Considering the Global Majority: Psychotherapeutic adaptation, and Clinical Psychology Trainee experiences in Pakistan

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Introductory chapter

Discourse around the global mental health context is increasingly growing, with significant findings in recent years around areas for research and clinical development. The global context is often mistakenly associated solely with low- and middle-income countries (LMIC). However, in truly taking a global view of mental health care, high income countries (HIC) must also be considered, particularly given that global majority populations also reside in HICs. This thesis, therefore, aims to look across, both, LMIC and HIC contexts.

Before providing an overview, it is essential that some of the language used across both chapters is demarcated. Given this research's attempt to add to global mental health research, *global majority* language will be used, as opposed to *ethnic minority*, *BAME*, *BME*, *POC*, unless making reference to literature using this language. It is important to name that no one label will be fitting for all, but the researcher attempted to take an empowering approach to language, placing the power with the global majority, centring them in conversations, particularly given that they constitute approximately 80% of the global population (Campbell-Stephens, 2020). Whilst it is recognised that global majority populations can be minoritised in some countries, this language can be disempowering by othering non-white populations. Whilst using global majority language, specific identities must still be seen and elevated, and their injustices highlighted.

To some extent, the researcher was still restricted by the system and existing research given that it historically and continues to greatly vary in language used. For example, the systematic review search strategy included *BAME* and used UK/US Census terminology given that it was attempting to collate HIC research wherein terms like *BAME* are still widely used. Terms like *BAME* assume that all ethnic minority populations are

homogenous and can be seen as one, leaving room for sweeping generalisations across significantly varying ethnic groups across the global population (Aspinall, 2021), whilst whiteness is centred and deemed normative (Selvarajah et al., 2020). However, in attempting to deconstruct and challenge existing structures and narratives, researchers must still be conscious and inclusive of widely used language, or else they may risk not shedding light on prior research/clinical findings.

LMIC and HIC terminology will largely be used across both chapters, as opposed to the *East* or *West*, *Global North* or *South* etc. unless these terms are used within cited literature. Categorising based on country incomes is clearly defined as per the World Bank (2023), whereas there is more grey around what constitutes the East and West. Just briefly outlining some of the differences in language here, it is clear how tangled we can become in the semantics of language, but how much weight it holds. A Pashto poem by Syed Shad Saud refers to the world by saying, *"some said it was divided by culture, some said it was divided by water"*. This speaks to some of the ideas underpinning this thesis, thinking about the global sphere, and historical and ongoing changes that manifest in affecting people's lives in various ways.

Chapter One's Systematic Review looked at culturally-adapted psychotherapeutic interventions for HIC-born populations. Following PRISMA guidelines, results were narratively summarised. Although a large number of the global majority population is made up of people who have migrated or been displaced, they were excluded from the review given the distinctiveness of their contexts irrespective of whether their migration was chosen or forced, which should be the sole focus of a review so as to not lose sight of the nuances of migration.

Chapter Two's empirical research was a qualitative exploration of Trainee's experiences of Clinical Psychology training and clinical practice in Pakistan. Using interviews and Interpretative Phenomenological Analysis (IPA), the paper aimed to provide a foundation understanding of training in Pakistan given the lack of research and insight into its' delivery and trainee associated experiences. The two chapters complimented each other. Whilst the empirical research was carried out in a LMIC, it allows for HICs to learn from a LMIC and vice versa, particularly when considering global majority experiences.

Author guidelines for both chapters can be found in Appendix 1.

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Chapter One: Adaptation of psychotherapeutic interventions for people from global majority backgrounds in high income countries

Abstract

There are no currently known systematic reviews looking at the adaptation of psychotherapeutic interventions for people from global majority in high income countries and specifically, the quality of the reporting of them. Due to the Western origins of many psychotherapeutic models and theories, their appropriateness for people from global majority backgrounds is brought to question. Although psychotherapeutic models are increasingly being adapted for global majority populations, there is little research regarding how well they are reported to allow for replicability of the interventions. Existing literature was reviewed using a systematic search strategy applied across four electronic databases. A total of fourteen qualitative, quantitative and mixed methods studies were reviewed, for which findings were narratively summarised. Bernal's framework for cultural adaptation and Hoffman's TiDieR checklist for the quality appraisal of intervention reporting were used to extract data and analyse results. It was found that the majority of studies did not provide an overview of adapted interventions, with largely insufficient reporting. The findings of this review suggest that future researchers may wish to better report their adaptations to allow for better widespread psychotherapeutic practice for global majority populations in high income countries.

Keywords: Adaptation, psychotherapy, global majority, ethnic minority, high income countries, systematic review

Introduction

Background

Given that a substantial number of psychotherapeutic interventions have been developed by and for western countries or cultures, this review aims to consider their adaptability for global majority populations residing within high-income countries (HICs). Given the origins and intent behind many psychotherapeutic approaches, they may lack suitability for people from global majority backgrounds. The global treatment gap within mental health provision can be attributed to a range of issues, including financial barriers, stigma, fragmented service approaches, poor resource, limited research, relevant policy and implementation (Kim et al., 2017; Wainberg et al., 2017). Research has significantly grown around the use and adaptation of psychotherapeutic interventions in low- and middle-income countries (LMICs; e.g. Eaton et al., 2011; Latif et al., 2021), with some research also highlighting the need of cultural adaptation for diverse populations in HICs (Sashidharan et al., 2016; Taylor et al., 2023). As HIC research in the area grows, such countries can learn from LMIC findings around better support for global majority populations with mental health difficulties (McKenzie et al., 2004). Bernal et al.'s (1995) framework for the cultural adaptation of interventions, amongst others, has been used to better tailor interventions across global settings. Prior to widespread implementation of adapted interventions, research must increase confidence in the efficacy of adaptation processes (Sashidharan et al., 2016).

Cultural adaptation

First, it is important to consider the variation in definitions of culture. Culture can be defined as shared or common languages, rituals, behaviours, values or beliefs (Chamberlain,

1999). Here, it will be referred to in relation to global majority populations, largely based on ethnicity and/or race, with considerations of language and spirituality where appropriate (Burnham, 2012). However, culture can be understood as broader than these forms of identity.

There is significant variation in psychological experiences dependent upon cultural background, with greater disparities in mental health care and outcomes for people of ethnically or racially minoritised backgrounds (Halvorsud et al., 2018; Kilbourne et al., 2018; Singh et al., 2013). People from minoritised backgrounds in HICs may experience difficulties related to a country's legacy, such as colonialism, slavery and racism (Weine et al., 2020). Findings have suggested that treatment available in HICs for global majority populations are limited and lack cultural appropriateness (Jidong et al., 2021).

Despite significant research advances highlighting treatment needs and areas for development in global mental health provision, application to real-world settings is slow (Patel et al., 2018). Person-centred care through tailoring interventions to the needs of specific populations and individuals is fundamental to better global health care provision (WHO, 2015). Poorer outcomes are arguably related to the vast majority of delivered interventions being based on Western ideology and narratives of mental health difficulties (Fernando, 2010), with a lack of focus on sociocultural diversity (Gopalkrishnan, 2018).

Given the weight that culture holds in impacting and changing an individual or group's beliefs, and the multiple treatment components that are essential to adaptation (Bernal & Saez-Sántiago, 2006), this requires further attention and clarity. Previous findings have shown that culturally adapted over non-culturally adapted interventions have better outcomes (e.g. Chowdhary et al., 2014), as they tend to use evidence-based approaches, which are then also accessible and considerate of cultural needs. Due to globalisation and

the increasing multiculturalism in HICs, there is a greater need for services to pay particular attention to increasing the quality-of-service provision (Arundell et al., 2021).

Bernal et al. (2009) defined cultural adaptation as systemically modifying an intervention through consideration of context, culture and language, and a client's values and narratives. Cultural adaptation may make changes to content, delivery and access or engagement (Castro et al., 2010). Frameworks for cultural adaptation outline considerations that differ to guidance for the development of new interventions (Castro et al., 2010). Each framework or model likely varies in focus, context, scope and comprehensiveness. Given the vast range of adaptation frameworks available (e.g. Domenech-Rodriguez & Wieling, 2004; Hwang, 2006), the argument that resource and access to adaptation is unavailable no longer stands. Adaptation can range from a need for low (e.g. inclusion of case examples) to high (e.g. adapting an intervention to cultural concepts of trauma) resource (Kohrt et al., 2014).

Bernal et al.'s (1995) framework for the cultural adaptation of interventions includes eight dimensions, which are outlined in Table 1.

Table 1: Bernal et al.'s (1995) Cultural Framework – dimensions and elements

Intervention		Culturally sensitive elements
1.	**Language**	Culturally appropriate; culturally syntonic language
2.	**Persons**	Role of ethnic/racial similarities and differences between client and therapist in shaping therapy relationship
3.	**Metaphors**	Symbols and concepts shared with the population; sayings or "dichos" in treatment
4.	**Content**	Cultural knowledge: values, costumes and traditions; uniqueness of groups (social, economic, historical, political)
5.	**Concepts**	Treatment concepts consonant with cultural and context: dependence vs. interdependence vs. independence; emic (within culture, particular) over etic (outside culture, universal)
6.	**Goals**	Transmission of positive and adaptive cultural values; support adaptive values from the culture of origin
7.	**Methods**	Development and/or cultural adaptations of treatment methods. Examples: "modelling" to include culturally consonant traditions (e.g., cuento therapy (therapy based on folk tales)); "cultural reframing" of drug abuse as intergenerational cultural conflicts; use of language (formal and informal); cultural hypothesis testing; use of genograms, "cultural migration dialogue"
8.	**Context**	Consideration of changing contexts in assessment during treatment or intervention: acculturative stress, phase of migration; developmental stage; social supports and relationships to country of origin; economic and social context of intervention

Although there are several other frameworks, this approach remains one of the most widely used in the adaptation of psychosocial interventions.

Rationale

Given the importance of adapting psychotherapeutic interventions it is important to synthesise research findings that have engaged in adapting psychotherapy interventions for global majority populations in HIC to date. This will help to highlight research and clinical

gaps, and subsequent areas for improvement in psychotherapeutic provision. Given that the need for adaptation has been increasingly evidenced, but translation to the real-world is minimal (Patel et al., 2018), the focus of this review is to consider the processes used in the adaptation and application of interventions.

The vast majority of interventions are developed by and for those living in the 'west'. Given the variation in which countries constitute the west, this review is looking at adaptation within HICs (World Bank, 2023), which are classified by the gross national income per capita of the country. These countries may arguably have more resource and infrastructure available for adaptation for a range of populations in comparison to LMICs.

To our knowledge, a review focusing on cultural adaptations of psychotherapeutic interventions specifically within HICs has not been published. Therefore, this review aims to comprehensively and systematically review the literature through answering the following questions:

1. Which interventions have been adapted for these populations?
2. What process of adaptation was used?
3. How well are the adapted interventions described in the studies?

Methodology

Categories from the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses; Page et al. 2021) checklist that were relevant to this systematic review were used to guide its write-up. The PICO (Population, Intervention, Comparison and Outcome) tool was used to maintain an appropriate focus throughout the review:

Table 2: The PICO tool

Population	Intervention	Comparison	Outcome
Global majority populations in High Income Countries	The reporting of cultural adaptation of psychotherapeutic interventions	Frameworks for the process/evaluation of the adaptation of interventions (e.g. Bernal and TIDieR)	Better reporting for better client outcomes

Search strategy

Following scoping searches, final searches were conducted in May 2023 on the following databases: PsycINFO, PsycArticles, CINAHL Plus and Proquest. The review was registered on PROSPERO (reg. no: CRD42023421169) following approval of a protocol.

Under four concepts (identity, psychology, treatment, integration), the search terms used to search titles and abstracts were: ("Minorit* group" OR "ethnic minorit*" OR "global majorit*" OR "BAME" OR "BME" OR Caribbean OR African OR Black OR Asian OR Indian OR Pakistani OR Bangladeshi OR Chinese OR Arab OR Hispanic OR "Alaska Native" OR "Native Hawaiian") AND (Mental" OR "mental health" OR psycholo" OR psychiatr* OR psychotherap* OR emotion* OR wellbeing) AND (Interven* OR treat* OR therap* OR program* OR group* OR support*) AND (Modif* OR adapted OR incorporat* OR cultur* w4 adapt*).

Search limiters were: English language, humans, peer-reviewed journals, exclude dissertations, 1983 to current date. Journal articles were only available from 1983 onwards across the databases used in the review. This strategy was minimally adapted across databases.

UK (Office for National Statistics, 2021) and US Census (United States Census Bureau, 2021) terminology was used to capture more studies referring to specific ethnic or cultural groups. Although this was not exhaustive, it was deemed a reasonable approach to capture studies

using language used by the HICs within which more ethnically-specific research is carried out.

Inclusion/exclusion criteria

The review's inclusion criteria were:

1. Peer-reviewed journal articles
2. Papers published in English
3. Papers published between 1983 and 2023
4. Studies that used qualitative and/or quantitative methodology
5. Studies that adapted an intervention and tested this with a sample
6. Studies adapting psychotherapeutic interventions for adult global majority groups
7. Studies carried out in a HIC

The review's exclusion criteria were:

1. Papers that were not written in English
2. Grey literature, including dissertations, theses, discussion papers, grey literature
3. Papers that reported secondary or consequential data
4. If the sample majority were displaced populations or not born in the HIC
5. Papers that did not outline adaptation for specific cultural groups, e.g. studies reporting on "multicultural" groups were excluded
6. Adaptation for a child or adolescent population
7. Adaptation of group or family-based interventions

The review included studies whereby interventions were adapted for a within-country majority population if they were a part of the global majority. For example, if an intervention was adapted for a Bahraini population in Bahrain (a HIC). Studies within which over 50% of the sample consisted of displaced populations or people not born in the HIC were excluded, given the additional difficulties that they may experience that cultural adaptation may not always account for. These difficulties may include the role of acculturation, trauma, discrimination, loss and uncertainty unique to their migration context (Kirmayer et al. 2011). The review excluded child and adolescent, and group or family, interventions given the significant variability in treatment focus, approach and delivery between children and adults, and one-to-one and group interventions. Given the variability across cultural groups, HICs, psychotherapeutic approaches and presenting difficulties, these exclusions were considered reasonable to minimise heterogeneity within an already variable review topic.

Search outcome

Across the four databases, 9548 papers were identified, of which duplicates were removed and 5045 papers' titles and abstracts were screened. Full texts were retrieved and reviewed for 88 papers using the inclusion and exclusion criteria, eight of which met inclusion criteria. A collaborator independently and blindly reviewed and rated 20% of the titles and abstracts of the 5045 papers, and then the full texts of the total of 88 papers. The collaborator queried whether some additional papers met the inclusion criteria. Through discussion and jointly revisiting the criteria against said papers, they agreed that the researcher's included papers were correct.

Six further papers were identified through hand-searching reference lists, journals, conducting additional web searches and contacting authors of the eligible studies to query if they were aware of any further potentially eligible studies. Therefore, the total studies included in the review were 14. The PRISMA diagram in Figure 1 outlines the search process and the characteristics of the included studies are outlined in Table 3.

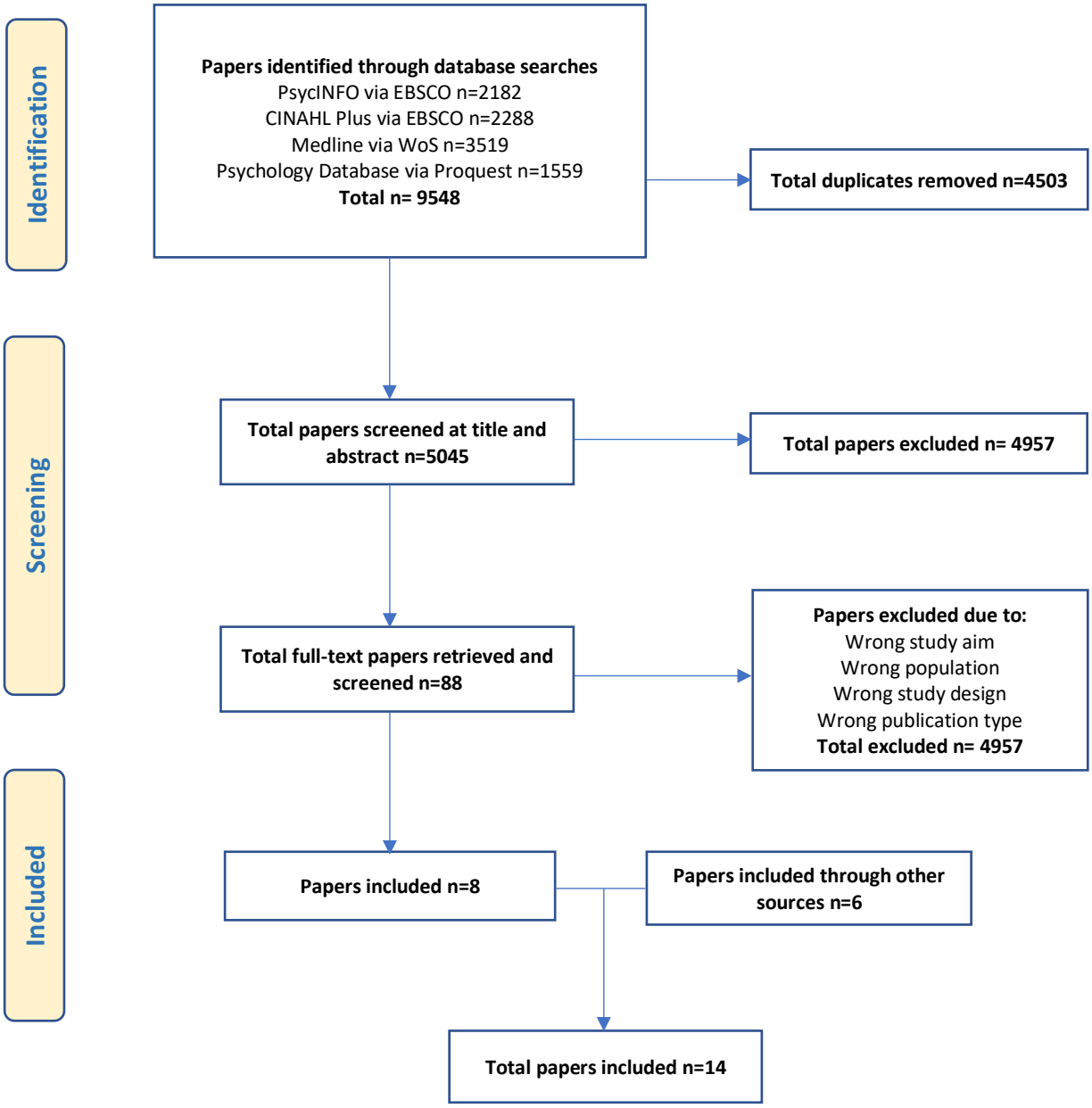

Figure 1: PRISMA diagram

Table 3: Study characteristics and findings

Study	Location	Population	Age range	Model	Study aim	Method	Brief results/ findings
1. Bennett et al. (2014)	New Zealand	Māoris	19-47 years	12 one hour sessions of CBT	Evaluate the efficacy of CBT adapted for the Māori population	Quantitative – uncontrolled naturalistic trial. measures of depression and negative automatic thoughts	CBT adapted for the Māori population significantly reduced symptoms related to depression and negative cognitions
2. Cachelin et al. (2014)	USA	Mexican American females	18-55 years	Self-help, with eight 25 minute guidance sessions over 12 weeks	Test the efficacy of Cognitive Behavioural Guided Self-Help adapted to treat binge eating in the Mexican American population	Mixed methods – focus groups; interviews measuring acculturation, eating disorders, psych. functioning, self-esteem, BMI, evaluation	CBTgsh for binge eating adapted for the Mexican American population led to reduction in binge eating and associated symptoms
3. Dwight-Johnson et al. (2011)	USA	Latinos	Not reported	Eight sessions of CBT	Test the efficacy of culturally adapted, telephone-based CBT for depression in Latino adults	Mixed methods – interviews using measures of depression and anxiety-related difficulties	Latino adults accessing culturally adapted telephone-based CBT are more likely to experience reduction in depression
4. González-Prendes et al. (2011)	USA	Latino male	45 years	12 50 minute sessions of CBT	Illustrate culture-based modifications of CBT for a Latino with depression	Qualitative – case study	Culturally-adapted CBT improved depression and anxiety, activity levels and wellbeing
5. Hwang et al. (2015)	USA	Chinese Americans	18-65 years	12 sessions of CBT	Compare the efficacy of CBT vs. culturally-adapted CBT for depression in Chinese American adults	Quantitative – RCT – measure of depression	CA-CBT showed a greater overall improvement in treatment retention rates and symptom reduction. Longer treatment may be more beneficial
6. Pan et al. (2011)	USA	Asian Americans	18+; average 22.1 years	One 2-3 hour of One-Session Treatment (OST)	Compare standard OST, culturally-adapted OST and self-help for phobias in Asian American adults	Quantitative – measures of avoidance of phobic stimuli related and anxiety, and general fear	Both OST-S and OST-CA are effective, with OST-CA showing additional improvements in some phobia-related areas
7. Pearson et al. (2019)	USA	American Indian and Alaska Native (AIAN) females	18-60 years	13 sessions of Cognitive Processing Therapy (CPT)	Assess the efficacy of culturally adapted CPT for AIAN females with PTSD symptoms, substance use, high-risk sexual behaviour	Quantitative – RCT – measures of PTSD, alcohol and substance use, and high risk sexual behaviour	Culturally-adapted CPT showed improvements in PTSD. high risk sexual behaviour and alcohol use

8.	**Rathod et al. (2013)**	UK	Black British, African Caribbean/Black African and South Asian Muslims	18-65, average 33.5 years	16 40-90 minute sessions of CBT for Psychosis	Evaluate the efficacy of culturally adapted CBT for psychosis (CaCBTp) vs. treatment as usual (TAU)	Quantitative – RCT – measures of medication, depression, anxiety, Schizophrenia-related symptoms, insight	CaCBTp showed greater overall improvements in symptoms
9.	**Skilbeck et al. (2020)**	UK	African-British female	22 years	12 sessions of CBT	Integrate familism as a culturally-related factor into CBT for depression	Qualitative – case study	Findings suggested that culturally-adapted CBT improved depression and anxiety in the context of family attitudes/behaviours
10.	**Valentine et al. (2017)**	USA	Latinos	20-50+ years	CPT	Evaluate the efficacy of culturally adapted CPT for PTSD in Spanish-speaking Latinos	Qualitative – data collected from therapy sessions, consultation team meetings, therapist and researcher fieldnotes	Culturally-adapted CPT improved the acceptability and implementation of the intervention
11.	**Wallace et al. (2021).**	USA	African American female	36 years	Eight sessions of CBT	Consideration of the efficacy of culturally-adapted CBT for panic and depression in an African American female	Qualitative – case study	Highlights positive client outcomes through a culturally-adapted approach to therapy
12.	**Webster et al. (2023)**	UK	South Asian, African, Caribbean	25-88 ye ars	Eight sessions of CBT	To culturally tailor START for dementia family carers	Mixed methods – interviews, measures of depression and anxiety, and no. of sessions attended	Culturally-tailored START showed improvements in mental health, quality of life and coping
13.	**Weingarden et al. (2011)**	USA	Jewish male and African American male	30-40 years	22 50-minute sessions of CBT	Highlight the ability to culturally adapt CBT for Body Dysmorphic Disorder (BDD) in Jewish and African American men	Qualitative – case study	Culturally adapted CBT significantly improved BDD symptoms
14.	**Williams et al. (2014)**	USA	African American	23-49 years	Prolonged Exposure (PE) Therapy	Discussion of culturally-adapted PE for PTSD in African Americans	Qualitative – case study	Culturally-adapted PE improved PTSD-related symptoms

Data analysis and synthesis

The identified studies were appraised using a framework regarding the cultural adaptation of interventions (Bernal et al., 1995). The Bernal framework outlines culturally-sensitive elements related to eight components of intervention; language, persons, metaphors, content, concepts, goals, methods and context. The framework was used to answer question two of this review. A collaborating peer researcher appraised four (a minimum of 25%) of the included studies to check for reliability.

The TIDieR Checklist (Hoffmann et al., 2014) was used to appraise how well the interventions were reported by the studies. Higher TiDieR scores equate to a reader's better understanding of the competency, fidelity and quality of the adapted intervention. The TiDieR Checklist (see Appendix 2) allows for authors to structure the reporting of their interventions, and for reviewers, alike the researcher here, to assess described interventions and use the information. The checklist was used to answer question three of this review, allowing for the meaningful interpretation and explanation of findings through a structured tool.

A narrative synthesis approach was used for data analysis. This method was deemed most appropriate given the variation in research design across studies, allowing for the synthesis of findings, patterns and differences across qualitative and quantitative methods. A narrative approach was also deemed useful when considering the nuances and intricacies of cultural difference, which is integral to this review. Narrative approaches can allow for the discussion of overlooked areas to identify gaps and subsequent future recommendations (Boland, Cherry & Dickson, 2017).

Results

Of the 14 studies, the majority of studies were carried out in the USA (n=10), then the UK (n=3) and New Zealand (n=1), largely using cognitive-behaviourally informed approaches. As this review focused on the extent to which studies reported intervention adaptation and this process, as opposed to the quality of adapted interventions, it does not currently provide in-depth consideration on the studies' findings. However, in general, the adapted approaches all showed positive outcomes across populations in terms of client outcomes and/or intervention transferability (see Table 3).

Table 4 provides an overview of each study's adaptation reporting and process. Only one study (Wallace et al., 2021) adequately provided a session-by-session outline of the adapted intervention, with three studies (Skilbeck, 2020; Weingarden et al., 2011; Williams et al., 2014) only giving some examples of adaptations or considerations to hold in mind regarding adaptation. Seven studies (Cachelin et al., 2014; Hwang et al., 2015; Pearson et al., 2019; Rathod et al., 2013; Valentine et al., 2017; Wallace et al., 2021; Webster et al., 2023) reported using a specific framework or approach to their adaptation, none of which used the same framework. Six studies (Bennett et al., 2014; Hwang et al., 2015; González-Prendes et al., 2011; Pan et al., 2011; Pearson et al., 2019; Webster et al., 2023) outlined other steps in the adaptation process, such as consulting professional or community figures, reviewing literature, and testing. Four studies (Dwight-Johnson et al., 2011; Skilbeck et al., 2020; Weingarden et al., 2011; Williams et al., 2014) did not report the process through which they adapted the intervention.

371 *Table 4: Adaptation reporting and process*

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Study	Adapted material overview provided	Specific adaptation framework used	Adaptation process/ framework used
1. Bennett et al. (2014)	No	No	Manual developed drawing on relevant cultural and CBT literature, and consultation with Maori/non-Maori psychologists, clients and elders
2. Cachelin et al. (2014)	No	Yes	Stage Model of Behavioural Therapies (Rounsaville, Carroll & Onken, 2001)
3. Dwight-Johnson et al. (2011)	No	No	Not reported
4. Hwang et al. (2015)	No	Yes	Psychotherapy Adaptation and Modification Framework (Hwang, 2009); focus groups with therapists, and interviews with Buddhist monks/nuns, Taoist masters and traditional Chinese medicine practitioners
5. González-Prendes et al. (2011)	No	No	Adaptation based on cognitive behavioural approaches, drawing on research re the importance of Latino-specific values in CBT
6. Pan et al. (2011)	No	No	Reviewing research, protocol, develop even cultural adaptations, test viability
7. Pearson et al. (2019)	No	Yes	Map of Adaptation Process (McKleroy et al., 2006); collaboration with tribal advisory board
8. Rathod et al. (2013)	No	Yes	Framework of Cultural Adaptations of Psychological Therapies (Tseng et al, 2005)
9. Skilbeck et al. (2020)	No; only brief treatment plan	No	Not reported
10. Valentine et al. (2017)	No	Yes	Five-Stage Model for Cultural Adaptation (Barrera et al., 2013)
11. Wallace et al. (2021)	Yes; session-by-session adaptations	Yes	Explanatory Bridging Model (Hinton & Patel, 2017)
12. Webster et al. (2023)	No	Yes	The Cultural Treatment Adaptation Framework (origins unclear from paper), and interviewing carers
13. Weingarden et al. (2011)	No; Technique embedded within case studies	No	Not reported
14. Williams et al. (2014)	No; Considerations outlined	No	Not reported

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Quality assessment: Reporting of intervention adaptation

Given that this review is interested in how well adapted interventions are reported by studies, the TIDieR Checklist (Hoffmann et al., 2014) was used was used to appraise this (see Table 5). Table 4 outlines the extent to which studies reported their adaptation process and if so, which framework or approach they used. The quality of and extent to which findings are reported affects their accessibility and subsequent replicability by other clinicians. For transparency, all studies were included in this review irrespective of how well they reported interventions, with considerations and implications of reporting quality considered during data synthesis and the discussion, particularly in consideration of future research recommendations.

Whilst still requiring more detail, Cachelin et al. (2014), Dwight-Johnson et al. (2011), González-Prendes et al. (2011) and Webster et al. (2023) can be considered better examples to look to in comparison to the other reviewed studies regarding the extent to which they reported on the intervention adaptation process. According to the TiDieR Checklist, Bennett et al. (2014), Pan et al. (2011), Weingarden et al. (2011) and Williams et al. (2014) might be considered examples of studies that do not effectively report adapted interventions.

All of the studies provided an intervention name and rationale for the adaptation of the intervention. However, the vast majority of studies lacked clear and detailed information regarding the adaptation process, including materials used, procedures taken, facilitators and information around intervention delivery, such as location and frequency.

397 *Table 5: TIDieR Checklist (Hoffman et al., 2014) Quality Appraisal*
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		Hoffman et al.'s (2014) TIDieR Checklist											
Study		**Brief name**	**Why**	**What (materials)**	**What (procedure)**	**Who provided**	**How**	**Where**	**When and how much**	**Tailoring**	**Modification**	**How well (planned)**	**How well (actual)**
1.	**Bennett et al. (2014)**	✓	✓	X	X	X	X	X	/	/	X	/	X
2.	**Cachelin et al. (2014)**	✓	✓	✓	X	/	✓	X	✓	X	X	/	/
3.	**Dwight-Johnson et al. (2011)**	✓	✓	✓	X	✓	✓	✓	✓	X	X	✓	✓
4.	**González-Prendes et al. (2011)**	✓	✓	/	✓	✓	✓	/	✓	X	X	X	X
5.	**Hwang et al. (2015)**	✓	✓	/	X	/	/	/	/	X	X	✓	✓
6.	**Pan et al. (2011)**	✓	✓	/	X	X	X	X	/	X	X	✓	/
7.	**Pearson et al. (2019)**	✓	✓	/	/	/	X	✓	X	X	X	/	/

8.	**Rathod et al. (2013)**	✓	✓	X	X	✓	X	/	✓	X	X	✓	/
9.	**Skilbeck et al. (2020)**	✓	✓	/	/	✓	/	/	/	/	X	X	X
10.	**Valentine et al. (2017)**	✓	✓	/	X	/	/	X	X	X	X	/	/
11.	**Wallace et al. (2021).**	✓	✓	/	✓	X	/	X	X	/	X	X	X
12.	**Webster et al. (2023)**	✓	✓	/	/	✓	✓	✓	✓	/	X	✓	✓
13.	**Weingarden et al. (2011)**	✓	✓	X	/	X	X	X	✓	X	X	/	/
14.	**Williams et al. (2014)**	✓	✓	/	X	X	X	X	X	X	X	X	X

Key: ✓: information provided. /: Information partly provided. X: information not provided.

Bernal Framework: Adaptations that were made

The Bernal et al.'s (1995) framework of cultural adaptation of interventions was used to scrutinise the scope of the adaptation as outlined in Table 6. Whilst the majority of studies offered commentary that can be considered within Bernal et al.'s (1995) eight dimensions, the studies largely outlined considerations for therapists to make, as opposed to the interventions' substantive content and how they can be replicated (see table 6). Examples of considerations for the therapist to make, as opposed to operational adaptations, included the things that a therapist might want to hold in mind during intervention delivery, such as cultural background, or do to develop their cultural competence (e.g. Dwight-Johnson et al., 2011; Weingarden et al., 2011; Williams et al, 2014). Overall, studies lacked information about the professional background of therapists and how they can be appropriately trained or supported during training delivery.

The findings reported in Table 6 have been further narratively synthesised below according to Bernal's eight dimensions:

1. Language

Five studies (Pan et al., 2011; Rathod et al., 2013; Skilbeck et al., 2020; Weingarden et al., 2011; Williams et al., 2014) did not report any language-related changes. Of the nine studies that did report changes, five reported a form of translation being carried out. Six studies (e.g. Dwight-Johnson et al., 2011; Wallace et al., 2021) described the incorporation of concepts or phrases relevant to the cultural group, linguistic, regional or semantic considerations being made, or the simplification of language. For the most part, the studies did not provide actual examples of translated content or where this can be accessed.

2. Persons

Two studies (Hwang et al., 2015; Rathod et al., 2013) did not report any changes related to this dimension. Ten studies commented on the therapist-client relationship, or the importance of who delivers the interventions and the way in which this is done. For example, Pan et al. (2011) reported that the cultural group gives important to hierarchy, thus placing emphasis on this being considered during intervention delivery. Some studies commented on techniques that might help the therapist to support the therapeutic alliance, such as additional session time to support engagement (e.g. Pearson et al., 2019; Williams et al., 2014). Despite the majority of studies highlighting the importance of the relationship with the client, few outlined examples of how this can be done in practice.

3. Metaphors

Five studies (Cachelin et al., 2014; Pan et al., 2011; Rathod et al., 2013; Skilbeck et al., 2020; Weingarden et al., 2011) did not report adaptation of relevant metaphors, concepts or proverbs. Some studies provided specific examples of culturally-sensitive metaphors, symbols or stories, including visual aids. Bennett et al. (2014) referred to the incorporation of Maori proverbs, known as *whakatauki* in the context of CBT, thus bridging the gap between the adaptation and original intervention, offering clarity in the adaptation process and related rationale for the reader. However, six studies (e.g. Dwight-Johnson et al., 2011) referred to changes being made, without changes clearly being reported.

4. Content

Two studies (Dwight-Johnson et al., 2011; Rathod et al., 2013) did not report any adaptations made under the content dimension. Of the other studies, some commented on the incorporation of religion or spirituality, such as the use of prayer in sessions (Bennett et al., 2014), tribal or cultural customs, values and traditions, and meaningful activity, such as

poetry or music. These considerations were made by seven studies (e.g. González-Prendes et al., 2011) in relation to factors for the therapist to be aware of and hold in mind, which in itself was considered integral to culturally-adapted approaches. Five studies (e.g. Pearson et al., 2019) identified ways in which activities could integrate appropriate narratives or practices.

5. Concepts

Two studies (Dwight-Johnson et al., 2011; Rathod et al., 2013) did not report adaptations made under this dimension. The other 12 studies referred to the intervention considering specific values that the cultural group may place importance upon. For example, considering the role of strength, family, community experiences (e.g. Valentine et al., 2017), and social context.

6. Goals

Four studies (Dwight-Johnson et al., 2011; Rathod et al., 2013, Valentine et al., 2017; Webster et al., 2023) did not report adaptations related to this dimension. Some studies commented on development of goals and the cultural space in relation to context, worldview and client narratives. Nine studies (e.g. Bennett et al., 2014) referred to how therapists may do this, whilst others provided minimal information, merely referring to the adaptation without additional guidance.

7. Methods

Two studies (Dwight-Johnson et al., 2011; Rathod et al., 2013) did not provide adaptations related to intervention methods. The vast majority commented on the intervention's practical adaptation, tailoring of materials and graphics, and use of culturally-sensitive techniques. For example, reframing anxiety according to cultural narratives and

beliefs (Pan et al., 2011). Five studies (e.g. Hwang et al., 2015) did not provide explicit examples of adaptation to methodology, but commented on considerations to make. For instance, considering social context during intervention delivery, but studies not explicitly stating how to do so.

8. Context

Two studies (Hwang et al., 2015; Rathod et al., 2013) did not report adaptations under this dimension. The other 12 studies commented on the importance of context, support systems, delivery of interventions in the community, client educational level, culturally-specific considerations around stigma or trauma, and history. For example, given heightened concerns in some Black and Asian communities regarding social opinion, Webster et al. (2023) included an additional prompt re confidentiality. Whilst the studies commented on the importance of these factors, the reporting of adaptations that they made were poor, as outlined in tables 5 and 6.

484 *Table 6: Data extraction using Bernal et al.'s (1995) framework for cultural adaptation of interventions*
485

Study		Bernal et al's (1995) Dimensions and Culturally Sensitive Elements							
		1. Language	**2. Persons**	**3. Metaphors**	**4. Content**	**5. Concepts**	**6. Goals**	**7. Methods**	**8. Context**
1.	**Bennett et al. (2014)**	Concepts translated in native language, but how this is incorporated into the manual is not reported	Emphasis on family, therapist-client relationship, sharing of personal information (e.g. tribal affiliation, family background)	Maori-appropriate metaphors, proverbs and vignettes used	Spirituality; sessions open and close with prayer	Values around connectedness	CBT goals considered in line with Maori proverbs	Yes, e.g. prayer incorporated into therapy	To some extent, e.g. tribal history, social support
2.	**Cachelin et al. (2014)**	English language sessions, materials and measures (as English-speaking sample recruited)	Family-focused role plays and vignettes incorporated	Not reported	Consideration of values, cultural narratives and activities	Relevant American and Latino foods considered	Sensitivity to worldviews, social context, life experience	Social context considered9	Consideration of family support, sensitivity to worldview
3.	**Dwight-Johnson et al. (2011)**	Workbook translated to Spanish, and content used Latino names/ contextual examples. Bilingual study team members reviewed manual	Option to do first session in person due to cultural considerations	Consideration of idioms, but no expansion on this	Not reported	Not reported	Not reported	Not reported	Considerations of context, but no expansion on this
4.	**Hwang et al. (2015)**	Manuals translated and back-translated to ensure conceptual, linguistic and semantic consistency. Materials reviewed across regions	Not reported	Cultural metaphors and symbols incorporated	Philosophical and cultural teachings integrated	Culturally-relevant issues and communication considered	Yes, but minimal detail	Therapists supported to do the work, but paper does not report how	Not reported
5.	**González-Prendes et al. (2011)**	Use of, both, English and Spanish as per client's preference. Spanish words used to establish rapport, e.g. at greeting	The therapist was mindful of and explored both of their cultural identities together. Reference to ethnic	Incorporation of cultural concepts and symbols, appropriate language use	Culturally-specific knowledge and traditions considered	Adaptation of terminology used, e.g. rational/irrational thoughts reframed to	Approach actively considered culture/context, sensitive to cultural views	Methods culturally adapted, e.g. behavioural activation in the context of the client and therapist's	Context integral to the approach; naming that not doing so can hinder collaboration

			matching and gender roles. Interplay between therapist and familial roles			helpful/unhelpful; code-switching		cultures/world views	
6.	**Pan et al. (2011)**	Not reported	Emphasise confidentiality and vertical nature of the client-therapist relationship (given cultural endorsement of hierarchy)	Not reported	Consideration of values, e.g. calmness	Integration of cultural view of emotions and disclosure	Explore client's narratives re problems and normalise	Extensive psychoeducation, therapist approach to emotional reactions and reframing anxiety	Consider acculturation and cultural background
7.	**Pearson et al. (2019)**	Simplified language, removal of jargon, improving readability	Additional pre-session to aid engagement and space for therapy rationale, and therapist tips to aid the relationship	Adapting definitions and concepts, use of visual aids	Additional content on relationships, indigenous, spiritual and tribal factors, and cultural activity	Exercises and examples relevant to the AIAN community	Additional pre-therapy session for setting up the space	Use of adapted handouts, protocols and ceremonies, and indigenous images	Cultural adaptation of materials, concepts and definitions for ease of community delivery
8.	**Rathod et al. (2013)**	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
9.	**Skilbeck et al. (2020)**	Not reported	Reference to therapist's own cultural position, but not re the adaptation	Not reported	Consideration of family/cultural values and attitudes	Concept of familism integrated into treatment plan	Space for client culturally-specific goals	Methods adapted to involve familism value, e.g. cognitive restructuring involving family	Family/cultural history and context held in mind throughout
10.	**Valentine et al. (2017)**	Manual translated to Spanish, consideration of regional language	Consideration of client mistrust of therapist; how adaptation addressed this not reported	Consideration of cultural idioms of distress, adaptation of the original manual's visual cues	Awareness of cultural values, customs and beliefs	Integration of community context (e.g. family or violence)	Not reported	Manual provided additional material re specific techniques, e.g. Socratic questioning, more relevant examples/vignettes	Relevance of client educational level, social factors affecting trauma

11.	**Wallace et al. (2021).**	Use the client's terms for cultural specificity	Build a strong therapist-client alliance around shared identity	Draw on cultural schemas and culturally-relevant metaphors	Incorporate culturally-relevant behaviour and coping, meaningful end of intervention celebration, e.g. poems, music	Consideration of client's technique preferences	Focus on establishing the treatment and client expectancy, how therapy will help with cultural roles	Reframe in culturally-sensitive ways	Consideration of stigma, cultural roles, social support
12.	**Webster et al. (2023)**	Translation to Urdu where needed; manual language simplified and amended	Acknowledgement of impact of therapist cultural competence, but unclear if adaptation incorporated this	Narratives, values and visual aids reflected cultural considerations	Adaptations considered cultural group narratives	Cultural examples and themes incorporated	Not reported	Materials/graphics diversified	Consideration of context, societal views, family, e.g. role of confidentiality
13.	**Weingarden et al. (2011)**	Not reported	Maintain openness between therapist and client	Not reported	Consideration of cultural beliefs and narratives	Drawing on and reframing cultural- concepts	Goals incorporated cultural values	Formulation integrated cultural interpretations, adapting therapist technique and exercises	Consideration of context
14.	**Williams et al. (2014)**	Not reported	Therapist cultural disclosure fosters safety and openness; have time for building trust, alliance, rapport. Address therapist-client race issues	Use of concepts that resonate	Understand role of values, beliefs, faith	Consider role of strength for the cultural group, intersectionality	Culturally-sensitive goals developed	Use of culturally-sensitive assessment and activities	Exploration of race in relation to trauma experiences, family, racial history

Discussion

This review aimed to explore which interventions were adapted, the process of adaptation used and how well this was described, and how well the adapted interventions themselves were reported. Given that a large number of psychotherapeutic interventions have not been developed with global majority populations in mind, the adequate adaptation of interventions and the subsequent reporting of them to allow for replication is necessary. For this review, 14 studies were identified through the systematic searching of four relevant databases and additional hand searching for completeness. The review aimed to explore the reporting of culturally adapted psychotherapeutic interventions within published qualitative, quantitative or mixed methods research.

Irrespective of model, population, HIC or adaptation process, the reviewed studies showed similarities in findings, predominantly showing positive outcomes for clients receiving the intervention. The studies were all clear in their rationale for adaptation for the specified population and which intervention was adapted. Regarding question 1, a range of interventions were adapted, 13 of which were variations of cognitive behavioural interventions, and the final intervention was START (Webster et al., 2023), for which the theoretical underpinnings were not clearly reported.

In answering question 2 of this review, Bernal's framework (1995) was used. This showed that whilst some studies were more comprehensive in outlining the process through which interventions were adapted and an overview of the tailored approach, the majority lacked transparency and detail, thus making replicability of the intervention difficult. It is helpful to note that the majority of studies suggested that further research is done to clarify or further reinforce their findings. This may explain a prospective reluctance

to publish intervention outlines or manuals where researchers intend to increase confidence in the evidence of their intervention's efficacy before their widespread clinical delivery.

Despite some studies reporting that the intervention content and/or materials were translated, the extent of this was not clear. Interventions involving lingual adaptation might have lacked consideration of regional or local linguistic factors. Future studies may benefit from explicitly naming the process of translating or integration of language-related factors.

Bernal's framework was used as an organising structure for this review due to its comprehensiveness and widespread use. Research has shown that intervention adaptation using the Bernal framework (Smith et al., 2011) led to positive outcomes. Contrastingly, critique of the framework suggests that its eight dimensions overlap, making differentiation between them difficult. For example, *content, concepts and context* dimensions interrelate to social context, with the framework's list format making real-world application challenging (Chu & Leino, 2017). Further, the framework was developed for the adaptation of face-to-face treatment, limiting its applicability to other intervention types such as online delivery (Harper Shehadeh et al., 2016). Given that the interventions reported in this review's 14 studies vary in model, mode and format, it can be suggested that Bernal's framework may not have been the appropriate tool for them all. However, arguably, no one adaptation framework is going to align with all approaches or interventions and to ensure the quality adaptation of interventions, clear, consistent and widely accepted ways of approaching adaptation need to be used.

Whilst the process of cultural adaptation can be systematic, it is open to subjectivity and interpretation. It cannot be said that outcomes of a culturally adapted intervention are solely due to the systematic adaptation when the therapists delivering the interventions may, intentionally or intentionally, make their own adaptations. For example, in an RCT

evaluating an adapted vs a non-adapted intervention (e.g. Hwang et al., 2015), therapists delivering the non-adapted intervention may implement their own adaptations.

Relating to question 3 of this review, the studies significantly differed in their description of the adapted interventions, as demonstrated using Hoffmann et al's (2014) TIDieR checklist (see Table 5). Given the review's key focus on reporting of cultural adaptation, the checklist was effective is supporting this process. The researcher was able to clearly delineate the studies' quality of reporting key aspects of an intervention, which demonstrated that this was generally poor.

Although some studies did outline adaptations, these were not always clearly reported. The author of the current review was required to thoroughly examine disparate parts of the majority of studies for details, particularly those which did not provide an intervention outline or plan. Given cross-cultural differences, and the assumption that some clinicians may use interventions adapted for a cultural group to which they do not belong, the complexity of having to decipher which adaptations are made, their meaning or narratives, and how to implement changes when studies have not clearly reported them is likely to present additional barriers to their use with underserved populations.

Strengths and limitations

The strengths of this review include its use of a broad search strategy whilst maintaining focus on clearly identifies aims and outcomes to increase the clarity of its findings. The review employed a structured approach to identifying consistencies and inconsistencies in adaptation work and highlighted that there is a need for further research to be carried out in specific areas, as highlighted below. The review answered its three questions, collating and summarising key findings, identifying areas for development.

Given that the studies only covered three out of 81 HICs (World Bank, 2023), despite the search being carried out systematically and extensively, this suggests that research is limited and requires expansion into other HICs. The current review was also limited to studies published in English, thus potentially excluding other relevant findings across global settings. It is also helpful to note that, as discussed previously, the search strategy was adapted to include culturally-specific terms. However, there is great variation in language used around culture and global majority populations, psychotherapeutic interventions and adaptation, hence, making a focused, yet broad search strategy challenging. Beyond the systematic search, extensive hand searching and contact with authors of eligible studies was used to ensure that a comprehensive review was carried out.

This review may be limited in the way in which culture was defined and populations were grouped. Although the cultural population was clearly defined as people from a global majority background, which may encapsulate ethnicity and race, and other intersectional identities, perception of these groups is somewhat open to interpretation given the complexity of individual and group identities (Fernando, 2010). The author attempted to overcome this challenge through identifying studies which focused on clear cultural groups, as opposed to the grouping of a range of cultures, which might have adapted interventions for "multicultural" groups, as opposed to a specific culture or race.

The overlap and distinction between global majority versus ethnic minority language presents a further consideration, as discussed in the introductory chapter. Both terms were held in mind during this review, including within the search strategy, as there is significant variance in published language. Whilst *global majority* is increasingly being used in research and clinical settings, the majority of literature refers to *ethnic minority* groups, particularly within HICs. The author chose to use *global majority* terminology, as it allows for a wider

584 world view of cultural groups, their origins, and the complexities within and around them,
585 and is more empowering of these populations. However, the author recognises that *ethnic*
586 *minority* terminology may better underline the inequalities that these groups face, given
587 that in many HICs they may be minoritised.

588 Although this review attempted to look at adaptation for HIC-born populations, this
589 was not made explicit by some studies, so some participants might have been LMIC-born,
590 thus affecting acculturation levels and subsequently, how effective a culturally-adapted
591 treatment may be for people who have migrated, been displaced or sought refuge,
592 particularly if they have experienced associated trauma.

593 Whilst the review used an established and widely recognised cultural adaptation
594 framework (Bernal et al., 1995) to explore the quality of adaptation of the studies, this is
595 just one of many frameworks. Other frameworks might have uncovered alternate findings.
596 Although Bernal's framework offers clear guidance related to each of the eight dimensions,
597 the author's data extraction relied upon their interpretation of Bernal's dimensions, and
598 whether each study's adaptations (where reported) aligned with the dimensions and
599 language used by Bernal to describe each of the changes that can be made to make an
600 intervention more culturally-sensitive. Whilst the author had discussions about data
601 extraction with their research team to minimise author bias and a collaborating peer
602 researcher appraised some of the studies to increase reliability, it is helpful to note that the
603 process was inevitably open to some subjectivity. Given the variation in the settings,
604 cultures, approaches and reporting across included studies, this subjectivity is arguably
605 unavoidable.
606

Clinical implications

Services working towards an evidence-based approach, which may rely upon research to guide intervention delivery, might struggle to do so whereby research significantly varies in its reporting of adapted interventions. As highlighted by this review, studies lack comprehensive and detailed reporting of adaptation, thus leaving readers in the dark about how to implement interventions where they are recommended.

Although not the focus of this review all of the interventions led to better client outcomes. This suggests services supporting ethnic minority or global majority populations within HIC, particularly in areas that are high in ethnic density, would benefit from adapting psychotherapeutic interventions according to the cultural group that one identifies with. In practice, this may be challenging, given the vast range of cultural groups that one service may serve. However, as discussed in this review, some changes can be slight, easy to implement and require low resource. Ideally, a service would systematically adapt an intervention, particularly to work to an evidence-based approach, which may be compromised with minor, less structured adaptations that may be open to bias and individual interpretation.

Research implications

As mentioned, some studies explicitly recommended that further research is done to clarify or increase confidence in their findings. Studies may benefit from reporting details of the intervention more comprehensively, such as through the use of Hoffmann et al.'s (2014) TIDieR Checklist. This will allow for clinicians to better extract and apply findings where needed, but also for researchers to better ascertain further gaps in findings.

Future reviews may also benefit from focusing on interventions adapted for migrant and displaced populations in HICs, exploring the role of acculturation and trauma-related experiences. A review replicating this strategy, but for child and family interventions in HICs may be beneficial, with future reviews also considering group interventions. Given that most cultural adaptation frameworks were developed for a particular population, model or therapeutic approach (e.g. one-to-one, face-to-face etc.) in mind, a review of cultural adaptation frameworks may be beneficial to clarify their relevance and use across populations and intervention type. Across all of these areas, future research might also benefit from hearing the voices of people accessing the interventions, or struggling to do so.

Conclusions

This review suggests that the majority of adapted interventions for people from global majority backgrounds in HICs are cognitive-behavioural. Studies are generally not reporting these adapted interventions with transparency and clarity, subsequently making it difficult for adapted interventions to be replicated and applied to practice. This highlights a disconnect between identified clinical needs and research quality, thus potentially maintaining ineffective care provision for underserved global majority populations. Future researchers and authors may wish to better report their findings and adaptations to allow for better widespread psychotherapeutic practice.

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Chapter Two: A qualitative exploration of Trainee's experiences of Clinical Psychology training and clinical practice in Pakistan

Abstract

This study aimed to explore the experiences of Trainee Clinical Psychologists in Pakistan, with a particular focus on their experiences of training, the context within which they train and working with local populations. Ten Trainee Clinical Psychologists participated in online interviews, which were transcribed and analysed via Interpretative Phenomenological Analysis. Four Group Experiential Themes (GETs) emerged; 1) Identity/intersectionality, 2) Narratives of the field, 3) Experiences of training and 4) Looking ahead. There were a total of 11 group-level subthemes across the GETs. The themes represented, both, individual and collective experiences, including sociocultural and political narratives. The themes reflected participant experiences of training itself and working with local populations, with a thread running through of the role of intersectional identities. Participants made connections between their intra and extra training experiences, and the interplay between these, their identities as Trainee Clinical Psychologists, and subsequently, the hopes that they had for training and the wider profession. The study concluded with recommendations for training in Pakistan and the UK, and future research.

Key words: Clinical Psychology, training, higher education, Pakistan, South Asia, experiences, clinical practice

Introduction

Pakistan is a low- and middle-income country (LMIC) located in South Asia. It has an approximate population of 215 million people. Urdu and English are Pakistan's official languages, with 44% of the population speaking Punjabi as their first language and 7% Urdu (Pakistan Bureau of Statistics, 2021b). Although Urdu is only the first language for 7% of the population, it is a second language for a majority of the population. Punjab is Pakistan's most populated province, with more than half of the country's population residing there (Britannica, 2023). The vast majority of the country's population are Muslim at 96%, with 1.5% Christians and 1.6% Jains (Pakistan Bureau of Statistics, 2021a).

Pakistan was historically under British rule between 1858 and 1947 (Rahman et al., 2018) and the impact of its colonial history has remained. Pakistan has faced significant socio-political instability and change since its partition from India in 1947, with instabilities continuing to manifest in various forms. Political parties have been accused of financial corruption and money laundering using the country's money at times, with less priority on improving healthcare, educational and social infrastructure (Talbot, 2022). This continues to have a profound effect on the identity and cohesion of its population, and their trust in leadership and authority. Understanding the country's political context is integral to understanding the foundations upon which educational systems and institutes have been built (Ashraf & Ismat, 2016).

Mental health in Pakistan

Knowledge and awareness of mental health care, its need and delivery in Pakistan is developing (Mirza & Rahman, 2019). This can be attributed to various influences, including the purported role that religion and spirituality are believed to play in causing mental health

difficulties (Naeem et al., 2010). For example, as Islam states that difficult experiences can be a test of faith from God, mental health difficulties may be understood as such by some (Bagasra & Mackinem, 2014).

Health care is difficult to access for many in Pakistan and is considerably under-resourced (Begum et al., 2020). Mental health provision is often sourced from private providers, and is largely unregulated and expensive (Malik et al., 2016). There has been the historical poor prioritisation of mental health care in the country (Bashir, 2018), with gradual increases in attention paid to its need. Mental healthcare in Pakistan significantly changed and developed following the British colonisation of Pakistan, much of which involved the introduction of mental health hospitals (Javed et al., 2020). There has also been progression in mental health rights, prevention and promotion through the 2001 Pakistan Mental Health Ordinance (Provincial Assembly of Punjab, 2001), although this requires updating and attention to this has varied between provinces. The Act bears similarities to UK Acts given the large numbers of UK-trained psychiatrists working in Pakistan and British-Pakistani psychiatrists with links to the field in Pakistan (Tareen & Tareen, 2016).

Financial stressors, gender, class, power-related difficulties (Mumford et al., 1997), migration, educational opportunities, and, variably living in urban areas (Kidwai, 2014) can increase psychological distress in Pakistan. A country's power and wealth can affect understanding and treatment of mental health difficulties (Bracken, Giller & Summerfield, 2016), which is integral to understanding mental health care in LMICs.

There are few policies and plans focusing on mental health provision in Pakistan and those in place are unclear and inaccessible, with little to no evidence and statistics around access to services and staffing (WHO, 2020), and little discussion in parliament regarding

health (Sadiq et al., 2019). Implementation of developed laws and regulations continues to be an issue (Mufti, 2010).

LMICs significantly under-resource mental health services, including Clinical Psychology (CP), thus decreasing the quality of care (Eaton et al., 2011). Sections of Pakistani society lacks consideration for mental health in various ways, including culturally, socially, economically, politically and educationally (Hussain et al., 2018). For instance, a policy supporting the growth of community mental health and incorporation of mental health care into primary services from 2003 has not yet been actioned (Hussain et al., 2018). Few professionals work in community services, with high numbers of mental health professionals lacking appropriate training (Irfan, 2013), This can partly be explained by a highly medicalised and psychiatrically-influenced approach when diagnosing and treating in Urbanised hospitals. Where professionals are trained, the often low political commitment to maintain standards can result in inconsistent service provision (Budosan, 2023). Statistics for the number of psychologists per 100,000 in Pakistan were reported as 0.05 by WHO (2020). Challenges related to the provision of quality care in Pakistan increase when there are insufficient numbers of qualified mental health professionals (WHO, 2014).

Clinical Psychology in Pakistan

Despite Clinical Psychology (CP) Institutes having existed in Pakistan for over 40 years, little research has been conducted into the approaches that are used, the impact on trainees and their experiences, and the subsequent quality of provision for local populations. The University in Karachi's Institute of Clinical Psychology was founded in 1983, making it the oldest CP training facility in Pakistan. CP training is offered by other universities, including Bahria University's Institute of Professional Psychology and the

University of Punjab's Centre for CP. The various institutes differ in their approaches and training pathways, with no national regulatory body and considerable variation across courses. They also vary in public versus private institute status, thus affecting tuition fee amounts. Training is offered across Masters, MPhil and PhD levels, incorporating academic, research and/or clinical internship elements. Given the variation in training types and approaches, the exact number of CP training programmes currently offered is unclear. PsyD programmes are not currently offered in Pakistan. Whereas a PhD (Doctor of Philosophy) is largely research-based, a PsyD (Doctor of Psychology) is a professional doctorate whereby qualification allows for work in clinical practice. However, some known CP PhDs in Pakistan encompass clinical placement elements, allowing for qualified individuals to subsequently work in clinical practice.

Global South

Long-term considerations about the implications of the use of Western materials and ideas in South Asian CP have been discussed (Lemma, 1999). Research has shown that there is a lack of information about the cultural and contextual relevance of mental health support in LMICs (Fernando, 2014). There is a need for mental health courses in higher education in Pakistan to be standardised, with local context being held in mind more so than it has been (Khalily, 2011).

Research suggests that although research into CP training in Pakistan is lacking, psychological interventions in the country were shown to be more successful when drawing on culturally-appropriate narratives and tasks (Atif et al., 2019), such as appropriate communication and language (Irfan et al., 2017). For instance, whilst the West might consider lowering the gaze as poor eye contact, this could be seen as respectful in Pakistan.

It can be suggested that Western-developed methods and training materials may not hold the relevance of Pakistan-appropriate social, cultural, religious and political factors, local accessibility and provision (Syed et al., 2007), and the influence of socioeconomic status and education in mind. This holds particular relevance when looking at how the population engages with and understands therapy (Naeem et al., 2014).

Barriers to accessing therapy in Pakistan can include financial implications, stigma and societal views, and little knowledge of mental health (Husain, 2020). Religious and/or spiritual factors are often used to explain mental health difficulties in Pakistani culture (Naeem et al., 2010). For example, Jinn (Arabic for *spirits*) may be seen as a cause of psychosis-related symptoms, such as through possession. Up to 73% of people with psychiatric diagnoses used traditional healing (Farooqi, 2006) and approximately 40% of people who sought help from a faith healer in Pakistan also met criteria for psychiatric diagnoses (Saeed et al., 2000). Accessing mental health support from traditional healers in Pakistan can be more cost-effective, socially acceptable, geographically accessible and often aligns more so with belief systems (Ali & Gul, 2018). Mental health professionals and younger people are more optimistic about the use of psychological therapy, however, findings vary regarding experiences of faith healing. Whilst some findings suggest that a minority of the population preferred psychological over traditional healing and/or medicalised approaches (Munawar et al., 2020), others showed that faith healing led to no relief for 32.4% of a sample also accessing support from a psychiatric service (Khoso et al., 2018). Traditional healing can involve the repetition of Quranic verses or use of a Taweez (a protective locket; Farooqi, 2006).

Some commentators have highlighted ways in which the Global South can model practice to the Global North. For example, mindfulness is widely used by the West, but

originates in philosophies and belief systems from the Global South (White et al., 2020). Whilst Western cultures might draw more so on individualistic approaches, non-Western cultures place importance on collective healing, which may be through community or family systems (Kirmayer, 2007). Family can play a key role in enabling people to access support (Naqvi et al., 2009).

Whilst research highlights the need for the cultural adaptation of therapy in Pakistan (Latif et al., 2021), the Global South tend to use or draw on models and materials that are developed in English using Western ideology by and for the Global North without adaptation (Yakushko, 2020). However, the impact of this upon CP training in Pakistan is not known.

This research aims to better understand the experiences of Clinical Psychology (CP) Trainees in Pakistan. In developing insight into the profession, the efficacy of training and the impact of CP provision upon local populations, the profession can continue to be developed with the local population and culture/s in mind. Gaining a better understanding of the way in which CPs are trained and their meaning-making may provide a foundation upon which further research can be conducted on the profession in Pakistan. This research is partly led by local CPs and an Institute wishing to better understand and regulate their training pathways, thus providing a clear rationale for local need and application.

Methodology

Underpinned by a phenomenological epistemology, the study used a qualitative methodology that was guided by Interpretative Phenomenological analysis (IPA; Smith et al., 2009) using data collected from interviews carried out with Trainee Clinical Psychologists. The use of IPA allowed for the development of an in-depth understanding of individual participant experiences.

Sampling

Following the IPA approach, the study generated a homogenous, purposive sample, maintaining a focus on meaning-making for the participant group. To gain rich, in-depth data whilst maintaining homogeneity, the study aimed to interview 8 to 10 participants (Smith et al., 2022). Ten Trainee Clinical Psychologists were recruited and interviewed. This sample size allowed for a range of experiences to be captured. Recruitment from a single site allowed for the in-depth exploration of individual experiences, with them all having undertaken the same training programme and curriculum, therefore, the participants form a homogenous sample as required for IPA.

The Professor at the ICP, who held a consultant role throughout the study, circulated the study poster (Appendix 3) and information sheet (Appendix 4) via email, and physical copies were placed around the institute. Prospective participants then expressed interest directly to the researcher to maintain confidentiality and minimise the risk of pressure or coercion that trainees may have felt from the Professor to participate. Upon email contact, participant questions were answered, and/or interviews were arranged and consent forms were completed.

The recruitment site

Participants were recruited through the University of Karachi's Institute of Clinical Psychology (ICP), a public academic institute and the oldest CP institute in the country. Participants within this study were enrolled on, either, the MPhil in CP, which lasts for four years or the PhD in CP, which lasts for up to eight years. Trainees can practice as Clinical Psychologists after the MPhil, with the option of doing further study with the PhD. Both, the MPhil and PhD involve undertaking coursework, a minimum number of clinical hours

through the institute's own clinic and short internships at other sites, and research. The courses are taught bilingually between Urdu and English, and clinical practice is led by client language preferences.

Participants were undertaking training to obtain the professional title of qualified Clinical Psychologist. This title is not protected, as CP training is not regulated in Pakistan. Participants were Pakistani nationals. The training at the University of Karachi is largely delivered in English and all trainees are proficient in English.

Ethical considerations

Ethical approval was sought from the University of Karachi's ICP (see Appendix 5) and the University of Liverpool's Research Ethics Committee (see Appendix 6). University sponsorship approval was not required for this research study.

Participants who emailed the researcher to express an interest in taking part in the research, and were happy to proceed after having the opportunity to ask questions or express concerns, were asked to sign and date a consent form (Appendix 7) prior to undertaking the interview, which they received and returned via email. The information sheet and consent form included information about study aims, what participation would involve and ethical considerations, including the informed consent, the right to withdraw from the study, anonymity and confidentiality procedures. None of the participants withdrew from the study during or after the interview.

Participants were made aware that all person-identifiable information would be removed from any direct quotes or discussion included in the study write-up. Participants were asked to choose a pseudonym for them to be referred as in the write-up. This allowed participants to take ownership of how they were referred to, as the researcher acknowledged

how personal and deeply rooted in identity names can be. Participants were able to opt out of this and ask the researcher to choose a name if they preferred. Four participants chose their pseudonym. The pseudonyms chosen by the researcher are names that may be used by people of Pakistani heritage.

Participants were informed that data was recorded on Zoom and stored on a secure laptop. Files were protected using passwords and transcripts were stored using numbers until pseudonyms were identified and used instead. Data is being stored according to the University of Liverpool's regulations and will be destroyed after 10 years. The conduct of the research team adhered to the EU General Data Protection Regulation 2016 and Data Protection Act 2018.

Participants were informed that their anonymised data was accessible to the study's research team, and that audio files, transcripts and confidential documentation were stored securely on the University of Liverpool server.

Procedure

Authentically following an IPA approach, the interviews opened with a single question (Smith et al., 2022), which was developed by the researcher, supervisors and in consultation with the advisory group of trainees at the University of Karachi's ICP. The advisory group was made up of current Trainee Clinical Psychologists at the institute from which participants were recruited. The number of trainees attending each meeting varied depending upon their availability, but a total of ten trainees made up the group. They supported offered insights into the local sociocultural, lingual and spiritual context. The advisory group offered input into study and material (e.g. recruitment poster) design, recruitment processes, the development

of the interviews' single opening question and prompts, analysis and discussions around dissemination.

The opening question, "Tell me about your experiences of Clinical Psychology training in Pakistan", allowed for the interview to be led by participant experiences and discussion points, as opposed to the researchers' preconceived ideas about what is relevant to explore. Whilst a set of potential follow-up prompts (see Appendix 8) were developed, this was not an interview schedule. The follow-up questions were centred around themes related to CP training; how equipped participants felt to work with local communities, whether training covered cultural adaptations of psychological therapies, and positive or challenging experiences of training and internships. Although the interviews allowed for participants to organically share their experiences without structured questioning, at times the prompts were used to refocus the researcher and participants. How much the prompts were used varied according to the flow and direction of each interview. Brief demographic data, including previous educational experience and age, was verbally collected during interviews.

The researcher conducted the interviews via Zoom, each one lasting between 32 to 68 minutes. Post-interview, participants were invited to reflect on the research and interview process. This included conducting the interview online and in English, and overall experiences. Before interviews were carried out, the role of language was also discussed with the advisory group to ensure that nuances and key considerations were held in mind at all stages of the process. Transcripts were then generated using the Otter TI software, which were de-identified and checked for accuracy by the researcher, increasing familiarisation in the process. The researcher also transcribed an interview in its entirety to fully immerse in the data.

To recognise the contribution and time that participants volunteered, they received money to the value of £15, which was converted to Pakistani rupees.

Analysis

The interview data was analysed using IPA (Smith et al., 2009). IPA is a qualitative approach to experiential research largely based on three areas of the philosophy of knowledge; hermeneutics, idiography and phenomenology (Smith et al., 2022). Philosophers including Heidegger, Husserl and Sartre influenced the approach's theoretical underpinnings and subsequent approach to drawing on in-depth human experiences.

Through using IPA, individual narratives were used to describe participant experiences, allowing for interpretations and links to be made about a set population (Smith & Osborn, 2003). Through the repeated reading of transcripts, note-taking, highlighting themes and making references across themes, a step-by-step inductive process was taken (Smith et al., 2022).

IPA's phenomenological hermeneutic (Larkin, Watts & Clifton, 2006) and idiographic approach (Eatough & Smith, 2008) allows for subjective and underexplored experiences to be investigated. This was helpful in this study, as it addressed some of the issues with viewing the difficulties that humans experience through Eurocentric and medicalised lenses (Cox & Webb, 2015). IPA uses the double hermeneutic through the researcher making sense of the participant's sense-making of their experiences (Smith & Osborn, 2003). The researcher is able to do this through engaging with their interpretation and the participants' language continually and reflexively (Smith et al., 2022).

At first, the researcher immersed themselves in the data by listening to and reading the interview transcripts twice, noting any initial observations. Secondly, the researcher made

exploratory notes, which included; *descriptive comments* on what was said, *linguistic comments* on the language used, and *conceptual comments* by engaging with the data more interrogatively. Thirdly, the researcher constructed *experimental statements* through summarising the initial exploratory notes, allowing for them to be synthesised and consolidated. This step continues to consider participant words, but moves closer to the researcher's interpretation (see Appendix 9). The fourth step involved searching for connections between each individual participant's experiential statements, creating their own set of *Personal Experiential Statements (PETS)*. The fifth step brought each participant's PETS together to consider similarities and differences, thus creating the *Group Experiential Themes (GETS)*, otherwise known as master themes, and *group-level sub-themes* within each of them (see Appendix 10). The final GETS brought the participants' experiences together, whilst still maintaining the voice and sentiments of each participant.

The researcher kept analytic notes for each participant, allowing for any assumptions, insights and queries to be reflected upon. Following this systematic procedure created a transparent, clear and cohesive interpretation of the participants' experiences (Yardley, 2000). Triangulation exercises, including discussion with supervisors and peers using IPA, keeping a reflective diary, and consultation with the Professor at the Institute in Pakistan, were used to increase the rigour of study findings (Carter et al., 2014). A peer also screened two of the transcripts against the themes to increase the validity of the findings.

The study aimed to use photo-elicitation (Collier, 1957) during analysis, which would have been triangulated with the themes. Participants were invited to bring photos representing what CP meant to them to their interviews, which they would then have been asked to describe and elaborate upon in relation to CP. Through analysis, participants' meaning-making through the photos would have added to the qualitative understanding their

experiences alongside the IPA themes. The photos also would have been included in the final thesis write-up. The photos would have aided discussion and offered more context beyond what participants verbalised during interviews. Evidence shows that the careful use of photos within interviews can aid rapport-building whilst also allowing participants to guide the interviews. It can also help meaning-making and reduce language barriers. Creative data collection methods alongside IPA can add depth beyond solely verbally describing experiences (Reid et al., 2018). However, as only one participant opted into this, the researchers decided against incorporating this aspect into analysis.

Epistemological and reflexive position

A phenomenological epistemology was used to explore how people experience the world (Davidsen, 2013). It allows for participant experiences to be understood in-depth, considering how they view the social world, and the way in which they relate to and connect with others. As this research aimed to better understand the individual experience and make general suggestions, not generate theory, a phenomenological epistemology aligned well.

Vygotsky's (1978) Zone of Proximal Development allowed the researcher to remain consciously aware of gaps in their knowledge and to focus on what they were yet to learn. This felt particularly important, as the researcher was viewing a LMIC through a HIC lens and from a HIC-based institute.

Through taking a flexible and exploratory stance, the study's approach was guided by the research process and participants. Through self-accountability, using a critical and systemic lens, and holding context in mind, the researchers considered the privilege of their positions. Social critique and reflexivity allowed for the transparent discussion and deconstruction of privilege and power (Finlay & Gough, 2003).

In order to consistently and adequately hold a reflexive approach throughout the study, the researcher kept a diary, which was regularly used, including after supervision, advisory group meetings and research interviews. These reflections were critically evaluated with supervisors and the advisory group. The researcher remained open, consciously aware of reflexive bracketing, curious of the context of the research, and accountable of their perspectives and position. This seemed particularly important given the researcher's identity and closeness to the topic. See Appendix 11 for further information about the researcher's and supervisors' reflexive positions.

Miranda Fricker (2003)'s concept of *Epistemic Injustice* suggests that as a result of identity, people are often not given credibility and/or are not accurately understood, both, by individuals themselves and others. Holding this idea in mind throughout the study allowed for the researcher to better name and, where possible, reduce the use of Western frameworks and epistemologies that research is largely conducted from, particularly in HICs. This allowed more room for participant context and experience.

Results

The analysis aimed to explore the experiences of Trainee Clinical Psychologists in Pakistan, examining their individual and collective experiences of training itself, working with local populations and the context within which they train. The sample consisted of nine females and one male aged between 23 and 31. Six of the participants were MPhil students and four were PhD students

Through the analytic steps previously outlined, four Group Experiential Themes (GETS) were identified, within which there were two to four Group-Level Subthemes each (see Table 1).

Themes

Table 7: IPA Themes

Group Experiential Themes (GETs)	Group-Level Subthemes
1. Identity/intersectionality	1.1. Class 1.2. Religion 1.3. Pakistan and the West
2. Narratives of the field	2.1. Family/societal views 2.2. Changes in narratives
3. Experiences of training	3.1. Complexity and breadth 3.2. Adaptation 3.3. Vigorous training 3.4. Support
4. Looking ahead	4.1. Building on current training 4.2. Moving forward in Clinical Psychology

1. Identity/intersectionality

> *"my training has taught me that it is always the human, whatever has it…the gender or have it as sexual orientation, whatever has its own thinking, what is actually basically a human. And every human, I would say that they thought a lot about basic human rights"* – Malik

A key aspect of participant experiences of training and working in the field were centred around the context within which they work and identities of clients accessing clinical services, which are represented in the below subthemes.

1.1. Class

The role of class in accessing and experiencing therapy in Karachi was discussed by numerous participants, with terminology such as “lower”, “middle” and “elite” classes widely used across the sample:

> *“there is a lot of difference in the socioeconomic status, like people from the very lower middle, very lower class to middle class to uh, good, like from, I wouldn't say elite, but a high, upper middle class [mm] definitely”* – Anaya

Anaya refers to the diversity between people from different socioeconomic backgrounds, highlighting that people belonging to the upper class may be seen as “good”. Other participants referred to upper class clients as belonging to the elite class, with this privileging them in ways:

> *“people who are uh, who belong to a elite class or can, you can say that who are more educated and more literate, they have more awareness comparative to those who are, who are educated till metric or who have just a secondary kind of education”* – Amira

Amira highlights the intersectionality between people belonging to the elite class and educational attainment, with higher education improving awareness of issues related to mental health and therapy. Sania stated that due to the elite class’ awareness, therapy “is more accessible”, which refers to their privilege. In contrast, despite having awareness of and access to therapy, the elite class:

"have that dilemma of not going there or it's not a good thing and people were like consider us mad and all that stuff" – Laiba

Laiba spoke about people within the elite class avoiding therapy out of fear of what people might think, which was corroborated by other participants. Sania described a contrasting view about how people from lower classes engage with mental health support:

"first I had this preconceived notion that maybe working with lower class people it would be very difficult, difficult, because they have their own terms and their own vocabularies, but it was very easy for us to communicate with them and to empathise with them…they're more open to…open to experience, they're more accepting…than people with…higher education or with belonging to a really good upper classes" – Sania

Sania spoke to her earlier bias that people belonging to a lower class would be more difficult to work with, however, this was not the case in comparison to people from elite classes. Laiba communicated a similar sentiment, as her preconceptions were challenged during training, with lower classes "very much into the mental health". Malik commented on a need to use more psychoeducation with lower classes, as they "don't have very uh, good knowledge of their own…how their mind works", reflecting their insight. Participants referred to access and therapy costs:

"private institutes, they charge way much and so other people cannot…afford it, so yeah, it's a, it can be a luxury" – Sania

With high costs in private institutes, people with lower socioeconomic status may struggle to access therapy. However, ICP's public status attempts to overcome this:

> *"They provide very good service in very reasonable prices, even there are also people who, who cannot pay for their assessment or for their therapy, so there's also an option for Zakat (Urdu for charity)"* – Tara

ICP takes a flexible approach to fees, allowing people with financial difficulties to pay lower to no fees for therapy using the option of Zakat (Islamic charity). Alishba stated that it is not common that Institutes "gives a lot like therapy for free".

1.2. Religion

There was variance in reports of the role of religion in therapy and training:

> *"in Pakistan, people really consider religion very important. And it can be a driving force for a lot of people. They can be motivated through…these type of, if, cert-certain, like verses could be had, because I've heard that there's some therapies that do base on…spirituality and such methods. But I think I don't know, I'm not aware of such things"* – Sania

Participants acknowledged the significance of religion for a lot of Pakistani clients, with common beliefs in "jinn and jadu (*Urdu for spirits and magic*)" and the use of "Maulvi (*Urdu*

for Islamic teacher), faith healers" (Tara), with its integration in therapeutic approaches differing:

> *"we used to learn…about their things, their spirituality that what they, how they used to pray and how they used to have their beliefs"* – Amira

Teaching during training covers religion, but how it is taught and used in the therapy room varies:

> *"we are hesitant to talk about it, because most of the Western literature says that religion should be kept aside from therapy, but what I have personally learned from my experiences, that religion is an integral part of your psyche"* – Aliza

Some participants were conflicted about how to use religion in therapy given their own beliefs and its importance for a lot of clients, but its absence from a lot of therapeutic literature and models. Therefore, trainees "try to keep a balance between them" (Tara). Given that Pakistan is an Islamic Republic:

> *"it is another inclusive effort to separate your Islamic perspective and to utilise only the pure concepts of a particular theory"* – Hiba

In acting in a therapeutically purist way, separating identity where possible, participants reported feeling more protected and boundaried:

"Even I have experienced one or two clients…'if you are from this sect, then I wouldn't be talking to you'" – Laiba

Participants spoke about the interplay between the differing religious identities that they and a client hold. Training explores some of these issues:

"we have been taught to identify the cultural thoughts, the religious thoughts. how to not to use these things, how to not, how not to use these terminologies not to use these concepts in your therapy sessions" – Hiba

Participants stated that training holds the position that religious bias should be accounted for away from the therapeutic space, with differing experiences of this amongst trainees.

1.3. Pakistan and the West

Pakistan in context to Western cultures was commented on by most participants in various respects, including variance in psychological approaches:

"all these theories are made from…they come from the western side, so they are…we can see that they have discrepancies in our culture, if we compare our culture…we learn these, these things in our theory classes, in our coursework…they explain us how it is different" – Tara

Widely used theories and models developed in and for Western cultures are frequently used by Clinical Psychologists in Pakistan. Tara comments on there being gaps in the theories for local use, but this is being considered during training. The need for cultural-sensitivity is essential given differences in population experiences and narratives:

> *"something which can be okay in the West, like a live in relationship for example is not okay in Pakistan …So, this is the thing, there are many things which are like, people like, what we say like, gender, kind of gender dysphoria kind of thing, people do have acceptance in West about this, but in Pakistan, there are cultural biases...so these are the things, which are like very much prevailing into Pakistani culture, but not in the West, I guess"* – Alishba

Differences in beliefs, social norms and behaviour between Pakistan and Western cultures present challenges for trainees and therapists in Pakistan, who may want to acknowledge both views, but also serve the needs of the local population. These differences also translate to the way in which models are applied to Pakistani clients and whether aspects of some models are appropriate to use:

> *"in our society it's not acceptable a lot by many of our clients' families, and it will be more destructive than beneficial for them. So, these kinds of things are taught in ethics class as well…we have to first um, like, find what is going on in their family background, where is acceptable, what is not acceptable and then we apply these therapies"* – Laiba

Laiba spoke about wanting to "find a middle road, because this is our culture", with the middle being between Pakistani cultural considerations, and Western-developed theories and models.

2. Narratives of the field

> *"So now with the passage of time, at a minority level, at government level, things are changing, and people are giving importance to mental health"* – Hiba

Societal views of psychologists and mental health varies and has also changed over time for varying reasons, which participants offered insight into through trainee and client perspectives.

2.1. Family/societal views

Several participants spoke about people within their personal and wider systems believing that the profession is "a female subject" (Malik) or that women "should like settle down" (Laiba) due to the length of training. CP is also seen as secondary to other disciplines:

> *"'you didn't get into medical, that's why you're opting for…psychology, the, the little sister of medical, which is not worth, worthful…it actually made me strong"* – Sania

Sania described comments that she has received and stated that societally, subjects like medicine or engineering are superior and may offer "better skills and better uh, uh, better

qualification". The superiority of medical doctors is also the view of some other professionals:

> *"they prefer psychiatry, they prefer medicine, counselling and therapy is this…they just ignore it. They keep psychologists for training purpose, for interview taking, for history taking, basically, but not for the treatment purposes"* – Aliza

In addition to views that psychology is professionally inferior, people societally may think that people with mental health difficulties are "dangerous" (Sania), with clients subsequently asking psychologists "'Please don't tell anyone that I'm coming here'" (Laiba). Participants also reported that others used belittling language regarding the impact of CP training and working in the field on their own mental health:

> *"everyone they were like the psycho- studying psychology will make you a mental case uh, and a nutcase, and you will not be able to survive normally in this society…I had to choose some other field"* – Laiba

Other participants shared similar sentiments to Laiba, whose family previously worried about her pursuing a career in CP, but were later impressed and supportive, with people "accepting it's not something that makes you a mental case":

> *"because in the start, it was always like ke (Urdu for that) 'okay, you can read my mind' but now, this isn't this case anymore"* – Anaya

Although some participants had to "fight a war" with their family to be able to study psychology, "now people want to get into psychology as a field" (Sania) and others' families were always open to and pleased with the idea:

> *"My father was, yeah, he was super excited that, yeah, she's going, she's doing this thing and he explained, he used the word that we use for psychology in Urdu, nafsiyat (Urdu for psyche)"* – Tara

Tara's father was also supportive and encouraging when she struggled at the start of training due to its intensity.

2.2. Changes in narratives

As highlighted in the previous subtheme, participants reported some changes in narratives. Reasons for this are wide ranging:

> *"media has played a lot of role, because the celebrities are coming on social media and on TV…the Mental Health Day and the other days in the Suicide Prevention Day…seminars are being held more commonly… and arranging camps in those areas which are rural or…which are underprivileged…lifting the stigma a little bit"* – Laiba

Participants largely attributed changes in narratives to advancements in social media, and representation of therapy in TV and film. Mental health campaigns, and psychoeducation, including in educational institutions and companies are also more widely used. Kainaat also

stated that “connection with the West in a good way” has exposed the population to alternate perspectives on mental health. Participants also spoke about people following “a trend, like people are doing or elite class…it helps other people to accept it” (Sania), with therapy seeming aspirational and a luxury as mentioned in theme 1.1. There have also been post-Covid changes:

> *“I actually think things changed a lot after Covid…it was also emphasised that it was not just a physical illness, it was also affecting people mentally, because of economic crisis and because of social isolation and everything…in these times, awareness really spread across the country”* – Aliza

In addition to Covid-related awareness, the country has been forced to think more about why there is an “increase of suicide rates, the decrease of the ages of the persons who are attempting suicide or being aggressive or turning towards substance abuse” (Hiba). There is also more exposure to mental health difficulties due to Pakistan’s socio-political climate and the difficulties that the country has gone through, and continues to do so:

> *“living in Pakistan, it's a constant fight, flight or freeze state…so there’s, there's this constant trauma that surrounding us, there's so many things that have happened, and even right now, everybody's in a fear state, financial instability, economic instability, the, I don’t know, earthquake instability...eventually it catches up to people”* – Kainaat

Participants spoke about the wider systemic issues affecting the population, and subsequently, the way in which the profession, and more specifically can Clinical Psychologists function.

3. Experiences of training

> *"ICP has its own value, which people will never…abandon it or some, no other place can replace ICP"* – Aliza

Participants offered insights into the positive and negative aspects of their training at the institute. They spoke about choosing to train at ICP as opposed to other institutes to increase exposure to client work, as opposed to just theory-based learning, and student fees being more manageable, as "there's a big gap" (Sania) between public and private institute fees.

3.1. Complexity and breadth

There was widespread agreement that training at ICP offered clinical experience with a diverse group of clients, with requirements "to do a set number of hours that certify us as therapists" (Kainaat):

> *"We also have exposures like clinical disorders, proper, the people that you can diagnose with clinical disorders, axis one disorders, anxiety, depression, psychosis…we have that sort of population as well that does not fall on a diagnostic spectrum"* – Aliza

Participants spoke about the complexity of client presenting difficulties, which they value, as it allows for the development of their therapeutic skills. They practice "outpatient or inpatient services, so that we can learn through medical perspective as well" (Sania), offering trainees multidisciplinary perspectives across settings. Their training experience offers exposure to a variety of models:

> *"in ICP, the more focus is on CBT. And then the second is a schema, apart from that we have like, went to psychodynamic style, Freud's theories and object relation…the ones we are using mostly with our clients…we felt that it is not more effective, then we try to study or research in our own or discuss it with our supervisor"* – Laiba

Trainees are taught to use a range of therapeutic models, whilst also being supported to think autonomously and through supervision about alternative approaches. Training through ICP also offers trainees exposure to clients from a range of backgrounds:

> *"that's the institute that gives you a lot of exposure, a lot of exposure, because that is basically government Institute right? So, people from every socioeconomic status come there"* – Alishba

Alishba's comments reflect the entire participant group's experiences of training at a public institute. Due to its lower client fees, trainees work with people from diverse socioeconomic backgrounds, but also from a "religion point of view, if you talk about the caste thing or

speak language" (Alishba). Participants referred to the systemic lens through which they are supported to use in practice:

> *"So I love how the curriculum is designed on working on a more dynamic, uh, frame of mind and I think that also helps the students a lot to…to process that and I feel like that, that ability to think dynamically, rather than just focus on the behaviour…that's kudos to ICP to…make sure that, even though I know the world is moving more towards…surface level work"* – Kainaat

Whilst participants spoke about seeing high numbers of clients, they also emphasised the quality of teaching, which translated to their application in practice. Teaching and practice during training is also changeable between Urdu and English:

> *"in classes we have our, they use English and Urdu both, however with clinics, it totally depends upon the client in which language he is comfortable"* – Anaya

Participants stated that use of language is largely led by clients that they work with, with them being transferred to colleagues who speak a suitable language, such as if clients cannot speak Urdu or English proficiently, given that they may be from other areas.

3.2. Adaptation

Participant experiences of the adaptation of therapeutic models were variable. Whilst CBT and some psychometric tests are adapted, adapting approaches outside of this were not structured or formalised during training:

> *"we usually study the models as they are, I don't think Pakistan in itself has or a therapist in Pakistan have focused on adaptations of a lot of the models, but…it's just something that we had wing it, but…we had to kind of, because, also, there are a lot of factors over here that make therapy very different than how it would have been practiced in the West"* – Kainaat

Most participants shared Kainaat's experience of individually adapting models on a client-by-client basis, "we might adapt a few things, then and there" (Anaya), and recognised the need for adaptation. This, however, seems to be increasingly integrated into training:

> *"We do that for our students now, even the senior teachers are…transforming their ways as well, but uh, as far as the documentation of those adaptations are concerned, we are way behind in that area"* – Aliza

In addition to more teaching on adaptation being covered, trainees also reported learning from peers and through supervision. Where participants have adapted models or tests, a key aspect of this is the translation of language and concepts:

> *"like for example, the questions are of dollars over there in the, in the manual. So, teacher used to say that you can convert it in a rupee, you can ask about the*

rupees…teacher used to also train us in translating the questions in Urdu in a proper professional manner" – Amira

Participants highlighted the importance of adaptation, as some clients "starts to, you know, question themselves" (Sania) when they are unable to understand or follow therapy given its unsuitability for them, but representation amongst institute staff helps with adaptation.

3.3. Vigorous training

A clear consensus was seen throughout analysis regarding the vigorous and challenging nature of training at ICP. Trainees undertake long clinic hours, with some reporting that they work from "8:30 'til 7:30 in the evening" (Laiba) and being unable to work outside of this to earn money. Whilst this was difficult for participants, they also recognised the benefits in this approach:

"my mother used to say that 'if you want, if a coal won't have to change in a precious diamond, so you need to bear pressures, pressure of that'. So now we're just smooth" – Amira

Participants stated that trainees often leave due to burnout and the intensity of the training environment:

"you should be very resilient to come here and to do the sort of training because it, it requires a lot, a lot of time. Because you're doing it with your studies, you're managing your studies, you're managing your courses, your assignments, your uh,

clients, their, their therapies, their files. So in, in the end, you don't have any time for yourself or your family" – Anaya

In addition to balancing various training responsibilities, participants undertake long clinic hours, with high client turnover, often presenting with complexity and risk issues. Due to the demand placed on a public institute, participants feel that this "often compromises the quality of what you're doing" and can affect experiences of training as a therapist (Kainaat). However, therapy and internship classes allow for in-depth reflection:

"So there was a lot of focus on…us improving ourselves, as well as dealing with our own countertransferences, our own issues, our own barriers to a therapy as well, so I think that was also very, very helpful, too" – Kainaat

Whilst the training is intense, trainees recognise the benefits of this upon their development as Clinical Psychologists:

"the students or the trainees at ICP are more refined [mm]. They are more, uh..what we can say, they are more knowledgeable in terms of diagnosing, differentiating, practising ethically" – Hiba

Participants reported that these challenges also attracted them to ICP given that due to the pressure they will "be more acquitted and more, you know, adapted" (Sania).

3.4. Support

Participants all shared experiences regarding the difficulty of training, but also in the support that they received:

> *"we have very experienced, very supportive teachers who have been here for fifteen, twenty years. So they really…help us navigate that, we do have internship classes that help us…process these experiences"* – Kainaat

In addition to the general supportive approach held by institute staff, they received support with clinical skills, such as through role plays and presentations, "so that we can understand more practically" (Amira). Supervision was also widely reported as a safe space to encourage trainee openness and development:

> *"My supervisor was very, very cooperative, I would, I would go to her anytime I had any issues…she would listen to me and she would say…'I'm here to guide you and this is my guidance…now the judgement lies to you nah (Urdu for you know) because you also have, you also have to develop your own judgments'. Tho (Urdu for so) she would guide me in this way and I love that" – Anaya*

Participants spoke about feeling held by supervisors, whilst also being gently challenged to develop competencies as individuals, allowing them to "behave in our own natural way" (Malik), which they valued on training, as they anticipated not receiving the same level of support when working. Trainees were encouraged to tell staff if they experienced difficulties

before they escalated, working collaboratively as staff and trainees, with the Institute taking "a combined procedure, strict and lenient" (Amira). Participants also spoke about valuing peer support and collective learning through "a really good peer bond" (Kainaat).

4. Looking ahead

> *"it's high time we start..we don't get out of our conventional boxes and start kind of really…being more open to how we can help people"* – Kainaat

Participants expressed an interest in supporting the development of CP training and the field more widely, and had ideas about how this can be done. This included, both, wider, collective considerations, and individualistic, personalised factors.

4.1. Building on current training

Overall, participants reported few changes that they would make to the MPhil and/or PhD training programmes at ICP. Some of changes included practical considerations given that trainees work long clinic days to the equivalent of a full-time job, leaving little time for socialising or earning money where needed. A suggestion of reducing fees was offered to address this, particularly given Pakistan's financial difficulties. Timing also referred to length of training itself:

> *"in international I have, I have listened that MPhil has been completed in two years and PhD in two to three years, but now in Pakistan at our Institute of clinical*

psychology MPhil is for four years and PhD for eight years…it can be shortened" – Amira

Participants wondered if theses can be carried out in a lesser time, as this is often due to "the lack of like focus from our supervisors...and technical issues" (Laiba). Other participants stated that the length of training allows for the consolidation of learning. Participants also offered suggestions regarding the clinical work carried out:

"make you learn more therapies related to adult psychotherapy instead of…child therapy, they do focus on it, but the more focus is, the more emphasis on adult psychology" – Sania

The focus on more psychotherapeutic approaches in the training curriculum was suggested by some participants, whilst others felt that this was covered quite well in training.

4.2. Moving forward in Clinical Psychology

Participants reflected on the wider context within which they are training in throughout their interviews, which was apparent during analysis. Suggestions to improve CP training in Pakistan included the introduction of a PsyD programme, as only PhDs currently exist, allowing for more emphasis on clinical practice and developing specialisms, which some participants did not feel as able to do at present:

"being able to carve out a niche when we're studying, I know, this will take probably a bit longer…for the institutes to design something according to that" – Kainaat

In addition to more focus on individual trainee pathways post-training, Kainaat suggested that there is more openness in the field:

> *"with different ways of thinking and different ways of helping other people, I think we need to be more open to that, to that we can't just hold on to the conventional methods of therapy"* – Kainaat

Examples of this included the use of group therapy or grief support, which are not currently available. Participants spoke about the field expanding beyond its current remit or more traditional, didactic methods of therapeutic support. They wondered if during training, more in-depth teaching on specific therapy models may help with this, which they believed to be the case during training courses in the West:

> *"if we talk about West, so, the, the trainees are, as far as I know, or I can, we can say that as far as I assume that there is more in depth training of therapists from therapy to therapy, for example, for example, diploma in CBT, for example, graduate in schema therapy, like this, right?"* – Hiba

Participants felt that teaching staff are "well versed" in their knowledge and skillset, but they would value more time on certain models. In respect to the wider profession, there was an identified need for better multidisciplinary working and clarification of roles:

"the way that they have it in the West…it's a whole network, like you have social workers who have their own JDs, you have therapists who have…their own roles defined, you have psychiatrists have their own roles defined. I think over here, it's, it's not that clear…it's not that connected" – Kainaat

Narratives around professional roles and representation was apparent across interviews, with participants also wanting more representation of "male Clinical Psychologists in Pakistan [mm mhm], particularly those with the professional degrees, doctorate degrees" (Malik) to address the gender disparity. Participants recognised that the above changes rely upon more and better research:

"there are very limited researches in our culture, like, on our…population. That's why we have not been able to…adapt to many tests or different theories, 'cause, of course, we have to have some researches first" – Sania

Participants recognised research to practice links, which currently require attention, thus affecting the development of the profession and training. Participants voiced a wish to be involved in pushing the profession forward and to see more change:

"I really want people from Pakistan to come up with…therapeutic paradigms and or the school of thought…we do not come up with things of our own, that are actually generalised on the population that we see, so we follow whatever there is, there already is" – Aliza

This quote resonates with a lot of what has been shared amongst other themes around the gaps in provision and training experiences, but also the passion and drive to help and do more for the profession and local populations.

Discussion

Clinical Psychology training in Pakistan is currently an under-researched area, with a lack of understanding and no known published research regarding how it is experienced by trainees in the context of working with local populations. Historically, mental health care has not been prioritised in Pakistan (Bashir, 2018). Although there are improvements in training across disciplines, societal education, and development and provision of services, this is largely through psychiatry (Ali & Gul, 2018). Psychiatry colleagues in Pakistan, too, identify a need for further training in psychology and related fields (Javed et al., 2020).

Through analysing interview data via IPA, this study addressed its key aims; to consider how Clinical Psychology training is experienced by trainees in Pakistan through focusing on training itself, working with local populations and the training context.

Subtheme 1.1 (*class*) highlights participant insights into preconceived ideas that they had about the local populations, such as that people belonging to lower classes may be harder to work with in therapy, which was challenged for some, who found that upper classes were in fact more treatment resistant and fixed at times. A participant spoke about the “power struggle” felt with some upper class clients, who had their own ideas of what therapy should look like.

Power seemed integral to trainee experiences of clinical practice given that socioeconomic status, education, geographical location, gender, familial and societal views

etc. played a mediating role in the opportunities for support presented to clients. This can be understood in relation to Ecological Systems Theory (Bronfenbrenner, 1974) wherein multiple system levels influence the individual. Power was also implicated in the participants' access to training and education given that they were required to pay fees to train, but were unable to work alongside training, particularly during the MPhil; these experiences are captured by subtheme 1.1. This assumed that trainees were financially secure enough to train and may be supported by family or friends to do so. Nonetheless, as a public institute, ICP is more accessible given that its training fees are reportedly significantly lower than those of other institutes. A participant reported that ICP's fees are five times lower than other CP Training programmes at private institutes in the region.

Mental health provision in Pakistan is influenced by religious and cultural beliefs (WHO, 2019), which may have historically placed greater emphasis on less Western-centric approaches to healthcare. Subtheme 1.2 (*religion*) highlights participants' comments on the societal use of religion to explain mental health difficulties in Pakistan (Naeem et al., 2010), such as Jinn for psychosis (Farooqi, 2006). They stated that clients often access faith healers instead of or in addition to therapy, which previous research has widely demonstrated given that it is more engrained in Pakistani culture, socially accepted and accessible (Shaikh & Hatcher, 2005). Interestingly, although all participants spoke to the weight that religion held for a lot of clients, they reported variability in its place during training. Participants stated that they were taught to consider client religion and how it can be conducive to client change, but to keep religion and therapy separate where possible. Reasons for this included a view that Western literature recommends this separation, and due to the interplay between therapist and client identity, such as differences in belief systems or sect affiliation. Although the training considers the role of religion, it may be that this is expanded upon

given how integral it is to the experiences of Pakistani clients and society. This is corroborated by prior findings which highlight the need for the integration of spirituality into healthcare curriculums in Pakistan (Jawaid, 2020).

In continuing to understand the context that participants trained in, they spoke to local Pakistani narratives in relation and contrast to the West, such as relational norms, which may set Pakistani experiences aside from those in the West, as seen within subtheme 1.3 (*Pakistan and the West*). Participants placed emphasis on this given that the theory and models that they were largely trained with were developed for the West, therefore, they felt impelled to find alternative methods of work through adaptation. Where their training's focus on adaptation ended, participants took responsibility to further adapt models with and for clients themselves. Given that culturally-adapted therapy in Pakistan has been found to be efficacious (Latif et al., 2021), it is encouraging that training somewhat focuses on this and trainees, too, are motivated to do this work. However, it seems that there may be more work to be done in this area, such as through the delivery of teaching on intervention adaptation models and ways in which these can be applied in practice, considering research underpinnings and the evidence base.

Participants offered insight into familial and wider societal narratives of the field, including that CP is a female profession or that it may impact the mental health of trainees themselves, as highlighted by subtheme 2.1 (*family/societal views*). Subtheme 2.2 (*changes in narratives*) speaks to participant accounts of changes in narratives over time due to reasons such as the influence of social media, the impact of Covid and the difficulties that the Pakistani population faces. These narratives lend themselves well to the hermeneutic theoretical nature of IPA wherein the part and whole are considered (Smith et al., 2022).

Given that CP training and the profession more widely is not regulated in the country, experiences are expected to differ on an institutional and regional basis. Based on the themes derived here, although ICP's training involves qualification in postgraduate *research* degrees, including the MPhil and an optional PhD, participants highlighted that it places emphasis on clinical skills, as opposed to research and academic skills alone. They reported that this seems somewhat distinct to some of the other training programmes in the region, which reportedly may give less time to direct clinical practice during training, thus attracting some trainees to ICP. Participants also emphasised their training's exposure to working with diverse populations within subtheme 3.1 *complexity and breadth*, namely due to the affordability of its fees and Zakat option. This is helpful to consider in the context of Pakistan's socioeconomic climate, with a 37.2% poverty rate (The World Bank, 2023). There is a high number of referrals into the service, thus increasing client need and turnover, and demand placed upon trainees.

The local populations that trainees at ICP work with during training also include clients travelling from surrounding areas, which may have fewer or less accessible therapeutic services. Trainees at ICP work with a vast range of client identities due to the intersection of the country's rich cultural heritage and traditions, and Islamic values (Gilbert, 2017). They, therefore, reported that training involved exposure to a breadth of complex clinical experience. Within subthemes 3.1 (*complexity and breadth*) and 3.3 (*vigorous training*), participants stated that they were better prepared for post-training experience and that the depth to their training experience enabled them to better work with adversity despite the challenges of doing this work during training. Although trainees spoke about training requiring them to work at a high level of intensity and frequency, this upskilled them and made them more proficient psychologists. In managing these difficulties, they

were well supported by training staff and were encouraged to think about the role of self, which considered their own feelings and experiences, as highlighted within subtheme 3.4 (*support*). Participants consistently felt supported by the institute more widely and individual staff members more closely, such as through supervision.

Participants unanimously reported that adaptation of interventions is essential to adequately work with local populations, which is captured by subtheme 3.2 (*adaptation*) and substantiated research findings of psychological interventions being more successful when cultural narratives are incorporated (Atif et al., 2019). Participant accounts reflected previous findings with child and adult populations in Pakistan (e.g. Syed et al., 2007; Naeem et al., 2009), which suggest that models developed for the West are not wholly relevant for Pakistani populations given their contextual differences. Participants corroborated findings that Pakistani clients' socioeconomic and cultural contexts affect the extent and nature of their engagement. For instance, analysis showed several reports of barriers to therapeutic support wherein clients lacked financial means or feared others' opinions, as also shown by Husain (2020)'s findings within a range of Pakistani cities. Participants stated that adaptation was not always integrated into their training programme in a structured way, but some trainees sought to adapt models themselves with clients and/or supervisors.

Participants suggested other areas for development within CP as a field and its training provision in Pakistan, as noted within subthemes 4.1 (*building on current training*) and 4.2 (*moving forward in clinical psychology*). It seems like an opportune time to build on this work, as conversations about mental health in Pakistan are rising, with provision gradually increasing, and as this study highlighted, there are positive shifts in societal narratives and ideas. Given the systemic changes that are occurring, there might be more space for development. Participant suggestions included more manageable training

pathways given its current lengthy duration, a greater psychotherapeutic focus during CP training, more research in the field, allowing for more Pakistan-specific model and theory development, more creative work and better interdisciplinary working.

Clinical implications

Leading on from participant suggestions for improvements, training in Pakistan may wish to consider the practicalities of current pathways. Whilst ICP is affordable, other institutes might benefit from offering more financial aid to trainees. Although ICP is more accessible to people from a wider range of socioeconomic backgrounds, trainees are still unable to work whilst training, thus inevitably affecting access to and representation in the field for people who are less financially privileged. With this, training courses may wish to review the length of their training programmes, as participants spoke to the length of training being at least double the length of courses in the West. This is not to say that Western training pathways are a gold standard, however, it brings to question how feasible such lengthy training pathways are and what the rationale for this might be.

Given the areas that participants discussed in this study, services may also wish to consider prospective areas for discussion and development in the accessibility of public versus private clinical services for clients. Alongside the socioeconomic status of clients, local narratives about mental health difficulties and support require continuous consideration. Services might benefit from building upon their emphasis on intersectional identities (Crenshaw, 1991), such as Pakistani culture in relation to religion and gender, holding these intersections in mind when considering the approaches that services take therapeutically, strategically and systemically; how does the way that a service functions enable or disable certain populations from accessing their support? With this, services and

training institutes might wish to consider more diverse ways of working clinically. Participants reported that more novel ways of working or modes outside of one-to-one therapy were less common. There may be a need for the expansion of therapeutic group work, developing services in less typical or traditional settings, such as reaching into communities, drawing on consultation more so etc.

It is also important to note what CP training in the UK can learn from this study's findings, particularly given that 2.7% of the UK population is Pakistani (Office for National Statistics, 2021). CP training in the UK may benefit from better considering the intersectional role of class, religion, and the interplay between one's ethnic or cultural identity and the West, particularly given that, as discussed above, models and theories and largely developed by and for the West. Research carried out with global majority populations in LMICs alike the current study can offer insight into training and/or working with global majority populations in HICs.

Strengths and limitations

A key strength of this research study was the cultural insights that the researcher and supervisory team held. They were able to openly learn from each other and sit with the tensions of their positions. For instance, despite the team, either, having a personal connection to Pakistan or working within global mental health, they recognised that they were still carrying out the research from positions of privilege in a HIC. The researcher's own ethnic identity allowed for them to understand cultural context, nuances in terminology, and Urdu phrases that were used during development of the research idea, data collection, analysis and write-up.

The research team had a good working relationship with ICP, allowing them to gain insights from the Professor and the advisory group of trainees. Although it was difficult to consistently get the advisory group's insights given their busy schedules, time difference and trainees leaving ICP over the last two years, they were keen to support the project and valued that the research was being done.

The research study strongly followed the IPA procedure through the use of a single opening question, allowing for interviews to be in-depth, yet organically led by the participant. The richness of the research was possible due to the openness of the participants, allowing for quality data and findings. The researcher had IPA teaching, discussed the approach with supervisors and also with peers who were also undertaking IPA, and a peer screened two transcripts against the themes to increase validity.

Given that this research solely focused on one institute, it is difficult to comment on alternate approaches to training or to compare the findings to other research in the area, given that there is no currently known, published research on CP training in Pakistan or standardised national regulatory guidance as of yet. Although the findings cannot be representative of training across Pakistan, this was pre-empted and research with multiple institutes was not deemed possible in the given time for a DClin research project and researching across multiple sites may have affected heterogeneity. The research also aimed to gather photographs from participants in order to carry out photo elicitation alongside IPA, however, only one participant provided photograph, so this was excluded.

Although the researcher considered the rapport developed with each participant meaningful, this is somewhat stunted over online interviews. This was unavoidable given the lack of time and resource available to travel from the UK to Pakistan to carry out interviews, but also due to Covid. Online interviews presented some challenges due to

technical issues, including due to load shedding in Pakistan; these were overcome with relying upon audio calls alone where necessary. Although the time difference was anticipated to be a prospective challenge, both, participants and the lead researcher were flexible. Overall, the researcher felt that positive relationships were formed with participants, who were appreciate of the opportunity to share their experiences.

Given IPA's phenomenological approach to representing multiple individual meanings and experiences, as opposed to finding a single truth, implementation of findings may arguably be more challenging. In instances where participant experiences, and subsequent themes, may contrast each other, the influence of research findings on clinical or academic provision may be difficult. Further, whilst suggested that an effective IPA study should shed light on a broader context, this may be hard to do with a specific and homogenous sample (Pringle et al., 2011). IPA can also be criticised for giving voice to lived experience without trying to understand why it occurred (Tuffour, 2017). Although this study did not aim to question *why*, future research may wish to do so. Whilst the researcher was aware of these limitations to IPA in advance of the study, it was still deemed the appropriate approach and they are helpful to bear in mind.

The transcription software was not wholly culturally and lingually appropriate for the participant group, as it was not sensitive to non-Western language or concepts. For example, it often translated Pakistan to Buxton. This reflects the wider societal and systemic challenges in carrying out research with non-Western populations. Transcription software cannot be expected to understand context or local language, for example, the name of a hospital in Karachi, however, common names and phrases were not recognised. The software may also have had limited therapeutic terminology, as it often transcribed

psychoanalytical to psychological. The researcher overcame these issues by checking all transcripts against audio files.

Research considerations

Future research might wish to build upon this study's findings by carrying out similar research at other institutes. This includes researching institutes across the country to better grasp nuances in regional differences in training, clinical provision, population needs, culture, and commissioning or strategy. Research considering similarities and differences between public and private institutes may be helpful to better understand this given that this study looked only at a public institute, but differences between the two were reported by participants. Whilst inferences were made based on participant knowledge and understanding of private institutes and some insights offered by the advisory group, the validity of these would be strengthened through research with said institutes.

Research capturing staff and client voices may add an additional layer to understanding the benefits of training for local populations, but also for professionals receiving and delivering training. Longitudinal research might lend itself well to this area of research, such as through tracking training experiences prior to the start of training through to post-qualification. The field may benefit from research into the experiences of the staff delivering CP training. It might also be interesting for a Pakistani Trainee Clinical Psychologist to replicate this study with UK trainees. A similar DClin study is currently underway with Uganda's CP trainees, so there may be opportunity for international comparisons to be made.

Reflexivity

A reflexive position allowed me to maintain awareness of unconscious motivations, biases and relational dynamics, which enable us to better understand the roles that we assume within complex systems, systems that become more complicated and layered when researching across cultures and continents. Although I am of Kashmiri-Pakistani heritage, I was very aware of my privilege in being born, brought up and educated in a HIC. My ethnic heritage afforded me insights into Pakistani culture, but I remained aware that this too can increase biases due to my experiences, beliefs and perceptions that are deeply implicated in the culture.

Whilst one of the research supervisors is also British-Pakistani, and the other research supervisor has significant research experience within Global Mental Health and LMICs, they too are in positions of privilege, which we were all able to openly and transparently talk about. We carried out the research from institutions in the UK, a HIC. We ensured that the Professor at the University of Karachi held a consistent position through the study, drawing on her views and experiences, increasing accountability and authenticity. However, arguably, in relation to the participating trainees, the Professor in Pakistan, too, was in a position of power.

As a trainee myself, it was a privilege to elevate the voices of other trainees, and for it to also be those with whom I felt a deeper cultural connection. Given my identity, I was naturally more attuned to the wider context in and around Pakistan, cultural sentiments shared in interviews and was able to interpret data through a lens that somewhat overlapped with that of the participants. This helped with rapport-building and allowed for participants to share more openly, such as communicating some phrases in Urdu, which might not have held the same meaning when translated in English.

A double hermeneutic was employed through participants making sense of their experiences and me making sense of the participants (Smith & Osborn, 2003). It is helpful to consider the added layer of me making sense of participant experiences as someone who shares trainee and Pakistani identities with them.

My identity in relation to the study topic presented challenges in ways. I sensed that some participants were unsure of my position and connection to Pakistan until I offered more insight into the research and myself after the interviews ended. I grappled between sharing more about myself before the interviews to build rapport and increase a sense of safety, and waiting until after the interviews to minimise the bias and influence of my position.

I also wondered if with my closeness to the culture, participants may have felt able to forego explaining some of the cultural details around their experiences through the assumption that I would already know. Thus resulting in over-supposing and under-telling (White et al., 2022). I wonder how the interview data might have looked if someone with a distinct identity carried out the research; does shared identity mediate feelings of safety between a researcher and participant?

During the interviews, I was conscious of my position within a HIC wherein some participants spoke about wanting to pursue further study and/or work in HICs. Whilst this can be understood in the context of opportunities available in LMICs and individual aspirations, I wondered whether this played a role in how some answers were constructed and shared within the interviews.

Conclusion

Through interviews with ten Trainee Clinical Psychologists, the study was able to meet its aims to better understand their experiences of training in Pakistan. Participants offered insights into their training experiences, academically and clinically, and shed light on the wider systems within which they work and clients access support. Findings suggested that participants valued their training programme, felt supported and well equipped to work in the field, particularly given the diversity and vigour of their training experiences, but there were areas for development, including around the length and focus of training. Whilst CP and its training pathways in Pakistan may require further development, this relies upon further research being done in the area, for which recommendations have been made.

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Appendices

Appendix 1 – Author guidance

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for Registered Reports.

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The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

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iii. The full names of the authors;
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v. Abstract;
vi. Keywords
vii. Data availability statement (see Data Sharing and Data Accessibility Policy);
viii. Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our **Author Services** site.

Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.
Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (objectives/methods/results/conclusions);
- Up to seven keywords;
- Practitioner Points: Authors will need to provide no more than 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Appendix 2 – TiDieR Checklist

The TIDieR (Template for Intervention Description and Replication) Checklist*:

Information to include when describing an intervention and the location of the information

Item number	Item	Where located **	
		Primary paper (page or appendix number)	Other † (details)
	BRIEF NAME		
1.	Provide the name or a phrase that describes the intervention.	_____	_____
	WHY		
2.	Describe any rationale, theory, or goal of the elements essential to the intervention.	_____	_____
	WHAT		
3.	Materials: Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers. Provide information on where the materials can be accessed (e.g. online appendix, URL).	_____	_____
4.	Procedures: Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.	_____	_____
	WHO PROVIDED		
5.	For each category of intervention provider (e.g. psychologist, nursing assistant), describe their expertise, background and any specific training given.	_____	_____
	HOW		
6.	Describe the modes of delivery (e.g. face-to-face or by some other mechanism, such as internet or telephone) of the intervention and whether it was provided individually or in a group.	_____	_____
	WHERE		
7.	Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.	_____	_____

	WHEN and HOW MUCH		
8.	Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity or dose.	_____	_____
	TAILORING		
9.	If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when, and how.	_____	_____
	MODIFICATIONS		
10.‡	If the intervention was modified during the course of the study, describe the changes (what, why, when, and how).	_____	_____
	HOW WELL		
11.	Planned: If intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.	_____	_____
12.‡	Actual: If intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.	_____	_____

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Appendix 3 – Study poster

A qualitative exploration of Trainee's experiences of Clinical Psychology training and clinical practice in Pakistan.

You are being invited to participate in a research study. Before deciding whether you would like to participate, take time to read the below information. Please ask any questions or for clarification if needed using the contact details below.

Why are we doing the study?

There is little understanding of the experiences of Trainee Clinical psychologists in Pakistan, and the ways in which training equips them to support local communities in clinical practice. We would like to understand this better by speaking to Trainee Clinical Psychologists about their experiences of training and clinical practice.

Who can take part?

Current Trainee Clinical Psychologists at the Insitute of Clinical Psychology at the University of Karachi, who are Pakistani Nationals.

What will it involve?

Participating in an online interview, expected to last around an hour.
Participation will be anonymous and voluntary. This study does not involve University of Karachi staff, they will be unaware of your participation and it will not affect your training or grades in any way.

Other considerations

- You will be reimbursed as acknowledgement for your time.
- There are no known risks associated with your participation in the study.
- You can withdraw from the study at any point up until commencement of data analysis and without explanation. Withdrawal would not adversely affect your training.
- Anonymised data is expected to be disseminated, including through publication.

If you have any questions or comments ,or there are any problems, please contact the researcher or their supervisors:

Researcher

Misbah.Hussain@liverpool.ac.uk

Supervisors

Anam.Elahi@liverpool.ac.uk

R.White@qub.ac.uk

If you remain unhappy, please contact ethics@liv.ac.uk

If you would like to ask questions or take part, please email Misbah Hussain.

Thank you for taking the time to read about our study.

UNIVERSITY OF LIVERPOOL

Appendix 4 – Participant information sheet

Version number & date: v2– 12/02/22
Research ethics approval number: TBC

UNIVERSITY OF LIVERPOOL

Participant Information Sheet

Title of the research project: A qualitative exploration of Trainee's experiences of Clinical Psychology training and clinical practice in Pakistan.

This information sheet is being provided to you after your expression of interest in this research study. Before deciding whether you would like to participate, take time to read the below information to understand what participation might involve. Please ask the researcher any questions or for clarification about aspects of this study using the contact details below. You are under no obligation to take part, it is entirely your decision.

Why are we doing the study?
There is little understanding of the experiences of Trainee Clinical Psychologists in Pakistan, and the ways in which training equips them to support local communities in clinical practice. We are aware that training experiences are likely to vary depending on contextual differences. We would like to understand this better by speaking to Trainee Clinical Psychologists about their experiences of training and clinical practice.

Who can take part?
We are inviting current Trainee Clinical Psychologists at the Institute of Clinical Psychology at the University of Karachi, who are Pakistani Nationals. We welcome Trainees from any point in their training.

Do I have to take part?
No, it is up to you whether you decide to take part. Participation will be anonymous and voluntary. This study does not involve University of Karachi staff. They will be unaware of your participation and it will not affect your training or grades in any way. You will be able to withdraw your participation at any time prior to the analysis of interview data without explanation.

What will happen if I participate?
If you choose to participate, you will take part in an online interview conducted in English with the researcher, Misbah Hussain (a Trainee Clinical Psychologist based at the University of Liverpool), which is expected to last around 60-90 minutes. The interview will be informal and conversational. The interview will explore your experiences of Clinical Psychology training, clinical practice and any related topics that you deem relevant to discuss. You interview will be guided by your experiences and what you would like to discuss, and you do not have to answer anything that you do not want to. You will be given the option to bring photo/s to the interview that represent Clinical Psychology training or practice to you to help add depth to our understanding of your experiences. With your permission, we will record the interview to allow for data to be transcribed and analysed.

How interview data will be used
All interview data will be anonymised, with person-identifiable information removed during transcription. The researcher and two supervisors will have access to anonymised transcripts, and audio recordings, transcripts and confidential documentation will be stored on a secure University of Liverpool server.

The University of Liverpool processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit." Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The Primary Supervisor acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Dr Anam Elahi using the below contact details.

Further information on how your data will be used can be found in the table below.

How will my data be collected?	Interviews will be recorded through the online platform (e.g. Zoom, Microsoft Teams) on which the interview will be carried out, and at the end of the interview will be immediately exported for storage. The data will then be transcribed and analysed.
How will my data be stored?	Data will be stored on the University of Liverpool's secure server.
How long will my data be stored for?	The University requires that research data necessary to support or validate a research project's observations, findings or outputs must be retained in an appropriate format and storage facility for at least 10 years. At the end of this retention period, the data custodian will ensure that the data is destroyed.
What measures are in place to protect the security and confidentiality of my data?	Data will be anonymised and stored on the University of Liverpool's secure drives. Personal data that identifies participants, for example, consent forms, will be stored separately from the actual data. Copies of the consent forms will be stored securely on the University of Liverpool's secure server.
Will my data be anonymised?	Yes. When the data is transcribed all personal identifying information will be removed.
How will my data be used?	Data will be transcribed, analysed and written up in a paper, which will form part of a thesis submitted in partial fulfilment of the University of Liverpool's Doctorate in Clinical Psychology. The paper may also be submitted for publication.
Who will have access to my data?	The research team will have access to the anonymised data. During the viva voce examiners may request to examine anonymised data.

Will my data be archived for use in other research projects in the future?	No.
How will my data be destroyed?	Transcripts will be submitted for secure destruction by the University Records Management Service.

Payment
Participants will be given a voucher or payment to the value of £15.00GBP (approx. 3500PKR according to the conversion rate at the time of payment) as acknowledgement for their participation.

Are there any risks in taking part?
We do not anticipate that there are any risks associated with your participation in the study. The study topic is not anticipated to cause distress, but should participants find the interview difficult, they can ask to stop at any time, or state that they do not feel comfortable answering specific questions. Participants will be able to discuss the experiences that they deem relevant or appropriate.

Are there any benefits in taking part?
The interview will give you the opportunity to openly share and reflect upon your experiences as a Clinical Psychology Trainee. This will hopefully contribute to a better understand of the experiences of and context around training in Pakistan.

What will happen to the study results?
The results will be written up as part of the researcher's thesis and may be submitted for publication in a peer reviewed journal. A short report will also be shared with relevant professionals and organisations, such as universities, to increase understanding of Clinical Psychology Trainee experiences in Pakistan. You will not be named in any write-ups or discussions that come from the study.

What do I do if I want to later withdraw from the study?
If you decide that you no longer wish to take part in the study, please contact the researcher, Misbah Hussain (Misbah.Hussain@liverpool.ac.uk). You can withdraw from the study at any point up until commencement of data analysis and without explanation. Withdrawal will not adversely affect your training and your participation will remain anonymous.

What if I am unhappy or if there is a problem?
If you are unhappy, there is a problem or you would like to discuss anything, please contact Dr Anam Elahi (Anam.Elahi@liverpool.ac.uk), who will try to help. If you remain unhappy about something or have a complaint which you feel unable to discuss with us, please contact the University of Liverpool's Research Ethics and Integrity Office (ethics@liv.ac.uk). When contacting the office, please provide the title of the study, the researcher and supervisors' names, and details of complaint that you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns you can lodge a complaint with the Information Commissioner's Office by calling +44303 123 1113.

Who has reviewed this study?

This study has been reviewed and approved by the Institute of Clinical Psychology, University of Karachi and the University of Liverpool Ethics Committees to make sure that it is being carried out in an appropriate and ethical manner.

What next?

If you would like to participate in the study or would like further information before deciding, please contact the researcher via email at Misbah.Hussain@liverpool.ac.uk.

Thank you for taking the time to read this information sheet and for considering taking part.

Lead Researcher
Misbah Hussain
Trainee Clinical Psychologist
University of Liverpool
Misbah.Hussain@liverpool.ac.uk

Under supervision of
Dr Anam Elahi
Primary Supervisor
University of Liverpool
Anam.Elahi@liverpool.ac.uk

Dr Ross White
Secondary Supervisor
Queen's University Belfast

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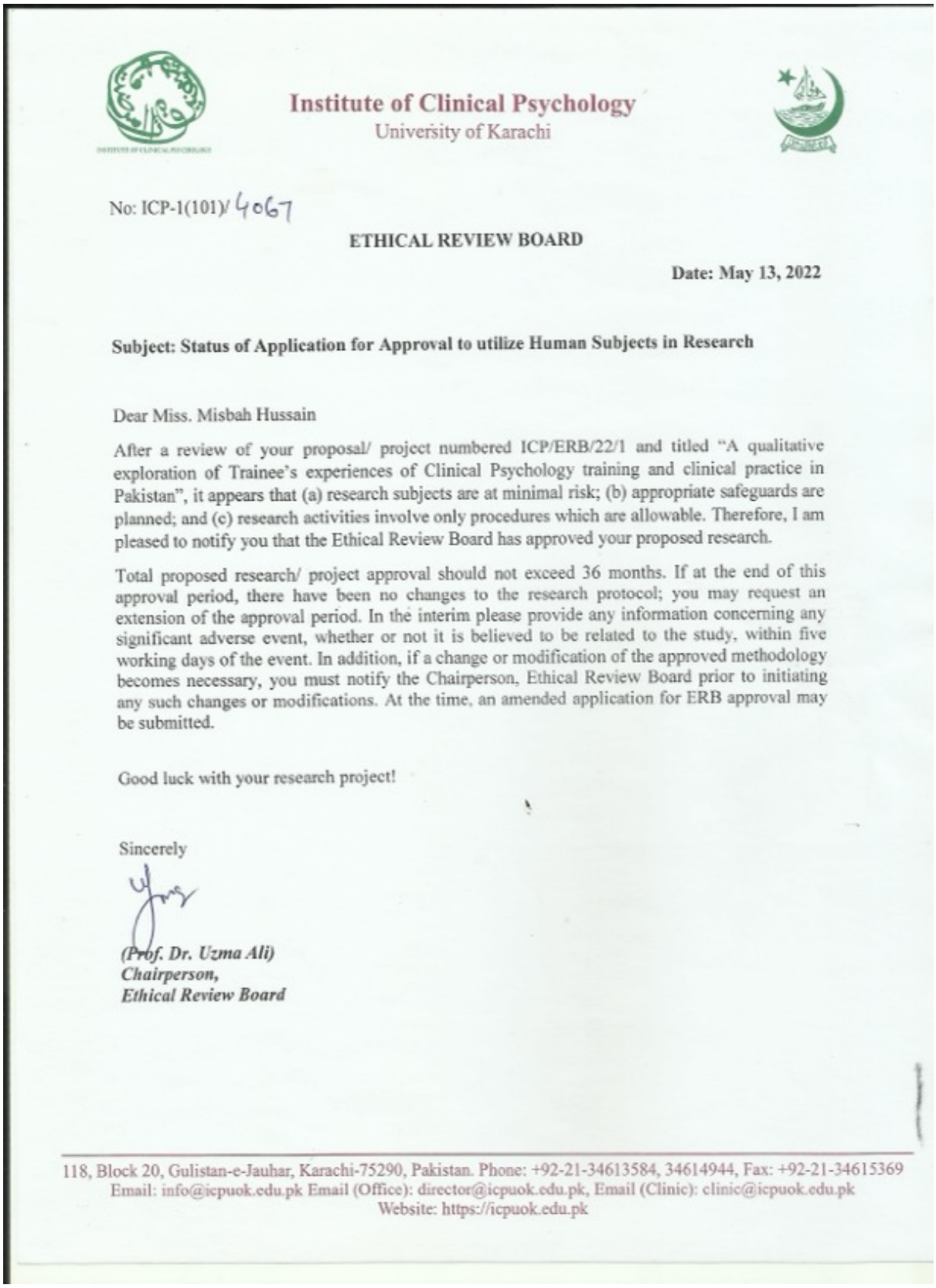
Appendix 5 – University of Karachi ethical approval



Institute of Clinical Psychology
University of Karachi

No: ICP-1(101)/4067

ETHICAL REVIEW BOARD

Date: May 13, 2022

Subject: Status of Application for Approval to utilize Human Subjects in Research

Dear Miss. Misbah Hussain

After a review of your proposal/ project numbered ICP/ERB/22/1 and titled "A qualitative exploration of Trainee's experiences of Clinical Psychology training and clinical practice in Pakistan", it appears that (a) research subjects are at minimal risk; (b) appropriate safeguards are planned; and (c) research activities involve only procedures which are allowable. Therefore, I am pleased to notify you that the Ethical Review Board has approved your proposed research.

Total proposed research/ project approval should not exceed 36 months. If at the end of this approval period, there have been no changes to the research protocol; you may request an extension of the approval period. In the interim please provide any information concerning any significant adverse event, whether or not it is believed to be related to the study, within five working days of the event. In addition, if a change or modification of the approved methodology becomes necessary, you must notify the Chairperson, Ethical Review Board prior to initiating any such changes or modifications. At the time, an amended application for ERB approval may be submitted.

Good luck with your research project!

Sincerely

(Prof. Dr. Uzma Ali)
Chairperson,
Ethical Review Board

118, Block 20, Gulistan-e-Jauhar, Karachi-75290, Pakistan. Phone: +92-21-34613584, 34614944, Fax: +92-21-34615369
Email: info@icpuok.edu.pk Email (Office): director@icpuok.edu.pk, Email (Clinic): clinic@icpuok.edu.pk
Website: https://icpuok.edu.pk

Appendix 6 – University of Liverpool ethical approval

Central University Research Ethics Committees

29 November 2022

Dear Dr Elahi,

I am pleased to inform you that the University is willing to accept the ethical review provided by the external ethics committee. Details and conditions of the approval can be found below.

Reference:	11448
Project Title:	A qualitative exploration of Trainee's experiences of Clinical Psychology training and clinical practice in Pakistan
Principal Investigator:	Dr Anam Elahi
Co-Investigator(s):	Miss Misbah Hussain
Student Investigator(s):	-
Department:	Primary Care & Mental Health
Approval Date:	29/11/2022
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions

- All serious adverse events must be reported to the Committee within 24 hours of their occurrence, via the Research Integrity and Ethics Officer (ethics@liv.ac.uk).
- Any amendments or changes to the study must be approved by the external ethics committee and the University of Liverpool ethics committee
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the research, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form using the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Central University Research Ethics Committees

Central-review (ethics@liverpool.ac.uk)

Appendix - Approved Documents

(Relevant only to amendments involving changes to the study documentation)

The final document set reviewed and approved by the committee is listed below:

Document Type	File Name	Date	Version
Evidence Of Peer Review	Misbah Hussain - Formal approval from RRC 20.10.2021	20/10/2021	1

Other Committee Application Form	ICP- ERB APPLICATION - final	25/01/2022	1
Participant Consent Form	Participant consent v3 - final	04/02/2022	3
Participant Information Sheet	Detailed information sheet v2	12/02/2022	2
Other Committee Approval Letter	UoK Letter of Ethical Approval Miss. Misbah Hussain	13/05/2022	1
Other Committee Terms Of Reference	UoK ICP ERB Terms of Reference	03/10/2022	Final
Fieldwork Risk Assessment	UoL ethics application risk assessment form	04/10/2022	1

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Appendix 7 – Participant consent form

Participant Consent Form

Version number & date: v3 – 04/02/22
Research ethics approval number: 11448
Title of the research project: A qualitative exploration of Trainee's experiences of Clinical Psychology training and clinical practice in Pakistan.

Name of researcher: Misbah Hussain (Trainee Clinical Psychologist)

	Please initial box
1. I confirm that I have read and have understood the information sheet dated 12/02/2022 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that taking part in the study involves completing a remote interview.	☐
3. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time (prior to data analysis commencing) without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any questions asked in the interview.	☐
4. I understand that I can ask for access to the information that I provide and I can request the destruction of that information if I wish at any time prior to analysis of the data. I understand that following analysis I will no longer be able to request withdrawal of the information that I provide.	☐
5. I understand that other authorised researchers may use my words in publications, reports, webpages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐
6. I understand that the information that I provide will be held securely and in line with data protection requirements at the University of Liverpool.	☐
7. I agree to take part in the above study.	☐

Please return this electronic consent form via email to Misbah.Hussain@liverpool.ac.uk.

_____	_____	_____
Participant name	Date	Signature

_____	_____	_____
Name of person taking consent	Date	Signature

Lead Researcher
Misbah Hussain
Trainee Clinical Psychologist
University of Liverpool
Misbah.Hussain@liverpool.ac.uk

Under supervision of
Dr Anna Chiumento
Primary Supervisor
University of Liverpool
Anna.Chiumento@liverpool.ac.uk

Dr Ross White
Secondary Supervisor
Queen's University Belfast

Appendix 8 – Interview guidance and prompts

Demographic information to collect

- Prior educational experience
- Age
- Geographical location
- Religion/cultural identity
- Language; mother tongue

Interview prompts

Opening question: *Tell me about your experiences of Clinical Psychology training in Pakistan*

Possible areas to explore:

- Why CP?

Training

- What the curriculum is like
- Gaps in the curriculum
- Whether the curriculum seems relevant to the local populations
- Teaching modes
- Length of training
- Access to training

Clinical experience

- Experience prior to training
- Experience during training
- Career aspirations; kind of psychologist you hope to be

General view of CP

- How you viewed it prior to and during training
- General understanding of CP from others; professionals and general public/family/friends etc.

Appendix 9 – Transcript example, with Experiential Statements and Exploratory Notes

Experiential statements	Data	Exploratory notes *Descriptive, linguistic, conceptual*
Insufficient adaptation	They're not that, I mean, in my personal opinion, they're not that much adapted to them [mm], a lot of people don't understand. It's and, but it has helped, the cultural adapted one, it has helped to make them understand 'cause in co- in CBT we have to help them understand a lot of things [mm] So when we don't know the words, right words, how to make them understand it has really helped, because with cog, like, if I'm telling them to, you know, understand what is cognitive errors, they couldn't understand what is cognitive errors. So, uh, are, they, in the culturally adapted manual, certainly cognitive errors could be made understanding them by saying, sorch ki gulthiya (Urdu for thinking mistakes) [mm], though, when I said that, sorch ki gulthiya hothia (Urdu for thinking mistakes happen). So it was more easier for my clients to understand ke (Urdu for that) okay, what we're talking about, but with a lot of, uh, p- clients, they are unable to understand, they become resistant [mm] to that kind of therapy, because they're like acha (Urdu for okay) they know a lot of things, and they're saying a lot of words that I don't understand. And then I think this is self-esteem, it starts to you know, get more [mhm], they starts to, you know, question themselves, ke (Urdu for that), we don't know a lot of stuff, and they're telling us a lot of things and we might be incompetent, we might be a failure, so all the core beliefs just start, you know, uh, starts act- start getting active and all that [mm]. I think ke (Urdu for that), it Pakistan does over here, we do need a lot of therapies, 'cause there are a lot of therapies, and uh, we there should be work on it, to make it more more culturally adaptive, so that we can help clients.	Not adequately adapted, but helps clients to understand terms/jargon, e.g. cognitive errors Culturally adapted interventions helps with using appropriate jargon and language Cultural adaptation does help with language and examples – e.g. using translated phrases. Use of Urdu phrase to illustrate point Language barriers in non-adapted intervention may increase treatment resistance Clients may start to question themselves more and affect their sense of self when they don't understand therapeutic jargon Need for more intervention adaptation to support the local population
Adaptation		
Adaptation		

Appendix 10 – Analytic excerpt for Group Level Subtheme *1.2. Religion*

Experiential Statement	Quotes
Integral role of religion	"I think it might help a lot of people, because over here in Pakistan, people really consider religion very important. And it can be a driving force for a lot of people. They can be motivated through, you know, these type of, if, cert- certain, like verses could be had, because I've heard that there's some therapies that do base on, you know, spirituality and such methods" – Sania
Religion in the curriculum	"we learn about the psychotherapeutic treatment, along with the religious beliefs and all, for example, like if I'm a Muslim and I have got client who is Christian, so they have different beliefs on it [mhm]…and for example, if there is a religious belief that uh, just like a kind of black magic and all" – Amira
Religion; strengths-based	"Real religiosity and others' spiritual things, we consider it as an as strengths in the needs of the client. If, if it benefits the client [mm], it, I..we would uh..we do that [mhm]. But mostly, we don't utilise the, utilise these things. Um, we only do it for the clients who have uh strong religious connections" – Malik
Religion as splitting	"religion, and politics are the two things which are prohibited, or which are not very much encouraged, so it's kind of discouraging, like, don't use these…I have experienced one or two clients, so who's got a big like, verbal aggressive, "do you belong to this sect? Or do you uh, relate it to this sect?" And when I said no, and then she said, "Oh, then it's if you are from this sect, then I wouldn't be talking to you"" – Laiba
Black magic	"Few weeks ago, we had this one workshop about jinn and jadu (Urdu for spirits and black magic) [mm]…when we have clients with schizophrenia, they talk about these things…and if they don't talk about this, their families do have this belief that there is certain, you know, certain jinn, who has possessed her, or him…they usually go to, they usually go to molvi (Urdu for Islamic teacher), faith healers, for their problems" – Tara
Mental health and religious explanations	"some which has possessed them, they have some uh, supernatural experiences. Um, they have experienced some

	sort of supernatural activity or anything. Um, however, if you go into detail, it's usually psychosis [mm]" – Anaya "Uh, I think it is, we are hesitant to talk about it, because most of the western literature says that religion should be kept aside from therapy..but what I have personally learned from my experiences, that religion is an integral part of your psyche, you cannot, you know, just keep it away or you cannot just completely exclude that from therapy [mm]" – Aliza "So basically, we are prepare for everything and if there is like any religious kind of thing, which we face and OCD, when they have like religious, like, thoughts related to religion, and how to deal with it. So they prepare us for, like, exclude any biases" – Alishba "we really go case by case, we try not to bring too much of religion into it, because then..you know, it gets very complicated, because religion is not just religion, religion, then is further in Pakistan divided into sects [mm]. So you know, so that's also very tricky…clients, you know, asking our names and second names, and, you know, trying to guess which sect we belong to" – Kainaat "So, during all this training procedure from time to time we have been taught to identify the cultural thoughts, the religious thoughts..how to not to use these things, how to not how not to use these terminologies not to use these concepts in your therapy sessions. So, it's a part of our training" – Hiba

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Appendix 11 – Researcher and supervisor reflexivity table

Initials	Gender	Involvement in study	Training	Credentials/Education	Occupation	Other relevant experience/views?
MH	Female	Every stage of the empirical study and systematic review	Research methods training to doctoral level in Clinical Psychology (DClin)	BA, PgDip, MRes, DClin (to be completed 2023)	Trainee Clinical Psychologist	Kashmiri-Pakistani, British born female living in the UK. Background in clinical psychology practice across physical and mental health settings. Experience of working with diverse populations in the UK, including displaced children and adults
AE	Female	Regular supervisory meetings, reading and providing feedback on the draft write up	Research methods lecturer on the DClin	PhD (2019)	Lecturer	British Pakistani female, born and raised in the UK. Academic background, particularly interested in mental health experiences of individuals in low income countries and of minority groups in the UK.
RW	Male	Regular attendance at supervision meetings and providing feedback on drafts of the systematic review	Research methods. Research director on the DClinPsy programme at Queen's University Belfast	PhD (2003) DClinPsy (2007)	Professor of Clinical Psychology	British born in Northern Ireland. Grew up in the protestant faith during The Troubles. Moved to Scotland to train as a Clinical Psychologist and worked there and in England for 15 years before returning to Northern Ireland in 2019. I directed a MSc programme on global mental health and have worked on research projects in sub-Saharan Africa and with forcibly displaced populations living in UK and EU.
AC	Female	Primary supervisor for first 18 months, providing input on research questions and study design.	Ongoing training and learning around qualitative and empirical ethics research methods.	PhD (global mental health / empirical ethics)	Tenure Track Research Fellow	Experience of conducting cross-cultural qualitative and mixed-methods global mental health research, including in Pakistan. Teaching research methods on DClin program and engaging with DClin trainees in diverse global settings. Research interest in the global translation of knowledge and practice. Personal interest in research mentorship and growth of those I supervise.