians construe people who are similar and different to themselves.

1.6.1. Search Strategy

The search strategy initially focused on papers concerning clinicians' construction of clients from different cultural backgrounds. There were very limited relevant papers that focused on clinicians' constructions. Therefore, the search was expanded to include clinicians' construing of clients generally. The terms were identified through previously read literature, through identification of related terms in the literature as well as databases for literature searching and suggestions by a research supervisor (Table 1 shows the summary of the search terms). The terms were truncated where appropriate (e.g. constru* = construct, constructs, construction, construal) in order to capture all relevant papers.

Table 1: Search Term Used in Systematic Literature Search

Clinician	Construction	Client	Cross-cultural
Clinician*	Construction	Client*	“Cross-cultur*”
Professional* AND	Construct* AND	Patient* AND	Culture*
Staff	View*	Service user*	Cultural
Practitioner	Perception*	“Mental health*”	“Cultural background*”
Psychiatrist*	Belief*		Diverse groups
Nurse*	Constru*		Ethnic*
Psychotherapist*	Understand*		Transcultur*
Psychologist*			
“Trainee Psychiatrist*”			
“Trainee staff”			
“Staff trainee*”			
“Mental health*”			
“Health professional”			

The search for relevant papers was carried out in Scopus, PubMed and Science Direct.

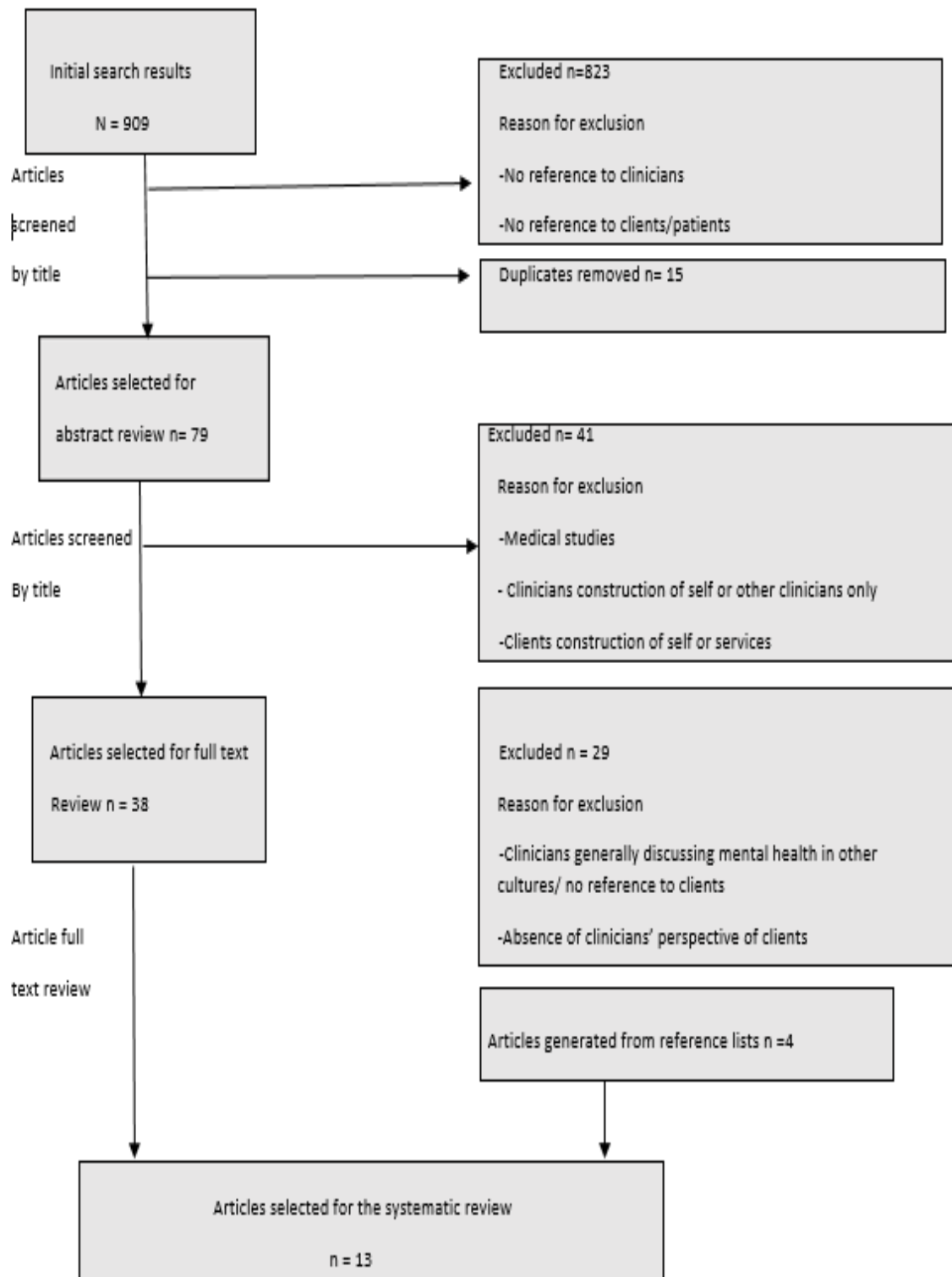
Google Scholar was used as a reference to find other citations of relevant papers. The search generated 909 papers. The titles of the papers were reviewed and papers were excluded if there was no reference to understanding or construction of clients or patients in different cultures or those accessing mental health services, generally. After accounting for duplicates,

79 abstracts were reviewed and papers were excluded based on the inclusion and exclusion criteria (see Table 2). Papers were excluded if they did not include clinicians' construction of clients and if the study was not in English. The remaining 38 papers were read in full text and it was noticed that the majority of the papers were of clinicians generally discussing mental health in different cultures or focusing on clients' construing of themselves and not necessarily the clinicians' constructions or construing of clients. The reference lists were also searched to identify papers that were not generated in the database. Ultimately, 13 papers were identified for review, which has been summarized in the flow chart shown in *Figure 1*.

Table 2: Literature Search Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Constructions of clients with varied mental health presentation, across the lifespan by clinicians working in a range of mental health services	Research in general medicine or health
Construction of clients, in the context of constructions of self and/ or of significant people in the clinicians life	Clinicians' construction of themselves or clinicians only, without including their constructions of clients
Constructions of clients cross-culturally in order to consider studies conducted internationally and not just in the UK as well as account for possible cultural variation	Clients' construction of clinicians
	Clinicians' constructions of services
	Clients' construction of services
	Clinicians' constructions of their own work
	Clients' constructions of clinicians' work

Figure 1: Systematic Literature Review Flow Chart



1.6.2. Summary of findings and quality review

The literature review was conducted in search of papers that covered clinicians' constructions of clients from different cultural backgrounds as well as the ways in which clinicians construe clients. To broaden the review, studies that looked at a range of staff members in all mental health settings were considered. The time period covered was from 1970 to the present day because there was very little research on how clinicians construe clients of different cultures. A number of studies looked at mental health constructions in different cultures. Other studies explored clinicians' constructions of themselves within their clinical work as well as during the process of training. Additionally, some studies focused on clients' constructions of themselves and how they make sense of their mental health problems. These studies seemed relevant to the general topic, but did not fit with the criteria for the current systematic literature review and they were therefore not included (summary of the research papers can be found in Appendix A).

Thirteen papers were included in the literature review. Five relevant papers were found that explored clinicians' constructions of clients from various ethnic backgrounds. Eight papers focused on studies that looked at clinicians' construing of clients, in the context of the clinicians' construing of significant people in their lives as well as themselves.

This section will be divided into two parts. The first part will look at the construction of clients of different cultural backgrounds by clinicians. The second part will look at construing of clients by clinicians, in the context of the clinicians' construing of significant people in their lives as well as themselves. Given the diverse methodologies of the papers included in the systematic literature review, different quality criteria guidelines were used to review, critically assess and appraise the quality of the papers. Thus, I will integrate the quality appraisal of each paper in the discussion of the findings by briefly highlighting points from

the appraisal criteria used for each study (complete appraisal of each study can be found in Appendix B)

1.6.2.1. Part 1: Clinicians' constructions of clients from different cultural backgrounds

Five papers were included in this part of the literature review. One of the studies was conducted with psychiatrists in New Zealand (Bush et al., 2005) and another study was carried out in Africa with psychiatrists from South Africa, Uganda, Nigeria and Ethiopia (Cooper, 2016). The three remaining studies (Biswas et al., 2016; Neimeyer and Fukuyama, 1984; Rastogi et al., 2014) were conducted in the United States with clinicians from diverse ethnic backgrounds. As there are limited papers in this part, I will give an overview of the findings of each study, according to the themes that were identified

I will first look at the study that explored clinicians of the same ethnicity's construction of clients of a specific ethnicity different to themselves. I shall then move on to the papers looking at clinicians' constructions of clients of their own ethnicity. This will be followed by a study of clinicians of diverse ethnicities' constructions of a group of clients from one specific ethnicity. The last paper in this part of the review will look at a clinician's constructions of clients of different ethnicities.

Construction of a specific client ethnic group different to the clinician's ethnicity

Bush et al. (2005) conducted a study that explored psychiatrists', of Western European background in New Zealand, understanding of themselves as well as the notion of the self by people of Samoan descent, who are a minority population in New Zealand. Three focus groups were conducted that aimed to find out the psychiatrists' view of themselves in the context of their psychiatry practice, the difference between their sense of self and that of the

Samoan people and the effects that these have in their clinical practice with the Samoan clients.

The study showed that the psychiatrists' views of themselves were different to their perceptions of the Samoans' views of themselves. The psychiatrists predominantly viewed themselves essentially as individuals; though some viewed their shared identity and family history as part of their individual selves. This contrasted with the psychiatrists' view of the Samoan people as they perceived the Samoan view of self as relational. Additionally, some psychiatrists described a sense of confusion as they had limited understanding regarding the relational self. Furthermore, the findings showed that there was considerable difference between the psychiatrists' perspective on religion and spirituality and how this was perceived by the Samoans. The findings indicated that even though religion was considered in psychiatry practice, it was often not viewed in a spiritual way but rather conceptualised in a secular way. The psychiatrists acknowledged that this secular way of thinking did not fit with the Samoan idea of self and recognised the need to be thoughtful of spiritual matters.

The psychiatrists perceived the Samoans' view of the self as holistic, which they described as a struggle to incorporate within their clinical work, given the reductionist way in which they practiced. Much more, the findings indicated that psychiatry was viewed as universal, which meant that the psychiatrists perceived mental health to be the same in spite of the ethnicity or cultural background of the client. Some psychiatrists described a feeling of perplexity regarding the Samoan view of the self in relation to others.

The difference in cultural views was said to create uncertainty in regard to the extent to which the psychiatrists felt able to apply the European concept of psychiatry to the Samoan people. As such the psychiatrists in the study suggested a need to include families and cultural workers in their work with the Samoan people.

In evaluating this study using the Critical Appraisal Skills Programme (CASP, 2018), it can be said that a particular strength of the research was that it helped to suggest ways to improve the mental health practice and the provision of service to the Samoans. Though the researchers did not explicitly mention their own ethnicities, there was a Samoan researcher on the team to validate the Samoans' perspective. The focus group data was analysed using content analysis. This provided rich data that enabled the participants to explore ideas that came up within the group process, which they considered as a helpful learning process.

Construction of clients of the same ethnicity as the clinician

Another study that looked at the perspective of psychiatrists was that of Cooper (2016), which was conducted in public health settings with 28 psychiatrists from four African Countries. These countries were South Africa, Uganda, Nigeria and Ethiopia. Though all the psychiatrists were of African nationality, seven of them had been trained in Europe, five in the United States and the remaining sixteen were trained in Africa. The study applied a narrative approach to investigate the mental health treatment gap in Africa.

Cooper found that the psychiatrists' narrative was predominantly within the biomedical model and their views were heavily influenced by European ideas of mental health because most of the psychiatrists showed a preference for biomedicine. Cooper (2015) reported that the psychiatrists viewed biomedicine as modern and rational compared with the cultural practices and beliefs of the native people, which they perceived as regressive and embedded in superstition. In the context of the psychiatrists' inclination to the biomedical model, the psychiatrists pointed out that the gap in the treatment of mental health problems in Africa was due to a lack of resources in mental health services, which they felt led local patients to seek non-Western traditional methods. The study suggested that most of the psychiatrists highlighted that 'people have no choice but to look elsewhere, to find other means, like holy

water sites or prayer sites' (Cooper, 2016, p. 210). It can be argued that the Cooper (2015) fails to acknowledge that religious practices such as the use of 'holy water' by faith healers are not specific to 'non-Western' or African traditions as they are widely practiced in Europe. More specifically, it can be said that practices such as the use of 'holy water' are embedded within the Christian faith, and were brought to Africa during the process of colonialization. Therefore, like the study by Bush et al. (2005), this study highlighted the relevance of spirituality regarding the local people's understanding of mental health. However, unlike the mental health service available to the Samoans, the psychiatrists across Africa highlighted a lack of access to resources as a barrier. They felt that novel ways of increasing access included training non-specialist mental health workers in primary care and community settings as well as working with traditional healers. However, these concepts were very much embedded in the biomedical model, which included diagnosis, psychotropic treatment and monitoring of medication, aspects of which they felt could be implemented by non-psychiatric health workers with guidance. Though psychiatrists indicated that they needed to work together with traditional healers, most of them viewed the practices of traditional healers as unsafe and that the healers were in need of education and supervision in order to promote referrals to psychiatry. However, other psychiatrists reported that traditional healers were apprehensive about interacting with psychiatrists due to fear of financial loss, if clients engaged with psychiatry services. Cooper (2016) interpreted these views as the 'colonial medicine's trope of Africa's traditional therapeutics, therapeutics which were incontrovertibly relegated to the realm of primitivism, degeneration and irrationality' (p. 213). Despite Cooper's interpretation, it can be argued that some traditional methods may be unsafe depending on the beliefs of the people. For example, though some may view the use of exorcism for people with epilepsy as historical, it can be said that there are some communities who continue to view people with epilepsy as being possessed by evil spirits.

For instance, though advances in knowledge in Europe have led us to understand epilepsy as a neurological condition, it can be seen that there are some parts of the world that continue to apply superstition to conditions such as epilepsy. For example, a community-based cross-sectional study by Teferi and Shewangizaw (2015) conducted in Ethiopia indicated that 33.5% of the respondents (who were from the general population) applied safe practices in treating epilepsy. It can therefore be argued that the remaining 66.5% may adopt unsafe practices, though this was not clearly stated in the study. The researchers suggested that this is likely to be due to attitudes, discrimination and stigma, which can influence treatment (Teferi and Shewangizaw, 2015).

It appeared that the psychiatrists also felt that the clients' and their families' lack of knowledge regarding mental health prevented them from engaging with mental health services. The psychiatrists described that often mental health problems are not viewed as illnesses by the clients and their families, but rather as a spiritual condition or a calling, which required spiritual intervention. Similar to the psychiatrists in the study by Bush et al. (2005), the clients' perceptions of mental health in a spiritual way appeared to be in conflict with the psychiatrists' view of the dominance of the biomedical understanding of mental health and illness. The psychiatrists expressed difficulty in changing the belief system of the clients as well as their families and therefore focused on improving mental health and accepting the diverse narrative.

One psychiatrist offering an alternative view point reported that mental health problems are personal experiences that the client attaches their own meaning to, which may result in uncertainty in the psychiatrist's own knowledge, especially when attempts are made to treat it in a generic or universal way. This is similar to the uncertainty described by the psychiatrists in the study by Bush et al. (2005) regarding the perplexity around the Samoans' view of themselves. Another psychiatrist offering a psychotherapeutic group suggested that the native

clients sought traditional healers because they provided meaning to their experiences and helped make sense of them, thus they were less interested in biomedical explanations of their illness. In addition, one psychiatrist spoke of the benefits in working with traditional healers, who can help expand on how the clients make sense of their mental health problems rather than assuming their practices are not as civilised as the biomedical model. Again, this is akin to the psychiatrists in the study by Bush et al. (2005), who suggested the inclusion of cultural workers and family. It can be argued that the suggestion that clients gain meaning and understanding of the presenting problem from working with traditional healers is in line with how others may view psychological therapy. For example, some service users may think that formulation, offered as a core part of psychological therapy, provides them with a better understanding of their presenting problem. On the other hand, others may feel that biomedicine provides them the explanation they require, especially when the presenting problem is embedded within medical understanding (such as organic disorders like Dementia). Therefore, where service users seek explanation for their presenting problem can be specific to their individual historical experience as well the problem they are experiencing and the mode of explanation that makes sense to them. Therefore, it may not necessarily be the case that a specific line of knowledge provides a better understanding than another.

In assessing the quality of the study by using the CASP (2018), it can be said that the researcher's own bias or position to the research, that may have influenced the interpretation of the study, was not made explicit. Additionally, it was not clear how the researcher sought ethical approval in the recruiting of the participants as most of the psychiatrists involved were previous clinical contacts and further recruitment was carried out using a snowballing technique. Furthermore, in evaluating the study it was not clear whether the data were analysed by another person and if the credibility of the findings, such as the validity of the responses, was checked. Nonetheless, the research clearly illuminated the subjective

experiences of the participants and took into account contradictory data. Additionally, the researcher highlighted that the study was modified in order to follow the psychiatrists' narratives.

Unlike Bush et al.'s (2005) and Cooper's (2016) studies that explored psychiatrists' constructions of clients in one specific continent, the study by Biswas et al. (2016) included psychiatrists from America and India. The study aimed to investigate whether there was a difference between the Indian and the American psychiatrists in how they perceived the most common mental health presentations of clients in their own native countries. The study was conducted using a survey.

The survey addressed questions around major mental health problems that included major depression, mania and psychosis. Additionally, symptom manifestations as well as barriers to accessing mental health services were explored. The findings showed that, compared to American psychiatrists, the Indian psychiatrists viewed insomnia and loss of appetite, in addition to somatic symptoms like pain, as more prevalent in symptoms of depression, whereas American psychiatrists perceived pessimism as significantly common in diagnosing depression. There was no difference in how psychiatrists from both parts of the world perceived fatigue, self-harming thoughts and suicidal thoughts as well as concentration and attention difficulty in depression. American psychiatrists were more inclined to notice reduced pleasure in activities in depression, even though this symptom was also noted by the Indian psychiatrists.

Regarding clients presenting with mania, the Indian psychiatrists were more likely to perceive behaviours such as anger and aggression than American psychiatrists. Though both groups reported pressured speech as one of two most common symptoms of mania, American psychiatrists viewed it as more common. The other common symptom in both cultures was

reduction in sleep. Regarding the diagnosis of psychosis, both groups viewed symptoms such as lack of insight, paranoia, delusions and auditory hallucination as common in both cultures, with visual hallucinations and peculiar motor movement perceived as least common in both cultures. Interruption in 'train of thoughts' was commonly viewed by the American psychiatrists whereas poor hygiene, and loss of interest in activities that involved social engagement as well as work were perceived by the Indian psychiatrists.

In terms of barriers to accessing mental health services, both groups noted that clients' difficulty to admit to the problem as well as the lack of social and financial support played a role. In the Bush et al. (2005) and Cooper (2016) studies, lack of engagement with the biomedical model was more salient rather than difficulty in admitting to the problem. Whilst the American psychiatrists viewed the abuse of substances and being homeless as barriers, the Indian psychiatrists perceived the lack of access to mental health services and family embarrassment as a barrier, which is akin to the Cooper (2016) study. Like the psychiatrists in the Cooper (2016) study, the implication of the study included training non-specialist health care workers in order to increase access to services, given the limited resources, especially in India.

Using Roever's (2015) appraisal tool to critically analyse the quality of the study, it can be said that it was not clear what format the questionnaires took, specifically whether there were open questions other than the rating scale. Additionally, it was reported that two of the participants were excluded for using the same rank number on multiple questions; however, this did not affect the results, given that there were 99 remaining participants', whose data were analysed. As the questionnaires were completed by the psychiatrists in their own time, it is not clear how response biases were reduced and how the accuracy of the data was maintained. Nevertheless, the research data led to important concluding remarks on how the findings can help to identify factors in patterns of diagnosis in different cultures and how this

can help psychiatrists to understand clients from diverse cultural backgrounds when working cross-culturally.

Construction of a specific client ethnic group by clinicians of diverse ethnicities

Contrary to the studies that have been discussed so far that have explored psychiatrists' perceptions of clients, the studies that will be discussed from here on will look at the perceptions of clinicians who are non-psychiatrists. Rastogi et al.'s (2013) study used focus groups to explore the clinicians' perspectives of South Asians in the United States (US), who present with mental health problems and the barriers that prevent them from accessing treatment. Twenty-nine clinicians were involved in this research: nineteen were born in India; three were born in Pakistan; and the remaining six, who were born in the US, included four clinicians from White European background, one African American and one South Asian. They consisted of physicians, nurses and counsellors with a minimum of five years' experience of working with clients from a South Asian background. Four focus groups took place in a period of a month with seven to eight participants within each group. The focus groups explored common mental health symptoms and barriers to treatment as well as what can be done to facilitate treatment.

The clinicians reported that younger clients from a South Asian background presented with different mental health issues to the older generation. They generally found that the distress of the younger generation was associated with stress of wanting parental approval, struggle with independence, and struggle to be accepted by Western peers. Additionally, the clinicians reported that parental disapproval of engagement with mental health services led younger South Asians to not seek help. This is similar to the suggestions in the study by Biswas et al. (2016) and Cooper (2016) that families act as barriers to engagement with mental health services in a non-Western context. On the other hand, the clinicians in this study reported that

the older generation in the South Asian community did not seek help unless referred by primary care services and often reported symptoms such as pain in various parts of the body as well as lack of sleep when they did present at mental health services, even though they may be experiencing major mental health problems. Furthermore, they alluded that the older clients often presented to services when the mental health problem was severe. The findings also indicated that male spouses did not approve of their wives receiving treatment from services because they did not believe in it, even though they sought to be a part of the process of treatment planning. This, in addition to disclosure of abuse, led clients to disengage from services.

The findings also suggested that the medical model was preferred by clients and these clients did not question the physician, which is contrary to the narrative given by the psychiatrists in Cooper's (2016) study. On the other hand, some clients challenged the physician's decision, especially those clients who were experts in their own profession. The study also suggested that the barriers that affected engagement with services included concerns with stigma and denying of mental health problems; not understanding and accepting treatment, especially psychotherapy as they preferred to take medication; fear that confidential information will be lost or leaked to people within their close circle; not adhering to medication due to side effects; over-involved parents; and lack of finances. Some of the reported barriers to engagement with services are similar to the barriers reported by the Indian psychiatrists in the study by Biswas et al. (2016), such as the denial of the problem and lack of finances. In terms of encouraging South Asians to be assessed and treated, the suggestions included providing education to clients on mental health problems, applying the biomedical model as that is the most preferred for this group of clients, comprehensively completing a medical evaluation prior to mental health diagnosis, creatively fitting treatment strategies to clients and being thoughtful of the clients' cultural and religious practices as well as beliefs.

It can be argued that this study only focused on clinicians report of one group of people and that the client population chosen was not compared to another sample. Therefore, the findings cannot be regarded as specific to the population studied and it can be argued that they represent cultural stereotypes. Thus, other cultures and communities may experience similar struggles, such as young people wanting approval from parents, seeking independence and older generation not seeking help unless referred. Also, with reference to everyday practices, it can be said that somatization of problems is not necessarily specific to the Asian community but there are individuals from most cultures and communities who may report their distress in a somatic manner (Bagayogo, Interian and Escobar, 2013).

In using CASP (2018) to assess the quality of the study, the researcher addressed how their own ethnicity (coming from Indian origin) may have impacted their interaction with the majority of the participants (who were also of Indian origin). As such, they minimised 'over-identification' with the participants by sticking to the focus group question guide. However, it was not clear how contradictory data was accounted for in the study. On the other hand, the research findings added to the knowledge of how services can be improved for people of South Asian background.

Construction of diverse client ethnic groups by a clinician

Neimeyer and Fukuyama's (1984) study was conducted using a different methodology to the four studies discussed so far. They aimed to develop a Cultural Attitude Repertory Technique (CART) that looked at the content and structure of a person's system of cultural constructs. The CART consisted of groups of people from twelve different cultural backgrounds (also known as elements). All the range of ethnicities were not highlighted in the study but examples of cultural groups considered were Black males, White females, Latin females as well as Native-American males. In order to determine how people from different cultures

were construed and to elicit the characteristics of these groups (also known as constructs), three of the elements were shown to the respondent and the respondent was asked in what way two of them were alike and different to the third.

In this study, a single case study was used to look at how a twenty-seven year old, white female, who was a graduate student undertaking counsellor studies, construed clients of different cultures, using the CART. The CART was administered to the participant before being taught a module on issues regarding the distinctive values of ethnic minority groups in the United States as these values influenced the counselling process. The findings on the CART before the teaching took place showed that the participant differentiated between 4 out of the 12 ethnic cultural groups and 2 groups of characteristics (constructs) emerged that could be used across the different cultures. The pre-test findings also showed that the participant's ability to flexibly view the cultural groups (integrate) across the characteristics (constructs) she had elicited was relatively low. Similarly, the degree of flexibility in applying the constructs across the different cultural groups was also low (integration). The findings following the teaching showed that there was an increase in the participant's differentiation between the cultural groups. She was able to differentiate between 9 out of the 12 groups of cultures. Additionally, 4 groups of constructs emerged that were used in differentiating between the cultural groups. However, the participant's ability to integrate cultural groups remained the same whilst the integration of the constructs decreased.

Atkins and Sampson's (2002) critical appraisal guideline for single case studies was used to evaluate the quality of this study. In using this guideline for evaluation, it can be said that the findings of this study can be used to inform cross-cultural work with clients of different ethnicities. Additionally, the study has to be tentatively generalised because it was a single case. Furthermore, it was not clear whether this study was a pilot that preceded further research. There was no evidence to show that bias was considered during the data analysis.

However, this study is a good start when considering how clinicians construe clients of diverse ethnic backgrounds.

Synthesis of the literature:

The literature in this part of the review highlighted clinicians' construction of clients. The clients construed were predominantly from non-Western cultures, which limits the generalizability of these findings to clients of Western cultures. The studies that explored the constructions of psychiatrists showed that they were more inclined to use a biomedical framework to make sense of mental health problems regardless of their ethnic background (Biswas et al., 2016; Bush et al., 2005; Cooper 2016). It appeared that there was often a lack of flexibility in how the biomedical model was applied, which made it difficult for some psychiatrists to conceptualise the alternative explanations of mental health problems that clients may present with.

More specifically, the psychiatrists often described feeling perplexed by the clients' explanations of their mental health problems, especially when embedded within spirituality and an interdependent way of living (Bush et al., 2005; Cooper 2016). One study suggested that clients often wanted to make sense of their mental health problems, but they felt that the biomedical model (diagnosis and medication) did not provide sufficient explanations and therefore often sought help from traditional healers (Cooper, 2016). On the other hand, another study suggested that the clients preferred the biomedical understanding of their mental health problems (though they would rather somatise the mental health problem) and often refused psychotherapy (Rastogi et al., 2014).

Some barriers to seeking help from mental health services were said to include denial of mental health difficulties, stigma and family embarrassment (Biswas et al., 2016; Rastogi et al., 2014). Other barriers highlighted were a lack of resources and finances (Biswas et al.,

2016; Cooper 2016) as well as the clinicians' lack of understanding of the alternative explanations of the mental health problems expressed by the clients' (Bush et al., 2005; Cooper 2016). It was suggested that factors that could improve clients' engagement with services included working alongside cultural workers and families (Bush et al., 2005); creatively working with clients in line with their interest (Rastogi et al., 2014); working in collaboration with traditional healers (Cooper, 2016) and training non-psychiatry staff to deliver care (Biswas et al., 2016; Cooper, 2016).

In regard to training, Neimeyer and Fukuyama (1984) highlighted that training regarding issues presented by people of different ethnicities can help clinicians differentiate between clients of different ethnic backgrounds. Perhaps this might be helpful within the psychiatry field as the biomedical model, embedded within diagnostic criteria, universalises the presenting problem of clients of different ethnicities. There appears to be a limited consideration of individual client cases within their own context. As shown in the Biswas et al. (2016) study, even though psychiatrists from different parts of the world use similar criteria to diagnose mental health problems, how they perceive these problems differs across cultures.

1.6.2.2. Part 2: Clinicians' constructions of clients generally, in the context of the clinicians' constructions of significant people in their lives as well as themselves.

Eight papers were included in this part of the literature review. Five of the studies were conducted in the UK (Bender (unpublished) cited in Tully, 1976; Blundell *et. al.*, 2012; Ralley et al., 2009; Hare et al., 2012; Woodrow et al., 2012) and three outside of the UK (Germany and USA: Kircaldy et al., 1993; Soldz, 1992; Soldz, 1989;). Two studies that were identified used the same participants and data set (Soldz 1989, 1992), but were both included because the aims and analyses had a different focus. It is important to note that all of these

studies used the repertory grid, which is a structured interview technique that was developed by Kelly (1955) and includes qualitative as well as quantitative methodologies. I will discuss the findings of these studies according to the themes that came up in the review.

Proximity of self and non-clients vs clients

Five studies explored how clinicians construed significant people in their lives and clients.

Three of these studies included mainly nursing staff (Blundell et al., 2011; Hare et al., 2012; Ralley et al., 2009; Woodrow et al., 2012). One study included clinical support workers in addition to nursing staff (Hare et al., 2012) and the other study involved a diverse group of professionals working in psychiatric hospitals (physician, nurses, psychologists, social worker, and hospital administrative team; Kirkcaldy et al., 1993).

Blundell et al. (2012) looked at the perception of nursing staff working with mothers with mental health difficulties in a specialist mother and baby unit (MBU), which provided both inpatient and day services. The mothers who were seen in this unit presented with depression, psychosis and personality disorder. A repertory grid was completed with 10 female nursing staff members who were recruited on a convenience basis. On the repertory grid, the participants were asked to elicit the following clients: clients with depression, clients with personality disorder, clients with psychosis, client perceived as a good mother, client perceived as a bad mother, a client with whom a good relationship is formed and a client with whom a bad relationship is formed. They also had to elicit significant people in their lives, which included: a mother known personally with no history of mental health. The participants were then shown titles of three of the people they had elicited and asked in what way two of them were alike but different to the third. In addition to the clients and significant people, the participants also had to consider themselves when looking at ways in which people were alike and different. The staff team reported close proximity to mothers whom they knew personally

and did not have a history of mental health problems, which means that they saw themselves as similar to this group. Nonetheless the study noted that 50% of the nursing staff rated themselves similar to clients, even though with the range of clients elicited it was not clear which clients these staff members construed themselves as similar to. Using the Effective Public Health Practice Project (EPHPP, 2009) quality assessment tool to appraise this study, it can be said that the sample was chosen on a convenience basis, which increases the possibility of selection bias.

Similar to the study by Blundell et al. (2012), the findings in the Kirkcaldy et al. (1993) study indicated that the nurses' descriptions of themselves were closely related to their descriptions of the patients. This study was conducted in a child and adolescent psychiatry clinic, where eleven participants were randomly selected to match roles that had already been decided on the repertory grid. These roles titles consisted of physician, psychologist, remedial teacher, medical technical assistant, physiotherapist, nursing and care personnel, occupational therapist, social worker, administrative personnel, parents of the patient and the child (patient). The authors elicited similarities and differences between these roles from each participant. Their findings showed that although nurses identified themselves closely with the patients and the parents of the patients, physicians viewed themselves as distant from the patients and the parents of the patients.

In evaluating the study with the EPHPP (2009), though Kirkcaldy et al. (1993) randomly selected members of staff to complete the repertory grid (a more robust method compared to the convenience sampling used by Blundell et al., 2011), it can be said that the findings from the small, heterogeneous sample may not be generalizable.

The study by Ralley et al. (2009) looked at the construal of White British staff working with clients with psychosis who also misuse substances. The study involved twelve nursing staff

who worked in an inpatient ward, primarily with clients who were experiencing schizophrenia. Participants were to elicit ten people who fitted with specific role titles, which included colleagues, clients, people the participant knows personally in their life and the participant's self. The study indicated that staff members construed themselves as dissimilar to the clients but similar to colleagues, acquaintances (not using substances) and an 'ideal' client. Additionally, clients were construed as dissimilar to people whom the participants construed themselves as similar to, which included colleagues, known acquaintances and a hypothetical ideal client.

Assessing the quality of this research with the EPHPP (2009), it was noted that the study reported that 3 out of the 12 participants were not able to elicit a 'client with a mental health problem other than psychosis', which was one of the role titles that all participants were required to elicit. Additionally, three participants were not able to provide all 10 constructs (that is, the similarities or differences between the people who had been elicited). Though the study states that three participants were excluded it is not clear which three participants were removed. Even though generalisability of the findings was already limited by the exclusion of data, the inclusion of grids with missing data would have confounded the results.

Like the study by Ralley et al. (2009), Hare et al.'s (2012) study of clinicians working with clients with intellectual disability showed that the majority of the participants (12 out of 14) saw themselves as different to clients. Even though the Hare et al. (2012) study consisted of a small sample size of 14 clinical staff, the findings were supported with qualitative information that included the participants' subjective perspectives, which provided richness to the data. Additionally, the validity of the responses was checked by the participants and confirmed.

These studies have been helpful in understanding the extent to which staff differentiate themselves from clients. It will now be of interest to examine the variability in the construction of different clients.

Variability in staff constructions of different clients

Some studies reported differentiation within the client domain compared with the non-client domain. Bender's (unpublished; cited in Tully (1976)) study that was conducted with twelve social workers in the UK suggested that the client constructs elicited from the social workers were independent of each other. Tully suggested that the differentiation in the client constructs could be a result of the distinct characteristics of their psychiatric presentations, which did not correlate with one another. Similar findings were seen in the study by Blundell et al. (2012), who showed that there was variability in the way in which clients with depression and those with psychosis were construed by participants. Thus, it can be said that these client groups were construed as independent of each other. Additionally, it appears that the clinicians' construed clients differently in terms of which group they found most challenging to work with. For example, the clinicians' often construed clients with a diagnosis of personality disorder similarly to the clients with whom they have a difficult relationship (Blundell et al., 2012).

However, it is difficult to appraise Bender's study as it is an unpublished study reported in Tully (1976). Therefore, the findings reported need to be referenced with caution.

Additionally, it is likely that the findings are not generalizable as the limited information provided suggests that they were derived from a sample of 12 social workers who worked in a specific mental health department in London. Nonetheless, it was one of the early studies that provided insight into clinicians' construal of clients and acquaintances.

Similarly, studies such as that of Woodrow et al. (2012) also indicated a variance as there was a difference in the way that staff perceived clients diagnosed with anorexia nervosa, who purged their food and those who restricted food. The participants in this study consisted of 14 clinicians from nursing background, who had to construe 8 groups of clients (who were described in different ways but were all inpatients with anorexia nervosa). Additionally, they construed their ideal client as well as their ideal self. Their findings supported Tully's (1976) interpretation of Bender's study that characteristics of the psychiatric label that clients are given can play a role in the variability of the clinicians' construal of the clients.

In evaluating Woodrow et al.'s (2012) study with the EPHPP (2009), it was observed that they implemented a 'self-selecting' process to recruit participants, which increased the possibility of a selection bias. Nonetheless, the study highlighted that the differences that exist between clients with a diagnosis of anorexia nervosa (who purge and those who restrict) have not been recognised by the diagnostic manual, ICD-10, which is commonly used in the UK for diagnosis. Thus, the findings are helpful in identifying new areas where research is necessary.

Soldz's (1989, 1992) study carefully attempted to eliminate the heterogeneous psychiatric presentation of the clients by asking participants to consider clients with non-psychotic diagnoses, which was also done, in part, to include clients who were not vastly different from the participant's acquaintances. In spite of this attempt, Soldz still found that there was a degree of differentiation within the client constructs. Therefore, it appears that the majority of the clinicians who participated in these studies perceived the client groups as consisting of unique individuals. However, the acquaintance group was seen to be more similar to each other.

Negative perception of clients and classification or psychiatric terminology used

In the study by Ralley et al. (2009), it appeared that participants construed clients who misused substances more negatively than they construed significant people in their lives who misused substances. Furthermore, even though participants construed clients as dissimilar to themselves and acquaintances (who did not misuse substance), they construed acquaintances who misused substances as more similar to clients without psychosis or without substance misuse.

The above findings are similar to that of the Blundell et al. (2012) study, which found that people with personality disorder were construed as similar to people with whom participants found it difficult to have a relationship with. The clients with personality disorder were construed more negatively, with one description portraying this group of clients as ‘selfish and you give them attention because you don’t want them to harm themselves, it is a risk that you can’t afford to take’ (p.8). With the mention of ‘risk’, it appeared that these descriptions were clinically informed. The study also showed that the descriptions given to clients with psychosis were associated with behaviours and difficulties linked with their mental health rather than with individual characteristics. Additionally, the majority of these clients were construed towards the least preferred poles (or direction) of staff members’ constructs. Unlike the construction of individuals with personality disorder, it was observed that the descriptions of individuals with psychosis and, even more so, depression, were varied and not always negative or medically classified.

The study by Hare et al. (2012) of staff working with people with intellectual disability indicated that the clients’ ability to control or not control their challenging behaviour was linked with how they were clinically perceived. They showed that clients who were thought to be in control were construed more negatively (with less focus on clinical attributions but

rather on individual characteristics such as ‘purposely upsetting people’). On the other hand, those who were viewed to not be in control of their behaviour as a result of physical or mental health problems were construed as having high needs and were less negatively described. Additionally, it appeared that the clients who were perceived to have a permanent or unchanging challenging behaviour were often perceived to have a likely diagnosis, such as having a personality disorder. However, behaviours that seemed to be modified as a result of medical and psychological intervention were viewed to be temporary. It therefore appeared that how stable the behaviour of the client was played a role in the staff member’s construal.

Similarly Soldz’s (1989) study indicated that the participants often construed clients in relation to emotional stability more than acquaintances. A re-analysis of the same data and results by Soldz (1992) indicated that clinicians construed clients negatively, in spite of asking them to think of clients who were non-psychotic. The high significance in their findings was an indication that clients were often construed negatively regardless of the severity of the mental health difficulties or presentation.

In the evaluation of Soldz’s (1989, 1992) study using the EPHPP (2009), it can be said that the study had a moderate sample size of 47 participants recruited from a range of sites. It is not clear how the study was advertised and whether the participants were recruited by convenience. Additionally, it is not certain how the variability in the participants’ age (ranging from 24-64 years old) and length of experience (ranging from 1-35 years) was controlled during the design of the study and analysis. Nevertheless, the findings from the study add to the body of research that looks at the different systems that clinicians use in construing clients.

Synthesis of the literature

The studies discussed in this part of the literature review showed that there was more differentiation in the construal of clients than of acquaintances or people similar to the participant (which were often clustered together). Additionally, most of the studies also indicated that similarities or differences often linked with how positively or negatively the clinicians' viewed the clients'. Not only were those who were viewed similar to the clinician's self or acquaintances viewed positively, but they were also less likely to judge this group of people on their mental, emotional and physical stability or instability. Again, clinicians appeared to position themselves in close proximity to people who were non-clients and similar to themselves and often viewed this group as less challenging or less difficult to deal with.

A number of studies indicated that clinicians have an 'individual' way of construing clients. It is likely that personal experiences of clinicians may have influenced their views of clients. Woodrow et al. (2012) suggested that the uniqueness of each clinician in their construal of clients supersedes the diagnosis. This is in line with Kelly's view of the unique way in which we individually make sense of the world around us. Given this variability and the influence of personal experience, there seems to be a necessity to look at how clinicians from different backgrounds construe individual clients.

It was found in most of the studies that clinicians used a different system to construe clients and acquaintances (or themselves). Constructs appeared to be more pertinent when applied to the rating of the people (or elements) in the domain from which they were elicited than when used in the rating of the people (or elements) in the contrasting domain (Bender cited in Tully (1976); Soldz, 1989). For example, it is suggested that a construct elicited in the client domain may not be applicable to the acquaintance domain. However, Soldz (1989) also

suggested that some participants were able to apply a construct from one domain to another. This may be in line with the suggestion by Ralley et al. (2009) that participants who were 'more open and less stereotyped in their construal of individual clients' (p. 156) made the distinction between clients and non-clients less clearly. They suggested that it is likely that these clinicians had experienced clients (or people like the clients they work with) in a non-client context, which may normalise the clients' actions. This seems to suggest that familiarity may play a role in the distinctive way that clinicians may construe clients and non-clients.

Soldz (1989) highlights the implication of when a clinician uses different systems to understand clients and people in their personal life by referencing the Mishler (1984) study that found that medical 'interviews tended to be characterized by a systematic struggle between the medical diagnostic perspective of the doctor and 'lifeworld' perspective of the patient' (p. 110). Similarly, another study (Light, 1980) suggested that when there is conflict between the clinician's construing of the presenting difficulty and how the clients perceive their difficulty, 'the psychiatrists tended to ignore the content of the patients' complaints, interpreting them, rather, as indicators of psychodynamic conflict in the patients' (Soldz, 1989, p. 111)

Soldz's (1989) study showed that the extent of discrepancy between the client and acquaintance construct system appeared to be unrelated to demographics such as sex, age, years of clinical experience, degree and professional discipline, but did not consider the ethnicity of the clinicians or the clients. In the context of similarity, familiarity and understanding, it is possible that sameness or difference of clinician-client ethnicity and culture can play a role in the interaction and construal process.

1.7. Rationale for the current study

The literature reviewed addressed different ways in which clinicians from a range of cultures construed clients from different cultural backgrounds (e.g. Biswas et al., 2016; Bush et al., 2005; Cooper 2016) or their general construal of clients in relation to oneself and close relations (e.g. Hare et al., 2012; Soldz, 1989). Turner et al. (1994) suggested that the way in which people categorise themselves is context dependent and can therefore be variable. They highlighted that variability in 'self-categorisation' can exist at a 'salient level' (p. 456), when one compares oneself to people who are different to oneself as well as people one knows. Turner et al. (1994) assert that 'social identity tends to become more salient in intergroup contexts' (p. 456), which can lead to 'us' and 'them' categorisation.

Although there may be fluidity in the way that people categorise themselves, the notion of collectivism and interdependence that is frequently observed in non-Western parts of the world has been contrasted with the concept of individualism and independence in the Western context (Triandis, 2001; Fernando, 2014). This appeared to have implications on how people understood their mental health presentations (Fernando, 2014; Kleinman, 1978; Laungani, 1999; Opare-Henaku and Utsey, 2017), which at times did not fit with the biomedical conceptualisation that clinicians tend to apply to their understanding of mental health problems (Bush et al., 2005; Cooper, 2015). It appeared that such difference between the clinician's and client's understanding can have an impact on the diagnosis and treatment options offered (Alarcon, 2009). Additionally, it has been suggested that though clinicians, more specifically psychiatrists, may use similar criteria to diagnose mental health problems, how they perceive these problems differs cross-culturally (Biswas et al., 2016).

Although the literature reviewed addressed key issues surrounding the idea of difference and sameness, there appeared to be limited discussion addressing how clinicians from different

cultures and ethnic groups understand clients of diverse ethnic groups. Therefore, the current research aims to address this gap. This might help increase understanding and awareness of the processes involved when interacting with clients of different backgrounds, more specifically in relation to making sense of the presenting mental health problem and the treatment options considered.

It was highlighted in the literature that people often preferred individuals similar to themselves (Soldz, 1989; 1992). However, the studies discussed did not address how ethnic and cultural similarities and differences may influence this process. Therefore, one of the hypotheses in this study will explore how the participants construe clients of the same and different ethnic groups to themselves. In light of the previous literature, it can be predicted that participants will construe clients whom they share a similar ethnic group with as more salient and similar to themselves (Turner et al., 1994). In addition, it can be predicted that they will find clients of a different ethnicity difficult to understand as they may be more conflicted in their understanding of these clients (as shown in Bush et al., 2005).

Additionally, it can be assumed that if they perceive clients of the same ethnicity as similar to themselves, then they will construe these clients as similar to significant people in their personal lives, who they tend to view as similar to themselves (Blundell et al., 2011; Ralley et al., 2009; Soldz, 1989).

Even though previous studies (e.g. Soldz, 1989; 1992; Bender's unpublished study cited in Tully, 1976) have suggested that clinicians' construal of clients and significant people is different in terms of content of the constructs and how applicable these constructs are to the different domains, this process of construing has not been explored with psychiatrists.

Therefore, the second main hypothesis will address this.

Specific to the Biswas et al. (2016) study that suggests that there are cross cultural difference in how psychiatrists perceive clients' views of their problems, the final main hypothesis in the current study will explore this in the context of the participants' ethnic backgrounds (that is, European and non-European groups).

A Personal Construct Psychology (PCP) approach (Kelly, 1955) will be applied because, as shown in the studies discussed in the literature review, clinicians are likely to construct their own explanations and meanings of the presenting problems (perhaps influenced by both their personal and professional cultural experiences), which may influence the process and outcome in clinical practice. Bannister (2003) asserts that:

Our worlds are different, not simply because we have experienced or are experiencing different events but because we interpret differently the events we do experience.

What one person thinks is important another thinks is trivial; what one feels is exciting another feels is dull; ugly to one is beautiful to another. This central idea offers its own explanation for the mysterious but everyday fact that people respond to the same situation in very different ways. (p. 3)

1.8. Research Aims

The aims of the research were to:

- a. Find out whether psychiatrists from different ethnic groups construe clients of a similar ethnic background to themselves differently to those of different ethnic groups.
- b. Consider whether psychiatrists construe clients and people significant to them in different ways

1.9. Research Hypotheses

1.9.1. Hypothesis 1: Construing of own ethnicity versus construing of other ethnicity

1A. Participants will be likely to see clients of the same ethnicity as more salient than those of different ethnicity.

1B. Participants will be more likely to show an understanding of clients who are of the same ethnicity as themselves than those of different ethnicity.

1C. Participants will be likely to show less differentiation between themselves and clients of their own ethnicity than between themselves and clients of other ethnicities.

1D. Participants will be likely to show less differentiation between the ideal self and clients of their own ethnicity than between the ideal self and clients of other ethnicities

1E. There will be more conflict in the construing of clients of other ethnicities than in the construing of clients of the participants' own ethnicity.

1F. Participants will be more likely to apply constructs elicited from significant people (personal domain) to clients of their own ethnicity than to clients of other ethnicities.

1G. There will be no difference in the application of client constructs to clients of the participants' own ethnicity and to those of other ethnicities

1H. There will be a difference in the construction of clients of the participants' own ethnicity and those of other ethnicity in relation to the content of the constructs elicited

1I. Participants will be likely to construe significant people in their personal lives as more similar to clients of their own ethnicity than to clients of other ethnicities.

1.9.2. Hypothesis 2: Construing of clients in general versus significant people

2A. There will be more discrimination between the elements in terms of client constructs (elicited from triads of clients) than in terms of personal constructs (elicited from triads of significant people).

2B. There will be difference in the content of the constructs elicited from clients and from significant people in the participants' personal lives.

2C. Participants will be better able to apply personal constructs to significant people in their personal lives than to clients.

2D. Participants will be better able to apply client constructs to clients than to significant people in their personal lives.

1.9.3. Hypothesis 3: Participants of different ethnic groups' perception of how clients view their mental health problems and treatment options

3A. Participants from a non-European (non-Western) ethnic background will be more likely to include spirituality or religiosity in their perceptions of how clients of their own ethnicity view their presenting mental health problem than participants from a European (Western) background.

3B. Participants from a non-European ethnic background will be more likely to perceive that clients of their own ethnicity will view religious or spiritual assistance as a benefit than participants from a European background.

3C. Participants from a non-European background will be less likely to perceive that clients of their own ethnicity will view their presenting mental health problem in biomedical or somatic terms than participants from European background

3D. Participants from a non-European background will be less likely to perceive that clients of their own ethnicity will view biomedical intervention such as psychotropic medication as a benefit than participants from a European background

3E. Participants from a non-European background will be less likely to perceive that clients of their own ethnicity will view their presenting mental health problem in psychological terms than participants from a European background

3F. Participants from a non-European background will be less likely to perceive that clients of their own ethnicity will view psychological intervention as a benefit than participants from a European background.

Chapter 2: Methodology

2.1. Design

The research used a non-experimental, non-randomised design with a cross-sectional approach. In order to investigate the principal aim of the study, a within-subject design was used to compare how psychiatrists construed clients of their own ethnicity and those of other ethnicity. Additionally, a within-subject design was used to explore whether psychiatrists construed clients and people significant to them in their personal lives in different ways. The study also used between-subject design to explore whether European and non-European psychiatrists construe clients of their own ethnicity and those of other ethnicity in different ways.

2.2. Participants and Recruitment

The samples chosen for this study were Trainee Psychiatrists because psychiatrists often see all the clients who access mental health services. Additionally, they take lead medical responsibility and play an important role in the diagnosis as well as the treatment referral process. It appears that psychiatrists often act as a ‘gateway’ to the team and with an increasing diversity in the psychiatry population, the current research aimed to discover whether culture influences psychiatrists’ construal of clients and to explore the processes involved.

Table 3: Inclusion and exclusion criteria for recruiting Trainee Psychiatrists

Inclusion criteria	Exclusion Criteria
Trainee Psychiatrists	Medical trainees working in general medicine
Experience of working in mental health settings	Undergraduate medical students
Level of training included Foundation 1, Foundation 2, Core Training 1, Core Training 2, Core Training 3, Specialist Training 4, Specialist Training 5 and Specialist Training 6	

Following a number of consultations with Consultant Psychiatrists, the researcher was provided with contacts for academic institutes and meetings that Trainee Psychiatrists could be recruited from. Outlined in Table 3 are the inclusion and exclusion criteria for recruiting the Trainee Psychiatrists. An email was then sent to the administrators of the academic programmes to request for a time slot in order to organise a presentation (this included discussion around topics relevant to the research) of the research study to the Trainee Psychiatrists.

The presentation was carried out at three different academic settings in three different localities: Essex, Hertfordshire and London. In total, approximately 45 Trainee Psychiatrists attended the presentations. After the presentation, trainees were invited to take part in the study and they were asked to write down their non-NHS email addresses so that they could be contacted about the research, if they were interested. Approximately 25 trainee psychiatrists expressed an interest in taking part in the study.

All the trainees who expressed an interest were sent an email with information about the study and then given an opportunity to opt-in to take part in the study or withdraw, if they were no longer interested. In total, 20 trainees responded to confirm their continued interest; however a total of 17 trainees confirmed a date and time for participation and the remaining 3 did not confirm a meeting, even when followed up. Following a power calculation (using G Power; Erdfelder et al., 1996), an effect size of 0.7 was used, which suggested a sample size estimate of fifteen. The value of 0.7 was used since a Cohen's $D > 0.7$ is commonly seen in repertory grid studies (Tan and Hunter, 2002). In regard to the estimated sample size of fifteen, this estimate is supported by previous repertory grid studies (Dunn, 1986; Ginsberg, 1989).

As an incentive, participants were offered a presentation of the findings of the research and possible training on self-reflection when considering cultural competence within practice. Additionally, all participants who took part in the study were offered a research certificate for their participation.

2.3. Description of participants

There were seventeen participants in total, thirteen women and four men. The ages of the participants ranged between 26 and 55 years (mean = 32.18). There were eight participants from a white European background (7 British and 1 Cypriot), four participants from an Asian background (2 East Asians, 1 South-East Asian and 1 South Asian), and five participants from an African background (2 West Africans and 3 North Africans). Their minimum length of work experience was 3 months and the maximum was 108 months (mean = 27.47). Twelve of the participants were undertaking their core training (eight level 1 trainees, three level 2 trainees and one level 3 trainee). The remaining participants consisted of three specialist trainees (level 6) and two foundation level trainees. The majority of the participants worked in General Adult Psychiatry (10), with the remaining participants working in Old Age Psychiatry (3), Learning Disability (3) and a Children and Adolescent Mental Health Service (1, CAMHS). Eleven out of the seventeen participants had previous experience of working and living outside the UK, irrespective of their ethnic background.

2.4. Measures

2.4.1. Repertory grid

The study used the repertory grid, which is a structured interview developed by George Kelly (1955). The repertory grid looks at the content as well as the structure of a person's construct system. In a grid there are elements (which can be people, objects and events that are construed) and constructs (the unique ways in which an individual attaches meaning to the

elements). The constructs are often described as ‘bipolar’ in that they are dichotomous, with two poles (emergent (explicit) pole and contrast (implicit) pole) that provide meaning to the whole construct (Sewell and Williams, 2001). For example, if an individual explicitly expresses ‘happiness’, it may be that they are implicitly aware of the feeling of ‘sadness’. According to Sewell and Williams (2001), the contrast or implicit pole can be described as the pole that holds the meaning of the construct. Repertory grid technique requires that the set of elements are defined, followed by eliciting a set of constructs pertaining to the elements, which is then followed by connecting each element to the constructs, such as rating them on a scale (Bell, 2003).

2.4.2. Rationale for choosing repertory grid methodology

Repertory grid technique appears to share similar aims to Interpretative Phenomenological Analysis (IPA) in that they both try to understand what the participant’s experiences are but also consider that the interpretation of the data can involve the researcher’s own constructions (Odusanya et al., 2017). However, the rationale for choosing the repertory grid is that it allows the researcher to implicitly identify the connections between the elements and the constructs that may not be explicitly communicated by the participant. For example, therapists’ tendency to view clients in a negative way and to perceive acquaintances positively in Soldz’s (1989) repertory grid study may not have been identified with an IPA methodology, where the participant may overthink and become concerned about the consequences of their responses. This could lead to a response based on social desirability (Podsakoff et al., 2003). Additionally, the repertory grid allows the researcher to look at the structure of the participant’s construing and to determine whether the constructs are ‘tightly’ (rigidly) or ‘loosely’ (more flexibly) organised (Winter, 1992). Thus, the repertory grid appears to be the most fitting methodology for this study because it looks at the implicit processes involved as well as the content of the personal meaning. Additionally, it allows the

researcher 'access to aspects' of construing that the participants may not be aware of, such as how the elements and constructs inter-relate (Winter, 1992, p. 32).

2.5. Procedure

The description of the procedure is divided into two parts. Part one covers the process that was involved in obtaining the supplied constructs for the repertory grid. Part two looks at the process of completing the repertory grid with the participants.

2.5.1. Part one – Developing the supplied constructs

During the presentation to the Trainee Psychiatrists at the three different localities, the group were invited to join in discussions around the following topics:

1. Factors that can affect the way we work with clients whom we perceive to come from a similar ethnic background.
2. Factors that can affect the way we work with clients whom we may perceive to come from a different ethnic background.
3. The major differences between clients from a similar ethnic background and those from a different ethnic background to the Trainee Psychiatrists.
 - a. In terms of the problems they present with
 - b. In terms of the ways they can best be helped

The responses generated in the discussion were written down and thematically analysed in order to examine the most frequent themes. This involved identifying, interpreting and reporting patterns within the data reported in the discussion (Clarke and Braun, 2014).

The themes that were generated were as follows:

- 1) The clients' likelihood to seek help

- 2) The clients' view of the presenting problem as medical (somatic), psychological or spiritual (religious).
- 3) The level of difficulty in understanding the client.
- 4) The psychiatrists' view of whether the clients consider that they would benefit from psychotropic medication, psychological therapy and religious or spiritual assistance.

These themes were then included in the repertory grid as the supplied constructs indicated in Table 4.

Table 4: The supplied constructs for the repertory grid

Emergent Pole	Contrast Pole
Likely to seek help	Unlikely to seek help
Views problem as medical/ somatic	Does not view problem as medical/ somatic
Views problem as psychological	Does not view problem as psychological
Views problem as religious/ spiritual	Does not view problem as religious/ spiritual
Difficult to understand	Easy to understand
Would benefit from psychotropic medication	Would not benefit from psychotropic medication
Would benefit from psychological therapy	Would not benefit from psychological therapy
Would benefit from religious/ spiritual asst.	Would not benefit from religious/ spiritual asst.

Winter (1992) noted that supplied constructs can be a 'robust' way of looking at how individuals are rated by others (p.31).

2.5.2. Part two – Repertory grid

Following the presentation, participants who expressed an interest in taking part in the study were emailed further information about the study. Once they confirmed their participation, a date, time and location for the interview was agreed. Participants were given the option of a face-to-face interview or online (Skype or Face-Time) interview. Six participants were

interviewed in person and eleven were interviewed online. The interviews lasted between 60 minutes and 90 minutes.

Prior to the repertory grid interview, each participant was sent (via email) an information sheet to read (see Appendix C) and a consent form to be signed if they agreed to take part in the study (see Appendix D). They also completed a demographic form (see Appendix E). The participants returned the signed consent form and demographic form before taking part in the interview.

For the elements part of the repertory grid interview (an example of the grid can be found in Appendix F), the following elements were elicited from the participants:

- 1) Six significant people in the participant's life. Significant people refer to people in the participant's personal life, including family and friends.
- 2) Two clients whom they have worked with from a white European ethnic background
- 3) Two clients whom they have worked with from a black African or Caribbean ethnic background
- 4) Two clients whom they have worked with from an Asian ethnic background.

The following were supplied elements:

- 5) Current self (how I am now)
- 6) Ideal self (how I would like to be)

The elements pertaining to significant people and clients (especially relating to ethnicity) were chosen based on their relevance to the current research. Additionally, as the study was a partial replication of Soldz's (1989) study, the elements considered in that study were taken into account for this study. The elements relating to the current self and the ideal self are

traditional elements used in most repertory grid studies (Fransella, 2003). Participants were asked to anonymise the elements by providing a pseudonym or initials.

Once the elements were established, constructs were elicited by using a 'triadic method' (Kelly, 1991). This process involved participants being presented with three elements (written on cards) pertaining to significant people or to clients. The participants were then asked some important way in which two of the elements were alike but different from the third. This was noted as the emergent pole on the grid. When participants did not give the contrast pole of the construct, they were then asked what they would call someone who is the complete opposite of the word elicited for the emergent pole. This was then noted as the contrast pole. This process of eliciting bipolar constructs is in accordance with Kelly's Dichotomy Corollary (Bell, 2003).

For this study, if the first triad consisted of elements of significant people then the second and third triad would consist of elements of clients, which would then be followed by two triads consisting of elements of significant people. The two triads that followed would contain client elements before the last triad of significant people elements was presented. This process was counterbalanced through alternation whereby if the first participant started with a triad of significant people, then the second participant would start with a triad of clients. The main reason for counterbalancing was to control for order effects on the structural properties of constructs. For each type of element (i.e. significant people or clients), each new triad was formed by replacing one element from the last triad with a new element of the same type.

Eight constructs were elicited from the participants and a further eight constructs were supplied (reported in part one). Each participant was asked to give each of the elements (including their current self and ideal self) a score on each of the constructs. The rating of the elements was carried out on a 7-point-scale, with 7 indicating the emergent pole of the

construct and 1 indicating the contrast pole. When participants were uncertain of what score to give the element, they either gave their best guess or a score of 4.

Each participant was verbally debriefed after the study and asked how they experienced the interview. They were then given written debrief information (see Appendix G) with contact details. All participants who took part in the study were sent a research certificate for their participation (via email).

2.6. Analysis of Repertory Grids

2.6.1. Grid measure extracted for analyses

The repertory grid can reveal the statistical relationships between constructs that can help understand the psychological connections between them (Bannister, 1965); similarities and differences between elements; and structural properties of the participant's construing (Bell, 2004a). These measures are described in Table 3.

Each repertory grid was analysed using IDIOGRID (Grice, 2004) and GRIDSTAT (Bell, 2004b) software.

2.6.2. IDIOGRID (Grice, 2004)

IDIOGRID is a computer programme used to derive measures from the repertory grid data, which carries out a Principal Component Analysis (PCA). This is a mathematical procedure that transforms the element and construct variables into fewer numbers of hypothetical components or factor variables that can then explain the possible variance in the grid data. This produces a two-dimensional graphical representation of an individual's construct system, which is also known as a grid plot. The first and second components are represented by horizontal and vertical axes respectively, and the elements and constructs are displayed according to their loadings on these components. Winter (1992) noted that if the first principal component accounts for a high percentage of variance then the participant's

construing can be described as ‘tightly organised and unidimensional’ (p. 34). It can also be said that the physical distance between elements in the grid plot represents the psychological distance between them. Elements in opposing quadrants are the most different and distant from each other.

Specific measures derived from IDIOGRID are detailed in Table 5, and are of the following types:

- Percentage sum of squares accounted for by elements: the higher this percentage, the more salient are the elements concerned;
- Distances between pairs of elements: the higher the distance (on a scale from 0 to 2), the more dissimilar is the participant’s construing of the elements;
- Percentage sum of squares for constructs: the higher this percentage, the more the constructs discriminate between the elements concerned.

2.6.3. GRIDSTAT (Bell, 2004b)

GRIDSTAT is a computer programme used for calculating the total conflict within each grid by taking into account the distance between an element and two constructs. For the purpose of this research, GRIDSTAT was used to explore hypothesis 1D, which can be seen in Table 5.

Conflict (Bell, 2004a) helps to examine the relationship between an element and constructs in order to assess the inconsistencies that may be present in construing. Conflict is said to be apparent when, firstly, an element is rated as close or similar to two construct poles, even though those poles are themselves distant or different. Secondly, conflicts can be evident when an element is rated as close or similar to one construct pole and different or distant

from another construct pole at the same time, even when these two poles can said to be close or similar (Bell, 2004a).

Table 5: Grid measures for analyses and how they relate to the hypotheses

Measure	Extracted from	Definition / Meaning	Statistics: Paired samples t-test or Wilcoxon signed rank test (comparison of score of own ethnicity vs. other) Independent t-test for exploration of other variables	Hypotheses
1. Average of percent total sum of squares accounted for by the clients of own ethnicity	Descriptive Statistics For Elements (IDIOGRID)	Measure of the salience of the elements and how meaningful they are	Compare measures 1 &2	1A. Participants will be likely to see clients of the same ethnicity as more salient than those of different ethnicities.
2. Average of percent total sum of squares accounted for by the clients of other ethnicities	Descriptive Statistics For Elements (IDIGRID)	Measure of the salience of the elements and how meaningful they are		As above

<p>3. Average distance of self (as now) from clients of own ethnicity (2 elements)</p>	<p>Element Euclidean Distances (Standardised) (IDIOGRID)</p>	<p>How much they see clients of own ethnicity as different to themselves (now)</p>	<p>Compare measures 3 &4</p>	<p>1C. Participants will be likely to show less differentiation between themselves and clients of their own ethnicity than between themselves and clients of other ethnicities.</p>
<p>4. Average distance of self (as now) from clients of other ethnicities (4 elements)</p>	<p>Element Euclidean Distances (Standardised) (IDIOGRID)</p>	<p>How much they see clients of other ethnicities as different to themselves (now)</p>		<p>As above</p>
<p>5. Average distance of ideal self from clients of own ethnicity (2 elements)</p>	<p>Element Euclidean Distances (Standardised) (IDIOGRID)</p>	<p>How much they see clients of own ethnicity as different to the ideal self</p>	<p>Compare measures 5 &6</p>	<p>1D. Participants will be likely to show less differentiation between the ideal self and clients of their own ethnicity than between the ideal self and clients of other ethnicities</p>
<p>6. Average distance of ideal self from clients of other ethnicities (4 elements)</p>	<p>Element Euclidean Distances (Standardised) (IDIOGRID)</p>	<p>How much they see clients of other ethnicities as different to the ideal self</p>		<p>As above</p>

<p>7. Average distance of all the significant people from the clients of their own ethnicity</p>	<p>Element Euclidean Distances (Standardised) (IDIOGRID)</p>	<p>How much they see clients of their own ethnicity as different to people significant to them</p>	<p>Compare measures 7 &8</p>	<p>1I. Participants will be likely to construe significant people in their personal lives as more similar to clients of their own ethnicity than to clients of other ethnicities.</p>
<p>8. Average distance of all the significant people from the clients of other ethnicities</p>	<p>Elements Euclidean Distances (Standardised) (IDIOGRID)</p>	<p>How much they see clients of their other ethnicity as different to people significant to them</p>		<p>As above</p>
<p>9. Total percent sum of squares for all the personal constructs (elicited from significant people)</p>	<p>Descriptive Statistics For Constructs (IDIOGRID)</p>	<p>The extent to which these constructs (personal constructs) discriminate between elements, thus how useful they are</p>	<p>Compare measures 9 & 10</p>	<p>2A. There will be more discrimination between the elements in terms of client constructs (elicited from triads of clients) than in terms of personal constructs (elicited from triads of significant people)</p>

<p>10. Total percent sum of squares for all the client constructs</p>	<p>Descriptive Statistics For Constructs (IDIOGRID)</p>	<p>The extent to which these constructs (client constructs) discriminate between elements, thus how useful they are</p>		<p>As above</p>
<p>11. Total midpoint (4) ratings for the clients of own ethnicity on personal constructs (constructs derived from significant people) divided by the number of 'own ethnicity' client elements. (2 elements)</p>	<p>Raw Data (REP GRID)</p>	<p>Inability to apply personal constructs to clients of own ethnicity</p>	<p>Compare 11 &12</p>	<p>1F. Participants will be more likely to apply constructs elicited from significant people (personal domain) to clients of own ethnicity than to clients of other ethnicities</p>
<p>12. Total midpoint (4) ratings for the clients of other ethnicities on personal constructs (constructs derived from significant people) divided by the number of 'other</p>	<p>Raw Data (REP GRID)</p>	<p>Inability to apply personal constructs to clients of other ethnicities</p>		<p>As above</p>

ethnicities' client elements. (4 elements)				
13. Total midpoint (4) ratings for the clients of own ethnicity on client constructs divided by the number of 'own ethnicity' client elements. (2 elements)	Raw Data (REP GRID)	Inability to apply client constructs to clients of own ethnicity	Compare measures 13 & 14	1G. There will be no difference in the application of client constructs to clients of own ethnicity and those of other ethnicities
14. Total midpoint (4) ratings for the clients of other ethnicities on client constructs divided by the number of 'other ethnicities' client elements. (4 elements)	Raw Data (REP GRID)	Inability to apply client constructs to clients of other ethnicities		As above
Measure: For each of the supplied constructs (8 in total) average rating given to clients of own ethnicity.	Raw Data (REP GRID)	How each supplied construct applies to clients of own ethnicity		1B. Participants will be more likely to show an understanding of clients who are of the same ethnicity as themselves than those of different ethnicities

<p>15.1. A. likely to seek help</p> <p>15.2. A. views problem as medical/ somatic</p> <p>15.3. A. views problem as psychological</p> <p>15.4. A. views problem as religious/ spiritual</p> <p>15.5. A. difficult to understand</p> <p>15.6. A. Would benefit from psychotropic meds</p> <p>15.7. A. Would benefit from psychological therapy</p>				<p>3A. Participants from non-European (non-Western) ethnic backgrounds will be more likely to include spirituality or religiosity in their perceptions of how clients of their own ethnicity view presenting mental health problems than participants from a European (Western) background.</p> <p>3B. Participants from non-European ethnic backgrounds will be more likely to perceive that clients of their own ethnicity will view religious or spiritual assistance as a benefit than participants from a European background.</p> <p>3C. Participants from non-European background will be less likely to perceive that clients of their own ethnicity will view their presenting mental health problem in biomedical or somatic terms than participants from European background</p>
--	--	--	--	---

<p>15.8. A.</p> <p>Would benefit from religious/ spiritual asst.</p>				<p>3D. Participants from non-European background will be less likely to perceive that clients of their own ethnicity will view biomedical intervention such as psychotropic medication as a benefit than participants from European background</p> <p>3E. Participants from non-European background will be less likely to perceive that clients of their own ethnicity will view their presenting mental health problem in psychological terms than participants from European background</p> <p>3F. Participants from non-European background will be less likely to perceive that clients of their own ethnicity will view psychological intervention as a benefit than participants from a European background</p>
--	--	--	--	--

<p>15. For each of the supplied constructs (8 in total) average rating given to clients of other ethnicities</p> <p>15.1. B. likely to seek help</p> <p>15.2. B. views problem as medical/ somatic</p> <p>15.3. B. views problem as psychological</p> <p>15.4. B. views problem as religious/ spiritual</p> <p>15.5. B. difficult to understand</p> <p>15.6. B. Would benefit from psychotropic meds</p>	<p>Raw Data (REP GRID)</p>	<p>How each supplied construct applies to clients of other ethnicities</p>		<p>As above</p>
--	--------------------------------	--	--	-----------------

<p>15.7. B. Would benefit from psychological therapy</p> <p>15.8. B. Would benefit from religious/spiritual asst.</p>				
<p>16. Total percentage conflict accounted for by clients of own ethnicity</p>	<p>GRIDSTAT</p>	<p>Conflict associated with the construing of clients of own ethnicity</p>	<p>Compare 17 & 18</p>	<p>1E. There will be more conflict in the construing of clients of other ethnicities than in the construing of clients of own ethnicity</p>
<p>17. Total percentage conflict accounted for by clients of other ethnicities</p>	<p>GRIDSTAT</p>	<p>Conflict associated with the construing of clients of other ethnicities</p>		<p>As above</p>
<p>18. Total midpoint (4) ratings for personal constructs (elicited from significant people) used to rate significant people</p>	<p>Raw Data (REP GRID)</p>	<p>Inability to apply personal constructs to significant people</p>	<p>Compare 18 & 19</p>	<p>2C. Participants will be better able to apply personal constructs to significant people than to clients</p>

19. Total midpoint (4) ratings for personal constructs (elicited from triad significant people) used to rate clients	Raw Data (REP GRID)	Inability to apply personal construct to clients		As above
20. Total midpoint (4) ratings for client constructs (elicited from clients) used to rate significant people	Raw Data (REP GRID)	Inability to apply client construct to significant people	Compare 20 & 21	2D. Participants will be better able to apply client constructs to clients than to significant people in their personal lives
21. Total midpoint (4) ratings for client constructs (elicited from clients) used to rate clients	Raw Data (REP GRID)	Inability to apply client construct to clients		As above

2.6.4. Content Analysis

A content analysis was conducted on the constructs elicited using the Feixas et al. (2002) 'Classification System for Personal Constructs (CSPC)'. CSPC consists of six coding categories, with forty-five sub-categories. This coding scheme was developed to code psychological constructs and the key categories were organised in a hierarchy (see Table 6). This means that should a construct fit in two categories then it is assigned to the category that is higher in the hierarchy. Additionally, both poles of a construct (emergent pole and contrast pole) are not coded individually, but they are coded as a 'bi-polar entity' (Green. 2004). Following the coding by the author of this research, a second rater also coded the constructs in order to assess inter-rater reliability and inter-coder agreement (Feixas et al., 2002). This analysis applies to the hypothesis (1H.) that states that there will be a difference in the participants' construction of clients of their own ethnicity and those of other ethnicity in relation to the content of the constructs elicited.

In order to decide which construct was applied to clients of a particular ethnicity, each grid was examined in order to note every construct on which the clients of the participants' own ethnicity and those of other ethnicities received an extreme rating. The ratings that were noted as extremes were 1 and 2 on the implicit pole and 6 and 7 on the emergent pole. In addition to this, the particular pole of the construct that was being applied to clients of a particular ethnicity was noted. The frequency of each of the extreme ratings that relate to the particular poles of constructs for clients of the participants' own ethnicity and those of other ethnicities was then calculated. For example, for the subcategory 'hardworking' (emergent pole) and 'lazy' (implicit pole), there were 5 extreme ratings for clients of the participants' own ethnicity as well as 5 extreme ratings for clients of other ethnicities on the emergent pole

and 1 extreme rating for clients of the participants' own ethnicity as well as 5 extreme ratings for clients of other ethnicities on the implicit pole. Additionally, the researcher explored whether there was a difference in the content of the constructs (elicited) from clients and from significant people in participants' lives (Hypothesis 2B.). This was done by calculating the frequency of each category of constructs (the six categories as indicated in Table 6) relating to the constructs elicited from the triads of significant people in the participants' personal lives and the triads of clients.

Table 6: CSPC categories and their hierarchical order

Area	Category		Area	Category
Area 1	moral		Area 2	Emotional
1A	good-bad		2A	visceral-rational
1B	altruist-egoist		2B	warm-cold
1C	humble-proud		2C	Optimist-pessimist
1D	respectful-judgmental		2D	balanced-unbalanced
1E	faithful-unfaithful		2E	specific emotions
1F	sincere-insincere		2F	sexuality
1G	just-unjust		2O	Others
1H	responsible-irresponsible			
1O	others			
Area 3	Relational		Area 4	personal
3A	extroverted-introverted		4A	strong-weak
3B	pleasant-unpleasant		4B	active-passive
3C	direct-devious		4C	hardworking-lazy
3D	tolerant-authoritarian		4D	organized-disorganized

3E	conformist-rebel		4E	decisive-indecisive
3F	dependent-independent		4F	flexible-rigid
3G	peaceable-aggressive		4G	thoughtful-shallow
3H	sympathetic-unsympathetic		4H	mature-immature
3I	trusting-suspicious		4O	others
3O	others			
Area 5	intellectual/operational		Area 6	values and interests
5A	capable-incapable		6A	ideological values etc.
5B	intelligent-dull		6B	specific values and interests
5C	cultured-uncultured		6O	others
5D	focused-unfocused			
5E	creative-not creative			
5F	specific abilities			
5O	others			

2.6.5. Demographic Questionnaire

The demographic questionnaire was designed by the researcher and considered the demographic information of the participants (see Appendix E). This questionnaire included the participants' demographic information noted in the Soldz (1989) study, such as age, gender and number of years of clinical experience, with further questions that enquired about ethnic origin, level of training, area or speciality they work within and experience of living and/or working in a different country.

2.7. Data Collation and Analysis on SPSS

A paired samples t-test or the non-parametric equivalent, Wilcoxon signed rank test, was used to analysis the hypotheses that required an analysis of within group difference. For hypotheses looking at between-group differences, one-way Analysis of Variance (ANOVA) was used, or its non-parametric equivalent, Kruskal-Wallis test. A parametric or non-parametric test was chosen on the basis of whether the data met parametric assumptions such as normal distribution. A one-tailed test was applied when a direction to the findings was hypothesised and when there was no direction or the findings were in the opposite direction to the predicted direction, a two-tailed test was used.

For associations between variables, the Pearson's correlation co-efficient test was used when the data met parametric assumptions, such as the normal distribution, homogeneity of variance and linearity. A non-parametric equivalent, Spearman's Rho correlation co-efficient, was used when the data did not meet the parametric assumptions.

Though it was initially planned that Chi-square test would be used to examine differences in the categories of constructs applied to particular elements, it was later decided that Fisher's exact test would be applied instead. This is because Fisher's exact test is the standard test to

use for low number statistics and provides an exact probability test whereas chi-square uses an approximation to a continuous distribution and is much less accurate for small number statistics.

2.8. Ethical Considerations

Ethical approval was sought and provided by the University of Hertfordshire , Health, Sciences, Engineering & Technology ECDA committee (Protocol number: LMS/PGR/UH/02879) in June 2017 (see Appendix H). In accordance with the ethical guidelines, each participant was advised of their right to willingly consent to the research and to withdraw from participation at any time, without providing their reason for doing so. Confidentiality was maintained throughout by anonymising the names of participants who took part in research and other Trainee Psychiatrists were not informed of those who had taken part in the research, neither were the Consultants who provided consultation on the study informed of the identity of the participants. The researcher was aware that the participants accessing implicit construct systems they were unaware of, may cause some distress and so a conversation around this was included in the debriefing. All participants were verbally debriefed on the purpose of the study as well as the main hypotheses. They were then given a written debrief that included the researcher's contact details.

2.9. Feedback

It was explained to the participants that feedback could not be given at the time of completion of the repertory grids. However, all participants were offered to attend a presentation of the research findings, upon final completion of analyses and write-up of the study. Each participant was made aware that they can request a copy of the written report, more specifically the published version or a summary of the results.

2.10. Service User Involvement

Consultation was sought from three Consultant Psychiatrists and a Trainee Psychiatrist. The consultation involved advice on the relevance of the study, how the trainee psychiatrists may respond during the interview process, the suitability of the methodology and its advantages and disadvantages as well as the appropriateness of the questions for discussion at the presentation. They also provided advice on where and how to access Trainee Psychiatrists and they contributed to this process by providing relevant contacts.

Chapter 3: Results

This chapter will be divided into four main sections. The first section will describe the within-subject differences of how participants construe clients of the same ethnicity as themselves and those of a different ethnicity to themselves. This part of section one is related to the sub-hypotheses outlined in hypothesis one. Additionally, this section will consider how participants construe clients and people in their personal life, who are referred to as significant people throughout the discussion of the results. This part of section one is related to the sub-hypotheses highlighted in hypothesis two. The second section will focus on the between-subject differences, by exploring participants of European and non-European background's construal of clients from the same ethnicity and those from a different ethnicity. Section two is related to the sub-hypotheses described in hypothesis three. The third section will highlight additional findings from the research. The fourth section will explore the plots of elements in construct space derived from the principal component analysis of the grid. Three case examples will be highlighted in this section, which will be supported with additional statistical findings. For the purpose of this report, in section one, clients of the same ethnicity as the participants shall be referred to as 'own ethnicity' and those of a different ethnicity to the participants shall be referred to as 'other ethnicities'. In section two, participants who are of a white European background are referred to as Europeans and those of an African and Asian background are referred to as non-Europeans. It should be noted that this is not the ideal way of grouping participants since neither group was ethnically homogenous. However, given the small sample size, it was difficult to consider each unique culture. The participants were therefore grouped into these broader categories because the numbers were uneven and too low for analyses to be conducted on specific ethnic groupings.

3.1. Section 1: Within-subject differences

3.1.1. Findings related to sub-hypotheses of hypothesis 1

Hypothesis 1: Construing of clients of own ethnicity versus construing of clients of other ethnicities

1A. Participants will be likely to see clients of the same ethnicity as more salient than those of different ethnicities.

Table 7: Comparing the salience of elements of clients of the participants' own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	8.60	3.32	-.20	.84
Other ethnicities	8.81	1.62		

n= 17.

A paired-samples t-test was conducted on the average of percent total sum of squares of the clients of own ethnicity and those of other ethnicities. This indicated that there was no difference in the salience of elements pertaining to clients from the same ethnic group as the participants and those from a different ethnic group. On average, clients who were of the same ethnicity as the participants were not more salient ($M = 8.60$, $SD = 3.32$), than clients from the other ethnicities ($M=8.81$, $SD = 1.62$). The difference, 0.21, 95% CI [-2.42, 2.00], was not significant $t(16) = -.20$, $p = .84$ (two-tailed), and represented no effect, $d = 0.08$

1B. Participants will be more likely to show an understanding of clients who are of the same ethnicity as themselves than those of different ethnicities

Table 8: Comparing the difficulty to understand clients of the participants' own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	4.47	1.55	-.18	.43
Other ethnicities	4.54	.90		

n= 17.

Additionally, it was found that there was no difference in the 'difficulty in understanding' (supplied construct) between clients who share the same ethnicity as the participant and those of a different ethnicity. A paired-samples t-test was conducted on the average rating on the 'difficult to understand' construct given to clients of the same ethnicity as the participant and those of a different ethnicity. On average, clients of different ethnicity to the participant (M= 4.54, SD = 0.90) were no more 'difficult to understand' than clients of the same ethnicity (M = 4.47, SD = 1.55). The difference, -1.25, 95% CI [-0.94, -0.79] was not significant $t(16) = -.18, p = .43$ (one-tailed) and represented a very small effect, $d = 0.05$

1C. Participants will be likely to show less differentiation between themselves and clients of their own ethnicity than between themselves and clients of other ethnicities.

Table 9: Comparing the distance of self (as now) from clients of the participants' own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	1.03	.18	.11	.91
Other ethnicities	1.02	.23		

n= 17.

The paired-samples t-test conducted on the average distance of the participants' self as they are now from the clients of their own ethnicity and those of the other ethnicities indicated that there was no difference in how they saw themselves in relation to clients of their own ethnicity and those from the different ethnic groups. On average, participants did not see themselves any more similar to clients of their own ethnicity ($M = 1.03$, $SD = .18$), compared with clients of other ethnicities ($M=1.02$, $SD = .23$). The difference, 0.009, 95% CI [-0.16, 0.17], was not significant $t(16) = 0.11$, $p = 0.91$ (two-tailed), and represented a very small effect, $d = 0.05$.

1D. Participants will be likely to show less differentiation between the ideal self and clients of their own ethnicity than between the ideal self and clients of other ethnicities

Table 10: Comparing the distance of ideal self from clients of the participants' own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	1.17	.20	.03	.97
Other ethnicities	1.16	.15		

n= 17.

Similar to the findings of distance of self from clients (own ethnicity and other ethnicities), there was no difference in how different participants see their ideal self from clients of their own ethnicity and those of the other ethnicities. On average, participants did not see the ideal self any more similar to clients of their own ethnicity ($M = 1.17$, $SD = 0.20$), compared with clients of the other ethnicities ($M=1.16$, $SD = 0.15$). The difference, 0.002 , 95% CI $[-0.11, 0.12]$, was not significant $t(16) = 0.03$, $p = 0.97$ (two-tailed), and represented a very small effect, $d = 0.06$

1E. There will be more conflict in the construing of clients of other ethnicities than in the construing of clients of the participants' own ethnicity

Table 11: Comparing the conflict associated with the construing of the clients of the participants' own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	14.67	4.37	-7.95	.001
Other ethnicities	27.87	4.18		

n= 17.

The paired samples t-test indicated that there was a significant difference in conflict associated with the construing of clients of own ethnicity and those of other ethnicities. On average, there appeared to be more conflict in the construing of clients of a different ethnicity to the participants (M=27.87, SD = 4.18) than in the construing of clients who shared the same ethnic background. The difference, -13.20, 95% CI [-16.72, -9.68], was significant $t(16) = -7.95$, $p = 0.001$ (one-tailed) and represented a very large-sized effect, $d = 3.02$.

1F. Participants will be more likely to apply constructs elicited from significant people (personal domain) to clients of their own ethnicity than to clients of other ethnicities

Table 12: Comparing the inability to apply personal constructs to clients of the participants' own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	1.00	.68	.45	.66
Other ethnicities	.91	.57		

n= 17.

The results indicated that there was no difference in the participants' ability to apply personal constructs (elicited from the significant people in the clinician's life) to clients of the same ethnicity and clients of other ethnicities. On average, participants did not apply personal constructs to clients of the same ethnicity (M = 1.00, SD = 0.68) any more (or less) than they did to those of different ethnicities (M = 0.91, SD = 0.57). This difference, .088, 95% CI [-0.33, 0.52], was not significant $t(16) = 0.45$, $p = 0.66$ (two-tailed), and represented a small effect, $d = 0.1$

1G. There will be no difference in the application of client constructs to clients of the participants' own ethnicity and those of other ethnicities

Table 13: Comparing the inability to apply client constructs to clients of the participants' own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	.65	.72	-.26	.80
Other ethnicities	.71	.51		

n= 17.

The findings indicated that there was no difference in participants' ability to apply client constructs to clients of the same ethnicity and clients of other ethnicities. On average, participants did not apply client constructs to clients of the same ethnicity (M = .65, SD = .72) any more (or less) than they did to those of different ethnicities (M = 0.71, SD = 0.51). This difference, -.06, 95% CI [-0.92, 0.22], was not significant $t(16) = -0.26$, $p = 0.80$ (two-tailed), and represented a very small effect, $d = 0.01$

1H. There will be a difference in the construction of clients of the participants’ own ethnicity and those of other ethnicities in relation to the content of the constructs elicited

Table 14: Comparing the frequencies of the classification for constructs of clients of the participants’ own ethnicity and clients of the other ethnicities

		Own ethnicity	Other ethnicities	Own ethnicity	Other ethnicities		Fisher’s exact test (p values)
Categories	Sub-categories					Sub-categories	
Personal	Flexible	0	4	1	1	Inflexible	0.33
	Mature	2	2	2	0	Immature	0.47
	Thoughtful	3	0	4	11	Shallow	0.043
	Self-acceptance	2	1	0	1	Self-criticism	1
	Strong	0	0	2	0	Weak	1
	Hardworking	5	5	1	5	Lazy	0.3069

	Organized	0	2	0	1	Unorganized	1
	Future oriented	0	0	1	2	Impulsive	1
Emotional	Balanced	5	10	6	11	Unbalanced	1
	Scared of own experience	1	3	0	0	No scared of own experience	1
	Visceral	2	2	1	0	Rational	1
	Warm	1	0	0	3	Cold	0.25
	More bubbly	1	0	0	1	Less bubbly	1
	Cultured	0	2	2	0	Uncultured	0.333

Intellectual/ operational							
	Intelligent	0	0	2	2	dull	1
	Knowledge/ common sense	1	0	0	1	More academic/ narrow focused	1
Values and interest: ideological values / special interest	Materialistic	0	0	1	2	Appreciative of what they have	1
	Close to family (/strong family support/ values/ more family oriented)	3	6	4	4	Distant from family (/ weaker family support/ values/ less family oriented)	0.637
	Religious	3	4	0	2	Not religious	0.5

	More aware of cultural value	1	1	0	0	Not so aware of cultural value	1
	More career driven	0	0	1	0	Less career driven	1
	Loves travelling	0	0	1	2	Does not love travelling	1
	Very distinct hobbies	0	2	1	0	No interest/hobbies	0.333
	Vain/glamorous	1	0	0	3	Not vain or focused on external appearance	0.25
	Relaxed parenting upbringing	0	2	2	1	Strict parenting upbringing	0.4

	Socially accepting profession/ financial status	2	0	0	1	Does not prioritise financial status/ importance on happiness	0.333
	Feels education is more important	2	0	0	3	Does not feel education makes a difference	0.1
	Likes to spend money	1	0	0	0	Spend thrift	1
	More into computer games	0	0	2	3	Less into computer games	1
Relational	Extroverted	9	35	14	33	Introverted	0.34

	Peaceable	1	1	3	9	Aggressive	0.505
	Trusting	1	1	0	0	Suspicious	1
	Sympathetic	0	1	2	3	Unsympathetic	1
	Tolerant	1	0	0	5	Authoritarian	0.1667
	Dependent	2	0	3	4	Independent	0.44
	Funny	0	0	2	2	Dull	1
	Pleasant	1	0	0	2	Unpleasant	0.333
Concrete descriptors	Similar topic of conversation (align with thinking)	0	0	2	4 (2 for each ethnicity)	Different topic of conversation (does not align with thinking)	1

	Tactile	1	2	0	0	Aversive to touch	1
	Not chronic drug user / more against drugs and alcohol	3	2	1	6	Chronic drug user/ open to the idea of drugs and alcohol	0.222
	Nasty attitude toward women	1	0	1	4	Not exhibit nasty attitude toward women	0.333
	Appears more harmless	1	3	0	0	Appears less harmless	1
	Often late / less punctual	1	3	1	1	Punctual (very)	1
	Fascination with gang culture	1	2	1	0	Not fascinated	1

	More difficult social circumstances	2	0	0	0	Less difficult social circumstances	1
Moral	Altruist	0	5	3	8	Egoist	0.509
	Responsible	1	3	1	2	Irresponsible	1
	Not judgemental	0	2	0	0	Judgemental	1

One hundred and thirty six constructs were elicited from the repertory grid, which were analysed using the Classification System for Personal Construct (CSFC) (Feixas et al., 2002). The thematic areas of coded constructs were identified along with content areas that did not fit in any of the coded themes. In order to assess inter-rater reliability and ensure quality check, a second rater also coded all 136 constructs (using the Feixas et al. (2002) 'Classification System for Personal Constructs (CSPC)'), independently. The second rater was a Doctoral student from another research program who was not involved in the research and was therefore blind to the research process and the original coding by the researcher. Using the (CSFC) and with no knowledge of the original coding by the researcher, the second rater independently identified thematic areas of coded constructs along with content areas that did not fit in any of the coded themes. Once both raters completed their individual coding, Cohen's (1960) κ (kappa) coefficient was used to explore the distribution of each rater's areas and categories in order to calculate the probability of chance agreement (McHugh, 2012). For the classification of the areas, there was a substantial agreement between the two raters, $\kappa=.719$, $p<.0005$. Similarly, there was a substantial agreement between the two raters for the classification of categories, $\kappa=.629$, $p<.0005$.

Given the small sample size of this research, Fisher's exact test was used to compare the observed frequencies of constructs, in the different categories, for clients of the participants' own ethnicity with that of clients of other ethnicities. Fisher's is the standard test to use for low number statistics. It is an exact probability test, whereas chi-square uses an approximation to a continuous distribution and is much less accurate for small number statistics. Additionally, a conventional chi-square rule is that when observed frequencies fall below 5 the chi-squared distribution should not be used (Fields, 2009).

The p-values reported (in Table 14) show that there is no difference in the categories of constructs applied to the two groups apart from the category '*Thoughtful*' – '*shallow*'

($p=0.043$, two-tailed Fisher's exact test). This finding indicates that there was a significant relationship between the ethnicity of the client and whether or not the participants viewed them as 'thoughtful' or shallow'. The table indicates that participants were more likely to view clients of other ethnicities as 'shallow' than clients of their own ethnicity.

11. Participants will be likely to construe significant people in their personal lives as more similar to clients of their own ethnicity than to clients of other ethnicities.

Table 15: Comparing the distance of significant people in the participants' life from clients of their own ethnicity and clients of the other ethnicities

	Mean	Standard Deviation	t	p-value
Own ethnicity	1.06	0.15	-.25	.40
Other ethnicities	1.07	0.07		

n= 17.

The findings reported in Table 15 suggested that there was no difference in the distance of significant people from clients of the same ethnicity and those from different ethnic groups. On average, participants did not see significant people in their lives any more similar to clients of their own ethnicity ($M = 1.06$, $SD = 0.15$) than clients of other ethnicities ($M=1.07$, $SD = 0.07$). The difference, -0.012 , 95% CI $[-0.12, 0.16]$, was not significant $t(16) = -0.25$, $p = 0.40$ (one-tailed), and represented a very small effect, $d = 0.09$.

3.1.2. Findings related to sub-hypotheses of hypothesis 2

Hypothesis 2: Construing of clients versus significant people

2A. There will be more discrimination between the elements in terms of client constructs (elicited from triads of clients) than in terms of personal constructs (elicited from triads of significant people)

Table 16: Non-parametric test comparing the extent to which the constructs discriminate between elements

	Median	z	p-value
Personal constructs	23.63	-2.01	0.02
Client constructs	26.92		

Note. Personal constructs: constructs elicited from the triads of significant people in the participants' life

Client constructs: construct elicited from the triads of clients

n= 17.

It is important to note that total percent sum of squares for the client constructs did not fit a normal distribution, which means that it is necessary to report the non-parametric test.

The findings of the Wilcoxon Signed Rank test indicated that there was a difference in the extent to which these constructs discriminated between the elements. On average there was more discrimination between the elements in terms of the client constructs ($Mdn = 26.92$) than there was in terms of the personal constructs ($Mdn = 23.63$). The Wilcoxon Signed Rank test revealed a statistically significant greater variance in the constructs elicited from the clients group than there was in the constructs elicited from the significant people, $z = -2.01$, $p = 0.02$ (one-tailed), with a medium sized effect ($r = -0.5$)

2B. There will be difference in the content of the constructs elicited from clients and from significant people in the participants' personal lives (content analysis)

Table 17: Frequency of each classification system for personal constructs and client constructs

	Personal (significant people) construct	Client construct	Fischer's Exact Test p-value
Moral	7	2	0.0898
Emotional	6	12	0.1189
Relational	19	29	0.0967
Personal	18	8	0.0429
Intellectual/ operational	2	1	0.5000
Values and interests	13	8	0.1916
Concrete descriptors	3	7	0.1718

Note: Personal constructs: constructs elicited from triads of significant people in the participants' life

Client constructs: construct elicited from triads of clients

The rationale for using Fisher's Exact Test, reported earlier in Table 14, applies here. Table 17 compares the distribution of each category of the classification system for personal constructs. The constructs elicited from the triads of significant people in the participants' life and the constructs elicited from client triads are compared here. It can be observed that the constructs derived from the group of significant people were more related to the 'personal'

characteristics than the constructs derived from the client group. However, there was no difference between the groups on any of the other categorical variables.

2C. Participants will be better able to apply personal constructs to significant people in their personal lives than to clients

Table 18: Comparing the inability to apply personal constructs to significant people and clients

	Mean	Standard Deviation	t	p-value
Significant people	2.76	2.22	-2.82	.01
Clients	5.59	3.02		

Note: Personal constructs: constructs elicited from triads of significant people in the participants' life

Client constructs: construct elicited from triads of clients

n= 17.

The results indicated that there was a significant difference in participants' ability to apply personal construct (elicited from the significant people in the participant's life) to significant people than to clients. On average, participants were highly significantly more able to apply personal constructs to significant people (M = 2.79, SD = 2.22) than to clients (M =5.59, SD= 3.02). This difference, -2.82, 95% CI [-4.95, -.70], was significant $t(16) = -2.82, p = 0.01$ (one-tailed), and represented a large effect, $d = 1.06$.

2D. Participants will be better able to apply client constructs to clients than to significant people in their personal lives

Table 19: Comparing the inability to apply client constructs to significant people and clients

	Mean	Standard Deviation	t	p-value
Significant people	3.12	2.60	-.61	.55
Clients	3.59	2.21		

Note. Personal constructs: constructs elicited from triads of significant people in the participants' life

Client constructs: construct elicited from triads of clients

n= 17.

The results indicated that there was no significant difference in participants' ability to apply client constructs to significant people and to clients. On average, participants did not apply client constructs to clients (M = 3.12, SD = 2.60) any more (or less) than they did to significant people (M = 3.59, SD = 2.21). This difference, -0.47, 95% CI [-2.09, 1.16], was not significant $t(16) = -0.61$, $p = 0.55$ (two-tailed), and represented a small effect, $d=0.2$

3.2. Section 2: Between-subject differences

3.2.1. Finding related to sub-hypotheses of hypothesis 3

Hypothesis 3: Participants of different ethnic groups' perception of how clients view their mental health problems and treatment options

3. A. Participants from non-European (non-Western) ethnic backgrounds will be more likely to include spirituality or religiosity in their perceptions of how clients of their own ethnicity view presenting mental health problems than participants from a European (Western) background.

Table 20: Comparing participants from European and non-Europeans backgrounds' perception of clients of their own ethnicity and clients of the other ethnicities' view of the presenting mental health problem in spiritual or religious terms

	European background	Non-European background	F	p-value
Own ethnicity	2.13 (1.66)	3.78 (1.62)	4.29	.03
Other ethnicities	3.91 (1.16)	3.36 (1.07)	1.02	.33

n= 17. Standard Deviations appear in parentheses below the means.

A one-way ANOVA test was conducted to determine whether there is a difference in the views of participants from European and non-European backgrounds in relation to whether clients of their own ethnicity and those of other ethnicity will view the presenting mental health problem in spiritual or religious terms. The findings indicated that, on average,

participants from a non-European background were significantly more likely to include religiosity and spirituality in their perception of how clients of their own ethnicity view their presenting mental health problem ($M = 3.78$, $SD = 1.62$) than participants from European background ($M = 2.13$, $SD = 1.66$). There was a significant effect of participants' ethnicity on whether they perceived that clients of their own ethnicity would view their mental health problem in terms of religiosity or spirituality, $F(1, 15) = 4.29$, $p < .03$ (one-tailed), and this represented a very large effect, $d = 1.01$

However, there was no difference between participants from European ($M=3.91$, $SD =1.16$) and non-European ($M=3.36$, $SD=1.07$) background regarding their perception of spirituality or religiosity in relation to how clients of the other ethnicities view their presenting mental health problem. There was no significant effect of participants' ethnicity on whether they perceived that clients of other ethnicities would view their mental health problem in terms of religiosity or spirituality, $F(1, 15) = 1.02$, $p < .33$ (two-tailed) and this represented a medium effect, $d = 0.5$.

3B. Participants from non-European ethnic background will be more likely to perceive that clients of their own ethnicity will view religious or spiritual assistance as a benefit than participants from European background.

Table 21: Comparing participants from European and Non-European backgrounds' perception of whether clients of their own ethnicity and clients of other ethnicities will consider that they would benefit from religious or spiritual assistance

	European background	Non- European background	F	p- value
Own ethnicity	3.19 (1.58)	3.39 (1.52)	.07	.40
Other ethnicities	4.41 (1.22)	3.36 (1.12)	3.38	.09

n= 17. Standard Deviations appear in parentheses below the means.

The findings from the one-way ANOVA test showed that, on average, there was no difference between Europeans and non-Europeans on whether clients of their own ethnicity would view religious and spiritual assistance as beneficial. There was no significant effect of participants' ethnicity on whether they perceived that clients of their own ethnicity would view religious and spiritual assistance as beneficial, $F(1, 15) = .07, p < .40$ (one-tailed), and this represented a very small effect, $d = 0.13$

The one-way ANOVA results indicate that on average, there was a difference between Europeans and non-Europeans on whether clients of other ethnicities would consider that they would benefit from religious or spiritual assistance. The findings in table 21 indicated that on average, participants from European background were closer to perceiving that clients of other ethnicities would consider that they would benefit from religious or spiritual assistance ($M = 4.41$, $SD = 1.22$) than participants from a non-European background ($M = 3.36$, $SD = 1.12$). There was a borderline significant effect of participants' ethnicity on whether they perceived that clients of other ethnicities would consider religious or spiritual assistance as beneficial, $F(1, 15) = 4.38$, $p < .09$ (two-tailed) and represented a large effect, $d = 0.9$.

3C. Participants from non-European background will be less likely to perceive that clients of their own ethnicity will view their presenting mental health problem in biomedical or somatic terms than participants from European background

Table 22: Comparing participants from European and Non-European backgrounds' perception of clients of their own ethnicity and clients of the other ethnicities' view of the presenting mental health problem in biomedical or somatic terms

	European background	Non-European background	F	p-value
Own ethnicity	4.25 (1.36)	3.61 (1.64)	.75	.20
Other ethnicities	3.66 (.98)	3.33 (.86)	.75	.48

n= 17. Standard Deviations appear in parentheses below the means.

The results highlight that there was no difference between the participants from European and non-European background in regard to their perception that clients of their own ethnicity and those of other ethnicities will view the presenting mental health problem in biomedical or somatic terms. There was no significant effect of participants' ethnicity on whether they perceived that clients of their own ethnicity would view their mental health problem in biomedical or somatic terms, $F(1, 15) = .75, p < .20$ (one-tailed) and this represented a medium effect, $d = 0.4$. Additionally, the result of clients of other ethnicities indicated no

significant effects of participants' ethnicity, $F(1, 15) = .75, p < .48$ (two-tailed), and this represented a medium effect, $d = 0.4$

3D. Participants from non-European background will be less likely to perceive that clients of their own ethnicity will view biomedical intervention such as psychotropic medication as a benefit than participants from European background

Table 23: Comparing participants from European and Non-European backgrounds' perception of whether clients of their own ethnicity and clients of other ethnicities will consider that they would benefit from psychotropic medication

	European background	Non- European background	F	p- value
Own ethnicity	4.44 (1.57)	3.88 (1.96)	.40	.27
Other ethnicities	3.78 (1.23)	4.19 (1.58)	.35	.56

n= 17. Standard Deviations appear in parentheses below the means.

The findings indicate that there was no difference between participants from European and non-European background regarding their perception that clients of their own ethnicity and those of other ethnicities would consider psychotropic medication as beneficial. There was no significant effect of the participants' ethnicity on whether they perceived that clients of their own ethnicity would consider psychotropic medication as beneficial, $F(1, 15) = .40, p < .27$ (one-tailed) and this represented a medium effect, $d = 0.3$. Additionally, the result of clients

of other ethnicities indicated no significant effects of participants' ethnicity, $F(1, 15) = .35$, $p < .56$ (two-tailed) and this represented a medium effect, $d = 0.3$.

3E. Participants from non-European background will be less likely to perceive that clients of their own ethnicity will view their presenting mental health problem in psychological terms than participants from European background

Table 24: Comparing participants from European and Non-European backgrounds' perception of clients of their own ethnicity and clients of the other ethnicities' view of the presenting mental health problem in psychological terms

	European background	Non-European background	F	p-value
Own ethnicity	3.69 (1.44)	3.11 (1.83)	.51	.25
Other ethnicities	3.75 (1.19)	3.56 (1.40)	.09	.76

n= 17. Standard Deviations appear in parentheses below the means.

The results show that there was no difference between participants from European and non-European background in regard to their perception that clients of their own ethnicity and those of other ethnicities will view the presenting mental health problem in psychological terms. There was no significant effect of participants' ethnicity on whether they perceived that clients of their own ethnicity would view their mental health problem in psychological terms, $F(1, 15) = .51$, $p < .25$ (one-tailed), and this represented a medium effect, $d = 0.4$.

Additionally, the result of clients of other ethnicities, indicated no significant effects of participants' ethnicity, $F(1, 15) = .09, p < .76$ (two-tailed), and this represented a small effect, $d = 0.2$.

3F. Participants from a non-European background will be less likely to perceive that clients of their own ethnicity will view psychological intervention as a benefit than participants from European background

Table 25: Comparing participants from European and Non-European backgrounds' perception of whether clients of their own ethnicity and clients of other ethnicities will consider that they would benefit from psychological intervention

	European background	Non-European background	F	p-value
Own ethnicity	4.31 (.80)	4.06 (1.59)	.17	.34
Other ethnicity	4.03 (.69)	3.97 (1.22)	.02	.91

n= 17. Standard Deviations appear in parentheses below the means.

The findings indicate that there was no difference between participants from European and non-European background regarding their perception that clients of their own ethnicity and of other ethnicities would consider psychological intervention as beneficial. There was no

significant effect of the participants' ethnicity on whether they perceived that clients of their own ethnicity would consider psychological intervention as beneficial, $F(1, 15) = .17, p < .34$ (one-tailed) and this represented a small effect, $d = 0.2$. Additionally, the result of clients of other ethnicities, indicated no significant effects of participants' ethnicity, $F(1, 15) = .02, p < .91$ (two-tailed), and this represented a small effect, $d = 0.1$.

3.3. Section 3: Additional findings

3.3.1. Summary of analysis procedure

Parametric and non-parametric correlational analyses were conducted to examine relationships between the relevant grid indices and the demographic variables of the participants. Analyses were conducted as two-tailed. Both Pearson's and Spearman's correlation coefficients were conducted because even though some variables were normally distributed, other variables violated this parametric assumption. However, after comparing the parametric and non-parametric data, it was observed that the values were almost identical. Therefore the Spearman's correlation coefficients were reported. Table 1 provides a summary of correlational analyses, with borderline significant ($p \leq .10$) and significant ($p \leq .05$) results highlighted.

3.3.2. Findings related to the correlations:

Table 26: Correlations between demographic and grid variables

Grid measure	Client group	Age	Length of training experience
Measure of the salience of the elements (Average of percent total sum of squares)	Clients of own ethnicity	$r = -0.127,$ $p = 0.628$	$r = -0.269,$ $p = 0.297$

	Clients of other ethnicities	r=-0.255, p=0.324	r=-0.188 p=0.470
How much participants see clients as different to themselves (now) (Average distance)	Clients of own ethnicity	r=0.209 p=0.420	r=0.262, p=0.309
	Clients of other ethnicities	r=0.035, p=0.894	r=0.185, p=0.477
How much participants see their ideal self as different to clients (Average distance)	Clients of own ethnicity	r=-0.143 p=0.584	r=-0.004 p=0.989
	Clients of other ethnicities	r=0.184 p=0.480	r=0.261, p=0.312
How much participants see significant people as different to clients (Average distance)	Clients of own ethnicity	r=-0.030 p=0.909	r=-0.233 p=0.368
	Clients of other ethnicities	r=-0.070 p=0.790	r=0.142, p=0.587
The extent to which constructs discriminate between elements	Significant people constructs	r=-0.293 p=0.253	r=-0.184 p=0.479
	Client constructs	r=-0.095 p=0.717	r=0.106 p=0.687
Inability to apply personal constructs (elicited from group of significant people) to clients	Clients of own ethnicity	r=0.222 p=0.392	r=0.192 p=0.460
	Clients of other ethnicities	r=0.003 p=0.990	r=0.013 p=0.960

Inability to apply client constructs (elicited from clients group) to clients	Clients of own ethnicity	r=-0.206 p=0.428	r=0.094 p=0.719
	Clients of other ethnicities	r=0.396 p=0.115	r=0.500 p=0.041
Perception of whether clients' are likely to seek help	Clients of own ethnicity	r=0.397 p=0.115	r=0.206 p=0.427
	Clients of other ethnicities	r=0.537, p=0.026	r=0.562, p=0.019
Perception of whether clients view problem as medical/somatic	Clients of own ethnicity	r=-0.013 p=0.960	r=-0.066 p=0.801
	Clients of other ethnicities	r=0.328 p=0.199	r=0.255 p=0.324
Perception of whether clients view problem as psychological	Clients of own ethnicity	r=0.033 p=0.901	r=0.026 p=0.921
	Clients of other ethnicities	r=0.247 p=0.338	r=0.260 p=0.313
Perception of whether clients view problem as religious/spiritual	Clients of own ethnicity	r=0.254 p=0.326	r=0.082 p=0.756
	Clients of other ethnicities	r=0.165 p=0.527	r=0.095 p=0.718
Perception of clients as difficult to understand	Clients of own ethnicity	r=0.108 p=0.679	r=-0.068 p=0.795

	Clients of other ethnicities	<i>r=0.492,</i> <i>p=0.045</i>	<i>r=0.428,</i> <i>p=0.087</i>
Perception of whether clients think they would benefit from psychotropic medication	Clients of own ethnicity	r=0.210 p=0.419	r=0.231 p=0.372
	Clients of other ethnicities	r=0.311 p=0.224	r=0.237 p=0.360
Perception of whether clients thinks they would benefit from psychological therapy	Clients of own ethnicity	r=0.068 p=0.797	r=0.066 p=0.801
	Clients of other ethnicities	r=0.156 p=0.550	r=0.127 p=0.627
Perception of whether clients thinks they would benefit from religious/ spiritual assistance	Clients of own ethnicity	r=0.395 p=0.117	r=0.138 p=0.598
	Clients of other ethnicities	r=-0.114 p=0.664	r=-0.231 p=0.373
Conflicts within the construing of clients	Clients of own ethnicity	r=0.109 p=0.676	r=-0.092 p=0.725
	Clients of other ethnicities	r=-0.066 p=0.801	r=0.020 p=0.938

Though there were no specific prior hypotheses in relation to the correlations between the demographics and the grid variables, the correlation matrix highlighted interesting significant

relationships. These significant relationships have been displayed in Table 26 and were as follows:

- Length of training experience and its relationship with the grid variables:

The correlation table shows that length of training experience was significantly related to participants' ability to apply client constructs to clients of other ethnicities, $r=0.500$, $p=0.041$.

The findings indicate that the participants with greater experience were less able to apply client constructs to clients of other ethnicities. Moreover, length of training experience was significantly related to the perception of participants as to whether clients of other ethnicities are likely to seek help, $r=0.562$, $p=0.019$. Here, the findings show that participants with greater experience were more likely to think that clients of other ethnicities are likely to seek help. Additionally, there was a borderline significant relationship between length of experience and whether participants find clients of other ethnicities difficult to understand, $r=0.428$, $p=0.087$. The results indicate that participants with more experience tended to find clients of other ethnicities more difficult to understand.

- Age and its relationship with the grid variables:

Age was significantly related to participants' perception of whether clients of other ethnicities are likely to seek help ($r=0.537$, $p=0.026$) and whether they find clients of other ethnicities difficult to understand ($r=0.492$, $p=0.045$). The findings point out that older participants were more likely to think that clients of other ethnicities are likely to seek help and they found these clients more difficult to understand.

3.4. Section 4: Plots of elements in construct space derived from principal component analysis of the grid

3.4.1 Understanding the plots

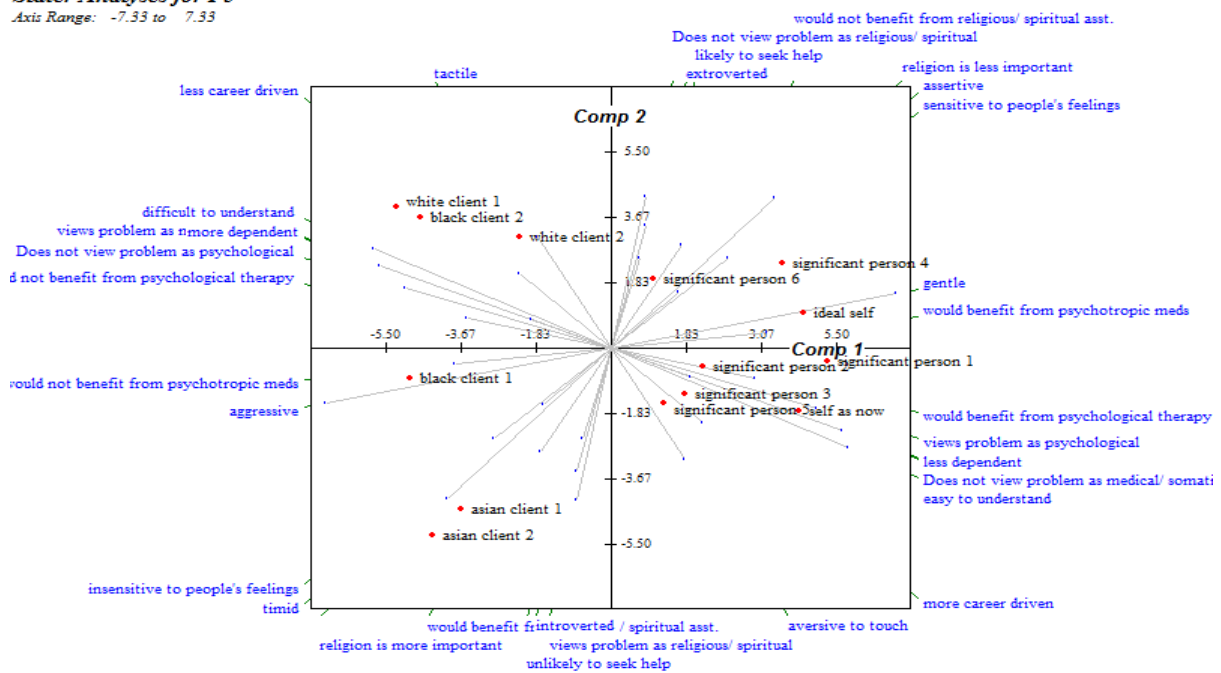
The figures reported are plots of elements in construct space derived from principal component analysis of the grid. The physical distance between elements in the plots represents the psychological distance between them, and elements in opposing quadrants are the most different. The numbers indicated in the description of the plots are the average element distances.

It should be noted that in order to increase anonymity, the ethnicity of the participants was kept broad and age as well as areas of work were removed so that the participants in the case examples were not easily identifiable.

3.4.2. Case Example 1

Figure 2: Self, ideal self and significant people were contrasted with clients, regardless of ethnicity

Slater Analyses for P5
Axis Range: -7.33 to 7.33



The participant in this case example (1) is a male, of White British background, who is a specialist trainee psychiatrist (level 6) with six years' experience of working in psychiatry (with no experience of working or living abroad). As seen in the plot of elements in construct space derived from the principal component analysis presented in Figure 2, his grid demonstrated that he construed himself as similar to significant people (0.76) and also close to the ideal self (0.66).

For this participant, he construed himself as distant from White clients (1.18), Black clients (1.27) and Asian clients (1.34). His ideal self was also construed as distant from clients of each of the ethnic groups (White clients, 1.05; Black clients, 1.21; Asian clients, 1.24). Like his construal of himself and ideal self, he construed people who were significant to him in his personal life as different to clients of each of the ethnic groups (White clients, 2.09; Black clients, 2.33; Asian clients, 2.23). This case example reveals that the participant views himself and his ideal self more similar to significant people in his life than to clients, regardless of ethnicity.

The grid indicates a favourable construction of himself (including the ideal self) and of significant people. The self, ideal self and significant people were viewed as less 'dependent', and more 'easy to understand' and 'career driven' than clients from the same ethnicity and different ethnicity. Like the ideal self, significant people were viewed as 'gentle', 'assertive' and 'sensitive to people's feelings' whereas clients were construed as 'aggressive', 'timid' and 'insensitive to people's feelings'.

This case example of the plot of elements in construct space derived from the principal component analysis is in line with the hypothesis that participants are likely to view themselves as more similar to significant people in their own lives than to clients. In this case,

clients and non-clients are totally discriminated on the horizontal axis, representing the first principal component.

3.4.2.1. Additional statistical finding related to Case Example 1

Table 27: Comparing participants from European and Non-European backgrounds' inability to apply personal construct to clients of the other ethnicities

	Mean	Standard Deviation	F	p-value
European background	1.28	.45	10.13	.006
Non-European background	.58	.45		

n= 17.

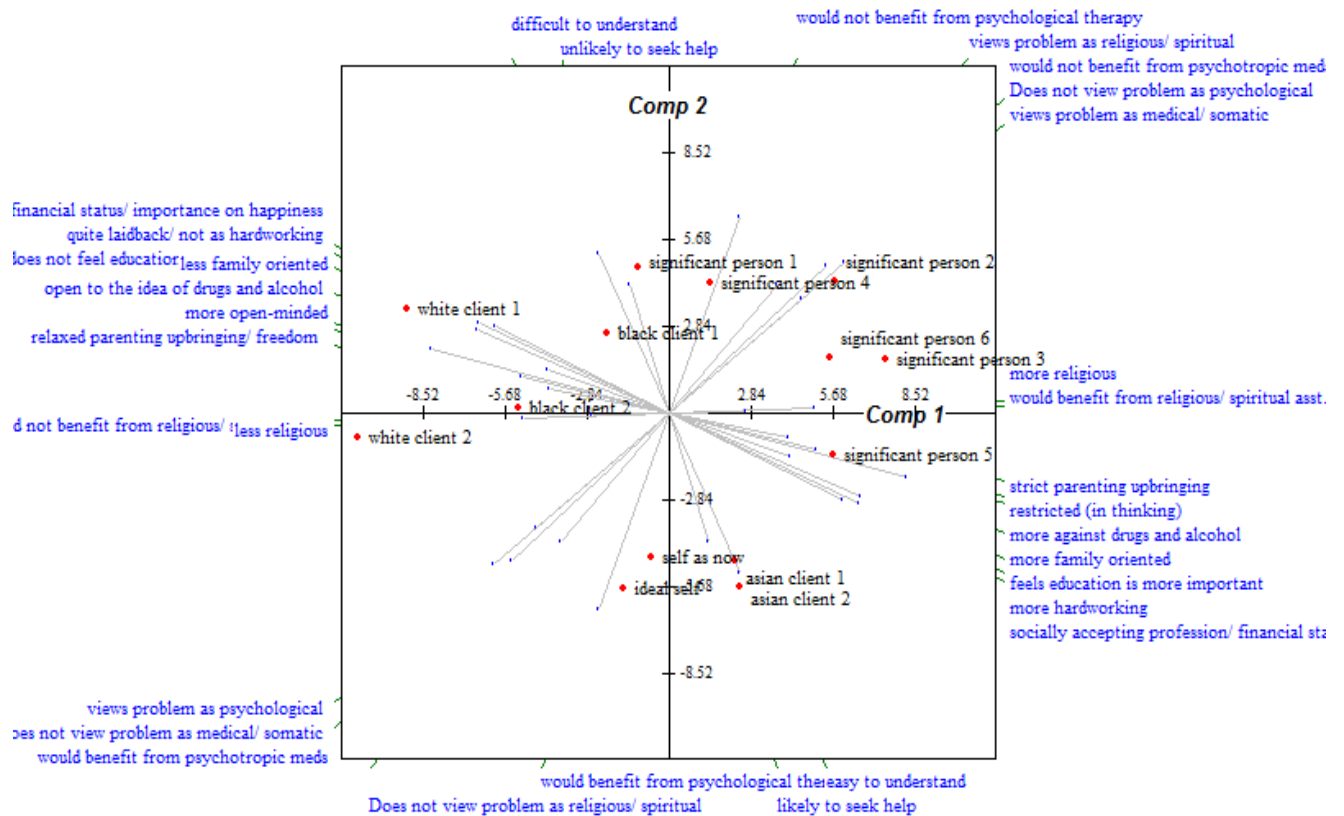
Additional findings extracted from the one-way ANOVA test indicated that, on average, there was a difference between Europeans and non-Europeans in their inability to apply personal constructs elicited from significant people to clients of other ethnicities. The findings indicated that on average, participants from European background were less able to apply personal constructs to clients of other ethnicities. There was a significant effect of participants' ethnicity on whether they were less able to apply personal constructs to clients of other ethnicities. $F(1, 15) = 10.13, p < .006$ (two-tailed), and this represented a very large effect, $d = 1.6$

3.4.3. Case Example 2

Figure 3: Self, ideal self, significant people and clients of own ethnicity were contrasted with clients of other ethnicities

Slater Analyses for P12

Axis Ranges: -11.36 to 11.36



The participant in this case example (2) is a female, of Asian background, who is a core trainee psychiatrist (level 2) with one and a half years' experience of working in psychiatry (26 years' experience of living and working abroad). As seen in the plot of elements in construct space derived from the principal component analysis presented in Figure 3, her grid demonstrated that she construed herself and ideal self as similar to clients who are from the same ethnicity as herself.

The participant in this case example construed herself and clients of the same ethnicity as herself as distant from clients of the other ethnicities. The respective average distances of the self from clients of her own and other ethnicities were 0.84 and 1.09. Similarly, her ideal self was closer to clients of her own ethnicity (0.82) than to clients of different ethnicities to herself (1.06).

The grid shows that she construed herself, the ideal self and clients of her own ethnicity as having 'strict parenting upbringing', 'restricted (in thinking)', 'more against drugs and alcohol', 'more family oriented', 'feels education is more important', 'more hardworking' and 'social accepting profession/ financial status', whereas clients of different ethnicities to herself were on the contrast poles of these constructs.

This example can be said to be in line with the hypothesis that participants are likely to show less differentiation between themselves and clients of their own ethnicity than between themselves and clients of other ethnicities. In this case, non-clients and the clients of the participant's own ethnicity are discriminated from clients of other ethnicities on the horizontal axis, representing the first principal component.

3.4.3.1. Additional statistical finding related to Case Example 2

Table 28: Comparing participants from European, African and Asian backgrounds' regarding the extent to which they use personal construct to discriminate between elements

	Mean	Standard Deviation	F	p-value
European background	23.76	5.04	2.93	.09
African background	20.30	2.85		
Asian background	27.20	3.85		

n= 17.

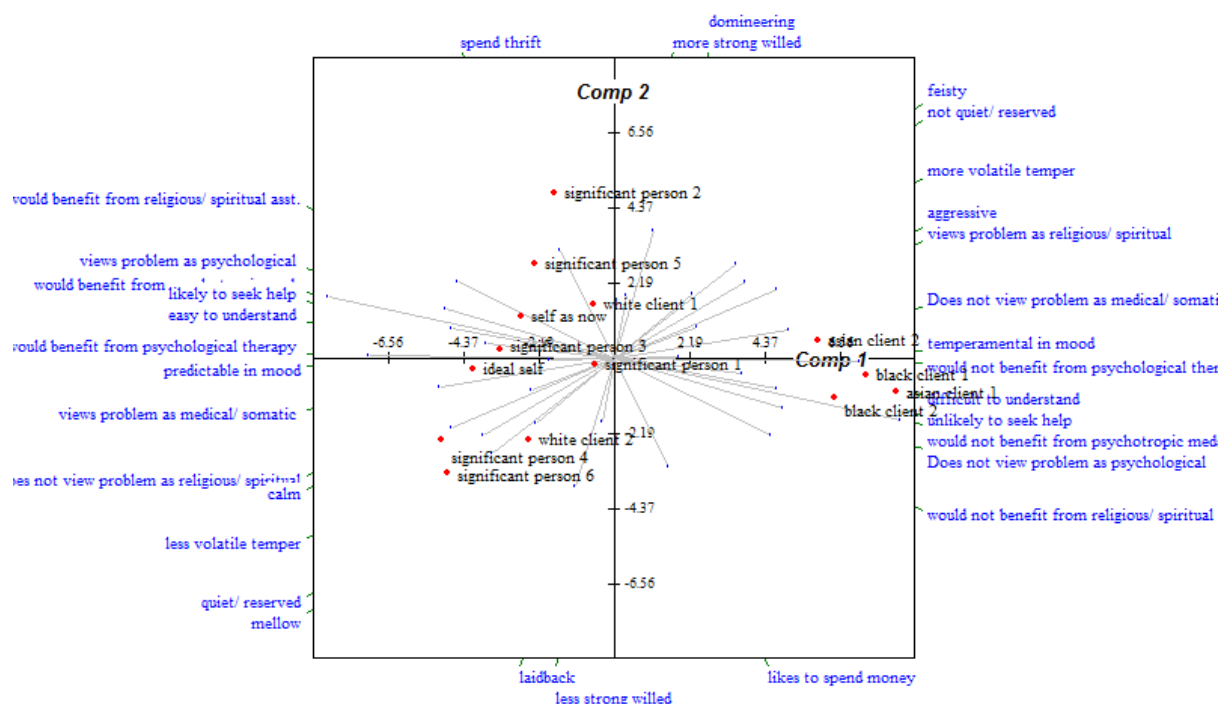
The finding indicates that participants of Asian background were more likely to discriminate between elements when using personal constructs (elicited from significant people). There was a borderline significant effect of participants' ethnicity on the extent to which they discriminated between elements using the personal constructs. $F(1, 15) = 2.93, p = .09$ (two-tailed), and this represented a large effect, $d = 0.9$

3.4.4. Case Example 3

Figure 4: Self, ideal self, significant people and clients of European ethnic group (different ethnic group to the participant) were contrasted with clients of the non-European ethnic groups (including those of the same ethnicity).

Slater Analyses for P16

Axis Range: -8.74 to 8.74



Case example (3) is a female, of Black African background, who is a core trainee psychiatrist (level 2) with two years’ experience of working in psychiatry (28 years’ experience of living abroad and 4 years’ experience of working in the field of psychiatry abroad). As seen in the plot of elements in construct space derived from the principal component analysis presented in Figure 4, her grid demonstrated that she construed herself, ideal self and significant people as more similar to clients who are of White ethnic background and distant from those of Black (who are of her own ethnicity) and Asian ethnic backgrounds.

In this case example, it was revealed that the participant's constructions of herself, ideal self and significant people in her life were not akin to clients of the same ethnicity as herself. This example indicates that the participant viewed herself as similar to the clients of White ethnic background (0.63) and distant from the clients of Black ethnic background (1.24) as well as the clients of Asian ethnic background (1.22). Similarly, her ideal self was closer to the clients of white ethnic background (0.65) and distant from clients of the two other ethnic groups (clients of Black ethnic background (1.36) and Asian ethnic background (1.37)). Though the significant people in her life were more dispersed on the grid, they were also closer in distance to clients of white ethnic background (1.46) than those of Black (her own ethnic group, 2.62) and Asian ethnic background (2.62).

The grid shows that she construed herself, the ideal self and clients of white ethnic background as 'likely to seek help', 'easy to understand', 'less volatile', 'calm', 'predictable in mood', and 'quiet and reserved' whereas clients of the Black (same ethnic background as herself) and Asian ethnic groups were on the contrast poles of these constructs.

This case example of plot of elements in construct space derived from the principal component analysis is not in line with any of the hypotheses. In this case, non-clients and clients of White European ethnic background are totally discriminated from non-European clients on the horizontal axis, representing the first principal component.

3.4.4.1. Additional statistical finding related to Case Example 3

Table 29: Comparing participants from European, African and Asian backgrounds' inability to apply client construct to clients of other ethnicities

	Mean	Standard Deviation	F	p-value
European background	.56	.37	3.70	.05
African background	1.15	.55		
Asian background	.44	.43		

n= 17.

In separating the three ethnic groups, the additional findings derived from the one-way ANOVA test indicated that there was a difference between Europeans, Africans and Asians on inability to apply client constructs to clients of other ethnicities. The findings showed that participants from African background were less able to apply the client constructs to clients of other ethnicities ($M = 1.15$, $SD = .55$) than participants from European ($M = .56$, $SD = .37$) and Asian background ($M = .44$, $SD = .43$). There was a significant effect of participants' ethnicity on whether they were unable to apply client constructs to clients of other ethnicities. $F(1, 15) = 3.70$, $p = .05$ (two-tailed), and this represented a very large effect, $d = 1.0$.

Chapter 4: Discussion

This chapter will begin with consideration of the findings in relation to the hypotheses. This will then be followed with a summary of additional results and novel findings from the case studies. The relevance of the empirical literature will be discussed throughout the reporting of the findings. This will be followed by consideration of the clinical implications of this study. Subsequently the quality of the study will be considered by highlighting strengths and limitations. Recommendation for further research will then be presented, which will be followed with a concluding remark.

4.1. Overview of results in relation to the hypotheses and relevance to empirical literature:

Hypothesis 1: Construing of own ethnicity versus construing of other ethnicity

1. A. Contrary to the hypothesis, clients of the same ethnicity were no more salient to the participants than clients of different ethnicity (*Table 7*). Though it can be assumed that similarities between people in intergroup context may make them more salient (Turner et al., 1994), a possible explanation for this finding could be that the repertory grid measure of sum of squares is not a valid measure of meaningfulness or salience.

1. B. The results also indicated that participants did not find those of the same ethnicity any easier to understand than those of a different ethnicity to themselves (*Table 8*).

This is in accordance with Cooper's (2016) study that found that African psychiatrists experienced difficulties in understanding clients of African origin, especially in relation to how the clients conceptualised their mental health problems. Therefore, despite sharing the same ethnicity there can still exist difficulties in understanding the client.

1. C & 1.D. Though it was hypothesised that the participants will see themselves (*Table 9*) and the ideal self (*Table 10*) as less different to clients of their own ethnicity compared to those of other ethnicities, the results indicated that this was not the case and that there was no difference. This suggests that overall participants did not see themselves or their ideal selves any closer to those of the same ethnicity than those of a different ethnicity.

This finding is contrary to Soldz's (1992) findings that suggested that therapists often liked clients who are similar to themselves more than those who are different.

1. E. As hypothesised, there was a significant difference in the conflict associated with the construing of clients of the same ethnicity as the participant and those of a different ethnicity (*Table 11*), indicating that the participants were more conflicted in their construing of clients of other ethnicities than they were in construing clients of their own ethnicity. It can therefore be said that clients of other ethnicities invalidated their construing system, which made these clients more difficult to understand.

This can be said to be in line with the Bush et al. (2005) study, where psychiatrists from Western European heritage in New Zealand experienced a sense of cultural conflict when they were first exposed to a group of people (Samoans) different to themselves with different views. Their findings indicated that the Samoan view of mental health aligned with the relativist perspective, which challenged and invalidated the participants' own Western views of psychiatry that were more in line with a universalist view of mental health presentations.

1. F & 1.G. It was hypothesised that the participants may be more likely to apply constructs (elicited from significant people) of the personal domain to clients of their own ethnicity than to clients of other ethnicities, but there was no difference (*Table 12*).

Soldz's (1989) study offers an explanation in that it highlighted that participants apply a distinctive 'construct subsystem' to construe clients, which is different to the subsystem they use in construing people they know personally. This means that as hypothesised in the current study (*Table 13*), there will be no difference in the application of client constructs to clients of own ethnicity and those of other ethnicity because both groups of clients fall within their range of convenience (Kelly, 1955). Therefore, it can be suggested that the constructs elicited from the significant people in the participant's life cannot be applied to the client group regardless of the ethnicity of the client whereas client constructs are more meaningful when applied to both groups of clients.

1. H. In regard to whether there was a difference in the content of construction of clients of the participants' own ethnicity and those of other ethnicity, it was found that there was no difference in the categories of constructs applied to the two groups apart from the category, '*Thoughtful – shallow*' within the '*Personal*' area (*Table 14*). The findings showed that participants were more likely to view clients of their own ethnicity as '*thoughtful*' and those of other ethnicity as '*shallow*'.

According to Ralley et al. (2009), staff members have a very individual way of construing clients, whilst Hare et al. (2012) suggested that the attribution of characteristics is one way of understanding the behaviour of clients.

1. I. Like the participants' self and ideal self, the participants did not construe significant people in their lives as more similar to clients of their own ethnicity than clients of other ethnicities (*Table 15*).

Studies have suggested that staff tended to construe themselves, the ideal self, colleagues and acquaintances as dissimilar to clients (Ralley et al., 2009; Soldz, 1992). It is possible that this

may not apply to all clients that the clinician encounters but is likely to be the case if the clinician experiences the client's behaviour as challenging (Hare et al., 2012). Additionally, Gergen (1990) offered an explanation that suggested that the therapist may possess a 'specific bias' influenced by the 'systematic context' in which they function therapeutically and that this can affect their construing of clients, especially as they are more exposed to the 'negative aspects' of the client's life (Soldz, 1992, p. 407).

Hypothesis 2: Construing of clients generally versus significant people

2. A. The findings indicated that the client constructs (elicited from the triads of clients) discriminated more between elements than the personal constructs (elicited from the triads of significant people) (*Table 16*).

Akin to the findings of this study, Soldz (1989) also highlighted that there was higher differentiation in the client domain than in the acquaintance domain. Neimeyer and Fukuyama (1984) highlighted that a more differentiated construct system is more likely to hold a 'pluralistic perspective' (p. 4). This means that participants are likely to have more varied viewpoints of clients because of the diverse presentations that they may encounter within their clinics. The extent of the differentiation within the client construct system can make the client group 'complex' to conceptualise (Neimeyer and Fukuyama, 1984, p. 7).

2. B. It was found that the content of constructs elicited from the triads of significant people (people in the participant's personal life) was more related to 'personal' characteristics compared with the content of constructs from the client triads (*Table 17*). This is to be expected, as participants see themselves as much more closely related to significant people in their lives than clients.

In relation to the difference in personal characteristics, Ralley et al., (2009) suggested that staff members' personal experience of clients may be normalised if these clients were to be experienced in a non-client context. They inferred that this may close the gap between the client and non-client group in relation to how they are construed.

2. C. The research findings illustrated that participants were more able to apply personal constructs (elicited from significant people) to significant people than they were to clients (*Table 18*).

This can be considered to be a replication of the Soldz (1989) study that suggests that the constructs elicited from one domain are more applicable to rate the elements of that domain than when used to rate the elements of another domain. This is supported by Bender's findings (reported in Tully, 1976) that indicate that the constructs from the client domain and those from the domain relating to significant people are distinct from each other.

In accordance with the Range Corollary (Kelly, 1955), the constructs can be described as limited in their 'range of convenience' and can only be used to anticipate the behaviours elicited by a specific group of people and cannot be generalised to all.

2. D. Interestingly, the current study revealed that there was no difference in the participants' ability to apply client constructs to significant people and to clients (*Table 19*). The study by Soldz (1989) also found that some participants were able to apply constructs from one domain to elements of the other domain.

The findings from the current research therefore suggest that constructs elicited from significant people have a range of convenience that is limited to significant people rather than to clients, whereas the range of convenience for client constructs is not limited to the client domain, which is contrary to Bender's findings (reported in Tully, 1976).

Hypothesis 3: Participants of different ethnic groups' perception of how clients view their mental health problems and treatment options

3. A & 3. B. As predicted, participants from a non-European ethnic background were more likely to consider spirituality or religiosity in their perception of how clients of their own ethnicity would view their presenting mental health problems than participants from European background (*Table 20*).

This finding is supported by Cooper's (2016) study that showed that African psychiatrists reported that patients often viewed their problems in spiritual or religious terms (either as a gift or evil possession) and often sought support from faith or traditional healers.

In line with this, it was predicted that non-European participants will be more likely to perceive that clients of the same ethnicity as themselves (non-European clients) will view religious and spiritual assistance as a benefit (*Table 21*). However, this was not the case as participants from European ethnic background were closer to considering that the clients of other ethnicities different to themselves (non-European clients) would think they would benefit from religious or spiritual assistance.

Cooper's (2016) study can offer an explanation of this finding in that though non-European psychiatrists may be aware of the clients' spiritual or religious inferences regarding their mental health problems, these professionals often continued to apply biomedical principles and methods when considering treatment. Cooper (2016) inferred that for the majority of the African psychiatrists in her study, the 'colonial' 'Eurocentric' medicine was more relevant than the 'primitive' traditional healing process, which often involved spiritual healers.

Though European participants were unlikely to include spirituality and religiosity when considering how clients of their own ethnicity would view their mental health problems, they did not consider spirituality when perceiving how clients of other ethnicities would view their

mental health problems. This finding is in accordance with the Bush et al. (2005) study, where it was observed that psychiatrists from Western European heritage felt a sense of confusion and cultural differences when they were exposed to the Samoan view of mental health, which included an emphasis on religion and spirituality.

Nonetheless, the European participants were much closer to perceiving that clients of other ethnicities would think they would benefit from religious and spiritual assistance (*Table 21*). The study by Bush et al. (2005) can offer an explanation, because they reported that in general the Western European psychiatrists felt 'ill-equipped' to address the cultural issues related to the mental health presentation of a culture that was different to theirs and felt that a consultation with cultural workers would be necessary. It is important to note that it has been suggested that spirituality or religiosity can play a role in how mental health is perceived by clients from both majority and minority ethnic groups (Bush et al., 2005). Nonetheless, neither group of participants perceived that clients of their own ethnicity would view religious and spiritual assistance as beneficial.

3. C & 3. D. The current study indicated that there was no difference between the non-European and European participants in their perception that clients of non-European or European background would view mental health problems in biomedical or somatic terms (*Table 22*). Additionally, there was no difference in both groups' perception of whether clients of non-European or European ethnic background would view biomedical intervention such as psychotropic medication as beneficial (*Table 23*).

3. E & 3. F. It was also found that there was no group difference regarding psychiatrists' perception of whether clients of non-European or European background would view mental health problems in psychological terms (*Table 24*). Like their perception of biomedical intervention such as psychotropic medication, there was no difference in the group's

perception of whether non-European or European clients would view psychological intervention as beneficial (*Table 25*).

Though Fernando (2014) suggested that mental health problems in Western countries are viewed in a biomedical or 'somatopsychic framework', the clinicians in Rastogi et al. (2014) study perceived that some clients of South Asian background would often decline psychotherapy input but were accepting of psychotropic intervention such as medication. However, this was not indicated in the current study, perhaps because clients of Asian and African ethnicities were combined together as one group.

4.2. Summary of additional findings

Looking at the demographic data, it can be said that the older participants were more likely to perceive clients of other ethnicities as likely to seek help, even though they found them more difficult to understand (*Table 26*). Similar to the older participants, participants who had more experience of training were more likely to think that clients of other ethnicities were likely to seek help, though they also tended to find them difficult to understand. Additionally, more experienced trainees were less able to apply client constructs to clients of other ethnicities. Overall, it can be said that older participants and those with greater experience tended to experience difficulty understanding clients who are of a different ethnic background to themselves.

Similarly, though the senior psychiatrists of Western European heritage in the Bush et al. (2005) study had over 5 years' experience of working with issues around culture, they still expressed difficulty in understanding the cultural views of the Samoan people. On the other hand, as shown in Cooper's (2016) study (involving African psychiatrists), psychiatrists who share the same ethnicity as the client can also experience difficulty in understanding and accepting the client's perception of their mental health. In both of these studies the

understanding of mental health by the local people comprised of spirituality and religiosity. It is likely that even though psychiatrists may acknowledge cultural factors of mental health, the Eurocentric biomedical framework in which they work can constrain their conceptualisation of these cultural factors. This can make those who present with non-Western concepts of mental health problems difficult to understand.

4.3. Case Examples

The first case example reported (*Figure 2*) was of a White British trainee psychiatrist who was at an advanced level of training with six years' experience of working in psychiatry, with no experience of living or working abroad. The psychiatrist in this case example positioned himself and his ideal self close to significant people in his life. In contrast, he viewed clients, regardless of their ethnicity, as distant from himself. This indicated that the clients and non-clients were totally discriminated. Clients were viewed by this participant as more 'difficult to understand', less 'career driven' and more 'dependent' compared to non-clients. This finding was supported by an additional statistical result that suggested that participants from European background were less able to apply constructs elicited from significant people to clients of other ethnicities (*Table 27*).

This appears to be in line with the study conducted by Biswas et al. (2016) that suggested that Europeans generally valued independence and were future oriented. Like the participants in the Bush et al. (2005) study, religion and spirituality were not held in high regard by the participant in this case example, but rather he perceived that the self and those close to him would benefit more from psychotropic medication and psychological therapy. In regard to how religion and spirituality were positioned in relation to the self, Neimeyer and Fukuyama (1984) postulated that Europeans are less likely to consider 'systemic factors' within their constructs (p. 15). Additionally, it can be said that the White British psychiatrist applied a

dichotomous (Kelly, 1955; 1991) way of viewing the world by polarizing himself and significant people from all clients.

Case example two (*Figure 3*) represented an Asian trainee psychiatrist in her early stage of psychiatry training, with 26 years' experience of living and working abroad. The results indicated that she construed herself and the ideal self as similar to clients of her own ethnicity. In support of this finding, an additional statistical finding indicated that participants from Asian background were more likely to discriminate between elements when applying constructs elicited from significant people in their lives. This may have been because they saw clients of the same ethnicity as closely related to significant people (*Table 28*).

This finding is in accordance with the Biswas et al. (2016) suggestion that within the Asian culture, people traditionally place value on 'a collectivistic interdependent social network' (p. 5). Therefore, like the non-Western Samoan culture discussed in the study by Bush et al. (2005), it can be said that the participant in this case example holds a 'relational view of self' (p. 625), which is reflected in her close proximity to clients of the same ethnicity. She is also able to apply a more systemic and collective perspective to her construing of herself, to significant people, and to clients who share the same ethnicity (Biswas et al., 2016; Bush et al, 2005; Neimeyer and Fukuyama, 1984). For example, she describes this group as 'more family oriented' and 'having a strict parenting upbringing', which Neimeyer and Fukuyama (1984) described as cultural constructs. Furthermore, the Asian psychiatrist's construction appeared to have been informed by *commonality* (Kelly, 1955; 1991) as she positioned herself close to clients of the same ethnicity and thus isolated from clients of other ethnicities.

Case example three (*Figure 4*) describes a Black African trainee psychiatrist who is also in the early stage of training, with 28 years' experience of living abroad and four years' experience of working in the field of psychiatry abroad. The findings observed highlighted

that the psychiatrist in this case example perceived clients of the same ethnicity as distant from herself, the ideal self and significant people. Rather, the psychiatrist positioned herself in close proximity to clients of other ethnicity, more specifically to the white European clients. This is indicated in an additional statistical finding in the current study that suggests that psychiatrists from African background were less able to apply client constructs to clients of other ethnicity (*Table 29*).

This finding appears to be in parallel with Cooper's (2016) study with African psychiatrists that suggested that they often favoured 'Eurocentric tendencies' invoked by the colonialism of medicine and psychiatry in these parts of the world. As Cooper (2016) highlighted, the majority of the African psychiatrists viewed the 'Western' medicine as more balanced and contemporary, which they distinguished from the supposed 'indigenous' beliefs of the local people in Africa. Therefore, in relation to this case example, it can be inferred that the psychiatrist's tendency to align herself with Western values in her profession may have led her to place herself in close proximity to the European clients. Additionally, similar to the participants in Cooper's (2016) study, the psychiatrist viewed mental health problems within a bio-medical framework, which was in contrast to the clients of her own ethnicity, whom she perceived to view mental health problems as religious and spiritual. It seems that the Black African psychiatrist made a *choice* (Kelly, 1955; 1991) to align with the alternative ethnicity (European clients) different to her own.

In the case examples described, it can be seen that psychiatrists from different ethnicities had different ways of construing clients, perhaps rooted in their different experiences. This is in line with Kelly's (1955) Individuality Corollary.

4.4. Clinical implications

4.4.1. Becoming aware of perceptions that influence practice

The feedback received from some of the trainee psychiatrists who took part in the study highlighted that the process of completing the repertory grid enabled them to reflect on their perceptions, which they openly reported that they had not been aware of. Some of the participants reported that they had become aware of how differently they construed people close and distant to them, which cultivated a discussion around reflection. It appeared that the target-driven NHS culture in which we practice can limit the opportunity for reflection, partly due to the increasing service demands (McCann et al., 2015). This research is crucial in highlighting that through reflection, the trainee psychiatrists (and all clinicians) can have the space to become more aware of factors that influence their practice.

By looking inwards, we as clinicians can become aware of our own biases we may hold in our work with those we share similarities with as well as differences. It is necessary to normalise these biases that we have as humans and to bring them to our awareness in order to process them (Holroyd, 2015). Clinically, this can be one way of fostering our understanding of ourselves as clinicians and what we may bring to the interaction with others of the same or different ethnicity to ourselves. However, conversations around race, ethnicity and culture can bring about discomfort (Bhui et al., 2012; Nolte, 2008). Thus, assisting reflections with self-exploratory measures, such as the Cultural Attitude Repertory Technique (CART; Neimeyer and Fukuyama, 1984), may help clinicians express these personal perceptions that may be implicit in their multi-ethnic work.

4.4.2. Identifying factors that can influence diagnoses and the treatment referral process

The psychiatric diagnostic manuals, such as the DSM-V and ICD-10, have acknowledged that psychiatrists serve diverse communities and have therefore recognised this as part of the consideration for diagnosis of mental health presentations. Though the inclusion of cultural formulation gives the client the opportunity to express their problems in their own cultural understanding, the guidelines for diagnosis continue to universalise these expressions by fitting them into a western narrative of understanding (Jacob, 2014). As indicated in the current research study, psychiatrists did not tend to apply distinct constructs to clients of particular ethnic backgrounds. Thus, it is likely that they apply a universal framework to all clients, regardless of their ethnicity. It may be that the failure to attend to the clients' understanding of their mental health distress rooted in their local culture, religion (or spirituality) and family context could lead to misdiagnoses (Fitzgerald et al. 1997b) and maintain clinical stereotypes that can be based on the ethnicity of the clients (Fernando, 2010; Kirmayer, 2012). This can lead to disparity in treatment provision (DeVecchio Good and Hannah, 2015; Snowden, 2003). Therefore, without assessing cultural and contextual factors, the psychiatry assessment process may not adequately inform diagnosis or the right choice of treatment (Dein and Lipsedge, 1998).

On the other hand, becoming highly focused on culture when assessing mental health problems may become a dilemma for clinicians because there is also a possibility of misjudging the clients' mental health problem as culturally appropriate when that may not be the case (Fitzgerald et al., 1997a). With such errors in mind, Stein (1985) described 'culture as a red herring' and that 'a clear distinction must always be made between what a patient's culture is and what clinicians presume it to be' (p. 4). Therefore, exploring psychiatrists'

cross-cultural construction of clients can provide insight into the implicit processes involved in making sense of clients' presenting problems.

Additionally, the universal way in which the diagnostic categories classify presenting mental health difficulties does not lend itself well to the acknowledgement of individual cultures regarding personal perceptions of mental health problems. This can lead psychiatrists to place cultural influences on the 'back-burner' (Jacob, 2014). It is important that in this case we are not only referring to the cultural context of people of ethnic minority groups, but to become aware that it just as crucial to recognise the cultural differences that also exist in the majority ethnic group (Alarcon, et al., 2009). This is because like ethnic minority groups, individuals who belong to the ethnic majority group can also express understanding of distress embedded in their own local family culture, region and religion (Alarcon, et al., 2009). Clinically, factors beyond the biomedical model, such as the influence of individual familial, regional and cultural differences, need careful consideration.

4.4.3. Enhancing cultural communication in mental health

Research studies have suggested that difficulty in communication between the doctor and patient can be influenced by the patient's ethnic background (Schouten and Meeuwesen, 2006). It can be suggested that doctors and psychiatrists (as well as all clinicians) can tap into the diversity within their own workforce and create a space whereby personal cultural experiences can be shared in order to cultivate cross-cultural understanding. Clinically, setting up a consultation within services that enable others to openly communicate and share their own cultures in a safe and non-judgemental space can be a helpful way of gaining information that can assist in a sound assessment and formulation of clients of diverse ethnic backgrounds.

Communication amongst psychiatrists (as well as members of the multidisciplinary team) of different ethnicities can enable others to become more aware of the varied ways in which distress can be expressed and understood in different cultures (Desai and Chaturvedi, 2017). During the presentation to and discussion with the trainee psychiatrists in this study, it was apparent that the diverse perspectives shared by their colleagues of Western and non-Western cultural backgrounds seemed to have created a dialogue where the language and beliefs of mental health problems of people of different ethnicities were valued. The continuation of such conversations within a consultation, supervision or reflective group setup is likely to help reduce the application of a 'one-size-fits-all', Western understanding of psychiatric syndromes to all cultures, even when this is not ecologically valid.

4.4.4. Incorporating cultural awareness at training level

Neimeyer and Fukuyama's (1984) study reported an increase in cultural awareness of a counsellor following a training course that covered 'Counselling Ethnic Minorities'. Therefore, it might be useful to facilitate training for psychiatrists that takes into account the influence of culture on mental health practice. The trainee psychiatrists who took part in the presentation and discussion were open to think about their own culture and the culture of others. As such, it can be inferred that such training will be welcomed. There appears to be a movement for training in cultural competence (Bhui et al., 2007; Kirmayer, 2012) that aims to provide cultural knowledge to professionals who work in multi-cultural societies. However, though such training may be useful in raising awareness, there have been criticisms suggesting that it stereotypes and disempowers clients due to issues such as essentialism and cultural appropriation (Kirmayer, 2012).

It is important to note that though there may be common practices within cultures, there is heterogeneity amongst individuals from the same ethnic groups (DeVecchio Good and

Hannah, 2015). Therefore, it cannot be assumed that an increase in awareness of the culture of a specific ethnic group generalises to everyone within that group. It is therefore imperative to get to know the individual client and the practices within their culture that they may subscribe to, on a case by case basis, and not as a universal phenomenon (DelVecchio Good and Hannah, 2015).

4.5. Consideration of the quality of the current study

4.5.1. Strengths

The current research is important because it adds to the understanding of how psychiatrists from different ethnic groups make sense of clients from different ethnicities. As can be seen in the papers presented in the Introduction, there appears to be a lack of research studies that have explored how psychiatrists construe clients from different ethnicities and those of their own ethnicity. This research was particularly important because there have been numerous papers suggesting that the ethnicity of the client plays a role in the doctor-patient relationship as well as the clients' explanations of their mental health problems. This research adds to knowledge of how clients are understood, in the context of ethnic similarities and differences between them and the psychiatrist, which addresses fundamental clinical implications regarding cross-cultural issues as highlighted above.

The study also looked at the difference between different psychiatrists and how the psychiatrist's own culture can impact their understanding of clients. Though psychiatrists go through a common training, they each bring with them their own unique way of making sense of clients whom they encounter within their day-to-day practice. The case examples provided an indication of the diversity that exists in the construction of clients of different ethnicities by psychiatrists of different ethnicities. This observation suggests that each psychiatrist brings their own unique way of construing the world based on their own personal

experiences, in spite of the shared training in biomedical approaches between psychiatrists or the psychiatrists' and clients' shared ethnic backgrounds.

The repertory grid methodology was particularly helpful in looking beyond how psychiatrists think they should be addressing the study questions and tapping into how they use their past or present experiences of clients and significant people in their lives to make judgements.

This enabled the researcher to access the subjective views of the participants in a way that highlighted not only areas of differences or similarities but also areas of conflict.

Additionally, the method adopted enabled the researcher to explore how ethnicity and culture influence the decision making process in practice by accessing implicit practices.

Using the Effective Public Health Practice Project (EPHPP, 2009; see Appendix I) quality assessment tool for quantitative studies to appraise the current study, it can be said that those selected to take part in this research represented the target population. Additionally, approximately 85% of the individuals who showed an interest in participating in the study following the teaching and discussion on 'Cultural Construction of Mental Health Problems in Practice' (facilitated by the researcher) agreed to take part in the study. Furthermore, there were no drop-outs as all the participants who agreed to take part completed the study. Even though the participants were of different ethnic backgrounds, they were all trainee psychiatrists who were undergoing training in the UK. Furthermore, the participants were not aware of the research questions prior to taking part in the interview.

In terms of reliability and validity of the repertory grid, it has been suggested that 'consistency' rather than reliability and 'usability' instead of validity are more meaningful because the repertory grid form is not standard (Winter, 1992, p. 46). On the other hand, it has been suggested that a grid completed by the same person at a different time should indicate 'stability', as long as the grid elicits important characteristics of the person's

construing (Winter, 1992, p.47). In relation to validity, Winter (1992) suggested that there are research studies that have indicated the validity of a range of repertory grid scores. In regard to the current study, it appears that the repertory grid technique, as a way to elicit constructs for a set of specific elements, measured what was required, indicating construct validity.

4.5.2. Limitations

The small number of participants in the study means that the findings need to be interpreted with caution. There is a possibility that the non-significant findings in relation to some of the hypotheses may have been significant should there have been more participants. Again, it can be said that some of the significance in the data may have happened by chance (Type 1 error) because of the large number of significance tests used. It can be suggested that setting the level of significance to $p < 0.01$ instead of $p < 0.05$ would have addressed this. However, for the present exploratory study, the probability range of $0.05 < p < 0.10$ was used as an indicator of potential borderline significance and as such to allow for more interpretation of the results.

The process of eliciting bipolar constructs meant that without further interviewing the participants, there was a limitation on the meaning that can be ascribed to these constructs (Marsden and Littler, 2000). This is because multiple meanings can be ascribed to the words and short sentences applied in describing the elements. It may have been helpful to supplement the elicitation process with further open questions that could have given the researcher a true meaning of the constructs rather than assuming what was meant by the participant (Honey, 1979).

Furthermore, in the process of elicitation, asking the participants for a way in which two elements are alike and thereby different to the third led some participants to give physical descriptors of the elements. This meant that further prompting was, at times, required to ensure that participants provided characteristics such as personality. This meant that the

response given may not match the participant's original response and they may reply in ways that they think the researcher requires them to respond.

Using the classification system for the personal constructs meant that the constructs had to be quantified. Furthermore the quantified data were aggregated and this arguably depersonalised the constructs that had been elicited. Therefore this process may have distorted the understanding of how the participants' own experience from their culture may have influenced their constructions (Katz, 1984).

Though a second rater was employed to increase reliability of the coding and to reduce researcher bias, it was clear that the raters brought their own cultural experiences to the research. The second rater coming from a Russian background meant that English was not her first language, though she was fluent in English. It is possible that some of her interpretations of the constructs may have been different to how a native English speaker understood the constructs. Additionally, the researcher as the first rater may have also interpreted the constructs based on her own cultural experiences. Nonetheless, it is important to note that even people who share the same culture and experiences may have a different way of understanding the constructs. Additionally, the classification system used was produced in Spain so therefore generalizability was already limited. Despite these possible limitations, the coding system was found to have very respectable reliability.

A limitation of the elicitation of the elements was that the researcher was unaware of how the participants related to the significant people in their lives and the ethnic background of these significant people. This confounds the results that take into account significant people in the lives of the participant, especially as some of the hypotheses were based on construing of people of the same and different ethnicity. Additionally, the age of the significant person chosen seemed to limit participants' responses. For example, when the significant person was

a young child of the participant, they particularly found it difficult to elicit what they perceived the child's (as a significant person) view of mental health problems (medical, psychological or spiritual) would be. Often participants were not able to give a definitive response to the rating, but rather selected a neutral rating.

Regarding the elicitation of the elements and providing constructs in relation to these elements, it became apparent that this process was affected by recency and primacy effects. For example, it appeared that for the most recent clients, participants were able to easily elicit constructs to describe these elements. However, with clients who had not been seen for a number of months or years, there appeared to be a struggle to recall characteristics of these individuals. At these times, participants were not able to access immediate characteristics that came to mind, but rather their responses seemed more considered, which can be influenced by social desirability.

The current research did not assess acculturation and, thus, did not look at the different cultures the psychiatrists come from (or identify with) and the extent to which they hold on to the traditional beliefs of these cultures. Studies have suggested that migrants' experience of mental health is different to their children born in the host country (Agbayani-Siewert et al., 1999; Hickling 2005). Therefore demographic data such as place of birth, length of stay in the UK (if the participant migrated) and which culture they identified with may have added to the understanding of the participants' cultural constructions. Additionally, three of the participants who were from North Africa described themselves as Arabic or Coptic because the demographic classification for Africans on the demographic form specified a category for 'black Africans' and did not consider the diverse ethnic groups within Africa. These participants were included in the African category during analysis, which may have confounded the results as they could not think of clients from the culture they identified with, even though they may have viewed themselves as different from all the clients they elicited.

Furthermore, race and ethnicity may have been blurred in this research. Therefore, even though most participants were able to think of clients of the same race, this did not mean that they could relate to them ethnically.

In using the EPHPP (2009), it can be said that the participants who took part in this study were a convenience sample, and that there was a possible selection bias, which may have limited the generalisability of the current research findings.

It is important to note that most of the relevant research studies that inform and support the current study are dated and therefore more research is required in this area.

Another limitation of this study is regarding the broad categories used, that is categorising participants into European and non-European. It can be argued that this can lessen the opportunity to look at subtle differences and as such appears to globalise individual cultures (Miller 2002) by implying European and Non-European ideals, which can perpetuate racial stereotyping and language. In addition, these categories do not seem to acknowledge heterogeneous practices within cultures.

Additionally, it should be noted that the focus on ethnicity in the current study does not take into account other contextual factors and cultural variations that may influence how people construe others. This is because basing participants construing on ethnic difference or sameness can be argued to be an insufficient way to understand the processes involved in understanding the behaviour of others. More specifically, it does not account for the complexity of cultural processes that influence variation in meaning-making such as power, class, religion and other 'macro' influences (Miller, 2002). Therefore, it is likely that there may contextual factors that may have influenced the differences observed in the analysis.

With reference to individuals who showed an interest in participating in the study following the teaching and discussion on 'Cultural Construction of Mental Health Problems in Practice'

(facilitated by the researcher), it is possible that the participants may have been primed to expect to partake in research that looks at cultural attitudes. It can therefore be argued that the information on culture in relation to the presentation may have been more cognitively accessible to these participants during their participation in the study, which is likely to confound the results.

4.6. Recommendations for further research

Firstly, it will be crucial for further research to repeat this study with a larger sample than was possible because of the time limitation on this project. For instance, it will be useful to expand on the findings of the case examples with a larger sample and to explore further the suggestions that psychiatrists of different ethnicities construed clients of different ethnicities differently. Additionally, this could be expanded by finding out whether there is a difference in the psychiatrists' view of each of the client ethnic groups instead of aggregating clients, especially those of non-European ethnic backgrounds (Asian and African). Similarly, the psychiatrists' ethnic groups could be explored individually, instead of grouping Asian and African psychiatrists as non-Europeans.

Secondly, given the broad categorisation of ethnic groupings in the current research, it will be imperative for future research to not assume homogeneity among cultural groups but rather to consider more nuanced and dynamic ways in which individuals from the same or different cultures make sense of their experiences. This may include the need to acknowledge a more 'fine-grained analysis' that takes into account the intricacy of certain perspectives as well as the homogeneity and heterogeneity that exist between and within different groups of people (Miller, 2002).

Future research could also compare psychiatrists' construal with the clients' construal to determine whether they correlate. Such a study could examine not only how clients are construed, but also how clinicians are construed.

It may be useful to look at how constructions of clients of different ethnicities change following the provision of teaching and training to clinicians on the influence of ethnic differences in practice.

Even though studies have suggested that cultural competence training was beneficial (e.g. Henderson et al, 2011) and that it was seen to improve the cultural competence of the providers (Fisher et al., 2007), it has been alluded that the transition from training to practice can be problematic and that more research is required in this area (Truong et al., 2014). One of the main issues identified in a systematic review of the studies, examining cultural competence, by Truong et al., 2014 is that there are so many varied ways in which cultural competence training or interventions are delivered and that it is difficult to ascertain the types of training with the most effectiveness and efficacy. Further research in this regard may need to consider outcomes from staff as well as patients and clients (Truong et al., 2014).

It is imperative that the outcome of this research study is not limited to the practices of psychiatrists, but considered by all clinicians working with clients from diverse ethnic backgrounds. More importantly, with the gradual increase in diversity within clinical psychology courses, future research can consider replicating this study with psychologists and examining whether the ethnicity of the client and the psychologist play a role in the therapeutic relationship and process.

4.7. Conclusions

This research study has provided some insight into how psychiatrists of different ethnicities perceive clients, which may fit with their own personal and professional experiences. In assessing the structure as well as the content of how the psychiatrists perceive clients of different ethnic groups in relation to themselves and those close to them, it helped us to understand possible ways in which the psychiatrists' construe others.

With the increasingly diverse population in the United Kingdom, there are inevitably some challenges that clinicians may experience when working cross-culturally. The drive to ensure that clinicians are culturally competent by increasing their knowledge and awareness of other cultures can be described as a reasonable start, but yet a limited way of understanding people from diverse, heterogeneous, cultures. This is because, fitting with the biomedical model, it attempts to universalise cultures even though culture can be idiosyncratic to the client.

Nonetheless, there still exists the dilemma of what is culturally specific to the individual and what is culturally specific to a group of people.

Exploring what is culturally specific to the client may help us work in a culturally sensitive way in line with the client's own perceptions and beliefs. Conceivably, this process may not be about becoming a cultural expert, but rather working through the uncertainties and biases to increase awareness of diverse cultural presentations as well as allowing flexibility when applying this knowledge in order to promote the appropriate provision of care.

References

- Abbe, A., Rentsch, J., & Mot, I. (2009). Cultural schema: Mental models guiding behavior in a foreign culture. *US Army Research Institute for the Behavioral and Social Sciences, with Joan Rentsch and Ioana Mot Organisational Research Group, LLC.*
- Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., Doku, V., & Mhapp Research Programme Consortium. (2010). 'Whether you like it or not people with mental problems are going to go to them': a qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International review of psychiatry (Abingdon, England)*, 22(6), 558.
- Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, 38(2), 171.
- Agbayani-Siewert, P., Takeuchi, D. T., & Pangan, R. W. (1999). Mental illness in a multicultural context. In *Handbook of the sociology of mental health* (pp. 19-36). Springer, Boston, MA.
- Alarcón, R. D. (2009). Culture, cultural factors and psychiatric diagnosis: review and projections. *World psychiatry*, 8(3), 131-139.

Alarcón, R. D., Becker, A. E., Lewis-Fernández, R., Like, R. C., Desai, P., Foulks, E.,

Gonzales, J., Hansen, H., Kopelowicz, A., Lu, F.G. & Oquendo, M. A. (2009). Issues for DSM-V: the role of culture in psychiatric diagnosis. *The Journal of nervous and mental disease*, 197(8), 559.

American Psychiatric Association. (2015). *DSM-5® Classification*. American Psychiatric Pub.

Atkins, C., & Sampson, J. (2002). Critical appraisal guidelines for single case study research. *ECIS 2002 Proceedings*, 15.

Bagayogo, I. P., Interian, A., & Escobar, J. I. (2013). Transcultural aspects of somatic symptoms in the context of depressive disorders. In *Cultural psychiatry* (Vol. 33, pp. 64-74). Karger Publishers.

Bannister, D. (2003). Kelly versus clockwork psychology. *International handbook of personal construct psychology*, 33-39.

Bannister, D. (1965). The rationale and clinical relevance of repertory grid technique. *The British Journal of Psychiatry*, 111(479), 977-982.

Bannister, D., & Fransella, F. (1986). *Inquiring Man: the Psychology of Personal Constructs* (3rd edn), Beckenham: Croom Helm.

Bassett, A. M., & Baker, C. (2015). Normal or Abnormal? 'Normative Uncertainty' in

Psychiatric Practice. *Journal of Medical Humanities*, 36(2), 89-111.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. University of Pennsylvania Press.

Beck, A. T., & Beck, R. W. (1972). Screening depressed patients in family practice: A rapid technic. *Postgraduate medicine*, 52(6), 81-85.

Beck, A. T. (2002). Cognitive models of depression. *Clinical advances in cognitive psychotherapy: Theory and application*, 14(1), 29-61.

Bell, R.C. (2003). *The Repertory Grid Technique*. In F. Fransella (Ed.), *Personal Construct Psychology*. Chichester: John Wiley and Sons Ltd.

Bell, R. C. (2004a). A new approach to measuring inconsistency or conflict in grids. *Personal Construct Theory & Practice*, 1, 53-59.

Bell, R. C. (2004b). *GRIDSTAT: A program for analysing the data of a repertory grid*. Version 4. Computer software] Melbourne: Author.

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.

- Bhui, K., Ascoli, M., & Nuamh, O. (2012). The place of race and racism in cultural competence: What can we learn from the English experience about the narratives of evidence and argument?. *Transcultural psychiatry*, *49*(2), 185-205.
- Biswas, J., Gangadhar, B. N., & Keshavan, M. (2016). Cross cultural variations in psychiatrists' perception of mental illness: A tool for teaching culture in psychiatry. *Asian journal of psychiatry*, *23*, 1-7.
- Blundell, J., Wittkowski, A., Wieck, A., & Hare, D. J. (2012). Using the repertory grid technique to examine nursing staff's construal of mothers with mental health problems. *Clinical psychology & psychotherapy*, *19*(3), 260-269.
- Brautigam, W., & Osei, Y. (1979). Psychosomatic illness concept and psychotherapy among the Akan of Ghana. *The Canadian Journal of Psychiatry*, *24*(5), 451-457.
- Bush, A., Collings, S., Tamasese, K., & Waldegrave, C. (2005). Samoan and psychiatrists' perspectives on the self: Qualitative comparison. *Australian & New Zealand Journal of Psychiatry*, *39*(7), 621-626.
- Constantino, M. J., Castonguay, L. G., & Schut, A. J. (2002). The working alliance: A flagship for the scientist-practitioner model in psychotherapy. *Counseling based on process research: Applying what we know*, 81-131.

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance:

Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training*, 43(3), 271-279.

Chen, S., Sullivan, N. Y., Lu, Y. E., & Shibusawa, T. (2003). Asian Americans and mental

health services: A study of utilization patterns in the 1990s. *Journal of Ethnic and Cultural Diversity in Social Work*, 12(2), 19-42.

Chiari, G., & Nuzzo, M. L. (1996). Psychological constructivisms: A metatheoretical

differentiation. *Journal of Constructivist Psychology*, 9(3), 163-184.

Chopik, W. J., O'Brien, E., & Konrath, S. H. (2017). Differences in empathic concern and

perspective taking across 63 countries. *Journal of Cross-Cultural Psychology*, 48(1), 23-38.

Clarke, V., & Braun, V. (2014). Thematic analysis. In *Encyclopedia of critical*

psychology (pp. 1947-1952). Springer New York.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and*

psychological measurement, 20(1), 37-46.

Comino, E. J., Silove, D., Manicavasagar, V., Harris, E., & Harris, M. F. (2001). Agreement

in symptoms of anxiety and depression between patients and GPs: the influence of ethnicity. *Family practice*, 18(1), 71-77.

Cooper, S. (2016). "How I Floated on Gentle Webs of Being": Psychiatrists Stories About the Mental Health Treatment Gap in Africa. *Culture, Medicine, and Psychiatry*, 40(3), 307-337.

Critical Appraisal Skills Programme (2018). *CASP Qualitative Checklist*. [online] Retrieved from: <http://www.casp-uk.net/checklists>

Dein, S. and Lipsedge, M. (1998) 'Negotiating Across Culture, Race and Religion in the Inner City' in Okpaku, S. O. (Ed.). (1998). *Clinical Methods in Transcultural Psychiatry*. Washington: American Psychiatric Press.

DeVecchio Good, M. J., & Hannah, S. D. (2015). "Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural psychiatry*, 52(2), 198-221.

Desai, G., & Chaturvedi, S. K. (2017). Idioms of Distress. *Journal of neurosciences in rural practice*, 8(Suppl 1), S94-S97.

Dunn, W. N. (1986). *Policy analysis: perspectives, concepts, and methods*. Greenwich, Connecticut: JAI Press.

Effective Public Health Practice Project (EPHPP). (2009). *Quality assessment tool for*

quantitative studies. Accessed April, 2018, from <http://www.ephpp.ca/tools.html>

Epting, F. R., & Leitner, L. M. (1992). Humanistic psychology and personal construct

theory. *The Humanistic Psychologist*, 20(2-3), 243.

Erdfelder, E., Faul, F., & Buchner, A. (1996). GPOWER: A general power analysis

program. *Behavior research methods, instruments, & computers*, 28(1), 1-11.

Fabrega, H. (1987). Psychiatric diagnosis: A cultural perspective. *Journal of Nervous and*

Mental Disease.

Feixas, G., Geldschläger, H., & Neimeyer, R. A. (2002). Content analysis of personal

constructs. *Journal of Constructivist Psychology*, 15(1), 1-19.

Fernando, S. (1991). *Mental health, race and culture*. Basingstoke: Macmillan.

Fernando, S. (2010). *Mental health, race and culture*. Palgrave Macmillan.

Fernando, S. (2014). *Mental health worldwide: Culture, globalization and development*.

Palgrave Macmillan.

Field, A. (2009). *Discovering statistics using SPSS*. Sage publications. Springer.

Fisher, T. L., Burnet, D. L., Huang, E. S., Chin, M. H., & Cagney, K. A. (2007). Cultural

leverage. *Medical Care Research and Review*, 64(5_suppl), 243S-282S.

Fitzgerald, M. H., Mullavey-O'Byrne, C., Clemson, L., & Williamson, P., (1997a).

Enhancing cultural competence training manual. *Australia: Transcultural Mental Health Centre.*

Fitzgerald, M. H., Beltran, R., Pennock, J., Williamson, P., & Mullavey-O'Byrne, C. (1997b).

Occupational therapy, culture and mental health. *Australia: Transcultural Mental Health Centre.*

Fransella, F. (1995). *George Kelly*. London: Sage.

Fransella, F. (Ed.). (2003). *International handbook of personal construct psychology*. John Wiley & Sons.

Fung, K., & Wong, Y. L. R. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International journal of social psychiatry*, 53(3), 216-231.

Gergen, K. J. (1990). Therapeutic professions and the diffusion of deficit. *The Journal of Mind and Behavior*, 353-367.

Ginsberg, A. (1989). Construing the business portfolio: A cognitive model of diversification. *Journal of Management Studies*, 26(4), 417-438.

Green, B. (2004). Personal construct psychology and content analysis. *Personal Construct*

Theory & Practice, 1(3), 82-91.

Grice, J.W. (2004). *Idiogrid: Idiographic Analysis with Repertory Grids*. Version 2.3:

Stillwater, USA.

Gyekye, K. (1995). *An essay on African philosophical thought: The Akan conceptual scheme*.

Temple University Press.

Hare, D. J., Durand, M., Hendy, S., & Wittkowski, A. (2012). Thinking about challenging

behavior: A repertory grid study of inpatient staff beliefs. *Intellectual and*

developmental disabilities, 50(6), 468-478.

Henderson, S., Kendall, E., & See, L. (2011). The effectiveness of culturally appropriate

interventions to manage or prevent chronic disease in culturally and linguistically

diverse communities: a systematic literature review. *Health & Social Care in the*

Community, 19(3), 225-249.

Hickling, F. W., McKenzie, K., Mullen, R., & Murray, R. (1999). A Jamaican psychiatrist

evaluates diagnoses at a London psychiatric hospital. *The British Journal of*

Psychiatry, 175(3), 283-285.

Hickling, F. W. (2005). The epidemiology of schizophrenia and other common mental health

disorders in the English-speaking Caribbean. *Revista Panamericana de Salud Pública, 18*(4-5), 256-262.

Holroyd, J. (2015). Implicit bias, awareness and imperfect cognitions. *Consciousness and cognition, 33*, 511-523.

Honey, P. (1979). The repertory grid in action: How to use it to conduct an attitude survey. *Industrial and Commercial Training, 11*(11), 452-459.

Hwang, W. C., Myers, H. F., Abe-Kim, J., & Ting, J. Y. (2008). A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model. *Clinical psychology review, 28*(2), 211-227.

Inglehart, R., & Baker, W. E. (2000). Modernization, cultural change, and the persistence of traditional values. *American sociological review, 19*-51.

Inglehart, R., & Welzel, C. (2005). *Modernization, cultural change, and democracy: The human development sequence*. Cambridge University Press.

Jacob, K. S. (2014). Insight in psychosis: An independent predictor of outcome or an explanatory model of illness?. *Asian journal of psychiatry, 11*, 65-71.

Ji, L. J., & Yap, S. (2016). Culture and cognition. *Current Opinion in Psychology, 8*, 105-

Katz, J. O. (1984). Personal construct theory and the emotions: An interpretation in terms of primitive constructs. *British journal of psychology*, 75(3), 315-327.

Kelly, G. (1955). *The Psychology of Personal Constructs: Vol. 2; Clinical Diagnosis and Psychotherapy*. WW Norton.

Kelly, G. (1991). *The psychology of personal constructs: Volume one: Clinical diagnosis and psychotherapy*. Routledge.

Kirkcaldy, B., Pope, M., & Siefen, G. (1993). Sociogrid analysis of a child and adolescent psychiatric clinic. *Social psychiatry and psychiatric epidemiology*, 28(6), 296-303.

Kirmayer, L. J. (2008). Empathy and alterity in cultural psychiatry. *Ethos*, 36(4), 457-474.

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49, 2.

Kleinman, A. (1978). Culture and depression. *Culture, medicine and psychiatry*, 2(4), 295-296.

Kleinman, A. (1988). *The illness narratives: suffering, healing, and the human condition*. Basic books.

Kpanake, L. (2018). Cultural concepts of the person and mental health in Africa. *Transcultural psychiatry*, 55(2), 198-218.

Laungani, P. (1999). Cultural influences on identity and behaviour: India and

Britain. *Personality and person perception across cultures*, 191-212.

Leavitt, R. (2002). Developing cultural competence in a multicultural world: Part 1. *PT Mag Phys Ther*, 10, 36-48.

Light, D. (1980). *Becoming psychiatrists: The professional transformation of self*. New York: Norton

Marsden, D., & Littler, D. (2000). Repertory grid technique—An interpretive research framework. *European Journal of Marketing*, 34(7), 816-834.

Mayer, B., Trommsdorff, G., Kagitcibasi, C., & Mishra, R. C. (2012). Family models of independence/interdependence and their intergenerational similarity in Germany, Turkey, and India. *Family Science*, 3(1), 64-74.

McCann, L., Granter, E., Hassard, J., & Hyde, P. (2015). “You Can't Do Both—Something Will Give”: Limitations of the Targets Culture in Managing UK Health Care Workforces. *Human resource management*, 54(5), 773-791.

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochemia medica: Biochemia medica*, 22(3), 276-282.

Miller, J. G. (2002). Bringing culture to basic psychological theory—Beyond individualism and collectivism: Comment on Oyserman et al. (2002). *Psychological Bulletin*,

128(1), 97-109.

Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews* (Vol. 3).

Greenwood Publishing Group.

Moodley, R., & Ocampo, M. (Eds.). (2014). *Critical psychiatry and mental health: Exploring*

the work of Suman Fernando in clinical practice. Routledge.

Morrison, J. (2017). *DSM-5 made easy: The clinician's guide to diagnosis*. Guilford

Publications.

Neimeyer, G. J., & Fukuyama, M. (1984). Exploring the Content and Structure of Cross-

Cultural Attitudes. *Counselor Education and Supervision*, 23(3), 214-224.

Neimeyer, R. A., & Winter, D. A. (2007). Personal construct therapy. In *Handbook of*

homework assignments in psychotherapy (pp. 151-171). Springer US.

Nelson, G., & Prilleltensky, I. (2005). *Community psychology: In pursuit of liberation and*

well-being. Basingstoke: Palgrave Macmillan.

Nolte, L. (2007). White is a colour too: engaging actively with the risks, challenges and

rewards of cross-cultural family therapy training and practice. *Journal of Family*

Therapy, 29(4), 378-388.

Odusanya, S. O., Winter, D., Nolte, L., & Shah, S. (2017). The experience of being a

qualified female BME clinical psychologist in a National Health Service: An interpretative phenomenological and repertory grid analysis. *Journal of Constructivist Psychology*, 1-19.

Olafsdottir, S., & Pescosolido, B. A. (2011). Constructing illness: How the public in eight Western nations respond to a clinical description of “schizophrenia”. *Social Science & Medicine*, 73(6), 929-938.

Opore-Henaku, A., & Utsey, S. O. (2017). Culturally prescribed beliefs about mental illness among the Akan of Ghana. *Transcultural psychiatry*, 54(4), 502-522.

Podsakoff, P. M., MacKenzie, S. B., Lee, J. Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of applied psychology*, 88(5), 879.

Ralley, C., Allott, R., Hare, D. J., & Wittkowski, A. (2009). The use of the repertory grid technique to examine staff beliefs about clients with dual diagnosis. *Clinical psychology & psychotherapy*, 16(2), 148-158.

Raskin, J. D. (2002). Constructivism in psychology: Personal construct psychology, radical constructivism, and social constructionism. *American communication journal*, 5(3), 1-25.

Rastogi, P., Khushalani, S., Dhawan, S., Goga, J., Hemanth, N., Kosi, R., Sharma, R. K.,

Black, B. S., Jayaram G., & Rao, V. (2014). Understanding clinician perception of common presentations in South Asians seeking mental health treatment and determining barriers and facilitators to treatment. *Asian journal of psychiatry*, 7, 15-21.

Reynolds, R. (2013). Personal construct theory. *Theory in information behaviour research*, 68-82.

Roever, L. (2015) Critical Appraisal of a Questionnaire Study. *Evidence Based Medicine and Practice*

Schouten, B. C., & Meeuwesen, L. (2006). Cultural differences in medical communication: a review of the literature. *Patient education and counseling*, 64(1), 21-34.

Schwartz, S. H. (2006). A theory of cultural value orientations: Explication and applications. *Comparative sociology*, 5(2), 137-182.

Sewell, K.W. and Williams, A.M. (Ed.). (2001). *Construing Stress: A Constructivist Therapeutic Approach to Posttraumatic Stress Reactions*. Washington: American Psychological Association.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). Committee on Understanding and

Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care. In *National Academy of Science* (Vol. 180, p. 191).

Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93*(2), 239-243.

Soldz, S. (1989). Do psychotherapists use different construct subsystems for construing clients and acquaintances? A repertory grid study. *Journal of social and clinical psychology, 8*(1), 97-112.

Soldz, S. (1992). Negativity in psychotherapists' evaluations of clients and personal acquaintances. *International journal of personal construct psychology, 5*(4), 393-411.

Speerforck, S., Schomerus, G., Pruess, S., & Angermeyer, M. C. (2014). Different biogenetic causal explanations and attitudes towards persons with major depression, schizophrenia and alcohol dependence: Is the concept of a chemical imbalance beneficial? *Journal of affective disorders, 168*, 224-228.

Spiro, M. E. (1993). Is the Western conception of the self “peculiar” within the context of the world cultures?. *Ethos, 21*(2), 107-153.

Stein, H. F. (1985). The culture of the patient as a red herring in clinical decision making: A

case study. *Medical Anthropology Quarterly*, 17(1), 2-5.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*.

Oxford, England: John Wiley & Sons.

Tan, F. B., & Hunter, M. G. (2002). The repertory grid technique: A method for the study of

cognition in information systems. *Mis Quarterly*, 39-57.

Teferi, J., & Shewangizaw, Z. (2015). Assessment of knowledge, attitude, and practice

related to epilepsy: A community-based study. *Neuropsychiatric disease and*

treatment, 11, 1239.

Triandis, H. C. (1995). *Individualism and Collectivism: New Directions in Social*

Psychology. Boulder, CO.

Triandis, H. C. (2001). Individualism-collectivism and personality. *Journal of*

personality, 69(6), 907-924.

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.

Tully, J. B. (1976). Personal construct theory and psychological changes related to social

work training. *The British Journal of Social Work*, 6(4), 481-499.

Turner, J. C., Oakes, P. J., Haslam, S. A., & McGarty, C. (1994). Self and collective:

Cognition and social context. *Personality and social psychology bulletin*, 20(5), 454-463.

Williams, B., & Healy, D. (2001). Perceptions of illness causation among new referrals to a

community mental health team: "explanatory model" or "exploratory map"? *Social science & medicine*, 53(4), 465-476.

Winter, D. (1992). *Personal construct psychology in clinical practice: Theory, research and*

applications. Routledge.

Winter, D.A. (1996). *Personal construct theory*. In A. Kuper and J. Kuper (Eds.), *The Social*

Science Encyclopaedia - Edition 2 (p. 599). London: Routledge.

Woodrow, C., Fox, J. R., & Hare, D. J. (2012). Staff construal of inpatients with anorexia

nervosa. *Clinical psychology & psychotherapy*, 19(1), 70-77.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural*

disorders: clinical descriptions and diagnostic guidelines (Vol. 1). World Health Organization.

Wu, S., & Keysar, B. (2007). The effect of culture on perspective taking. *Psychological*

science, 18(7), 600-606.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors

that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing*, 14(2), 88-95.

Yeung, E. Y. W., Irvine, F., Ng, S. M., & Tsang, S. (2017). How People from Chinese

backgrounds Make Sense of and Respond to the Experiences of Mental Distress: a Qualitative Study. *Journal of psychiatric and mental health nursing*.

APPENDICES

Appendix A: Summary of the research in the systematic literature review

Summary of literature review papers in PART 1:

Title; Author; Location	Aim	Participants/ Service-User group	Research Methodology	Summary of study key findings	Strengths and Limitations
<p>Using the repertory technique to examine nursing staff's construal of mothers with mental health problems</p> <p>Blundell, Wittkowski. Wieck & Hare (2012)</p> <p>UK</p>	<p>Repertory grid to explore the construal of psychiatric nursing staff working in a specialist MCU towards clients with whom they worked and in what way this was different, or similar to, participants' construal of self and mothers whom they knew personal.</p>	<p>Convenience sample</p> <p>10 psychiatric nursing staff in specialist mothers and baby unit (MBU), providing day and inpatient care. Minimum of 6months of working on the ward</p> <p>Age 26- 48</p> <p>6 qualified nurses and 4 qualified nursery nurses</p> <p>Clients on the ward: depression and psychosis, personality disorder</p>	<p>Repertory grid lasting 90mins</p> <p>Quantitative*</p> <p>Eight role titles and to think of people whom they has known for the past 6months who fitted these role titles :</p> <p>Construct were elicited using triadic method in order to generate bipolar constructs by comparing and contrasting three elements</p> <p>Generated 10 bipolar constructs</p>	<p>Close proximity:</p> <p><u>*'self' and mothers known personally with no history of mental illness'</u></p> <p><u>*Few staff members construed clients similar to themselves</u></p> <p>Variability in construal of client with depression and client with psychosis</p> <p>Attributions made by staff regarding clients behaviour as well as the interactional style of clients, negatively influenced the ability of staff members to develop</p>	<p>+ Rich data as they asked meaning of construct</p> <p>+ <u>Participants often spoke of the influence that personal experience had on their construal of clients</u></p> <p>- small, not generalizable to population</p> <p>- Multiple grid analyses places assumptions on the data as only provide a general representation of the construal of elements across the staff group.</p> <p>- All element data are combined in this way, a certain amount of</p>

				<p>positive relationships with clients</p> <p>Those clients construed as demonstrating difficult interactional styles were regarded as being the most difficult clients to work with. Example clients with personality disorder construed negative, difficult and distinct from self</p> <p>Staff members made critical judgements of some clients.</p> <p>Challenging experience and difficult experience can affect care received by clients and the amount of stress and burnout experienced by staff</p>	<p>integrity is lost, and individual participant differences are obscured.</p>
<p>Personal construct theory and psychological changes related to social work training</p> <p>Bender unpublished study in Tully (1976) systematic review</p>	<p>Bender examination of 12 psychiatric social workers in London.</p> <p>Review of social workers construct</p>	<p>Bender's study included social work</p>	<p>Personal constructs used by professionally trained social workers</p> <p>Compares personal construct clients and for 'influentials', that is important friends, relative, colleagues, etc.</p>	<p>Client construing subsystem involved significantly more psychiatric terminology.</p> <p>The constructs concerned with influentials was characterised by self-involvement and affect.</p> <p><u>The social worker rated constructs elicited for one group, substantially</u></p>	<p>+Informed future studies on how clinician (social workers) construe people in their lives and clients</p> <p>+ Suggested future clinical implication that training received require social workers to impose order on the 'chaos' of the client behaviour, to prevent over-identification with the</p>

<p>UK</p>			<p>Examined how far one system was applicable to the other group of people.</p>	<p><u>'non-applicable' when asked to use them for the other group.</u></p> <p>[There was very little overlap indicating the limitation of ranges of convenience of the sets of constructs.]</p> <p><u>There were significantly more isolated constructs within the clients' grids than in the 'influential' grids.</u></p> <p>Influential grids on the other were more likely to reveal several clusters of constructs liked with other constructs and partially correlated with two or more constructs.</p>	<p>clients and to establish some degree of emotional insularity</p> <p>-An unpublished study</p> <p>-No clarity on the aims, recruitment, analysis and implications</p>
<p>The use of the repertory grid technique to examine staff beliefs about clients with dual diagnosis</p> <p>Ralley, Allot, Hare and Wittkowski (2009)</p> <p>UK</p>	<p>Exploring how individual psychiatric staff construe client with psychosis who misuse substances</p>	<p>A convenience sample of 12 nursing staff (7 female; 5 male; 26yrs-54yrs; 5nursing asst.; 7 qualified mental health nurses) from three long-stay low-secure inpatient wards, providing intensive treatment and rehabilitation to adults with enduring mental health difficulties, primarily with</p>	<p>Quantitative</p> <p>Repertory grid – lasting 1hr</p> <p>10 constructed elicited for each participant</p>	<p>Two participant tended to construe people using one construct only, termed either 'stability' or 'friendliness' (low complexity)</p> <p>In contrast to those two construct systems, the construing of clients by two other participants was very complex.</p>	<p>+Rich data</p> <p>+While the data-driven approach used allows for strong conclusions because hypotheses were generated from within the data and hold true for each individual in the researched group</p> <p>+Suggestion for the future study, i.e., <u>that it is possible that</u></p>

		<p>schizophrenia diagnoses who has been on the unit for between 2years and 3years. Minimum of 6months experience of working with clients with psychosis</p>		<p>The remaining eight participants showed moderately complex construct systems (i.e., two principal components).</p> <p>All indicating differentiated systems of dimensions for construing the actions of others (Bieri et al., 1966).</p> <p><u>There was a tendency to construe oneself, colleagues, known acquaintances (who did not misuse substances) and the hypothetical 'ideal client' as similar to each other. *Actual clients were construed as dissimilar from this group but did not cluster together, suggesting differences in how different clients' were construed.</u></p> <p>The known acquaintance who misused substances and the client without psychosis or misuse were construed as more similar to the cluster of</p>	<p><u>experiencing 'clients' in 'non-client' contexts (e.g., through personal experience as a carer) may normalize clients' actions and reduce the dissimilarities perceived between the so-called 'clients' and 'non-clients'.</u></p> <p>+ <u>Implications for future research, which should consider both specificity (of individual known clients) and variability (differing attitudes between staff and towards different clients) in staff attitudes towards clients.</u></p> <p>-Small sample size</p> <p>-3 participants could not provide elements of clients with mental health without psychosis</p> <p>-3 participants could not think of construct because they could not think similarities or difference within triads of elements</p>
--	--	---	--	--	--

				<p>non-clients than the other clients.</p> <p>Lower cognitive complexity/ higher levels of variance is moderately associated with higher differentiation between clients and non-clients.</p> <p>*Six participants made a clear distinction between clients and non-clients, construing the former towards the least preferred construct poles. <u>*The remaining six participants did not make categorical distinctions between clients and non-clients and were aware of similarities.</u></p> <p>Staff varied in their construal of clients with psychosis, with four participants construing non-psychotic clients more positively and as more similar to themselves than clients with psychosis, but other participants did not make this distinction.</p> <p>Construal of psychosis were attributing</p>	<p>-omitting the three grids lacking element</p> <p>-unrepresentative, being comprised entirely of White British</p> <p>-inpatient ward staff, and this coincidental circumstance might also limit the generalizability of the current findings.</p>
--	--	--	--	---	--

				<p>behaviours and difficulties to the client's mental illness, rather than to the Individual.</p> <p>All staff expressed negative views towards clients who misused substances, but half were more accepting of misuse by acquaintances.</p> <p>Differentiated systems of dimensions used to process the behaviour of clients and non-clients, and were associated with less distinction between these groups</p> <p>The highly individual nature of staff construing of different clients.</p> <p>All staff construed some, if not all, clients negatively, with critical judgements made and clients construed as possessing negative personal qualities and social inadequacies.</p> <p><u>However, some staff explained the development of their views, which included</u></p>	
--	--	--	--	--	--

				<u>their own experiences, both professional and personal, and clients' mental illness and difficult life experiences.</u>	
Thinking about challenging behaviour: A rep grid study of inpatients study Hare, Hendy and Wittkowski (2012) UK	exploring how care staff in one intellectual disability service perceived clients with intellectual disability whose behaviors were challenging, using their own words Participants were recruited from an inpatient assessment and treatment unit for adults with intellectual disability	The participants were 14 out of a possible 16 clinical staff (71% female). Seven of these were learning disability nurses and seven were clinical support workers. The mean number of years of experience with people with intellectual disability and/or behavior that challenges was 17.21 years (SD 5 9.1 years), ranging from less than 1 year to 31 years of experience. All except one of the participants used all 10 elements in their repertory grid generating	Repertory grid – 90 - 120mins Participants were asked to think of people they had known well who fitted the following role, including 7clients, hypothetical ideal client, carer who struggles and self.	In control versus not in control. Being in control of their behavior was associated with a range of constructs, the majority of which were seen more negatively; for example, miserable, quick tempered, purposely upsetting people, liking their own way, and making your job more stressful. In contrast, mental and physical health problems were thought to be the cause of uncontrollable behaviors, and staff tended to construe these clients as having higher levels of need. Permanent versus temporary. People whose behavior was thought to be permanent, enduring, or unlikely to change were identified by a long history of exhibiting those	<u>+Suggested future implications that training should take into account the social context within which the carers work and the impact of idiosyncratic perceptions on how training is applied. Future research should acknowledge the subjective and diverse ways that carers understand people with intellectual disability and behavior that challenges and should pay attention to the context within which carers' cognitive, emotional, and behavioural responses emerge.</u> + Helpful suggestion: In this study, examination of the individual grids suggested that the prevailing culture was neither homogenized nor egalitarian, in that some staff may have been

				<p>behaviors or coming into services—the behavior being perceived as unchanging or the client being perceived to have a personality disorder. These clients were most frequently positioned closely to the challenging behavior constructs. It seemed that behaviors were perceived to be temporary if they changed in response to the environment, including through medical or psychosocial interventions. Thus, it seemed that the stability of behavior was a meaningful construct; although clients with temporary behavior problems were not consistently construed in the same way by participants.</p> <p>Clients versus carers. <u>The ideal client, the self, and the client without challenging behaviour were placed close together by eight participants (along with the carer who struggles</u></p>	<p>marginalized on account of their different construing of and their behaviour. <u>Such individual differences could be helpful as different carers may develop better relationships with different clients.</u> However, it also raised <u>the question of how clinical decisions are made within the team and whether carers respond in inconsistent ways to behavior that challenges.</u></p> <p>- There was a social desirability bias within the findings (e.g., minimizing the negatives of behavior that challenges).</p>
--	--	--	--	---	---

				<p><u>by five) at the preferred end of an important construct around behavior or functioning. However, two participants did not construe themselves as very different from the clients. In contrast, other participants appeared to use the self as a way to construe clients. For example, P3 said, “Ideally you like working with people who are like yourself don’t you?”</u></p> <p>Another participant appeared to construe others in terms of her own personality traits and interests.</p> <p>Other themes. Clients were construed in terms of their life experiences (e.g., loss or trauma) by nine participants as well as in terms of mental health problems or medical/psychiatric diagnoses by six participants. Labels such as schizophrenia, personality disorder, and</p>	
--	--	--	--	---	--

				<p>perhaps unsurprisingly within an intellectual disability service, autism were used as ways to explain behaviors.</p> <p><u>There was a high degree of variability in the construct systems of the participants, despite the use of attributional dimensions within the elements</u></p> <p>The results suggested that the team did not hold a collective or stereotyped view of clients with behavior that challenges. Participants did appear to ascribe different meanings to the internal and external causes of challenging behavior, but those clients considered to have internal and external causes of their behavior were not actually construed in systematically different ways. Thus, it appeared that it was the construal of the whole person and her or his history that appeared to be the most</p>	
--	--	--	--	--	--

				<p>relevant to understanding behavior in this staff team.</p> <p>Attribution...The results suggested that attributions were one way among others for carers to understand people with intellectual disability and behavior</p>	
<p>Staff construal of inpatients with anorexia nervosa</p> <p>Woodrow, Fox and Hare (2012)</p> <p>UK</p>	<p>investigate whether staff working in a specialist inpatient eating disorders services differentially construed different types of clients, e.g., those who purged compared with those who restricted.</p>	<p>The participants comprised seven nurses and seven nursing assistants, who had each worked on the unit for a minimum of 12 months and could be taken as representative of the staff group as a whole</p>	<p>The elements (entities being construed) used to elicit the repertory grids with participants were as follows: 10 constructs including clients who purged and restricted, as well as ideal client and ideal self</p>	<p>Clients were not construed as being similar by any participant.</p> <p><u>Each participant viewed the clients in their own unique way. The differences in participant's perception of clients suggest that the individual nature of people overrides diagnosis.</u></p>	<p>+Clinical implication: support evidence of a differentiation between anorexia subtypes</p> <p>+Possible future studies: <u>"whether some client groups tend to be more 'likeable' than other could provide interesting information in relation to difficult to treat 'illnesses'."</u></p> <p>-Not possible to be certain whether participants are representative of staff who work with the client population studied</p>
<p>Sociogrid analysis of a child and adolescent psychiatric clinic</p>	<p>The focus of the present study was an analysis of the role perceptions of a variety of personnel,</p>	<p>The study was based in a Westphalian clinic for child and adolescent psychiatry in a town</p>	<p>The 11 roles comprised the physician, psychologist, remedial teacher, medical technical assistant,</p>	<p>Whilst the nurse viewed herself in similar terms to those of the patient and child's parent, the doctor</p>	<p>+Sociogrid analysis allowed for similarities and difference with each grid</p>

<p>Kirkcaldy, Pope and Siefen (1993) Germany</p>	<p>particularly the role of the doctor and nurse. Particular attention was focussed on the doctor-patient relationship, as this is a communication dyad identified by many writers as important (Tuckett et al. 1985).</p>	<p>situated on the northern periphery of the Ruhr region. This is a predominantly industrial area. Wards</p>	<p>physiotherapist, nursing and care personnel, occupational therapist, social worker, administrative personnel, parents of the patient, and the child (patient).</p>	<p>did not see the parent or patient as linked to himself. These differences in construing may well affect the interpersonal relationships amongst the various professional groups and the patients themselves. Physician, psychologist, occupational therapist, social worker, remedial teacher and the medical technical assistant all viewed the parent of the child as similar to the patient; a view not shared by the patient or the parent. The parent of the child saw the nursing and care personnel and the social worker as the elements most similar to the patient. The views of both the physiotherapist and the nursing and care personnel were consistent with those of the parent and patient. The consensus amongst the medical personnel made sense in that therapeutic aid was</p>	<p>-Data was not rich</p>
--	--	---	---	---	---------------------------

				<p>directed towards the patient and the family. It was also of interest to note the reciprocal agreement regarding the views of the medical technical assistant and the administrative</p> <p><u>Physicians emerged as powerful and influential characters</u></p> <p><u>in the multidisciplinary team, particularly in decision making and delegating</u></p> <p>For the physician there were two major professional clusters, the first (labelled "medically proximal") comprised the social worker, psychologist, nurse and physician, and the second comprised the "activity" or "bodily"- related therapists (physiotherapist, remedial teacher and occupational therapist).</p> <p><u>In contrast was the nurses' belief about their professional role, feeling closely affiliated to the</u></p>	
--	--	--	--	---	--

				<p>patient. This identification with the patient seemed to accurately reflect the child's own perception of the "care-taker".</p>	
<p>Negativity in psychotherapists evaluations of clients and personal acquaintances</p> <p>Soldz (1992)</p> <p>USA</p>	<p>Compare therapist construal of clients with their construal of personal acquaintances (second analyses of Soldz, 1989, data).</p> <p>Hypothesis:</p> <p>Therapist would selectively focus on negative characteristic when construing clients and positive characteristics when construing acquaintances</p>	<p>47 psychotherapist (from community MH service, conference advanced students</p> <p>19 psychologists; 4 psychiatrists, 12 social workers, 2 psychiatric nurses, 2 mental health counsellors and 8 psychoanalytics</p> <p>Therapist were also asked to rate each person on several scales such as:</p> <p>-Liking for the person,</p> <p>-Similarities to the self</p> <p>-how much they wanted the client as a clients and expected improvement with psychotherapy</p>	<p>Each therapist provided a list of 6 clients, 6 personal acquaintances</p> <p>-The self included in rating</p> <p><u>Four construct-contrast pairs resulted from comparison of clients, four from comparing acquaintances</u> and four from comparing clients and acquaintances</p> <p>5 supplied constructs were included: talkative-silent; good-natures – irritable; responsible- undependable; calm-anxious and imaginative – simple, direct</p> <p>Subjects indicated, which pole was a desirable personal characteristic</p> <p>Three valutive measures were derived from the grid from each element:</p>	<p>In every case clients were judged more negatively than were acquaintances and the difference were highly significant.</p> <p><u>Acquaintances were construed as more similar to each other than were clients, contradicting the stereotyping hypothesis</u> (cognitive differentiation in client group).</p> <p><u>Sex differences – possible sex difference in the differential evaluation, use of negative constructs and differentiation between clients and acquaintances were examined – No significant difference were found... **/[what about ethnicity]**</u></p>	<p>+shows how therapists construe clients, which may not be explicit in practice</p> <p>+offers insight into the unspoken processes that may impact the therapist work with clients</p> <p>-the generalizability of findings to other therapists is not clear</p>

			<p>-Positive evaluation, -Measuring the degree of positivity of the elicited construct ratings used to describe the person, -Elicited similarity, -Measuring the degree to which the element was construed as similar to the self in ratings on the elicited construct, and supplied similarity, -Assessing similarity to self in supplied construct ratings.</p>	<p>The psychoanalytic candidates exhibited less discrimination between clients and acquaintances than either of the other groups and the difference between them and at least one of the groups was significant ... the psychoanalytic group judged acquaintances more negatively than did the other group ... community mental health centre sample exhibited the most discrimination, and for several variables this group discriminated significantly more than did the personal construct group.</p> <p><u>Therapists rated clients more negatively than they rated acquaintances</u></p> <p><u>Clients were judged to be less similar to self and clients were liked less than acquaintances</u></p> <p>Affective evaluation is even more unitary when therapists are construing clients rather acquaintances... This means that a positive or</p>	
--	--	--	---	---	--

				<p>negative judgment on one dimension is more likely to correspond to a similar judgement on other evaluative dimensions for clients than for acquaintances</p> <p><u>Therapist may hold systematic context specific bias when construing clients that arises from the nature of therapeutic ideology (Gergen, 1990).</u></p> <p>Therapist may be aware of negatives aspects of their clients' lives and, at the same time, may be predisposed to pay attention to those negative aspects.</p> <p>The result regarding greater differentiation of the client domain is consistent with the vigilance hypothesis (*ref), <u>which asserts that construal of more socially distant or deviant people is more differentiated because such people pose a greater threat to the subject.</u></p>	
--	--	--	--	---	--

				<p><u>Therapist tended to like people who are similar to themselves and wanted people as clients whom they liked... if disliked clients are those who are different from and are unwanted by therapists, concern should be raised as to whether disliked clients can receive effective therapy</u></p>	
<p>Do Psychotherapists use different construct subsystems for construing clients and acquaintances? A Repertory Grid Study Soldz (1989) USA</p>	<p>Whether therapist use separate construct subsystems for client and acquaintance construal</p>	<p>Same as above</p>	<p>Same as above</p>	<p>Therapist used distinct construct subsystems for construing clients and personal acquaintances. There were difference in the content and range of convenience (the range of people to which the constructs could be usefully applied) of constructs elicited.</p> <p>Client domain exhibited greater cognitive differentiation and hierarchical organization than did the acquaintance domain.</p> <p><u>The degree of differentiation to the client and acquaintance subsystems appeared to be unrelated to age, sex,</u></p>	<p>+Provides strong support for the existence of distinct construct subsystems for client and acquaintances in the construal in (primarily) psychodynamically oriented therapists engaged in individual therapy</p> <p>+Informs further research in whether “Individual differences among therapists: Do therapists with more differentiated acquaintance – and client construing subsystems form better or worse relationships with their clients?”</p>

				<p><u>years of clinical experience, degree, orientation, discipline or recruitment group... indicate that subsystem differentiation is a general feature of construct systems of therapists</u></p> <p><u>Constructs were more applicable when applied to the same domain from which they had been derived than to the opposite domain (Range of convenience)</u></p> <p>Distinct domains for client and acquaintances (Bender in Tully, 1976) in tendency and not magnitude because <u>Soldz found that participants were able to apply constructs from one domain to the other domain most of the time.</u></p> <p>Clients system had more constructs loading on the emotional stability factor than did the acquaintance system.</p>	<p>-studies of other groups of therapists are require of generalisability of results.</p>
--	--	--	--	---	---

Summary of literature review papers in PART 2:

Title; Author; Location	Aim	Participants/ Service-User group	Research Methodology	Summary of study key findings	Strengths and Limitations
Exploring the content and structure of cross-cultural attitudes Neimeyer and Fukuyama, (1984) USA	To develop a Cultural Attitudes Repertory Technique (CART) that examines the content and structure of the individual's personal system of cultural constructs	1 case example; A 27year old white female graduate student in counsellor education	Pre- and post- test of the CART – before and after 45 hours of teaching on issues regarding the unique values of non-majority population within the United States (American and International) as they impact counselling. The elements consisted of 12 different cultural groups... (Black males, Latin females, white females, native American males, etc.)... The participant is then asked think of ways in which two of them are alike one alike one another... the procedure is repeated until 12 constructs are elicited...	Content of the construct appeared to appreciate the diversity of cultural values which might impact on counselling... The degree of integration of the cultural groups remained unchanged – the integration of constructs showed slight decrement The overall degree of differentiation increased markedly The constructs were used in more differentiation fashion. This increased differentiation among the constructs may indicate that the same constructs become more useful in differentiating among the various cultural groups after completing the	+Use for self-exploratory exercise +Clinical implication: assisting counsellor to articulate those private dimensions of judgement which may otherwise remain implicit in their cross-cultural intervention +Clinical implication: interest in examining cross-cultural issues and stimulates discussion concerning unique, as well as shared, cultural constructions. +Useful in a variety of settings ranging from workshops to supervision + Can be used as tool to monitor changes in

			Construct are transferred on to separate rating sheet and asked to rate each of the 12 elements on a 7-point scale (3, 2, 1, 0, 1, 2, 3)	course Counselling ethnic minorities *she gained increased awareness of cultural difference, following the training and this was reflected on her ability to differentiate better the various cultural groups along the personal constructs. Despite the increased complexity (differentiation) of the cultural awareness, her system remained poorly integrated	constructions over the course of cross-cultural experience. -Not all ethnicities were listed -Lack of appropriate controls. -Case study – may not be generalizable -Absence of statistical analysis -Heuristic and though not scientific -Cannot make definitive empirical statement. Opens up discussion about cross-cultural issues
<p>Samoan and psychiatrists' perspectives on the self: Qualitative comparison</p> <p>Bush, Collings, Tamases, Waldegrave (2005)</p> <p>New Zealand</p>	<p>To understand the Samoan notion of self to Somoan mental health and are able to use the construct in their formulation of mental health problems presented by the Samoan people</p>	<p>Psychiatrists with over 5 years' experience of public practice in New Zealand</p> <p>All participants were of Western European descent, New Zealand or UK born</p> <p>Psychiatrists chosen on the basis of homogeneity</p> <p>Most completed specialist training locally and occupied senior non-academic positions at adult community psychiatric practice</p>	<p>Three focus groups at two-weekly intervals...</p> <p>Focus group 1: participants explored their personal perspectives on the self, ideas about the self-dominant in psychiatry and the relevance of these to their clinical work.</p> <p>Focus 2: read Somoan mental health study</p> <p>-Presentation of the study by researcher, which included a detailed account of the Somoan view of self</p> <p>-Participant discussed contrasts with their</p>	<p>Individualistic vs collective notions of self</p> <p>*<u>psychiatrists identified their core self as individual</u></p> <p>*considered collective identity and family history but describe core self as individual</p> <p>*idea of self as an individual was dominant</p> <p>Spirituality versus secular notion of self</p> <p>*uncomfortable discussing it initially, though others felt it important – perhaps assumed little place for it in psychiatry</p>	<p>Strength:</p> <p>+Contribute to improvement in psychiatric practice and mental health service delivery</p> <p>+Cultural accountability to address issues of cultural safety</p> <p>+focus group provided rich data in that they encouraged participants exploration of ideas and was considered positive learning experience by them</p> <p>+Informs cross-cultural work as it stressed the</p>

			<p>personal views of self and between the Samoan view and what they considered as the dominant views in psychiatry</p> <p>Focus 3: Focused on the implications of these differences for their clinical work with Samoan patients</p>	<p><u>*Major difference between the dominant psychiatric view and the Samoan perspective on religion and spirituality</u></p> <p>*religion was commonly examined in psychiatry from a non-spiritual perspective</p> <p>Reductionist vs. holistic</p> <p>*Samoan idea of self as holistic in nature</p> <p>*aspiring to holistic ideas but this was constrained by characteristics of the health system such as large caseloads, under-resourcing and the climate of legalistic accountability</p> <p>Universalist vs relativist notions of self</p> <p>*universality views were dominant in psychiatry</p> <p>*some psychiatrist perplexed by the concept of we-ness (relational self)</p> <p>*Samoan idea of self challenged western developmental theories, especially where individuation and separation are considered more important or healthier than interdependence.</p>	<p>necessity for working with family and community and individual therapy might be less relevant for and less acceptable to patients from the Samoan culture because of the relational nature of self</p> <p>+Acknowledges training in Samoan concept of self and sensitivity to spiritual issues.</p> <p>-Relatively homogenous professional group in one location – other mental health professional group would have brought other perspectives and enhanced this study.</p> <p>-Not specific psychopathology</p> <p>-Study with bigger sample would determine whether the views of psychiatrists here is generalizable</p>
--	--	--	--	--	--

<p>Understanding clinician perception of common presentations in South Asians seeking mental health treatment and determining barriers and facilitators to treatment</p> <p>Rastogi, Khushalani, Dhawan, Goga, Hemanth, Kosi, Sharma, Black, 2013</p> <p>USA</p>	<p>Explore the perspectives of clinicians on the presentation of mental health symptoms among South Asians in the US and identify facilitators barriers to treatment of South Asians with mental health issues</p>	<p>29 participants: physicians, nurses and counsellors – experience in taking care of South Asian patients with mental health issues – 5years experience – involved in the care at least 5 Asian patients/clients...</p> <p>19 clinicians – indian born 6 – US born – 4 Caucasian, 1 African American, 1 South Asian 3 born in Pakistan</p>	<p>Four Focus groups – four in a space of one month – 7 participants in three and 8 participants in 1</p> <p>Questions: Common types of emotional/ mental symptoms encountered in practice Factors seen as barriers to treatment Factors seen as facilitators of treatment Do and don'ts in care of South Asian patients in US Response audio-recorded and on flip chart</p>	<p>1)Symptom presentation and factors affecting treatment Difference between younger (<40) and older generation of South Asians YG contributors to distress: dating, adapting to the western culture, struggling to be accepted by their western peers, struggling to be independent, wanting parental approval and support and feeling inadequate because of unmet parental expectations. *YG patients struggle between wanting professional help to deal with this stress and not seeking help because of parental disapproval of their involvement with mental health professionals *OG South Asian patients often did not seek mental health treatment independently but were referred by their primary care providers, OG patients often presented with physical symptoms such as abdominal pain, shoulder pain, joint pain,</p>	<p>+Add to understanding of patients of a specific culture by a diverse sample population +Add to the knowledge of what services can do to include ethnic minority groups -Absence of data on patients perspective or data on actual presentations on south Asian patient to mental health services. -participants from one geographical location, therefore may not be applicable to other regions -lack of conversation around specific psychopathologies affecting that specific community. Possible uneasiness of participants and researches of such topics -Both moderators and researchers from same culture may lead to over-identification and countertransference (but questions kept neutral). -age limit for young as 40 was arbitrary</p>
--	--	---	--	--	--

				<p>and sleeplessness, but on evaluation were found to have major mental illnesses such as major depression, psychosis or anxiety disorder. Participants also noted the OG patients presented in crisis with increased severity</p> <p>*male partners often wanted to be involved in planning and treatment of their wives ... females dropping out because their spouses did not believe in psychiatric treatments and were unwilling to pay for it</p> <p>*patients preferred a paternalistic medical model and considered their doctors to be God-like – these patients had an unquestioning faith for the physicians and left treatment choices entirely up to the physician.</p> <p>*The patients who tended to contradict their physician were professionals, experts in their own field and often critically questioned the judgement of their physician</p>	
--	--	--	--	--	--

				<p>*Abuse: once female partners disclose abuse and partners find out, they pull out of therapy</p> <p>2)Barriers to evaluation and treatment</p> <ul style="list-style-type: none"> *stigma and denial *lack of understanding and acceptance of treatment <u>*patients would choose medication over work with therapists</u> <u>*psychotherapy and counselling were unacceptable but rather preferred</u> -loss of confidentiality *fear of information being shared -increased sensitivity to medication *report more side effect so stop meds -helicopter parents *parents who are over involved stops children from seeking help *financial barrier <p>3) Facilitators to evaluation and treatment:</p> <ul style="list-style-type: none"> *Education about psychiatric illness *use of a medical model . *-use of creative strategies specific to 	
--	--	--	--	---	--

				<p>culture such as music, mythological stories, community support</p> <p>-sensitivity to patients' cultural and religious beliefs</p>	
<p>How I floated on gentle webs of being: Psychiatrists stories about mental health care 'treatment gap' in Africa – Cooper (2015) Africa</p>	<p>To find out about the mental health treatment gap, using narrative-based approach in order to find out the meaning making that lay behind the stories told</p>	<p>28 psychiatrists from public mental health care setting in South Africa, Uganda, Nigeria and Ethiopia 19 men, 9 women 8 South Africans, 6 Ugandans, 7 Nigerians, 7 Ethiopians. All African nationals. 7 undertaken psychiatry training in Europe. 5 in US. Remaining in Africa</p> <p>Eighteen worked in standalone psychiatric hospitals, while the rest were based on psychiatric units located in general hospitals or clinic-based settings</p> <p>Recruited through contact and snowballing techniques</p>	<p>Individual interviews with each psychiatrist in an attempt to elicit stories or 'whatever comes to mind'. -interested in why people who need mental health care may or may not be getting the care they need. -Followed by open-ended question which were structured as 'Narrativised' topics or storytelling invitation</p> <p>Each interview lasted 1.5 hrs to 4hrs</p> <p>Thematic analyses to extract themes, supplemented with Parkerian discourse enquiry approach that helps understand language as an ideological tool and aims to expose the ways in which language serves to reproduce, maintain or transform different 'realities' and power relations... this was used in</p>	<p>-biomedical paradigm, rationalist assumptions, Eurocentric tendencies and binary oppositions were strongly reflected and reproduced in the stories the large majority of the psychiatrists when talking about the gap in mental health care</p> <p>Two themes: Lack of access to mental health services *tremendous lack of material and human resources dedicated to mental health care is one of the main factors contributing to large gap <u>*patients use traditional means because they don't have access to modern means</u> *creative and innovative thinking is needed to ensure patients get the help they, that include, non-specialist health care workers and collaborating</p>	<p>+Bring light to psychiatrists perspective +Detailed narrative -Second rater not mentioned -Researcher asking leading questions -Social desirability in formal interview but different perspective voiced in informal conversation -Interviewers own judgement but their position not highlighted</p>

			<p>order to locate the psychiatrist stories with broader social resources and dynamics of power</p>	<p>with ‘traditional healers’ – elaboration of these were still deeply steeped in biomedical epistemologies *numerous psychiatrist unambiguously stated that ‘integrating mental health into primary health care is the way to go, the only way forward’ and we need task-shifting strategies in primary and community care’. *accounts had a tendency to emphasis clear cut nature of mental illness and ‘straight-forward nature’ of the function the perform, with the common conclusion that patients can therefore easily be dealt with by non-specialist health workers. *some highlight they offer diagnosis, give meds and provide some therapy – seemingly uncomplicated endeavour *highlighted manualised way of working for non-psychiatrist, i.e. <u>World Health Organization MHGap Intervention Guide – ‘what-to-do’ guideline ...</u></p>	
--	--	--	---	--	--

				<p>*psychiatrists viewed collaboration with healing workers as matters of education, supervision and monitoring. They viewed traditional healers as harmful and abusive, who are suspicious of psychiatrists</p> <p>Lack of uptake of available mental health care services</p> <p>-underutilization of services available</p> <p>*inadequate levels of knowledge, or what was commonly referred to insufficient “mental health literacy” amongst clients, their families and the general population</p> <p><u>*spiritual attributes, like the belief that this is a calling and by taking medication or seeing as you’re resisting the calling</u></p> <p>*beliefs around mental health not being medical but spiritual that sought spiritual healing – in conflict with the psychiatrists biomedical view that looks to educate about the ‘proper’ nature of mental illness and ‘appropriate’ forms of care</p>	
--	--	--	--	---	--

				<p>*For psychiatrists, patients own understandings and experiences of illness are invalid and in need of correction or alternatively irrelevant and need to be 'worked around'. In both cases, the implicit assumption there is a clear distinction between the real world of physiological objects and the personal experiences of this reality; between the objectivity of biomedical knowledge and the subjectivity of beliefs. And the primary goal of clinical care is to utilise the principles and methods of biomedicine in order to identify and address the underlying sign and symptoms of supposed real disease</p>	
<p>Cross-cultural variations in psychiatrists' perception of mental illness: A tool for teaching culture in psychiatry</p> <p>Biswas, Gangadhar, Keshavan (2016)</p> <p>USA/ India</p>	<p>To identify cultural variation between psychiatrists perceptions of most common presentations of mental illness in Harvard affiliated hospitals in the Longwood area of Boston, MA and a comparable large</p>	<p>In Dec 2013, an anonymous survey sent out to fourth year residents and psychiatrists practicing in various departments in the Boston area... through a web-based online Survey Monkey program. In Jan 2014, the same survey was circulated in</p>	<p>The survey asked was person to rank 9-10 symptom from most commonly seen to least commonly seen in three types of acute major mental illness: major depression, mania and psychosis. The symptoms were gathered from both ICD-10 and DSM-IV-TR and survey included each</p>	<p>Out 101 two participant data were excluded for not filling out form correctly. Exclusion were of indian clinician group because they had paper surveys and were able to use the same ranking number multiple times whereas the electronic survey did not allow for this issue.</p>	<p>+Offers cross-cultural perspective of how symptomatic presentation of psychiatrists from different parts of the world vary across culture, though they may use similar criteria. + Helps understand different perceptions of illness</p>

	<p>mental health centre in Bangalore, India. Sampling survey study compared psychiatrists perceptions of the most common symptoms of major mental illness in two separate cultural environments</p> <p>How does the expertise needed to build global innovations in diagnosis, therapeutics and access cross cultures? When constructing curricula for global psychiatry to train future doctors should we consider whether all psychiatrists see mental illness the same despite using similar criteria? Are psychiatrists diagnosing the same disorder but considering different symptom clusters to get their diagnosis? and if so, how can we harness this information in order to better identify and treat mental illness in different parts of the world?</p>	<p>document form via email to psychiatrist in Bangalore, India at National Institute of Mental Health and Neuroscience (this cohort was less familiar with survey monkey program so this method was used.</p> <p>-All licensed psychiatrists that were currently in training in psychiatry or practicing and were working in an academic institution in Boston USA or Bangalore, India.</p> <p>101 psychiatrists took the survey. There were 99 academic psychiatrists that were included in the study, 47 in Boston and 52 in Bangalore.</p> <p>Demographic: Age Years of training Type of practice</p>	<p>manifestation of a symptom from both manuals of diagnostic criterion. The psychiatrists were also asked to rate barriers to mental health care access from most frequently seen to least frequently seen from a compiled list of care access issues</p> <p>Compared measures of central tendency without assuming normality between the two groups. The two groups of ordinal data that were not parametrically distributed, so they used Mann-Whitney U test to determine results.</p>	<p>No statistical difference in age or years of psychiatric practice between the US group and the Indian groups of clinicians</p> <p><u>Depression:</u> Indian psychiatrists perceived somatic symptoms like somatic pain to be significantly more common in depression than American psychiatrists</p> <p>Other neurovegetative symptoms like insomnia and diminished appetite were significantly frequent in the Indian psychiatrists view whereas pessimism were significantly more frequent in the diagnosis of depression among American psychiatrists.</p> <p>No statistical difference in both groups and ranked similarly in frequency between the two clinician groups included fatigues, thoughts of self-harm, suicidal thoughts and difficulty with attention and concentration</p> <p>Though both groups felt that decreased interest in pleasurable activities was</p>	<p>+highlights the need to highlight the 'implicit cultural biases that international trainees may have about mental illnesses based on what they have seen in population in their own country of origin.</p> <p>-there was no option for the survey to explain what each doctor in regard to their ranking</p> <p>-Cross-cultural difference in the psychiatry training in different part of the world</p>
--	--	--	--	--	---

				<p>the most common symptom seen in depression, American psychiatrists showed a trend to report it as being more commonly seen than did Indian psychiatrists</p> <p><u>Manic patients</u></p> <p>Indian psychiatrists perceived violent aggressive behaviour and anger to be significantly more common in manic patients than did American psychiatrists. American psychiatrists more frequently found pressured speech among patients with pressured speech among patients with mania.</p> <p>Both groups found decreased need for sleep and pressured speech to be among their top two symptoms used to diagnose mania in patients but disagreed about symptoms of anger and agitation.</p> <p>**Both groups agreed that they were least likely to see symptoms of hypersexuality and tearfulness in their manic patients, which is often</p>	
--	--	--	--	--	--

				<p>used to diagnose mixed state mania</p> <p>Psychosis: Both American and Indian psychiatrists reported the most frequent symptoms of psychosis to be paranoia, lack of insight, delusions and auditory hallucination and both groups agreed that visual hallucinations and motor peculiarities to be least common symptoms seen in psychotic disorders. Certain symptoms were ranked significantly differently between the two groups of psychiatrists. American psychiatrists saw breaks in train of thought significantly more commonly and Indian psychiatrists saw lack of hygiene, lack of interest in social activities or work and peculiarities in voluntary movement significant more commonly than American psychiatrists</p> <p>Barriers to mental health care access Both agreed that difficulty acknowledging the</p>	
--	--	--	--	---	--

				<p>problem and lack of supports (social and financial) were the biggest obstacles in getting mental health care. American psychiatrists found substance abuse and homelessness to be significant barrier to care compared to Indian psychiatrists. Indian psychiatrists found embarrassing the family and having no mental health in the area a more significant obstacle to accessing care.</p>	
--	--	--	--	--	--

APPENDIX B: Quality appraisal of the research in the systematic literature review**Critical Appraisal Skills Programme (CASP, 2018)**

	Clear statement of aims?	Qualitative method appropriate?	Design appropriate to address aims, justified design/method?	Recruitment strategy appropriate?	Data collected appropriately?	Relationship between researcher and participants adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings, credibility addressed?	How valuable is the research?
Bush et al. (2005)	Yes	Yes	Yes	Yes	Yes	No	Can't tell (not explicitly highlighted)	Yes	Yes	Valuable contribution and suggested ways to improve the mental health practice and the provision of service to the Samoans
Cooper (2015)	Yes	Yes	Yes	Yes	Yes	No	Can't tell (not explicitly highlighted)	Yes	Clear statement of findings but not clear if credibility of responses were checked	Valuable contribution to cross-cultural study if psychiatrist perceptions and clear clinical implications
Rastogi et al., (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution and finding added to knowledge on

										how services can be improved for people of South Asian background
--	--	--	--	--	--	--	--	--	--	---

Roever’s (2015) appraisal tool for questionnaire and survey

Biswas et al. (2016)	What information did the researchers seek to obtain?	-Survey comparing psychiatrist perceptions
	Was there a clear research question, and was this important and sensible?	-YES
	Was a questionnaire the most appropriate research design for this question, what design might have been more appropriate?	-YES
	What was the sampling frame and was it sufficiently large and representative?	-Psychiatrist in India and America; sufficiently large
	Did all participants in the sample understand what was required of them, and did they attribute the same meaning to the terms in the questionnaire?	-Can’t tell [participants from two different cultures]
	Were there any existing measures (questionnaires) that the researchers could have used? If so, why was a new one developed and was this justified?	Can’t tell [limited information provided regarding the questionnaire]
	Were the views of consumers sought about the design, distribution, and administration of the questionnaire?	Can’t tell [limited information provided regarding the questionnaire]
What claims for reliability and validity have been made, and are these justified? Did the questions cover all relevant aspects of the problem in a non-threatening and non-directive way? Were open-ended (qualitative) and closed-ended (quantitative) questions used appropriately? Was a pilot version administered to participant’s representative of those in the sampling frame, and the instrument modified accordingly?	Can’t tell [no clearly stated]	
What claims for validity have been made, and are they justified? (In other words, what evidence is there that the instrument measures what it sets out to measure?)	Result indicates that the survey measured what was intended	

What claims for reliability have been made, and are they justified? (In other words, what evidence is there that the instrument provides stable responses over time and between researchers?)	Can't tell [no clearly stated]
Was the title of the questionnaire appropriate and if not, what were its limitations?	Can't tell [limited information provided regarding the questionnaire]
What formats did the questionnaire take, and were open and closed questions used appropriately?	Can't tell [limited information provided regarding the questionnaire]
Were easy, non-threatening questions placed at the beginning of the measure and sensitive ones near the end?	Can't tell [limited information provided regarding the questionnaire]
Was the questionnaire kept as brief as the study allowed? What was the response rate and have non-responders been accounted for?	High response rate (101) and 2 responders were excluded for using the same rank on multiple questions
Did the questions make sense, and could the participants in the sample understand them? Were any questions ambiguous or overly complicated?	Can't tell [limited information provided regarding the questionnaire]
Did the questionnaire contain adequate instructions for completion— e.g. example answers, or an explanation of whether a ticked or written response was required?	Can't tell [limited information provided regarding the questionnaire]
Were participants told how to return the questionnaire once completed	YES
Did the questionnaire contain an explanation of the research, a summary of what would happen to the data, and a thank you message?	Can't tell [limited information provided regarding the questionnaire]
Was the questionnaire adequately piloted in terms of the method and means of administration, on people who were representative of the study population?	Can't tell [limited information provided regarding the questionnaire]
How was the piloting exercise undertaken? What details are given?	Can't tell [limited information provided regarding the questionnaire]
What was the sampling frame for the definitive study and was it sufficiently large and representative?	High response rate (101) and 2 responders were excluded for using the same rank on multiple questions
Was the instrument suitable for all participants and potential participants? In particular, did it take account of the likely range of physical/mental/cognitive abilities; language/literacy, understanding of numbers/scaling, and perceived threat of questions or questioner?	Can't tell (not stated in study)
How was the questionnaire distributed?	Survey monkey program and email

How was the questionnaire administered?	Completed by participants
Were the response rates reported fully, including details of participants who were unsuitable for the research or refused to take part?	High response rate (101) and 2 responders were excluded for using the same rank on multiple questions
Have any potential response biases been discussed?	YES
What sort of analysis was carried out and was this appropriate? (e.g. correct statistical tests for quantitative answers, qualitative analysis for open ended questions)	Quantitative analysis
What measures were in place to maintain the accuracy of the data, and were these adequate?	Can't tell (not clearly stated in study)
Is there any evidence of data dredging—that is, analyses that were not hypothesis driven?	Can't tell (not clearly stated in study)
What were the results and were all relevant data reported	Prevalence of the most common mental disorders as well as risk and protective factors varies across cultures but comorbid patterns and treatments are universal YES
Are quantitative results definitive (significant), and are relevant non-significant results also reported?	YES
Have qualitative results been adequately interpreted (e.g. using an explicit theoretical framework), and have any quotes been properly justified and contextualized?	N/A
Was the analysis appropriate (e.g. statistical analysis for quantitative answers, qualitative analysis for open-ended questions) and were the correct techniques used? Were adequate measures in place to maintain accuracy of data?	YES
What do the results mean and have the researchers drawn an appropriate link between the data and their conclusions?	There are similarities and variation in the perception of psychiatrists who see many patients within their communities
Have all relevant results ('significant' and 'non-significant') been reported? Is there any evidence of 'data dredging' (i.e., analyses that were not 'hypothesis driven')?	YES
Have the researchers drawn an appropriate link between the data and their conclusions?	YES

	Have the findings been placed within the wider body of knowledge in the field (e.g. via a comprehensive literature review), and are any recommendations justified?	YES
	Can the results be applied to your organization?	N/A
	Conflicts of interest are declared.	N/A
	Rate the overall methodological quality of the study, using the following as a guide: High quality (++): Majority of criteria met. Little or no risk of bias. Acceptable (+): Most criteria met. Some flaws in the study with an associated risk of bias. Low quality (-): Either most criteria not met, or significant flaws relating to key aspects of study design. Reject (0): Poor quality study with significant flaws. Wrong study type. Not relevant to guideline.	Cannot be adequately rated given the limited information available

Atkins and Sampson’s (2002) critical appraisal guideline for single case study

Neimeyer and Fukuyama (1984)	Way of thinking	1. Is a credible argument given for why a case study is appropriate?	Yes
		2. Are the philosophical stance and perspective of the authors stated?	Yes
		3. Is there evidence that any bias is taken into account when performing data analysis?	Not clearly stated
	Way of controlling	4. Have the criteria for analysis been confirmed by an independent researcher?	Not clearly stated
		5. Have any opportunities for various forms of triangulation been exploited?	Not clearly stated

		<p>6. Is the research process auditable?</p> <p>7. Has relevant literature been used to support the selection of an appropriate theoretical framework to guide the research?</p> <p>8. Does the study use appropriate theory to support the findings?</p> <p>9. Does the study describe how the conclusions were arrived at and how they are justified by the results?</p> <p>10. Are assertions / conclusions made well-grounded in the data?</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>
	Way of working	<p>11. Are the criteria used to select the appropriate case and participants clearly described?</p> <p>12. Does the study provide a clearly formulated question describing an important IS issue?</p> <p>13. Are the approaches and techniques for data collection and analysis described in detail?</p> <p>14. Is the conceptual framework for the research explicitly described?</p>	<p>Yes</p> <p>Can't tell</p> <p>Yes</p> <p>Yes</p>
	Way of supporting	<p>15. Does the study describe an orderly process for the collection of data?</p> <p>16. Does the study describe and employ a systematic way to analyse the data?</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>

		17. Is the history and context of the research clearly described?	
	Way of communicating	18. Are the aims and objectives of the study clearly stated? 19. Are limitations to the study acknowledged and described? 20. Does the study suggest if and how the findings might be transferable to other settings? 21. Is sufficient detail given to allow readers to evaluate the potential transferability of the research to other contexts? 22. Does the report identify questions or issues for future research? 23. Is the presentation of the research appropriate to the intended audience? 24. *Could this research potentially make a contribution to the work of IS practitioners? 25. *Does the research provide new insights into some aspect of IS work? 26. *Is the research presented in such a way that there is evidence of logical rigour throughout the study? 27. *Does the study place the findings in the context of IS practice?	Yes Not clearly stated Yes Yes Not clearly stated Yes Yes Yes Can't tell Yes

		28. *Does the study place the findings in the context of IS research? 29. *Is the research process open to scrutiny?	Yes Yes
--	--	---	----------------

Effective Public Health Practice Project (EPHPP, 2009)

	Selection Bias Q1. Participants likely to be representative of the target population Q2. What percentage of selected individuals agreed to take part? Rate Section: Strong Moderate Weak	Study Design Was the study described as randomized? [if NO, go to Component C]	Confounders Q1. Were there important difference between groups prior to the intervention? Q2. If yes, indicate the percentage of relevant confounders that were controlled?	Blinding Q1. Was the outcome assessor aware of the intervention or exposure status of participants? Q2. Were the study participants aware of the research question?	Data collected Methods Q1. Were data collection tools shown to be valid? Q2. Were data collection tools shown to be reliable?	Withdrawals and Drop-outs Q1. Were withdrawals and drop-outs reported? Q2. Percentage of participants completing the study	Intervention Integrity Q1. What percentage of participants received the allocated intervention or exposure of interest? Q2. Was the consistency of intervention measured? Q3. Is it likely that subjects received an unintended intervention?	Analyses Q1. Indicate the unit of allocation? Q2. Indicate the unit of analysis? Q3. Are the statistical methods appropriate for the study design? Q4. Is analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?
Blundell et al. (2012)	1. Yes 2. Less than 60%	No, convenience sampling	1. No	1. Yes (the researchers) 2. No	1. Yes 2. Can't tell (Not clearly stated in study)	1. No 2. 80-100%	1. 80 – 100% 2. Can't tell 3. Can't tell	1. N/A 2. N/A 3. Yes for quantitative information, not clear what analysis was used for the qualitative information 4. N/A

Kirkcaldy et al. (1993)	<ol style="list-style-type: none"> 1. Yes 2. Can't tell 	It states that participant were randomly selected but does but not clear whether study was randomised	<ol style="list-style-type: none"> 1. Yes 2. not clear how confounders were controlled 	<ol style="list-style-type: none"> 1. Yes (the researchers) 2. No 	<ol style="list-style-type: none"> 1. Yes 2. Can't tell (Not clearly stated in study) 	Not clearly stated	<ol style="list-style-type: none"> 1. 80 – 100% 2. Can't tell 3. Can't tell 	<ol style="list-style-type: none"> 1. N/A 2. N/A 3. Yes 4. N/A
Ralley et al. (2009)	<ol style="list-style-type: none"> 1. Yes 2. Not clearly stated 	No, convenience sampling	<ol style="list-style-type: none"> 1. No 2. Not clear how confounders were controlled 	<ol style="list-style-type: none"> 1. Yes (the researchers) 2. No 	<ol style="list-style-type: none"> 1. Yes 2. Can't tell (Not clearly stated in study) 	<ol style="list-style-type: none"> 1. No 2. approx. 50-75% of participants completed the study as required 	<ol style="list-style-type: none"> 1. 50-75% 2. Can't tell 3. Can't tell 	<ol style="list-style-type: none"> 1. N/A 2. N/A 3. Yes 4. N/A
Bender's unpublished study (cited in Tully 1976)	<ol style="list-style-type: none"> 1. Likely as they are a clinical group 2. Can't tell (an unpublished study cited in another paper) 	Can't tell (an unpublished study cited in another paper)	Can't tell (an unpublished study cited in another paper)	Can't tell (an unpublished study cited in another paper)	Can't tell (an unpublished study cited in another paper)	Can't tell (an unpublished study cited in another paper)	Can't tell (an unpublished study cited in another paper)	Can't tell (an unpublished study cited in another paper)
Hare et al. (2012)	<ol style="list-style-type: none"> 1. Yes 2. Less than 80-100% 	No, convenience sampling	<ol style="list-style-type: none"> 1. No 	<ol style="list-style-type: none"> 1. Yes (the researchers) 2. No 	<ol style="list-style-type: none"> 1. Yes 2. Can't tell (Not clearly stated in study) 	<ol style="list-style-type: none"> 1. No 2. 80-100% 	<ol style="list-style-type: none"> 1. 80 – 100% 2. Can't tell 3. Can't tell 	<ol style="list-style-type: none"> 1. N/A 2. N/A 3. Yes for quantitative information, however the a formal qualitative analysis was not used for the qualitative information 4. N/A
Woodrow et al. (2012)	<ol style="list-style-type: none"> 1. Yes 2. Not clearly stated 	No, opportunity sampling,	<ol style="list-style-type: none"> 1. No 	<ol style="list-style-type: none"> 2. Yes (the researchers) 3. No 	<ol style="list-style-type: none"> 1. Yes 2. Can't tell (Not clearly stated in study) 	<ol style="list-style-type: none"> 1. No 2. 80-100% 	<ol style="list-style-type: none"> 1. 80 – 100% 2. Repertory grid elicited were different for every 	<ol style="list-style-type: none"> 1. N/A 2. N/A 3. Yes for quantitative information, not clear

APPENDIX C:**PARTICIPANT INFORMATION SHEET**

As you have been invited to take part in this study, please take some time to read the information below. This will provide you with further understanding of the study that is being carried out and the nature of your involvement. Please do not hesitate to contact me for further clarity or information at m.addo@herts.ac.uk. Thank you.

Research study title

The influence of different cultural constructions of mental illness in practice: Repertory Grid study

Who is carrying out the study?

The study is being carried out by Mary Addo (Trainee Clinical Psychologist), as part of a Doctoral qualification in Clinical Psychology. The study is supervised by Prof. David Winter (Professor Emeritus, Centre for Personal Construct Psychology at the University of Hertfordshire) and Dr. Keith Sullivan (Research Tutor, Clinical Psychology Doctoral Training College at the University of Hertfordshire)

What is the aim of this study?

There is currently limited understanding of how psychiatrists from different ethnic groups construe clients from a range of ethnic backgrounds. There has, however, been increasing interest in cultural competence training and service delivery. This has resulted in the Royal College of Psychiatrists to revise post-graduate training in order to incorporate cultural influences on mental health care. The current research study will explore psychiatrists' (in training) constructs underlying their understanding of mental health problems presented by diverse client groups and the treatment options considered.

Why have I been invited and do I have to take part?

The study will involve psychiatrists (in training) participating in a structured interview, known as a repertory grid, and answering a few additional questions. It is completely up to you whether you decide to take part in this study. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can also withdraw from the study if you change your mind during the study or at any stage of the process. Your decision to participate or withdraw will not be communicated with others outside the research team.

What will be involved?

You have been invited to complete a grid in order to understand how you make sense of clients' presenting problems, treatment options and referrals. The grid will involve considering clients from three different categories of ethnic groups as well as people known to you. This will be followed by comparing and contrasting different groups of people as well as rating them, and yourself, on a series of adjectives elicited from you as well as some provided descriptions.

Other information collected will include current level of training and clinical experience, gender, age and ethnicity. Any of this information collected will not be matched to individual comments or discussions when reported and only used to describe the overall sample. Thus confidentiality will be upheld and no individual will be identifiable in any subsequent write up or publication.

What are the restrictions that may stop me from participating?

You can take part in this study if you are undertaking your training in Psychiatry in the UK. This would include those undertaking the foundation training (F1; F2), core psychiatry training (CT1; CT2; CT3) and higher psychiatry training (ST4; ST5; ST6).

When and where do you expect this research to take place?

The interviews are expected to take place between October and December 2017. If you decide to take part, you will be sent an email to agree a date and time to take part in a face-to-face or Skype interview at your preferred location, which may take approx. an hour.

What are the benefits of taking part and possible risk?

If you decided to take part, a Research Certificate for your Trainee Psychiatry Portfolio will be provided following your participation, with a letter of thanks for participating. I hope to present the overall findings to the teams I recruit from and to offer training on self-reflection when considering cultural competence within practice.

The risk of discomfort or distress can be said to be extremely low.

How will my participation be kept confidential?

If you decide to take part, you will be assigned an anonymous number that will be attached to your interview data and your identity will only be known to members of this research team. The research may be published in a journal paper and to protect your identity, all data will be anonymized by changing details that would identify you such as removing your name from the data.

What will happen to the data collected within this study?

All information obtained will be stored in a locked drawer and transferred onto a computer and stored on a password-protected computer, for a period of ten years after which it will be destroyed securely. It is possible that the data may be further analysed or re-used in ethically approved studies in the future.

The findings from this study will be written in a thesis for doctoral –level research. A research paper or article will then be written and submitted to relevant journals for publication. There will be no identifying names or details written in the thesis or academic journal.

Have you got ethical approval for this research?

This study has been reviewed and approved by The University of Hertfordshire, the Health and Human Sciences, Engineering and Technology Ethics Committee with Delegated Authority. The protocol number is LMS/PGR/UH/02879.

Who should I contact if I have any questions or wish to participate?

If you wish to ask any questions or participate in this research, please do not hesitate to get in touch with me by email or by phone.

If you have any concerns or complaints about any aspect of this study, please speak to the Main Researcher, who will do their best to respond to any questions or please write to the University's Secretary and Registrar.

Mary Addo

Email: m.addo@herts.ac.uk

Tel: 07506 485145

Address: Clinical Psychology Doctoral Training College, College Lane Campus, University of Hertfordshire, Hatfield AL10 9AB

Thank you for taking the time to read through this information & I look forward to hearing from you.

APPENDIX D:**CONSENT FORM**

I, the undersigned [*please give your name here, in BLOCK CAPITALS*]

.....
of [*please give an email address here, if you wish for the investigator to get in touch with you*]

.....
hereby freely agree to take part in the study entitled:

THE INFLUENCE OF DIFFERENT CULTURAL CONSTRUCTIONS OF MENTAL ILLNESS IN PRACTICE: REPERTORY GRID STUDY

This study has been reviewed and approved by The University of Hertfordshire, the Health and Human Sciences, Engineering and Technology Ethics Committee with Delegated Authority. The protocol number is *LMS/PGR/UH/02879*

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, and any plans for follow-up studies that might involve further approaches to participants. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

4 I have been told that I may at some time in the future be contacted again in connection with this study or further study.

Signature of participant..... Date.....

Signature of investigatorDate.....

Name of investigator: Mary E. Addo

Please return the signed form to: m.addo@herts.ac.uk. Thank you.

APPENDIX E:**Demographic Information**

Please complete the information below and return to: m.addo@herts.ac.uk. Thank you.

Initials of your full name (e.g.: J.D for John Doe):

Age:

Gender: Male Female Non-binary

What is your ethnic origin?**A. White**

- English/ Welsh/ Scottish/ Northern Irish/ British
- Irish
- Gypsy or Irish Traveller
- Any other White background, please write in the box below

B. Mixed/ multiple ethnic groups

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed/ multiple ethnic background, please write in the box below

C. Asian/ Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background, please write in the box below

D. Black/ African/ Caribbean/ Black British

- African
- Caribbean

APPENDIX G:**DEBRIEF INFORMATION****The influence of different cultural constructions of mental illness in practice:
Repertory Grid Study**

Thank you for your participation in this study. Your participation is greatly appreciated.

Why was this study conducted?

There is increasing interest in revising post-graduate training in order to incorporate cultural influences on mental health care (The Royal College of Psychiatry). The current research study explores psychiatrists' (in training) constructs underlying their understanding of mental health problems presented by diverse client groups and the treatment options considered. The research was conducted to find out whether there is any difference in the construing of those with similar background as the self and those with a different background. It is possible that the study may show that participants may use a different system to construe clients and those they know in their personal lives, which may be influenced by relatedness and familiarity.

It would be appreciated if you do not discuss the details of the study with others until the end date of the study (30th June '18)

What will happen next?

It is possible that a member of the investigating team may contact you in the future, to ask if you would like to participate in a follow-up study. The principal investigator will be in contact with you to let you know the outcome of the study following its completion.

If you would like any further information regarding the study or have any further questions, please do not hesitate to contact the principal researcher using the contact details below:

Mary Addo

Trainee Clinical Psychologist

Email: m.addo@herts.ac.uk

THANK YOU AGAIN FOR YOUR PARTICIPATION AND CO-OPERATION

*This study has been reviewed and approved by The University of Hertfordshire, the Health and Human Sciences, Engineering and Technology Ethics Committee with Delegated Authority. The protocol number is **LMS/PGR/UH/02879**.*

APPENDIX H: Ethics Approval Notification

HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO: Mary E Addo
CC: David Winter
FROM: Dr Simon Trainis, Health, Sciences, Engineering & Technology ECDA Chair
DATE: 27th June 2017

Protocol number: LMS/PGR/UH/02879

Title of study: *The influence of different cultural constructions of mental illness in practice: How clinicians from different ethnicities make sense of mental health problems.*

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: 03/07/17

To: 28/02/18

Additional workers: no additional workers named

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

APPENDIX I: Quality appraisal of the current study

(Effective Public Health Practice Project (EPHPP, 2009))

	Selection Bias Q1. Participants likely to be representative of the target population Q2. What percentage of selected individuals agreed to take part? Rate Section: Strong Moderate Weak	Study Design Was the study described as randomized ? [if NO, go to Component C]	Confounders Q1. Were there important difference between groups prior to the intervention? Q2. If yes, indicate the percentage of relevant confounders that were controlled?	Blinding Q1. Was the outcome assessor aware of the intervention or exposure status of participants? Q2. Were the study participants aware of the research question?	Data collected Methods Q1. Were data collection tools shown to be valid? Q2. Were data collection tools shown to be reliable?	Withdrawals and Drop-outs Q1. Were withdrawals and drop-outs reported? Q2. Percentage of participants completing the study	Intervention Integrity Q1. What percentage of participants received the allocated intervention or exposure of interest? Q2. Was the consistency of intervention measured? Q3. Is it likely that subjects received an unintended intervention?	Analyses Q1. Indicate the unit of allocation? Q2. Indicate the unit of analysis? Q3. Are the statistical methods appropriate for the study design? Q4. Is analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?
Current Study	3. Yes 4. 80 -100%	No	No	3. Yes 4. No	1.Yes 2. There appeared to consistency in responses	1. No withdrawals or dropouts 2. 80-100%	1. 100% 2. Yes 3. No	1. N/A 2. N/A 3. Yes 4. N/A

