# University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

**An exploration of the cultural applicability of Cognitive Behaviour Therapy and the Three Flows of Compassion in the South Asian population**

By

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# University of Southampton

## Abstract

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Psychological interventions such as Cognitive Behaviour Therapy (CBT) and Compassion Focused Therapy (CFT), have a growing literature base that suggest their potential effectiveness in a range of mental health presentations across cultures (individualistic and collectivistic cultures). However, South Asian populations, for example, are often under studied in psychological intervention research, specifically Sri Lankan populations.

With this in mind, the first chapter of this thesis comprises a narrative systematic review and a meta-analysis of the effectiveness of CBT for depression in South Asian populations. The review identified 20 randomised controlled trials (RCTs) that met the study's inclusion criteria, with a total of 4758 participants. The findings suggested CBT to be effective as an intervention for depression in South Asian populations.

The second chapter is a reflexive account of the researcher's experience in conducting their empirical research. As the researcher is from the same cultural identity as the target population in the empirical study, the researcher provides an insight about their cultural influences, their motivations for the research, conducting the research, and their hopes for the future.

The empirical paper looks at the experiences of shame and the cultural applicability within the context of Gilbert's(2010) three flows of compassion in second-generation Sri Lankan men living in the UK. The study implemented a qualitative design and conducted semi-

structured interviews with twelve participants who were met the eligibility criteria. A reflexive thematic analysis identified four themes: ‘shame driven by expectation’, ‘living between worlds’, ‘when the three flows of compassion feels safe’, and ‘the emerging self’. Clinical implications recommend for culturally-adapted interventions to be delivered, and/or delivered by clinicians who identify as South Asian or speak their preferred language. Future research should explore the effectiveness of CBT for depression in men and other South Asian communities. Additionally, for second-generation Sri Lankan me, clinicians are recommended to explore mental health presentations linked to experiences of shame, connected to their cultural heritage and community, their masculinity, pressures to succeed, and providing a space to experience the three flows of compassion. Future research in this area should explore the quantitative measures of the three flows of compassion in this population using standardised measures and explore whether second-generation Sri Lankan women also experience three flows of compassion, in the context of shame.

**Keywords:** CBT, depression, South Asian, three flows of compassion, CfO, CtO, SC, shame, men, second-generation, Sri Lankan

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# Research Thesis: Declaration of Authorship

Print name: Prashan Diddeniya

Title of thesis: An exploration of the cultural applicability of Cognitive Behaviour Therapy and the Three Flows of Compassion in the South Asian population.

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: ..... Date: 19/05/2025.....

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# Definitions and Abbreviations

AC .....Active Control

AIDS.....Acquired immunodeficiency syndrome

BaCBT.....Adapted Bengali CBT

BA-M.....Behavioural Activation for Muslims

BAME .....Black, Asian Minority Ethnic

BDI-II.....Beck Depression Inventory II

CBT.....Cognitive Behaviour Therapy

CfO.....Compassion from Others

CES-D .....Centre for Epidemiologic Studies

CFT.....Compassion Focused Therapy

CMD .....Common Mental Disorders

CRD.....Centre for Review and Dissemination

CtO.....Compassion to Others

DS .....Depression Scale

DSM-V.....Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

F2F .....Face-to-face

GP .....General Practice

HADS .....Hospital Anxiety Depression Scale

HDRS .....Hamilton Depression Rating Scale

HIV .....Human Immunodeficiency Virus

IAPT .....Improving Access to Psychological Therapies

ICD-10 .....International Classification of Diseases, Tenth Revision

LHW.....Lady Health Workers

LTP+ .....Learning Through Play Plus

LTTE.....Liberation Tigers of Tamil Eelam

NHS.....National Health Service

Definitions and Abbreviations

PHQ.....Patient Health Questionnaire,

PHP .....Positive Health Programme

PM+ .....Problem Management Plus

PRISMA .....Preferred Reporting Items for Systematic Review and Meta-Analyses

RCT.....Randomised Controlled Trial

ROB .....Risk of Bias

RTA .....Reflexive Thematic Analysis

SC .....Self-Compassion

SRQ .....Self-Reporting Questionnaire

SSDS.....Siddiqui Shah Depression Scale

TAU.....Treatment-As-Usual

THP.....Thinking Healthy Programme

UK .....United Kingdom

WLC.....Waitlist Control

WHO.....World Health Organisation

# Chapter 1 Cognitive Behaviour Therapy for Depression in South Asian populations: A Systematic Review and Meta-Analysis

**Journal Specification:** The Clinical Psychology & Psychotherapy was selected to guide preparation of this paper (Appendix A). Journal guidelines request any format style. The manuscript followed an APA 7th format style. Manuscripts submitted as comprehensive reviews or meta-analysis have no word limit.

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## Abstract

South Asian populations are among the most vulnerable sub-ethnic groups to experience depression (Jain et al., 2025). While Cognitive Behaviour Therapy (CBT) is widely recommended as the first-line psychological treatment for depression (David et al., 2018; NICE, 2022), its effectiveness in South Asian populations remains underexplored. This systematic review and meta-analysis aimed to examine the effectiveness of CBT-based interventions for depression in South Asian adults. Twenty randomised controlled trials (RCTs) involving 4758 participants from India, Pakistan, Bangladesh, and the UK were included. Meta-analytic findings supported the overall effectiveness of CBT-based interventions. Moderator analyses, however reported statistically non-significant results across gender composition, control type, intervention type and culturally adapted interventions. Risk of bias was also measured as a moderator analysis and identified no significance to the overall meta-analysis results. Clinically, the review suggests that although good practice recommends culturally adapting CBT to improve accessibility and relevance for South Asian populations, CBT can still be effective in this population in improving depression if this is not possible. Further research is required to continue exploring the effectiveness of CBT in underrepresented groups, particularly men and South Asians living in Western societies.

## 1.1 Introduction

### 1.1.1 Mental health in South Asian populations

The South Asian community is the largest ethnic minoritised group in the UK, accounting for 9.3% of the overall population (Office of National Statistics, 2021), as they have been settling in the UK for 400 years (Visram, 2002). The surge of South Asian migrants increased considerably following the end of the Second World War from Commonwealth countries, encouraged by British colonial authorities, to support the shortage of post-war labour (Peach, 2006). As they settled in the UK, experiences of direct and indirect, structural and interpersonal, racism and discrimination, have been commonplace for South Asian communities (Byrne et al., 2020; Bhui et al., 2018; Nazroo et al., 2020). Furthermore, poor structural socioeconomic statuses have also been a significant problem for South Asians in the UK including inadequate housing, poor educational opportunities, poverty and unemployment (National Institute for Mental Health in England, 2004; Toleikyte & Salway, 2018). Based on the latest figures by the Census report, South Asian communities in the UK are made up of Indians (3.1%), Pakistanis (2.7%), Bangladeshis (1.1%), and 'Other' Asians (1.6%; Office of National Statistics, 2021).

The differing South Asian ethnic groups share cultural similarities in their collectivistic approach to life (Zaidi et al., 2013); however they are also significantly diverse in their cultural heritage, language, economy and religion (Prajapati & Liebling, 2022). The latter notion is often misconstrued by the assumption that Asians are a homogenous population when they are represented by 'A' in 'Black, Asian, Minority Ethnic (BAME) groups. The term 'South Asian' is commonly used to describe individuals who are brown-skinned living in the UK, instead of black or white (Gnanapragasam & Menon, 2021). It is important to clarify the sub-ethnic groups within the South Asian sphere, to ensure accurate prevalences of mental health are reported in epidemiological and health research.

In support, a recent report by the NHS Race and Health Observatory (2023) detailed that the 'Bangladeshi', 'Pakistani' and other 'Other' Asian categories (excluding Indian) have the worst

mental health outcomes compared to other ethnic minority groups. Migration-related stress and pressures to acculturate after leaving their country of heritage, contributed towards psychological distress (Anand & Cochrane, 2005; Gater, 2009; Taylor et al., 2013). Furthermore, the experiences of social deprivation and discrimination exacerbate vulnerability towards psychological distress, by maintaining social exclusion and intergenerational trauma (e.g., Bhui et al., 2018). Despite this need, accessing mental health care continues to be one of the biggest challenges for this community, together with completing and benefitting from treatment (Alam et al., 2024).

### 1.1.2 Depression in South Asian populations

Depression is a mental health condition characterised by patterns of low mood, loss of pleasure and interest, and fatigue, which impacts daily functioning (World Health Organisation, 2022). Depression is the most diagnosed mental health problem within South Asian communities in the UK (Anand & Cochrane, 2005; Gnanapragasam & Menon, 2021). The predictors of depression for these communities include financial difficulties, literacy, older age (Lai & Surood, 2008), gender roles (Karasz et al. 2007), perceptions of illness (Taylor et al., 2013), poor physical health, disability and social isolation (Gater et al., 2009; Williams et al., 2015). Women from South Asian communities, particularly of Indian and Pakistani heritage, appear more vulnerable to experiencing depression, with comorbidity rates of anxiety and depression found to be higher in Pakistani females compared to White women populations (Rees et al., 2016). Factors such as South Asian women reporting higher prevalence of relationship difficulties with their families (Cooper et al., 2006), with South Asian families often influenced by the concept *Izzat* (i.e., honour/respect; Husain et al., 2006), and cultural conflicts (Bhugra, 2004), all pose a risk to psychological distress and self-harm.

### 1.1.3 Cognitive Behaviour Therapy

CBT is an evidence-based therapy model for a variety of mental health conditions, with some arguing for it to be the “gold standard” of psychotherapy (David et al., 2018). The CBT model

focuses on the individual's relationship with the self, others, and the future and how these impact their thoughts, feelings and behaviours (Beck, 1964). CBT is the recommended psychological intervention for depression (National Institute for Health and Care Excellence, 2022) and has become more accessible for individuals to access since the introduction of the 'Improving Access to Psychological Therapies' (IAPT) services across the United Kingdom (Clark, 2018).

The applicability of CBT to South Asians may be restricted by its western ideals (Rathod & Kingdon, 2009). For instance, CBT encourages a sense of autonomy and agency on the individual which is in alignment of individualistic values (Rathod et al., 2019). In contrast, South Asian cultures prioritise values of family and community that are connected to collectivistic values (Zaidi et al., 2013). This cultural conflict may impact upon the experience of therapy because CBT focuses on the thought patterns of the individual which may not resonate with individuals who associate their experience from a community perspective (Graham et al., 2013). In support, Prajapati and Liebling (2022) suggest that family and community network integrated into therapy may enhance engagement for people of South Asian background and from collectivist cultures. Therefore, adaptations made to the therapeutic space, where a South Asian individual's network is integrated as part of therapy, may allow an openness to CBT and possibly benefit overall treatment outcomes.

Within the limited research in this area (e.g. Bhugra, 1997, 2004; Rathod & Kingdon, 2009, 2014), a meta-analysis review of meta-analyses investigated the effectiveness of culturally adapted psychosocial interventions for mental health problems across a range of cultural identities (Rathod et al., 2018). The results found a significant effect in the reduction of participants' mental health problems when psychosocial interventions were culturally adapted. Examples of cultural adaptations included using explicit statements of culture, incorporating cultural values and world views into sessions, collaborating with cultural others, matching race or ethnicity between client and therapist, or using client's preferred language.

However, the findings should be considered with caution due to methodological limitations. For example, several studies (e.g. Benish et al., 2011; Hodge et al., 2010; Huey & Polo, 2008) lacked active control conditions, making it difficult to determine whether observed improvements were due to the intervention itself or other non-specific factors, such as the therapeutic relationship, participants' expectations for improved outcomes or the facilitator's personality (Donovan et al., 2009). In addition, very few studies (e.g. Degnan et al., 2018; Griner & Smith, 2006) offered a direct comparison between adapted and standard CBT, meaning the unique contribution of cultural adaptation remains unclear (Naeem, 2023). Small sample sizes and overlooking within-group differences among South Asian communities as a homogenous group, may have masked subgroup differences in treatment response (e.g. Gordon et al., 2019; Holland & Palaniappan, 2015). The authors recommend the need for further high-quality trials, with a focus on culturally sensitive randomised controlled trials (RCT), that incorporate varied control arms such as non-adapted CBT comparisons and/or active control conditions (Rathod et al., 2018). Moreover, they report that meta-analyses should explore specific ethnic groups or diagnostic populations, and for interventions of the same theoretical underpinning to be grouped together to understand whether adapted mental health interventions (Rathod et al., 2018), are effective for their populations.

### 1.1.4 Rationale

South Asians make up the largest minoritised community in the UK (Iqbal et al., 2012), but remain disproportionately affected by structural disadvantages, including racism, social exclusion and poor socioeconomic conditions, all of which contribute to increase risk for mental health difficulties (Toleikyte & Salway, 2018). Depression is widely reported within these communities, with South Asian women disproportionately affected due to overlapping cultural expectations and societal challenges (Gnanapragasam & Menon, 2021; Rees et al., 2016). Although CBT is a recommended treatment for depression (National Institute for Health and Care Excellence, 2022), its Western, individualistic framework may not align with the collectivistic values centred within South Asian cultures. Recent studies suggest that culturally

adapted psychosocial interventions can produce significant positive outcomes in mental health outcomes (Rathod et al., 2018). There is the need however, to look more specifically within cultures, such as South Asian populations. The current review, therefore, is the first to explore whether CBT is an effective intervention for depression in South Asian populations locally and in their diasporas.

## 1.2 Method

### 1.2.1 Protocol

The systematic review was conducted in guidance of the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA). The protocol for the systematic review was registered with the international Prospective Register for Systematic Reviews (PROSPERO) on 15/01/2025 (CRD42025522324). This can be accessed via: https://www.crd.york.ac.uk/PROSPERO/view/CRD42025522324

### 1.2.2 Information sources

This review was conducted, and reported, in accordance with the principles as recommended by the Centre for Reviews and Dissemination (CRD; Akers et al., 2009). Initial scoping searches were conducted through Google Scholar, Prospero and the online library portal of University of Southampton. Subsequently, the following databases were used for the search: CINAHL, Embase, Medline, PsycInfo, ProQuest, and Web of Science. The preliminary search of these databases took place between 27th 30th May 2024, and later the second search was conducted between 21st – 24th October 2024 for the initial focus of anxiety. The review question was later adapted to depression and the final search took place between 11th – 14th January 2025. The scope of the review was refined to depression rather than anxiety, as more studies related to depression were identified during initial searches, which made it feasible to undertake a meta-analysis.

### 1.2.3 Eligibility Criteria

The eligibility criteria are presented in Table 1.1. The inclusion criteria included South Asian communities only using adult based quantitative research and qualitative studies were excluded. The quantitative studies that considered comparative analysis such as Randomized Controlled Trials (RCTs) with a CBT-based intervention as one of the intervention groups were included regardless of their mode of delivery (E.g. face-to-face, group, self-guided). CBT-based interventions in this review encompasses both traditional cognitive behavioural therapy and interventions grounded in its core principles. Approaches of CBT typically include one or more of the following components: cognitive restructuring, behavioural activation, psychoeducation, problem-solving, thought challenging, graded exposure, homework assignments, and goal settings (Beck, 2011;Dobson & Dozois, 2019). Studies identified as CBT or CBT-informed and incorporated such techniques were included, even if a standardized protocol was not followed.

Studies included in the review were required to have used a validated measure of depression, although the intervention itself did not need to be designed specifically to treat depression. Studies that addressed depression indirectly including those targeting comorbid conditions, were also eligible. If a study did not clearly state the ethnicity of its sample, the study location was used as a proxy for inclusion. No date restrictions were applied to maximise the inclusion of relevant research, given the limited number of studies in this area. Additionally, grey literature was also included in the review search to reduce the risk of publication bias (Cherry et al., 2023).

### 1.2.4 Selection process

Screening and selection processes adhered to the PRISMA guidelines (Page et al., 2021). The primary reviewer (main author) assessed all studies for eligibility, while a second reviewer (a doctoral student) independently reviewed 10% of the studies (n = 57) This proportion aligns with established practice in systematic reviews, where 10% random sampling is commonly used to ensure consistency while balancing resource constraints (Phulkerd et al., 2016). The second

reviewer's assessments were cross-checked against the primary reviewer's decisions to ensure that studies met inclusion criteria. Five studies were flagged for discussion due to uncertainties – including whether the article was a study protocol, the clarity of the study's location, the presence of a control group, the definition of the CBT intervention, and whether the study design met eligibility. All disagreements were resolved through discussion and consensus.

For both data extraction and risk of bias assessment, 10% of studies were again independently reviewed by the second coder (Phulkerd et al., 2016). Extracted data included author, year, study design, country, setting, sample size, depression outcome measures, whether CBT was delivered as a standalone intervention, and clinical outcomes. One additional study required consultation during the quality assessment phase; this was resolved through agreement between reviewers. No further disagreements arose throughout the screening or appraisal process. Inter-rater agreement was not formally calculated (e.g., via Cohen's Kappa; Cohen, 1992) due to the small number of jointly reviewed papers (n = 2), however 100% consensus was achieved in all dual-coded cases.

**Table 1.1**

*Systematic Review Inclusion and Exclusion Criteria*

| | Inclusion Criteria | Exclusion Criteria |
|---|---|---|
| Population | 18 years plus; South Asian origin* | Under 18 years; Non-South Asian origin or setting. |
| Intervention | Tests of difference; aimed at CBT | Non-RCTs / Non-CBT |
| Comparator | Waitlist control, active control group | No comparator/control |
| Outcome | Validated measures of depression | Does not measure depression or non-validated measure |
| Studies | Quantitative; Published/unpublished studies, English languages | Qualitative; Literature reviews, letters, posters, abstracts only, policy reports |

**South Asian origin: Individuals living in their respected home country or their diaspora – India (Indians), Pakistan (Pakistani), Bangladesh (Bangladeshi/ Bengali), Sri Lanka (Sri Lankans), Nepal (Nepalese), Bhutan (Bhutanese), Maldives (Maldivian) and Afghanistan (Afghan).*

### 1.2.5 Search Strategy

The search strategy was developed and a librarian from the University was consulted in the process, and four sets of keywords were used. The first keyword was based on 'Cognitive Behaviour Therapy': "Cognitive Behaviour Therapy" OR "Cognitive Behavior Therapy" OR "Cognitive Behavioural Therapy" OR "Cognitive Behavioral Therapy" OR "CBT" OR "Cognitive Behavioural Therapies" OR "Cognitive Behavioral Therapies". The second set of keywords was based on 'Depression': "Depression" OR "Depressive Disorder" OR "Major Depression" OR "Major Depressive Disorder" OR "MDD" OR "Persistent Depressive Disorder" OR "Dysthymia" OR "Postpartum Depression" OR "Perinatal Depression" OR "Seasonal Affective Disorder" OR "SAD" OR "Atypical Depression" OR "Treatment-Resistant Depression". The third set of keywords was based on the 'Effectiveness' of treatment: "effectiveness" OR "efficacy" OR "treatment outcome" OR "treatment effectiveness" OR "therapeutic outcome" OR "intervention outcome" OR "treatment success" OR "clinical outcome" OR "therapeutic efficacy". The final set of keywords was based on 'South Asian' populations: "South Asian" OR "South Asian populations" OR "Indian" OR "Indians" OR "Pakistan*" OR "Bangladesh*" OR "Sri Lanka*" OR "Sri Lankan" OR "Nepal*" OR "Nepali" OR "Bhutan*" OR "Bhutanese" OR "Maldiv*" OR "Maldivian" OR "Desi" OR "Asian Indian" OR "Asian Indians" OR "South Asians" OR "Asian ethnic group" OR "ethnic group" OR "ethnic minority" OR "migrant" OR "immigrant" OR "diaspora". The four keyword searches were then combined with the 'AND' Boolean Operator function to generate the final search results. The reference lists of each selected studies were also searched for articles that potentially fit the inclusion criteria.

### 1.2.6 Data Extraction

The following data information about the studies' sample characteristics were extracted: author names, year of publication, design, population, number of participants recruited, number of participants analysed at post, attrition rate, gender, mean age, country and ethnicity. The study intervention characteristics were also extracted: intervention content, intervention cultural adaptations (if adapted), intervention duration, intervention delivery, comparator, data time

points, depression measure, whether the measure was adapted, Cronbach's alpha and the main findings. For the meta-analysis, sample size, means and standard deviations for each intervention groups at pre-and post-intervention were extracted.

### 1.2.7 Analysis Strategy

A meta-analysis was conducted using version 5.4 of the RevMan software (The Cochrane Collaboration, 2020). The effect size guidelines by Cohen's d (1992) were used to interpret the results as either small (0.2), medium (0.5) or large (0.8) and reported as *d*. Cohen's calculations were based on the collective average effect sizes of each study, also reported as the weighted mean or standardized mean difference, using a random-effects model. The model accounts for variability within studies by sampling error, and between-studies by true effect size differences. Heterogeneity such as differences in sample size or outcome measures are normally distributed and, generalizable outcomes can be reported (Borenstein et al., 2010). Moderator analyses was considered if high levels of heterogeneity were reported from the meta-analysis output.

### 1.2.8 Risk of Bias

The PRISMA statement states the inclusion of a risk of bias assessment (Page et al., 2021). The Revised Cochrane risk-of-bias tool for randomized controlled trials (RoB 2) was used to assess the risk of bias within studies and inputted into the RevMan software (Higgins et al., 2021). The tool assessed each study for the following: selection bias (how participants are assigned to groups), performance bias (difference in care or awareness of group allocation), detection bias (how outcomes are measured or assessed), attrition bias (missing outcome data or participant drop-out), reporting bias (selective reporting of study results) and other biases. Each study was then graded based on the level of bias risk they posed: 'low risk', 'high risk' or 'unclear'. In addition, publication bias was evaluated using a funnel plot to determine whether studies with significant findings were disproportionately represented in the published literature (Sterne et al., 2011). An Egger's test was conducted if asymmetry in the funnel plot was identified (Sterne et al., 2011; Suurmond et al., 2017).

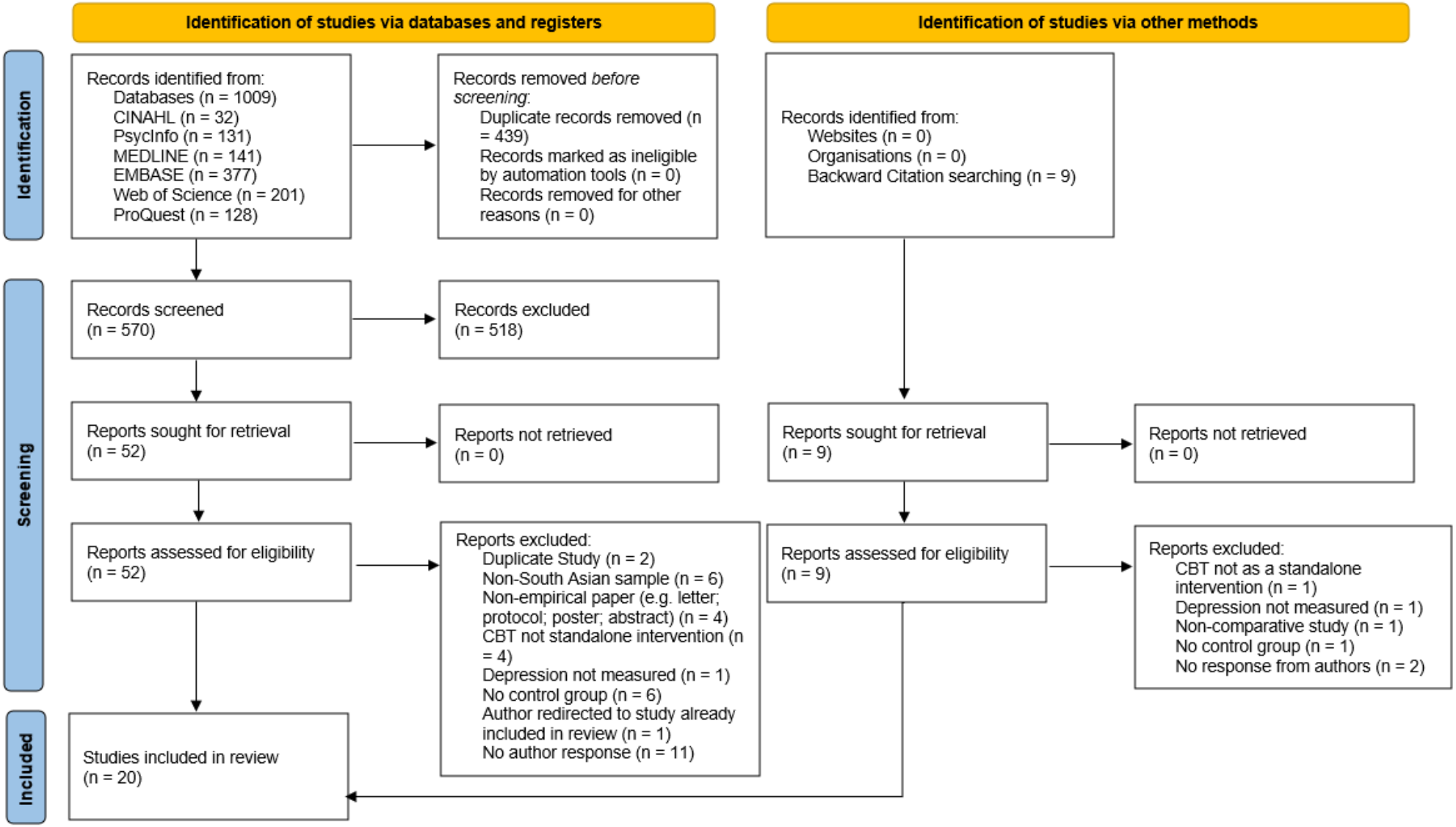
## 1.3 Results

### 1.3.1 Systematic Search Results

Figure 1.1 presents a diagrammatical representation of the selection process using the PRISMA flow diagram (Page et al., 2021). A total of 1009 papers were identified from six databases including ProQuest which publishes grey literature. There were 439 duplicates removed manually from the search. Titles and abstracts of 570 papers were screened for their eligibility. From this, 518 titles were excluded from the initial selection process for not meeting the inclusion criteria. The remaining 52 papers were eligible for full-text screening, with 33 papers being excluded for not meeting the inclusion criteria. Reasons for being excluded involves duplication of study, non-south Asian samples, non-empirical papers published, CBT as not a standalone intervention group (e.g. medication treatment combined), depression not measured, no control groups, and author signposting to a study that was included in the review already. No responses were received from 11 authors who were contacted for their raw data. From this search, 19 studies remained to be included in the review. Backward citation was conducted from the 52 eligible papers for full-text screening, whereby their reference lists were reviewed for relevant titles and abstracts that met the inclusion criteria. This retrieved 9 papers for full-text screening. From this, 6 papers did not meet the inclusion criteria due to CBT not being a standalone intervention group, depression not being measured, a study being non-comparative, and not including a control group. A total of 2 authors had not responded upon request of their raw data. Therefore, 20 papers were included in the final review.

**Figure 1.1**

*PRISM Flow Diagram (Page et al., 2021)*



### 1.3.2 Quantitative Results

Data information about the sample characteristics and the study characteristics are presented in Table 1.2 and 1.3 respectively. Most of the studies had one intervention that was CBT-based and was compared to a control group. One study (Ghosh et al., 2023) was the only study to include two control groups, active control and waitlist control. To avoid inflating the influence of this shared intervention group, guidance from Borenstein et al.'s (2011) and Wakelin et al., (2022) were followed, whereby the sample size in the CBT intervention was divided by the number of control groups to reduce the risk of the study weighting the analysis disproportionately to its sample size. Therefore, Ghosh et al., (2023) was counted as two separate samples, where half the sample size of the intervention was each compared to one of the control groups, in the meta-analysis. A

#### 1.3.2.1 Intervention Characteristics

All the 20 studies were randomized controlled trials with a total of 14 studies based in Pakistan (Abbas et al., 2023a, 2023b; Dawood et al., 2023; Hamdani et al., 2021; Husain et al, 2014, 2017, 2021a, 2021b; Naeem et al., 2014, 2015; Rahman et al., 2008, 2016, 2019; Zareen & Jahangir, 2019); three from India (Ghosh et al., 2023; Mishra & Singh, 2023; Reddy & Omkarappa, 2019), two from the United Kingdom (Husain et al., 2023, 2024) and one from Bangladesh (Ara et al., 2023).

A total of nine studies had mixed genders (Abbas et al., 2023a, 2023b; Ara et al, 2023; Dawood et al., 2023; Ghosh et al., 2023; Hamdani et al., 2021; Naeem et al., 2014, 2015; Rahman et al. 2016), whilst the remaining 11 studies were female only (Husain et al, 2014, 2017, 2021a, 2021b, 2023, 2024; Mishra & Singh, 2023; Rahman et al., 2008, 2019; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019).

Regarding the treatment facilitators' country of origin, only the two UK studies (Husain et al., 2023, 2024) did not specify the facilitators' country of origin were from. Remaining studies,

included treatment facilitators' who were of the same country of origin of where the study was conducted and of the sample (Abbas et al., 2023a, 2023b; Ara et al., 2023, Dawood et al., 2023; Ghosh et al., 2023; Hamdani et al., 2021; Husain et al., 2014, 2017, 2021a, 2021b; Mishra & Singh, 2023; Naeem et al., 2014, 2015; Rahman et al., 2008, 2016, 2019; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019).

Four studies incorporated a WLC group (Abbas et al., 2023a, 2023b; Ara et al., 2023; Ghosh et al., 2023), 16 studies included an AC group (Dawood et al., 2023; Ghosh et al., 2023; Hamdani et al., 2021; Husain et al, 2014, 2017, 2021a, 2021b, 2023, 2024; Mishra & Singh, 2023; Naeem et al., 2014, 2015; Rahman et al., 2008, 2016, 2019; Zareen & Jahangir, 2019) and one study did not define their control group (Reddy & Omkarappa, 2019). To note, Ghosh et al. (2013) was the only study to include data from a Waitlist control group and an Active control group.

Regarding the CBT intervention format, 10 studies were conducted individually face-to-face (Abbas et al., 2023a, 2023b; Ara et al., 2023; Hamdani et al., 2021; Mishra & Singh, 2023; Naeem et al., 2015; Rahman et al., 2008, 2016; Zareen & Jahangir, 2019), seven studies were conducted as a group (Husain et al., 2014, 2017, 2021a, 2021b, 2023, 2024; Rahman et al., 2019), one study as a self-help intervention (Dawood et al., 2023) one as self-help computerised CBT (Ghosh et al., 2023); and one study as a carer-guided self-help intervention (Naeem et al., 2014).

Regarding culturally adapted CBT interventions, 18 studies highlighted that they had adapted their intervention to the population group (Abbas et al., 2023a, 2023b; Ara et al., 2023; Dawood et al., 2023; Hamdani et al., 2021; Husain et al., 2014, 2017, 2021a; 2021b; 2023; 2024; Mishra & Singh, 2023; Naeem et al., 2014, 2015; Rahman, 2008, 2016, 2019; Reddy & Omkarappa, 2019). Sixteen of the culturally-adapted CBT intervention studies reported that they were delivered in their country's native language – Urdu (Abbas et al., 2023a, 2023b; Dawood et al., 2023; Hamdani et al., 2021; Husain et al., 2014, 2017, 2021a, 2021b; Naeem et al., 2014, 2015; Rahman et al., 2008, 2019 ), Bengali (Ara et al., 2023), Pashto (Rahman et al., 2016); Punjabi

(Mishra & Singh, 2023) – with Husain et al. (2023, 2024) reporting that facilitators were bilingual in English and one other language (Urdu, Bengali, Gujarati) and participants had the choice of what language they wanted the intervention to be delivered in. Reddy & Omkarappa (2019) did not specify a specific language the intervention was delivered in, yet their inclusion criteria required participants to read and write in either Kannada or English for the study, thereby participants having the flexibility to choose which language they wanted the intervention delivered in.

Fourteen of the culturally adapted CBT interventions reported that adaptations were made in the intervention themselves beyond the language they were facilitated in (Ara et al., 2023, Dawood et al., 2023; Hamdani et al., 2021; Husain 2014, 2017, 2021a, 2021b, 2023, 2024; Naeem et al., 2014, 2015; Rahman 2008, 2016, 2019). Four of the studies (Ara et al., 2023; Husain et al., 2014; Naeem et al., 2014, 2015) developed bespoke culturally adapted interventions that considered the local cultural contexts, using jargon-free language, folk stories relatable to their populations as part of their culturally adapted CBT (Ca-CBT) interventions. Three of the studies Hamdani et al., 2021; Rahman et al., 2016, 2019) used an established culturally adapted and translated versions of the Problem management plus (PM+) programme (WHO, 2016, 2020). Three of the studies (Husain et al., 2017, 2021a, 2021b) used a culturally adapted group-based parenting programme integrating CBT with a pictorial child development calendar, local parenting practices and cultural values in the form of Learning through Play Plus (LTP+). Two of the studies (Husain et al., 2023, 2024) used a culturally adapted group-based CBT intervention design for British South Asian women with postnatal depression, incorporating culturally relevant examples (e.g. religion, spirituality family dynamics). One of the studies (Rahman et al., 2008) delivered the Thinking Healthy Programme (THP) which is a culturally adapted CBT-based programme for perinatal depression in Pakistan, developed indigenously (Rahman et al., 2007). One study (Dawood et al., 2023) incorporated religious teachings into their intervention of behavioural activation for Muslims (BA-M).

Two studies did not specify any form adaptations in the intervention groups (Ghosh et al., 2023; Zareen & Jahangir, 2019).

As part of the delivery of interventions, 8 studies (Abbas et al., 2023a, 2023b; Ara et al., 2023; Hamdani et al., 2021; Husain et al., 2014, 2017; Mishra & Singh, 2023; Reddy & Omkarappa, 2019) were facilitated by Clinical Psychologists. Three of the studies (Rahman et al., 2008, 2016, 2019) were facilitated by 'Lady' or Lay health workers (LHW). Two of the studies (Husain et al., 2021a, 2021b) were facilitated by community health workers (CHW), with Husain et al (2021a) reporting that these were Master-level psychologists. Naeem et al. (2015)'s intervention group was facilitated by psychology graduates. Two of the studies (Husain et al., 2023, 2024) were facilitated by NHS mental health researchers (band 4-6).

#### 1.3.2.2 Depression Outcome Measures

A total of six studies (Abbas et al., 2023a, 2023b; Dawood et al., 2023, Ghosh et al., 2023; Husain et al., 2021a; Husain et al., 2024), included the Patient Health Questionnaire (PHQ-9; Kroenke, 1999, 2001) which is a validated measure in screening and measuring the severity of depressive symptoms across diverse settings. Three of these studies (Abbas et al., 2023a, 2023b; Husain et al., 2024) explicitly used validated Urdu versions of the PHQ-9 (Ahmad et al., 2018; Gallis et al., 2018).

Five studies (Hamdani et al., 2021; Naeem et al., 2014,2015; Rahman et al., 2016, 2019) included the Hospital Anxiety Depression Scale – Depression (HADS-D; Zigmond & Snaith, 1983), which is a validated measure to assess depressive symptoms in medical and general population across various clinical settings, and four papers (Hamdani et l., 2021; Naeem, 2015; Rahman, 2016, 2019) explicitly used validated Urdu versions of the HADS-D (Mumford et al., 1991).

Five studies (Husain et al., 2014; Husain et al., 2017; Husain et al., 2021b, Husain et al., 2023; Rahman et al., 2008) included Hamilton Depression Rating Scale (HDRS; Hamilton, 1960, 1967), which is clinician-administered tool to assess the severity of depressive symptoms applicable to

various clinical populations and three studies (Husain et al., 2014, 2017, 2021b) explicitly used and cited validated Urdu versions of the HDRS (Gater et al., 2010).

Only one study by Mishra and Singh (2023) used the Beck Depression Inventory-II (BDI-II; Beck et al., 1996), which is a self-report measure to assess the presence of severity of depressive symptoms, applicable to clinical and non-clinical populations. In contrast, Reddy and Omkarappa, (2019) used the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977), which is a validated and widely used screening tool for depressive symptoms in general and community-based populations. Ara et al. (2023) used the Depression scale (DS; Uddin & Rahman, 2005), which is a culturally developed and validated self-report measure to assess depressive symptoms within Bangladeshi populations. Also, Zareen and Jahangir (2019) used the Siddiqui Shah Depression Scale (SSDS; Siddiqui & Shah, 1997), which is a culturally validated self-report measure developed for use in Pakistani populations.

**Table 1.2**

*Sample Characteristics*

| Study | Design | Participant Population | *N* recruited (Int/Con) | *N* analysed post intervention (Int/Con) | Attrition Rate (% dropout) | Gender (% female) | Mean Age (SD) | Country | Ethnicity |
|---|---|---|---|---|---|---|---|---|---|
| **Abbas et al. (2023a)** | Individual RCT | Pakistani patients with Type-2 diabetes mellitus | 90 (45/45) | 62 (27/35) | 31.10% | Int: 51.2%<br>Con: 60.1% | Int: 36.93 (6.87)<br>Con: 37.62 (6.77) | Pakistan | Pakistani (100%) |
| **Abbas et al. (2023b)** | Individual RCT | Pakistani patients with HIV/AIDS | 126 (63/63) | 80 (40/40) | 36.50% | Int: 60.3%<br>Con: 57.1% | Int: 31.87 (8.35)<br>Con: 31.93 (8.53) | Pakistan | Pakistani (100%) |
| **Ara et al., (2023)** | Individual RCT | Bengali diagnosed with depression (DSM-V) | 107 (54/53) | 106 (54/52) | 0.93% | Int: 33.6%<br>Con: 38.3% | Int: 32.67 (7.04)<br>Con: 28.75 (7.83) | Bangladesh | Bengali (100%) |
| **Dawood et al. (2023)** | Individual RCT | Pakistani patients with depression | 114 (57/57) | 103 (50/53) | 9.65% | Int: 58%<br>Con: 70% | Int: 33.8 (11.5)<br>Con: 32.3 (9.6) | Pakistan | Pakistani (100%) |
| **Ghosh et al (2023)**[1] | Individual RCT | Indian residents | 598 (204/189/205) Int/AC/WLC | 168 (22/7/139) - Int/AC/WLC | 71.90% | Int: 21.6%<br>AC: 20.1%<br>WLC: 18.5% | Int: 23.76 (0.30)<br>AC: 23.42 (0.28)<br>WLC: 23.48 (0.29) | India | Indian (100%) |
| **Hamdani et al. (2021)** | Individual RCT (Single-blind) | Pakistani outpatients with depression | 489 (96/96) | 131 (64/67) | 73.20% | Int: 64.6%<br>Con: 68.8% | Int: 33.03 (9.94)<br>Con: 35.07 (10.95) | Pakistan | Pakistani (100%) |
| **Husain et al. (2014)** | Individual RCT (Rater-blind) | Pakistani women who scored within the depression | 66 (33/33) | 64 (32/32) | 3.03% | 100% | Int: 31.3 (5.1)<br>Con: 31.3 (5.9) | Pakistan | Pakistani (100%) |

[1] This study presents data for a WLC group and an AC group and will be reported twice in the meta-analyses.

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| | | range of the SRQ. | | | | | | | |
| **Husain et al. (2017)** | Individual RCT (Rater-blind) | Pakistani mothers with depression | 247 (123/124) | 222 (112/110) | 10.12% | 100% | Int: 28.20 (5.47)<br>Con: 27.26 (5.50) | Pakistan | Pakistani (100%) |
| **Husain et al. (2021a)** | Cluster RCT | Pakistani mothers with depression | 774 (402/372) | 769 (399/370) | 0.64% | 100% | Not reported | Pakistan | Pakistani (100%) |
| **Husain et al. (2021b)** | Individual RCT | Pakistani mothers with depression | 107 (54/53) | 95 (47/48) | 11.21% | 100% | Int: 27.9 (5.6)<br>Con: 26.9 (4.8) | Pakistan | Pakistani (100%) |
| **Husain et al. (2023)** | Individual RCT | South Asian mothers with perinatal depression | 83 (42/41) | 66 (34/32) | 20.50% | 100% | Int: 30.4 (6.0)<br>Con: 30.1 (5.4) | UK | Not specified |
| **Husain et al. (2024)** | Cluster RCT | South Asian mothers with perinatal depression | 732 (368/364) | 566 (283/283) | 22.70% | 100% | Int: 31.3 (5.2)<br>Con: 31.4 (5.2) | UK | Int: Indian (25%), Bangladeshi (16%), Pakistani (55%), Other South Asian (3%)<br><br>Con: Indian (24%), Bangladeshi (19%), Pakistani (55%), Other South Asian (2%) |
| **Mishra & Singh (2023)** | Individual RCT | Indian women who scored above range for depression using the BDI-II. | 384 (192/192) | 151 (114/37) | 60.70% | 100% | Int: 23.03 (5.29)<br>Con: 24.89 (6.44) | India | Indian (100%) |
| **Naeem et al (2014)** | Multi-centre RCT | Pakistani diagnosied with depression (ICD-10) | 192 (96/96) | 183 (94/83) | 4.69% | Int: 58.5%<br>Con: 52.8% | Int: 33.2 (12.7)<br>Con: 33.7 (13.0) | Pakistan | Pakistani (100%) |
| **Naeem et al. (2015)** | Individual RCT (Rater-blind) | Pakistani diagnosied with | 137 (69/68) | 129 (66/63) | 5.83% | Int: 52.7%<br>Con: 47.3% | Int: 30.0 (11.4)<br>Con: 33.4 (10.7) | Pakistan | Pakistani (100%) |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | depression (ICD-10) | | | | | | |
| **Rahman et al. (2008)** | Individual RCT (Rater-blind) | Pakistani mothers with perinatal depression | 903 (463/440) | 818 (418/400) | 9.30% | 100% | Int: 26.5 (5.2)<br>Con: 27.0 (5.1) | Pakistan | Pakistani (100%) |
| **Rahman et al. (2016)** | Individual RCT | Pakistani patients with emotional distress | 346 (172/174) | 137 (60/77) | 40.6% | Int: 75%<br>Con: 82.8% | Int: 32.7 (12.1)<br>Con: 33.4 (11.4) | Pakistan | Pakistani (100%) |
| **Rahman et al. (2019)** | Cluster RCT (Rater-blind) | Pakistani women who scored within range. | 612 (306/306) | 598 (298/300) | 2.29% | 100% | Int: 37.35 (10.50)<br>Con: 35.19 (9.11) | Pakistan | Pakistani (100%) |
| **Reddy & Omkarappa (2019)** | Individual RCT | Indian menopausal women with depression | 102 (51/51) | 80 (40/40) | 21.60% | 100% | Int: 48.63 (0.55)<br>Con: (49.16 (0.80) | India | Indian (100%) |
| **Zareen & Jahangir (2019)** | Individual RCT | Pakistani female patients with fibromyalgia | 120 (60/60) | 120 (60/60) | 0% | 100% | Not reported | Pakistan | Pakistani (100%) |

*Acronyms: Active Control (AC); Acquired immunodeficiency syndrome (AIDS); Beck Depression Inventory II (BDI-II); Control (Con); Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5); Human Immunodeficiency Virus (HIV); International Classification of Diseases, Tenth Revision (ICD-10), Intervention (Int); Sample (N); Randomised Controlled Trial (RCT); Standard Deviation (SD)l Self-Reporting Questionnaire (SRQ); Waitlist Control (WLC).*

**Table 1.3**

*Study Characteristics*

| Study | Intervention Content | Intervention culturally adapted | Intervention duration | Intervention delivery | Control | Time points | Depression measure | Measure adaptation | Cronbach's Alpha for measure | Finding |
|---|---|---|---|---|---|---|---|---|---|---|
| **Abbas et al. (2023a)** | **Individual CBT** structured according to CBT protocol was structured according to Beck (2020), Hilliard et al. (2021) and Hood et al., 2021)<br><br>**Components:** psychoeducation, cognitive conceptualization, adherence training, activity scheduling, problem-solving, improving coping strategies, muscle relaxation and imagery, and, lapse and relapse prevention. | Not specified - including language used by therapist or components of intervention.<br><br>Implied - the intervention was delivered in its native language. | 16 weeks<br>1 session every 10-12 days intervals, with 45-60 minutes | Individual therapy | WLC | Pre<br>Post | PHQ-9 | PHQ-9 (Validated Urdu translation, Ahmad et al., 2018) | 0.91 (Ahmad et al., 2018) | Patients who received CBT got a significant reduction in their diabetes distress and depressive symptoms. |
| **Abbas et al. (2023b)** | **Brief CBT (B-CBT)** structured for 8-sessions was designed as a synthesis of classic CBT and other B-CBT (Beck, 2020; Bond, 2004).<br><br>**Components:** B-CBT aimed at effectively dealing with depressive symptoms, enhancing motivation, and reducing stigma through psychoeducation, cognitive restructuring, skill training, stress management, and relapse prevention | Not specified - including language used by therapist or components of intervention | 8-session | Individual therapy | WLC | Pre<br>Post | PHQ-9 | PHQ-9 (Validated Urdu translation, Ahmad et al., 2018) | 0.91 (Ahmad et al., 2018) | B-CBT significantly reduced the level of depression among patients with HIV/AIDS. |

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| **Ara et al., (2023)** | **Adapted Bengali CBT (BaCBT)** adapted from the CBT protocol of Beck (1995).<br><br>**Components:** The BaCBT manual focuses on psychoeducation, symptoms management, changing negative thinking, behavioural activation, problem-solving, and communication skills. | BaCBT developed and assessed across four phases was based on information gathered from depressed patients (Ara & Deeba, 2018)about their symptoms, personal experiences of therapy and clinical practices, were organized to develop an adapted treatment manual that considered cultural issues, psychoeducation, motivational interviewing related to depression, and strategies to maximize a collaborative therapeutic alliance in the cultural context of Bangladesh. | 6-10 sessions | Individual therapy | WLC | Pre<br>Post<br>1 month follow-up | DS (Uddin & Rahman, 2005) | DS was developed for the Bangladeshi population to measure symptoms of depression. | 0.96 | Significant reductions in depression severity, anxiety, perceived stress, and suicidal ideation in intervention group. |
| **Dawood et al. (2023)** | **Behavioural Activation culturally adapted for Muslims (BA-M)** was the main intervention.<br><br>**Components:** BA-M comprises of a values assessment, and if participants selected 'religion' as a personal value, support drawn from Islamic religious teachings is shared. | BA-M draws on Islamic religious teachings to promote therapeutic goals and 'positive religious coping'<br><br>CBT as the control group was not specified to be culturally adapted | BA-M comprised of 6-12 sessions | Self-Guided Therapy | AC (CBT) | Pre<br>Post | PHQ-9 | PHQ-9 Urdu version (not cited). | 0.89 (Kroenke et al., 2001) | Patients in the BA-M arm experienced greater improvement in PHQ-9 score compared to the CBT arm. |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Ghosh et al (2023)** | **Computerised CBT (cCBT)** called 'TreadWill' was developed based on Beck (2011) as primary reference.<br><br>**Components:** CBT is structured in 6 modules, each consisting of 4 sections: *Introduction, Learn*, *Discuss*, and *Practice*. Psychoeducation was introduced in the 'Learn' section, and these were applied to real-life situations to be reflected in the 'Discuss' section. The AC did not have the 'Practice' section.<br><br>Two interactive games were shown: the 'identifying thinking errors game' to spot thinking errors in their negative automatic thoughts, and the 'identify the friendly face' game to train participants to overcome negative attention bias and improve self-esteem. TreadWill had interactive CBT forms including Thought record worksheet, Core belief worksheet, Behavioural experiment worksheet, Problem Solving worksheet, prepare for setback worksheet, and Schedule Activity worksheet | None - TreadWill was delivered in English; components of intervention was not specified to be culturally adapted. | 6 weeks to complete 6 modules in intervention group and active control group. The WLC were give access after 42-days of pre-measures. | Self-Guided Therapy | AC<br>WLC | Pre<br>Post<br>90-day follow-up | PHQ-9 (Kroenke et al., 2001) | Not reported | 0.89 (Kroenke et al., 2001) | Users who completed at least half of the modules in TreadWill showed significant reduction in depression-related symptoms compared with the waitlist control. There was no effect between Intervention group to the AC group. |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Hamdani et al. (2021)** | **Problem Management Plus (PM+)** individual version (Dawson et al., 2015) by the World Health Organisation (WHO) is a transdiagnostic approach to the management of common mental disorders (CMDs). Based on principles of problem solving and behavioural techniques. The TAU was also received in the intervention group from psychiatrists/psychologists, comprising of initial assessments, consultations where required, and psychological support consisting of semi-structured psycho-education sessions.<br><br>**Components:**<br>Four modules: 'Stress management strategy' (psychoeducation), 'Managing problems' (problem solving strategy), Get going, keep doing' (behavioural activation strategy), 'Strengthening social support'<br><br>(Study did not specify CBT throughout their study, but based on the components reported, it suggests that this intervention fits the criteria for a CBT intervention). | Author reports that all of the study tools were administered in local Urdu language | 5 weekly sessions 90 minutes each (average) | Individual therapy; face-to-face sessions | AC (TAU - routine appointments by primary care physicians). | Pre<br>Post<br>Follow-up | HADS-D | HADS-D validated Urdu version – Mumford et al., 1991 | 0.64 (Waqas et al., 2019) | There was a significant reduction in symptoms of in the Intervention (PM+ plus TAU) arm for depression |

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| **Husain et al. (2014)** | **Group psychosocial intervention** developed by adapted CBT manual.<br><br>**Components:** information on symptoms of depression, causes of stress, depression treatment options and the likely outcomes, getting involved in pleasant activities, cognitive therapy and problem solving techniques, and improving relationships. | Locally acceptable "jargon" used, culturally acceptable homework assignments, and therapists used folk stories and religious examples relevant to the cultural context. | 10 group sessions - 8 weekly sessions and 2 fortnightly sessions. 60-90 minutes, over a 12-week period. | Group intervention | AC (Anti-depressants) | Pre<br>Post<br>Follow-up (6-months) | HDRS (Hamilton, 1967) | Urdu version – Gater et al. (2010) | 0.71 | Both treatment and AC groups improved at end of therapy at 3 months, however differences in treatments were not statistically significant. |
| **Husain et al. (2017)** | **Learning Through Play Plus (LTP+)** - combination of two components - Learning Through Play (LTP) & Thinking Healthy Program me(THP).<br>THP is a CBT-based intervention while LTP is a parent-based intervention for early child development.<br><br>**Components:** The THP component has 5 modules and adopts a "here and now" problem-solving approach. CBT techniques implemented include active listening, changing negative thinking, collaboration with the family, guided discovery and homework. | The LTP component of the LTP plus intervention was translated into Urdu. The THP component was not explicitly reported to have been in Urdu, but it is implied that it was delivered in Urdu based on the study's setting and native language spoken. | 10-session group intervention delivered weekly in 60-90 minutes over 12 weeks. | Group intervention | AC (TAU - routine follow-ups by Lady Health Workers (LHW) | Pre<br>Post<br>Follow-up (6-months) | HDRS (Hamilton, 1967) | Urdu version – Gater et al. (2010) | 0.71 | There was a significant reduction in depression among women who received the group parenting program LTP Plus. |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Husain et al. (2021a)** | **Learning Through Play Plus (LTP+)** - combination of two components - LTP & Thinking Healthy Program me(THP).<br>THP is a CBT-based intervention (Rahman, 2008), adapted for group setting (Husain et al., 2017) while LTP is a parent-based intervention for early child development.<br><br>**Components:** The THP component has 5 modules and adopts a "here and now" problem-solving approach. CBT techniques implemented include active listening, changing negative thinking, collaboration with the family, gudied discovery and homework. | LTP+ intervention has been reported to be culturally adapted to the Pakistani context and designed to be delivered in Urdu. | 10-session group intervention delivered weekly in 60-90 minutes over 12 weeks. | Group intervention | AC (TAU - routine follow-ups by Lady Health Workers (LHW) | Pre<br>Post<br>Follow-up (6-months) | PHQ-9 (Kroenke et al., 2001) | PHQ-9 Translated into Urdu | 0.89 (Kroenke et al., 2001) | Mothers in the LTP+ group reported significantly lower depression scores compared to those in the TAU group. |
| **Husain et al. (2021b)** | **Learning Through Play Plus (LTP+)** - combination of two components - LTP & Thinking Healthy Program me(THP).<br>THP is a CBT-based intervention (Rahman, 2008), adapted for group setting (Husain et al., 2017) while LTP is a parent-based intervention for early child development.<br><br>**Components:** The THP component has 5 modules and adopts a "here and now" problem-solving approach. CBT techniques implemented include active listening, changing negative thinking, collaboration with | LTP+ intervention has been reported to be culturally adapted to the Pakistani context and designed to be delivered in Urdu. | 10-session group intervention delivered weekly in 60-90 minutes over 12 weeks. | Group intervention | AC (TAU - not specified) | Pre<br>Post<br>Follow-up (6-months) | HDRS (Hamilton, 1960) | Urdu version – Gater et al. (2010) | 0.71 | Mothers in the LTP Plus group significantly showed improvements in depression. |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | the family, guided discovery and homework. | | | | | | | | | |
| **Husain et al. (2023)** | **Positive Health Programme (PHP)** - based on CBT principles to support British South Asian women experiencing postnatal depression.<br><br>The ABC model was used to demonstrate the relationship between thoughts, feelings and behaviour. Specific interventions included psycho-education, behavioural activation, problem solving, relaxation, and managing negative thoughts. | Cultural adaptations of the PHP manual was made to cater British South Asian women experiencing postnatal depression. Such adaptations include 'Identifying the pressures and expectations of being a British Pakistani woman', exploring culturally sensitive assertiveness and confidence building' and 7 other modules (Khan et al., 2019; Masood et al., 2015).<br><br>A pair of ethnically matched female facilitators delivered the sessions in both English and participants' preferred language (e.g. English, Urdu, Bengali or Gujarati) | 12 session delivered weekly for 60-90 minutes, over 3 months | Group intervention | AC (TAU - routine care by GP including assessments and routine management and monitoring) | Pre<br>Post<br>Follow-up (6-months) | HDRS (Hamilton, 1960) | HDRS was available in Urdu, Hindi, Gujurati and Bengali. | 0.71 | Using an intention to treat analysis, there was no significant results between the PHP intervention and the TAU groups. |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Husain et al. (2024)** | **Positive Health Programme (PHP)** - based on CBT principles to support British South Asian women experiencing postnatal depression.<br><br>**Components:** The ABC model was used to demonstrate the relationship between thoughts, feelings and behaviour. Specific interventions included psycho-education, behavioural activation, problem solving, relaxation, and managing negative thoughts. | A pair of ethnically matched female facilitators delivered the sessions in both English and participants' preferred language (e.g. English, Urdu, Bengali or Gujarati) | 12 session delivered weekly for 60-90 minutes, over 3 months | Group intervention | AC (TAU - routine care by GP including assessments and routine management and monitoring) | Pre<br>Post<br>Follow-up (12-months) | PHQ-9 (Gallis et al., 2018) | PHQ-9 - Urdu version for community-based pregnant women in Pakistan (Gallis et al, 2018). Also made available in other languages (i.e. Hindi, Bengali, Gujarati, and Tamil) – not cited. | 0.84 (Gallis et al., 2018) | Participants in the PHP group recovered more from depression compared to the control group. |
| **Mishra & Singh (2023)** | **Community-based psychosocial** intervention is a 5-session module that aims to address critical vulnerabilities and crucial strengths associated with depression.<br><br>**Components**: cognitive restructuring and goal/problem-focused from CBT, as well as elements such as emotion regulation training and techniques to deal effectively with stress from DBT | Not explicitly specified - including language used by therapist or components of intervention.<br><br>Implied that based on the inclusion criteria of participants ("ability to read Gurmukhi script and write Punjabi language"), that the intervention was delivered in native language. | 5 sessions for 45 minutes, every 2 weeks. | Individual intervention | AC ('General awareness' sessions) | Pre<br>Post | BDI-II (Beck et al., 1996) | Measure was translated into the local language by experts | 0.81 (Beck et al., 1988)<br><br>0.91 for the target population | Participants' scores on depressive symptomatology and associated vulnerabilities and defences improved as compared to the baseline and the control group. |

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| **Naeem et al (2014)** | **Culturally-adapted CBT (CaCBT)** for depression via self-help, supervised by carers.<br><br>**Components:** psychoeducation, symptoms management, changing negative thinking, behavioural activation, problem solving, improving relationships and communication skills. | The CaCBT manual was written in Urdu and used locally accepted idioms and phrase, stories and images.<br><br>The chapters on changing negative thoughts focused on identifying negative thoughts, challenging these thoughts and finding alternative thoughts by being aware of negative thoughts and the use of diaries. It focused on stories of a farmer (called Khushi, a common name in rural Pakistan, but it also means happiness) and a woman (called Khatoon, who is married to a family doctor). The book also uses other examples from local folklores as well as from Islamic religion. | N/A | Self-Guided Therapy | AC (TAU) | Pre<br>Post | HADS-D - (Zigmond & Snaith, 1983) | Translated version in Urdu used widely in Pakistan (Naeem et al., 2011) | 0.64 (Waqas et al., 2019) | CaCBT based self-help was found to be effective against care as usual in reducing the symptoms of depression. |

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| **Naeem et al. (2015)** | **Brief culturally-adapted CBT (CaCBT)** - Naeem and Ayub (2013).<br><br>**Components:** psychoeducation, symptoms management, changing negative thinking, behavioural activation, problem solving, improving relationships and communication skills. | Intervention was culturally adapted in the following ways:<br>– Urdu equivalents of CBT jargons were used in the therapy.<br>– Culturally appropriate homework assignments were selected and participants were encouraged to attend even if they were unable to complete their homework.<br>– Folk stories and examples relevant to the religious beliefs of the local population were used to clarify issues. | 6 sessions from a traditionally 10-16 session manual. | Individual Therapy | AC (TAU - routine care by primary care services) | Pre<br>Post<br>Follow-up (9 months) | HADS-D - (Zigmond & Snaith, 1983) | Validated Urdu version (Mumford et al., 1991) | 0.64 (Waqas et al., 2019) | Participants in treatment group showed statistically significant improvement in depression compared to control. |
| **Rahman et al. (2008)** | **Thinking Healthy Programme** - intervention based on principles of CBT.<br><br>**Components:** The THP component has 5 modules and adopts a "here and now" problem-solving approach. CBT techniques implemented include active listening, changing negative thinking, collaboration with the family, guided discovery and homework. | Not explicitly specified - including language used by therapist or components of intervention.<br><br>Implied - the intervention was delivered in its native language because the study was delivered in rural areas in Pakistan. | 16 sessions - from pregnancy to post-birth | Individual therapy | AC (TAU - LHW visits) | Pre<br>Post<br>Follow-up (12-months) | HDRS | Urdu version used - not cited | 0.71 | Mothers in the intervention group had lower depression scores at both time points than did mothers in the control group. |

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| **Rahman et al. (2016)** | **Problem Management Plus (PM+)** individual version (Dawson et al., 2015) by the World Health Organisation (WHO) is a transdiagnostic approach to the management of common mental disorders (CMDs). Based on principles of problem solving and behavioural techniques**.**<br><br>**Components:**<br>Four modules: 'Stress management strategy' (psychoeducation), 'Managing problems' (problem solving strategy), Get going, keep doing' (behavioural activation strategy), 'Strengthening social support'<br><br>(Study did not specify CBT throughout their study, but based on the components reported, it suggests that this intervention fits the criteria for a CBT intervention). | Not explicitly specified - including language used by therapist or components of intervention.<br><br>Implied - the intervention was delivered in its native language. | 5 weekly sessions<br>90 minutes each | Individual therapy; face-to-face sessions | AC - TAU (routine appointments by primary care physicians) | Pre<br>Post<br>Follow-up (3-months) | HADS-D - (Zigmond & Snaith, 1983) | Validated Urdu version (Mumford et al., 1991) | 0.64 (Waqas et al., 2019) | The intervention group had significantly lower HADS mean scores than the control group for depression. |
| **Rahman et al. (2019)** | **Community group adaptation of the Problem Management Plus (PM+) intervention** by WHO.<br><br>**Components:**<br>Psychoeducation, goal setting, brief motivational interviewing, stress management, problem solving, behavioural activation, and strengthening social support. | Participants were described to be 'non-literate', and so the intervention was adapted to include locally relevant pictorial materials and adopt a narrative format when sharing case examples of women experiencing common practical and emotional problems. | 5 weekly group sessions<br>2 hours each | Group intervention | AC - TAU | Pre<br>Post<br>Follow-up (3-months) | HADS-D - (Zigmond & Snaith, 1983) | Validated Urdu version (Mumford et al., 1991) | 0.64 (Waqas et al., 2019) | Women in the intervention group had significantly lower mean total scores on the HADS than women in the control group. |

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| **Reddy & Omkarappa (2019)** | **Group CBT sessions.**<br><br>**Components:** psycho-education, relaxation exercises, and cognitive and behavioural strategies to overcome depression. | Not explicitly specified - including language used by therapist or components of intervention.<br><br>Implied - the intervention was delivered in its native language because the inclusion criteria states that participants were required to read and write Kannada or English | 6 weekly sessions 50-60 minutes | Individual therapy | Undefined | Pre<br>Post<br>Follow-up (6-months) | CES-D (Radloff, 1977) | Not reported | 0.85 - 0.90 (Radloff, 1977) | Statistically significant reduction in depression scores were seen among experimental group compared to control group. |
| **Zareen & Jahangir (2019)** | **Individual CBT**<br><br>**Components:** stress reduction technique, behaviour modifications, formal lectures on fibromyalgia, and aerobic exercises. | Not explicitly specified - including language used by therapist or components of intervention. | 15-20 sessions 60 minutes | Individual Therapy | AC (TAU - pharmacological treatments) | Pre<br>Post | SSDS (Siddiqui & Shah, 1997) | Population specific measure of depression | Not reported | Fibromyalgia patients in experimental group obtained low scores on SSDS after completion of the CBT sessions compared to control group. |

*Acronym: Active Control (AC), Acquired immunodeficiency syndrome (AIDS); Adapted Bengali CBT (BaCBT); Beck Depression Inventory II (BDI-II); Behavioural Activation for Muslims (BA-M); Brief- Cognitive Behavioural Therapy (B-CBT); Cultural Adapted Cognitive Behaviour Therapy (Ca-CBT); Cognitive Behaviour Therapy (CBT); Common Mental Disorders (CMD); Center for Epidemiologic Studies Depression Scale (CES-D); Depression Scale (DS); General Practice (GP); Hamilton Depression Rating Scale (HDRS); Hospital Anxiety Depression Scale - Depression (HADS-D); Human Immunodeficiency Virus (HIV); Lady Health Workers (LHW); Learning Through Play Plus (LTP+); Patient Health Questionnaire (PHQ-9); Positive Health Programme (PHP); Problem Management Plus (PM+); Siddiqui Shah Depression Scale (SSDS); Thinking Healthy Programme (THP); Treatment-As-Usual (TAU); Waitlist Control (WLC); World Health Organisation (WHO).*

### 1.3.3 Results of the Narrative Synthesis

Nineteen studies (Abbas et al., 2023a, 2023b, Ara et al., 2023; Ghosh et al., 2023; Hamdani et al., 2021; Husain et al., 2014, 2017, 2021a, 2021b, 2023, 2024; Mishra & Singh, 2023; Naeem et al., 2014, 2015; Rahman et al., 2008, 2016, 2019; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019) were included in at least one meta-analysis presented. Dawood et al. (2023) was the only study that was not included in the overall meta-analysis due to methodological difference in its intervention compared to the rest of the studies included. Details are presented below.

#### 1.3.3.1 Culturally Specific Outcome Measures

Two studies (Ara et al., 2023; Zareen & Jahangir, 2019) included outcome measures that were culturally specific to their designated population groups. Ara et al. (2023) administered the DS (Uddin & Rahman, 2005) which is a specific measure for Bangladeshi populations and reported a significant reduction in depression severity in the CBT intervention group. Zareen and Jahangir (2019) administered the SSDS (Siddiqui & Shah, 1997) that is a specific measure for the Pakistani populations and identified a reduction in scores for patients with fibromyalgia in the CBT intervention group. As the DS and SSDS outcome measures vary considerably in their scale administration, structure and scoring, they were excluded from subsequent meta-analyses as it would have introduced substantial heterogeneity (Ajele & Idemudia, 2025).

#### 1.3.3.2 Multiple Treatment Groups

Dawood et al. (2023) explored the effectiveness of Behavioural Activation for Muslims (BA-M) against CBT, for Muslim patients with depression in Pakistan. BA-M is a defined by the authors as a culturally adapted version of traditional Behavioural Activation, that comprises 6-12 sessions. They highlighted that the treatment involves a values-based assessment, in which if participants selected Religion as a value, then they had the option to receive a self-help booklet that drew on Islamic teachings in line with therapeutic goals. The control group in this study was defined as an Active Control group in the form of ‘treatment as usual’ and this was 8

sessions of non-adapted CBT. The study reported a reduction in PHQ-9 scores for those in the intervention group compared to CBT. However, due to the methodological difference of this study compared to all other studies included in this review, as CBT is an intervention itself within this study, and no other control group types (e.g. WLC) was involved, Dawood et al., (2023) was excluded from meta-analyses to reduce the risk of heterogeneity.

#### 1.3.3.3 Undefined Control Groups

Reddy and Omkarappa (2019) examined the efficacy of a group CBT intervention for menopausal women in India. The results showed a significant reduction in CES-D measure within the intervention group. The study, however, was not included in the meta-analyses because the control group in the study was not properly defined (i.e., WLC or AC). Authors were contacted to clarify this, however there was no response.

### 1.3.4 Quality Appraisal of Studies

The risk of bias for all the studies included is presented in Table 1.4 and summarised in Figure 1.3. The majority of studies indicated low risk of bias overall (Ara et al., 2023; Husain et al., 2014, 2017, 2021a, 2023, 2024; Naeem et al., 2014, 2015; Rahman et al., 2016, 2019). However, risk of bias was present in the following studies: method of randomization (Zareen & Jahangir, 2019), performance bias (Abbas 2023a, 2023b; Dawood et al., 2023; Ghosh, 2023; Mishra & Singh, 2023; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019), detection bias (Dawood et al., 2023; Husain, 2021b; Mishra & Singh, 2023; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019), attrition bias (Ghosh et al., 2023; Hamdani et al., 2021; Husain 2021b; Mishra & Singh, 2023; Rahman et al., 2008), and reporting bias (Ghosh et al., 2023; Hamdani et al., 2021; Zareen & Jahangir, 2019). See Appendix B for a summary of the quality assessments using RoB 2 tool (Higgins et al., 2019).

### 1.3.5 Overall Meta-analysis findings

A total of 20 samples from 19 papers, which involved 4655 participants, compared a CBT-based intervention to a control condition. Based on a random-effects model, the meta-analysis indicated a mean weighted effect size of Cohen's $d$ = -1.19, 95% CI [-1.19, -0.89], $p < 0.001$. Figure 1.2 presents the Forest plot. The overall meta-analysis indicates a high effect size and suggests that the participants in CBT-based interventions experienced a greater reduction in depressive symptoms than those allocated in the control conditions.

**Figure 1.2**

*Forest Plot: overall meta-analysis*

| | CBT | | | Control | | | | Std. Mean Difference | Std. Mean Difference |
|---|---|---|---|---|---|---|---|---|---|
| Study or Subgroup | Mean | SD | Total | Mean | SD | Total | Weight | IV, Random, 95% CI | IV, Random, 95% CI |
| Abbas 2023a | 8.81 | 2.59 | 45 | 16.54 | 3.97 | 45 | 4.8% | -2.29 [-2.82, -1.75] | |
| Abbas 2023b | 3.1 | 2.79 | 40 | 9.62 | 3.2 | 40 | 4.7% | -2.15 [-2.71, -1.60] | |
| Ara 2023 | 62.63 | 11.77 | 54 | 115.62 | 9.71 | 52 | 4.1% | -4.87 [-5.64, -4.10] | |
| Ghosh 2023a | 7.41 | 5.52 | 11 | 6.71 | 4.39 | 7 | 3.6% | 0.13 [-0.82, 1.08] | |
| Ghosh 2023b | 7.41 | 5.52 | 11 | 9.32 | 4.47 | 139 | 4.5% | -0.42 [-1.03, 0.20] | |
| Hamdani 2021 | 8.16 | 4.17 | 73 | 9.92 | 4.37 | 73 | 5.3% | -0.41 [-0.74, -0.08] | |
| Husain 2014 | 10 | 6 | 32 | 10 | 6.2 | 32 | 4.9% | 0.00 [-0.49, 0.49] | |
| Husain 2017 | 9.6 | 6.05 | 112 | 15.95 | 5.87 | 110 | 5.4% | -1.06 [-1.34, -0.78] | |
| Husain 2021a | 6.6 | 4.5 | 399 | 13.8 | 5.3 | 370 | 5.6% | -1.47 [-1.63, -1.31] | |
| Husain 2021b | 5.1 | 3.9 | 48 | 16.9 | 3 | 49 | 4.5% | -3.37 [-4.00, -2.74] | |
| Husain 2023 | 5.9 | 5.6 | 32 | 6 | 5.7 | 32 | 4.9% | -0.02 [-0.51, 0.47] | |
| Husain 2024 | 7.22 | 5.8 | 282 | 9.09 | 3.64 | 280 | 5.5% | -0.39 [-0.55, -0.22] | |
| Mishra 2023 | 10.22 | 7.92 | 114 | 23.49 | 7.09 | 37 | 5.1% | -1.71 [-2.13, -1.29] | |
| Naeem 2014 | 6.2 | 3.6 | 94 | 10.4 | 3.9 | 89 | 5.3% | -1.12 [-1.43, -0.80] | |
| Naeem 2015 | 4.4 | 3.8 | 66 | 7.6 | 3.6 | 63 | 5.2% | -0.86 [-1.22, -0.50] | |
| Rahman 2008 | 4.5 | 6 | 418 | 8.7 | 7.4 | 400 | 5.6% | -0.62 [-0.76, -0.48] | |
| Rahman 2016 | 6.49 | 3.25 | 111 | 9.45 | 3.38 | 97 | 5.4% | -0.89 [-1.18, -0.60] | |
| Rahman 2019 | 4.74 | 3.95 | 300 | 8.01 | 4.21 | 298 | 5.5% | -0.80 [-0.97, -0.63] | |
| Reddy 2019 | 16.4 | 4.33 | 40 | 19.86 | 5.03 | 40 | 5.0% | -0.73 [-1.18, -0.28] | |
| Zareen 2019 | 61.9 | 16.16 | 60 | 81.6 | 10.6 | 60 | 5.1% | -1.43 [-1.83, -1.03] | |
| **Total (95% CI)** | | | **2342** | | | **2313** | **100.0%** | **-1.19 [-1.49, -0.89]** | |

Heterogeneity: Tau² = 0.41; Chi² = 373.79, df = 19 (P < 0.00001); I² = 95%
Test for overall effect: Z = 7.79 (P < 0.00001)

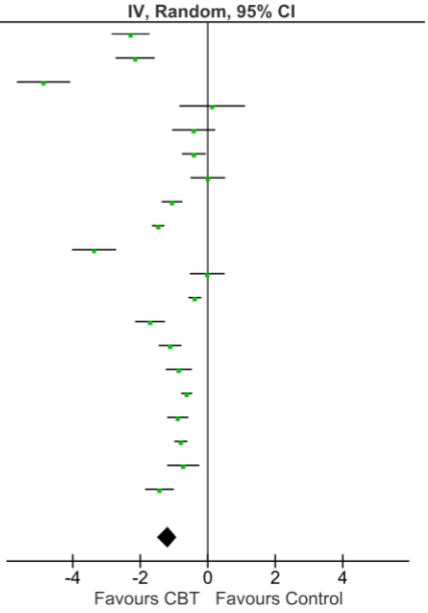

**Table 1.4**

*Risk of bias assessment*

| Author and Year | Selection Bias | Selection Bias | Performance Bias | Detection Bias | Attrition Bias | Reporting Bias |
|---|---|---|---|---|---|---|
| | Random sequence generation | Allocation concealment | Blinding of participants and personnel | Blinding of outcome assessment | Incomplete outcome data | Selective reporting |
| **Abbas et al., 2023a** | Low | Low | Unclear | Low | Low | Low |
| **Abbas et al., 2023b** | Low | Low | Unclear | Low | Low | Low |
| **Ara et al., 2023** | Low | Low | Low | Low | Low | Low |
| **Dawood et al., 2023** | Low | Low | Unclear | High | Low | Low |
| **Ghosh et al., 2023** | Low | Low | High | Low | High | Unclear |
| **Hamdani et al., 2021** | Low | Low | Low | Low | High | High |
| **Husain et al., 2014** | Low | Low | Low | Low | Low | Low |
| **Husain et al., 2017** | Low | Low | Low | Low | Low | Low |
| **Husain et al., 2021a** | Low | Low | Low | Low | Low | Low |
| **Husain et al., 2021b** | Low | Low | Low | High | High | Low |
| **Husain et al., 2023** | Low | Low | Low | Low | Low | Low |
| **Husain et al., 2024** | Low | Low | Low | Low | Low | Low |
| **Mishra & Singh 2023** | Low | Low | Unclear | High | High | Low |
| **Naeem et al., 2014** | Low | Low | Low | Low | Low | Low |
| **Naeem et al., 2015** | Low | Low | Low | Low | Low | Low |
| **Rahman et al., 2008** | Low | Low | Low | Low | Low | Low |
| **Rahman et al., 2016** | Low | Low | Low | Low | Low | Low |
| **Rahman et al., 2019** | Low | Low | Low | Low | Low | Low |
| **Reddy & Omkarappa, 2019** | Low | Low | Unclear | High | Low | Low |

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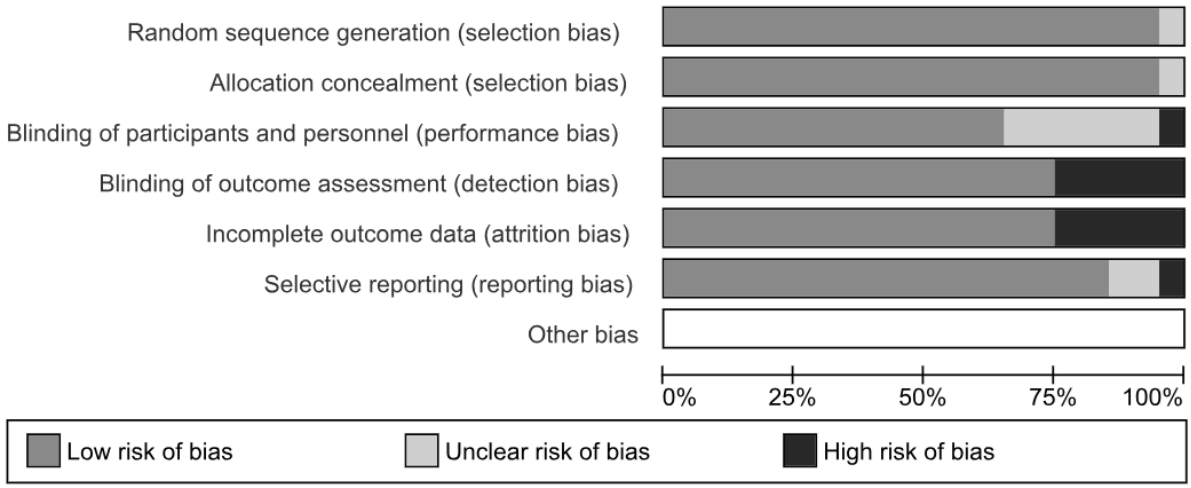
|---|---|---|---|---|---|---|
| **Zareen & Jahangir, 2019** | Unclear | Unclear | Unclear | High | Low | Unclear |

**Figure 1.3**

*Risk of bias graph summary*

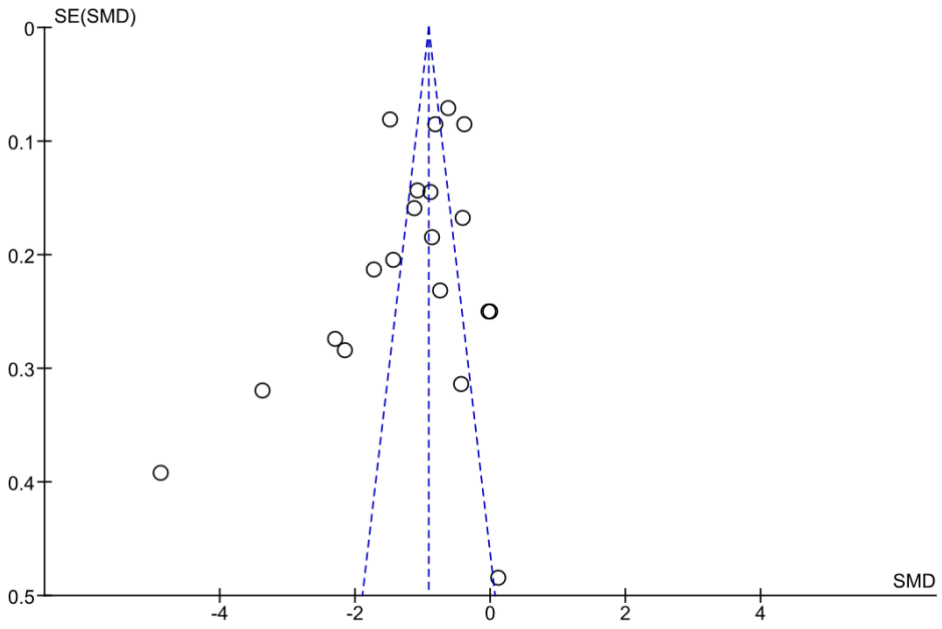



### 1.3.6 Publication Bias

Publication bias was assessed for the meta-analysis of the 19 studies that compared CBT interventions to control groups using a funnel plot of standard error (SE) by standardized mean difference (SMD; Sterne et al., 2011). The plot (see Figure 1.4) showed some asymmetry, with a greater concentration of studies on the left-hand side of the mean effect and a few studies falling outside the expected funnel boundaries. An Egger's regression test was conducted to test for funnel plot asymmetry and showed that it was not significant (intercept = 9.71, $p$ = 0.193), suggesting limited evidence of publication bias (Sterne et al., 2011).

**Figure 1.4**

*Funnel plot of overall meta-analysis*




### 1.3.7 Moderator analysis

Homogeneity analysis of the overall sample indicated that the effect sizes for CBT-based interventions were highly heterogenous, $Q(19) = 373.79$, $p < 0.001$, $I^2 = 95\%$. This suggests that the variability in effect sizes was greater than would be expected by chance alone, warranting further investigation of potential moderating variables (Rosenthal, 1991). As a result, a series of moderator analyses were conducted. Given the small number of studies included in the meta-analysis ($k = 20$), it was not feasible to run a meta-regression model including multiple covariates, as meta-analytic conventions recommend at least 10 studies per moderator variable (Borenstein et al., 2011). Therefore, each moderator was examined independently using subgroup analyses. Six moderators were tested: gender (female only vs. mixed), control type (waitlist vs. active control), intervention type (individual vs. group vs. self-guided), if the CBT intervention was culturally adapted (yes vs. no), the culturally adapted intervention type (Group vs. individual ), and risk of bias (low vs. high/unclear), and all moderators were

categorical in nature. Table 1.5 presents how the studies were coded for moderator analysis.

None of the moderator analyses were significant (see Table 1.6. for results).

**Table 1.5**

*Moderator coding for meta-analysis*

| Study | Gender | Control Type | Intervention Type | Culturally adapted (C/A) | C/A Intervention Type | Risk of Bias |
|---|---|---|---|---|---|---|
| **Abbas et al., 2023a** | Mixed | WLC | Individual | Yes | Individual | High/Unclear |
| **Abbas et al., 2023b** | Mixed | WLC | Individual | Yes | Individual | High/Unclear |
| **Ara et al., 2023** | Mixed | WLC | Individual | Yes | Individual | Low |
| **Ghosh et al., 2023a** | Mixed | AC | Self-guided | No | Not Included[1] | High/Unclear |
| **Ghosh et al., 2023b** | Mixed | WLC | Self-guided | No | Not Included[1] | High/Unclear |
| **Hamdani et al., 2021** | Mixed | AC | Individual | Yes | Individual | High/Unclear |
| **Husain et al., 2014** | Female | AC | Group | Yes | Group | Low |
| **Husain et al., 2017** | Female | AC | Group | Yes | Group | Low |
| **Husain et al., 2021a** | Female | AC | Group | Yes | Group | Low |
| **Husain et al., 2021b** | Female | AC | Group | Yes | Group | High/Unclear |
| **Husain et al., 2023** | Female | AC | Group | Yes | Group | Low |
| **Husain et al., 2024** | Female | AC | Group | Yes | Group | Low |
| **Mishra & Singh 2023** | Female | AC | Individual | Yes | Individual | High/Unclear |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Naeem et al., 2014** | Mixed | AC | Self-guided | Yes | Not Included[1] | Low |
| **Naeem et al., 2015** | Mixed | AC | Individual | Yes | Individual | Low |
| **Rahman et al., 2008** | Female | AC | Individual | Yes | Individual | High/Unclear |
| **Rahman et al., 2016** | Mixed | AC | Individual | Yes | Individual | Low |
| **Rahman et al., 2019** | Female | AC | Group | Yes | Group | Low |
| **Reddy & Omkarappa, 2019** | Female | AC | Individual | Yes | Individual | High/Unclear |
| **Zareen & Jahangir, 2019** | Female | AC | Individual | No | Not Included[2] | High/Unclear |

[1] Studies could not be coded as they were self-guided interventions.
[2] Study did not culturally adapt their individual F2F intervention.

**Table 1.6**

*Moderator effects*

| Moderator | *k* | Cohen's *d* [95% CI] | *Z* | Heterogeneity |
|---|---|---|---|---|
| Gender of the Sample | - | | | Between groups: $Q(1) = 1.08$, $p = 0.30$ |
| Female sample | 11 | -1.03 [-1.37,-0.68] | 5.80*** | $Q(10) = 208.66$, $p < 0.000$***, $I^2 = 95\%$ |
| Mixed Sample | 9 | -1.41 [-2.06,-0.77] | 4.29*** | $Q(8) = 156.78$, $p < 0.000$***, $I^2 = 95\%$ |
| Control Type | | | | Between groups: $Q(1) = 3.36$, $p = 0.07$ |
| Active Control | 15 | -0.94 [-1.22, -0.66] | 6.61*** | $Q(14) = 222.48$, $p < 0.000$***, $I^2 = 94\%$ |
| Waitlist Control | 4 | -2.42 [-3.97, -0.86] | 3.04** | $Q(3) = 78.56$, $p < 0.000$***, $I^2 = 96\%$ |
| Intervention type | - | | | Between groups: $Q(2) = 5.08$, $p$ =0.08 |
| Individual | 10 | -1.53 [ -2.04, -1.02] | 5.90*** | $Q(9) = 191.98$, $p < 0.000$***, $I^2 = 95\%$ |
| Group | 7 | -0.98 [ -1.49, -0.48] | 3.84*** | $Q(6) = 172.88$, $p < 0.000$***, $I^2 = 97\%$ |
| Culturally adaptation | - | | | Between groups: $Q(1) = 1.55$, $p = 0.21$ |
| Culturally-adapted | 17 | -1.27 [-1.59, -0.95] | 7.69*** | $Q(16) = 360.29$, $p < 0.000$***, $I^2 = 96\%$ |
| Not culturally-adapted | 3[1] | -0.64 [-1.57, -0.29] | 1.35 | $Q(2) = 10.56$, $p = 0.001$***, $I^2 = 85\%$ |
| Culturally-adapted intervention type | | | | Between groups: $Q(1) = 2.17$, $p = 0.14$ |
| C/A Individual | 9 | -1.55 [-2.10, -0.99] | 5.46*** | $Q(8) = 185.75$, $p < 0.000$***, $I^2 = 96\%$ |
| C/A Group | 7 | -0.98 [-1.49, -0.48] | 3.84*** | $Q(6) = 172.88$, $p < 0.000$***, $I^2 = 97\%$ |
| Risk of bias | - | | | Between groups: $Q(1) = 0.47$, $p = 0.49$ |
| High/Unclear | 10 | -1.31 [-1.84, -0.78] | 4.85*** | $Q(9) = 156.56$, $p < 0.000$***, $I^2 = 94\%$ |
| Low | 10 | -1.19 [-1.49, -0.89] | 5.14*** | $Q(9) = 217.23$, $p < 0.000$***, $I^2 = 96\%$ |

[1]Considers Ghosh et al. (2023a, and 2023b) with Zareen and Jahangir (2019).
Note: *k* = number of studies, *Z* = Z score, *Q* = test statistic for heterogeneity, $I^2$= measure of degree of heterogeneity. *d* = 0.2–0.5 = small effect, *d* = 0.5–0.8 = medium effect, *d* > 0.8 = large effect (Cohen, 1988).
*p < 0.05.
**p < 0.01.
***p < 0.001.

## 1.4 Discussion

### 1.4.1 Summary of findings

To our knowledge, this is the first systematic review to examine the effectiveness of CBT-based interventions for depression in South Asian populations. The review incorporated 20 RCTs conducted over a 16-year period, involving 4758 participants from Bangladesh, India, Pakistan and the UK (Abbas et al., 2023a, 2023b; Ara et al., 2023; Dawood et al., 2023; Ghosh et al., 2023; Hamdani et al., 2021; Husain et al, 2014, 2017, 2021a, 2021b, 2023, 2024; Mishra &

Singh, 2023; Naeem et al., 2014, 2015; Rahman et al., 2008, 2016, 2019; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019). Nineteen of those studies (Abbas et al., 2023a, 2023b; Ara et al., 2023; Ghosh et al., 2023; Hamdani et al., 2021; Husain et al, 2014, 2017, 2021a, 2021b, 2023, 2024; Mishra & Singh, 2023; Naeem et al., 2014, 2015; Rahman et al., 2008, 2016, 2019; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019) comprising of 4655 participants were included in a meta-analysis and a series of moderator analyses. While subgroup analyses revealed that control type, intervention format, and cultural adaptation each yielded large effect sizes, none of the moderator effects reached statistical significance. Additional analyses on culturally adapted intervention types and risk of bias also showed no significant moderation. Overall, the findings suggest that CBT-based interventions are effective in reducing depressive symptoms among South Asian populations, though this conclusion should be interpreted with caution given the moderate quality of studies and substantial heterogeneity observed across trials.

#### 1.4.1.1 Gender composition

The gender composition was explored as a potential moderator of treatment outcomes, given the overrepresentation of female participants. However this was not statistically significant. This is in alignment with previous meta-analytic evidence that reported that gender rarely moderates psychological outcomes in a meaningful way, and when this occurs, it may be due to sample characteristics or methodological limitations rather than gender itself (Aulisi et al., 2025). Detecting gender moderation in meta-analyses is challenging due to restricted between-study variance, whereby most studies include primary female participants or mixed samples, leaving little room for meaningful comparisons, e.g. male-only vs. female-only samples (Aulisi et al., 2025).

Additionally, the lack of involvement of men in this review is consistent with broader findings that men are less likely to engage in mental health studies and services (Seidler et al., 2018). Social norms and cultural beliefs about masculinity may deter men, particularly from South

Asian communities, from engaging in therapy (Bhugra et al., 2011). As a result, researchers often design studies specifically for women, as South Asian women conceptualise depression symptoms as a relatively normal response to social problems (Karacz et al. (1997; Lawrence et al., 2006) and are more accessible within healthcare and community settings (Chew-Graham et al., 2002). Some studies focused on perinatal or postnatal depression, which naturally limited participants to women (Husain et al., 2017, 2021a, 2021b, 2023, 2024; Rahman et al., 2008). While the studies offer valuable insights, the lack of evidence on how South Asian men and of other genders experience and respond to CBT means that present findings cannot be generalised confidently to them. Future studies should aim to address this gender disparity to ensure findings are representative of men, women, transgender and other gender identities from diverse cultural backgrounds.

#### 1.4.1.2 Control type

The control type, whether they were a waitlist control (WLC) or an active control (AC), was also explored as moderator but was not significant.. This is not consistent with previous meta-analytic research by Cuijpers et al. (2016) who evaluated CBT for major depressive disorder and anxiety disorders and found that when CBT produced a larger effect size when it was compared to a WLC group than two AC group groups (Treatment-as-usual and Placebo). AC groups often involve minimal intervention, psychoeducation, or treatment-as-usual providing a more conservative and realistic benchmark of efficacy compared to WLC groups. Whereas, in WLC groups where participants receive no therapeutic input, they can overestimate the effect sizes of psychological interventions compared to AC groups (Cuijpers et al., 2024). However this was not found to be the case in our moderator analyses. Therefore, recommendations for future research should employ well-defined active control conditions to further explore the effectiveness of CBT-based interventions in South Asian adults beyond general support and expectancy effects (Cuijpers et al., 2024).

#### 1.4.1.3 Intervention type

Regarding intervention type, individual CBT-based interventions and group formats were not statistically different from one another. Prior meta-analytic research found different results which report that while both formats are effective, individual CBT often demonstrates stronger outcomes (Craigie & Nathan, 2009). This is based on the assumption that individual CBT offers a more tailored and flexible approach, potentially fostering a stronger therapeutic alliance between the clinician and the client (Beck, 2011; Kazantzis & Dobson, 2024). Our non-significant findings indicate that group CBT remains a valuable modality, especially given its accessibility and cost-effectiveness in reaching a broader number of participants (Hall et al., 2022).

Notably, all group-based interventions in this review were conducted with female-only samples and were effective in reducing depressive symptoms (e.g. Husain et al., 2017, 2021a, 2021b, 2023, 2024; Rahman et al., 2019). The effectiveness of these groups may be linked to the therapeutic value of women-only spaces, which provide psychological safety, foster openness, and promote mutual support (Greenfield et al., 2013; Philips et al., 2022). This may be particularly relevant within collectivistic cultures, such as South Asian contexts, where community and relational connectedness are central (Agha & Rai, 2020). Future research should further investigate whether intervention format interacts with gender or cultural norms to shape treatment outcomes and preferences.

#### 1.4.1.4 Culturally adapted interventions

Despite the cultural and linguistic diversity among South Asian populations (Faroqi-Shah, 2012), the studies in this review reported no statistically significance between studies that culturally-adapted CBT (n = 18) and studies that did not culturally adapt CBT (n = 2).
Type of cultural adaptations that were considered in these studies ranged from selecting preferred language of the intervention being delivered, to the intervention being delivered in the

native language spoken, to simplified psychoeducation, the use of culturally relevant metaphors and imagery, and examples, the involvement of family members, and delivery through trusted community figures such as Lady Health Workers (LHW).

Language congruence emerged as a key feature of cultural adaptation in this review. Most studies conducted within South Asian countries were delivered in participants' native languages by facilitators from the same region, and intervention materials were developed or translated into the native languages (Abbas et al., 2023a, 2023b; Ara et al., 2023; Dawood et al, 2023; Hamdani et al., 2021; Husain et al, 2017, 2021a, 2021b; Mishra & Singh, 2023; Naeem et al., 2014, 2015; Rahman et al., 2008, 2016, 2019; Reddy & Omkarappa, 2019). Nonetheless, the present findings of the overall meta-analysis are not consistent with existing literature that suggests culturally adapted CBT such as clients choosing their preferred language enhances understanding, rapport, and therapeutic alliance (Sentell et al., 2007; Rathod et al., 2019).

### 1.4.2 Risk of bias

Publication bias is commonly reported as a limitation in meta-analysis (Wakelin et al., 2021). In this review, a visual inspection of the funnel plot indicated some asymmetry that prompted for an Egger's regression test. The outcome of the test showed that it was not statistically significant and therefore reported limited evidence of publication bias (Sterne et al., 2011). However, the mismatch between the visual and statistical indicators highlights that caution is warranted when interpreting the pooled effect size. As with many reviews, the absence of unpublished trials may limit the comprehensiveness of the evidence base. To strengthen the validity of future meta-analyses, researchers should consider including grey literature to minimise the risk of publication bias.

Consistent with previous literature assessing CBT-based trials (e.g. Mazo, et al., 2023; O'Toole et al., 2025), the most frequently observed risks in this review were performance bias and attrition rates. Performance bias was particularly high across studies (Abbas et al., 2023a,

2023b; Dawood et al., 2023; Ghosh et al., 2023; Mishra & Singh, 2023; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019), indicating the challenges of blinding participants completely from RCT psychological interventions. Attrition bias arose in studies (Ghosh et al., 2023; Hamdani et al., 2021; Husain et al., 2021b; Mishra & Singh, 2023) with incomplete outcome data or high dropout rates that were note adequately addressed. Rahman et al. (2016) reported high attrition rate at the 1-week post-intervention point (only 60.4% follow-up), due to a local security threat which disrupted fieldwork. Although the authors prioritised the 3-month follow-up in their conclusions, the short-term data used in this meta-analysis may still be influenced by attrition bias. These risks may introduce systematic differences in how participants experienced the interventions and potentially affect treatment outcomes. Contributing factors may include lengthy intervention durations or reduced facilitator contact during delivery (O'Toole, 2025). To improve methodological quality, future studies should adopt robust retention strategies and clearly report how missing data are handled, including the use of intention-to-treat analyse where appropriate (Higgins et al., 2024).

All studies apart from Zareen & Jahangir (2019) demonstrated low risk of bias in selection, and all studies apart from 3 studies (Ghosh et al., 2023; Hamdani et al., 2021; Zareen & Jahangir, 2019) reported low risk of reporting bias, indicating adequate randomisation methods and alignment between stated objectives and reported outcomes. However, some studies (Dawood et al., 2023; Husain et al., 2021b; Mishra & Singh, 2023; Reddy & Omkarappa, 2019; Zareen & Jahangir, 2019) received "high" ratings for detection bias, largely due to limited reported of blinding procedures for outcome assessment. Therefore, it is recommended that future RCTs follow robust reporting frameworks, specifying procedures used to minimise detection and measurement bias.

### 1.4.3 Limitations

While this review offers a novel contribution to understanding the effectiveness of CBT-based interventions for depression in South Asian populations, several limitations must be acknowledged.

Firstly, although 20 RCTs were identified, the overall number of included studies remains modest, limiting the statistical power to explore moderators more comprehensively. The studies were also highly heterogeneous based on design, sample characteristics, outcome measures, delivery formats and cultural adaptations. This heterogeneity, alongside the varying diagnostic thresholds for depression, reduces the generalisability of the pooled effect sizes to wider South Asian populations, particularly those underrepresented in this review, such as Sri Lankan, Bhutanese or Nepalese communities.

Secondly, grey literature and non-English research in this field was not included in this review. The absence of these papers, particularly of grey literature may have inflated the effect sizes (Hopewell et la., 2007). Future reviews should consider including unpublished/grey literature sources and trial registries to address this limitation.

The risk of bias assessment was conducted using the RoB-2 tool, with the first reviewer appraising all studies and a second reviewer independently assessing a random 10% subset. This approach, while commonly used in the literature reviews (Phulkerd et al., 2016), may still be limited in its robustness as using a 10% (or any %) does not take into account the appropriateness of the overall number that are checked. Inter-rater reliability was not formally calculated due to the small number ($n$ = 2) of dual-coded studies; however, 100% consensus was achieved in all reviewed cases. Nonetheless, future reviews would benefit from a higher proportion of dual-coding and the subsequent use of inter-rater agreement statistics to enhance transparency and rigour.

Finally, while the review explored cultural adaptations both narratively and through subgroup analysis, no formal statistical comparison was conducted between culturally adapted and non-adapted CBT-based interventions. Therefore, although trends suggest that culturally tailored CBT may be more effective, conclusions regarding their superiority should be interpreted with caution. Future research should aim to explicitly test the differential effectiveness of culturally adapted versus standard CBT in South Asian populations.

### 1.4.4 Clinical implications

Based on the findings, CBT-based interventions are effective in improving depression in South Asian populations. However, whilst the following recommendations are made for good practice of delivering CBT-based interventions to South Asian populations, our results suggest that even when these are not in place, CBT-based interventions are still effective for the outcome of depression focused on in this meta-analysis. However there may be other outcomes, not measured in this meta-analysis, that cultural adaptions are beneficial for. Future research is needed to explore this further.

Cultural adaptations made to CBT-based interventions such as therapy delivered by practitioners who are fluent in the client's preferred language and / or share a similar cultural background may be welcomed by them. Similarly, incorporating culturally relevant metaphors, acknowledging somatic or spiritual expressions of distress, involving family where appropriate, and considering group formats that are gender-specific but also reflect collectivist values (Jain et al., 2025) may be benefit South Asian clients. This helps to tailor therapeutic models that fits the linguistic and cultural realities of South Asian populations (Rathod & Kingdon, 2009). Given the collectivistic norms prevalent in many South Asian communities, a structured or directive approach may also be preferred in therapy (Jin et al., 2022), as therapists are often viewed as authoritative, charismatic figures who guide the process (Prabhu, 2004). These adaptations can

support therapeutic engagement and trust, particularly when therapy may be unfamiliar or carries stigma (Prajapati & Liebling, 2022).

Moreover, services could ensure that clinicians are equipped with cultural humility – an approach that promotes self-awareness, openness, and a willingness to learn from clients' cultural identities and lived experiences. This mindset can help dismantle "us vs. them" dynamics, fostering more collaborative and equitable therapeutic relationships (Leka, 2020). Finally, to enhance accessibility and relevance of services, the recruitment of more culturally and linguistically diverse mental health workforce could be vital. This could help ensure that individuals from South Asian and other ethnically minoritised backgrounds feel represented and supported when accessing mental health care (Ononaiye, 2024).

### 1.4.5 Conclusions

This review and meta-analysis found that CBT-based interventions are overall effective in reducing depression among South Asian populations. Moderator analyses exploring gender, control type, intervention type, and cultural adaptations were not statistically significant, indicating that whilst adapting and tailoring CBT-based interventions are welcomed for good practice, these interventions are still effective in improving depression without adaptations. Overall, the findings reinforce the effectiveness of CBT-based interventions for depression in South Asian populations.

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# Chapter 2 Conducting Research on an Under-Represented Population: Reflexivity of a Male Sri Lankan Trainee on the Doctorate of Clinical Psychology – Bridging Chapter

**Word Count:** 2493 words (Excluding title and references)

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## 2.1 Prelude

The Sri Lankan diaspora in the UK has been neglected in demographic and health research (Aspinal, 2019). For example, being 'Sri Lankan' is not a pre-existing ethnic group category in the 10-year UK Census governmental survey (Office for National Statistics, 2021). Most Asian individuals providing a written entry being 'Sri Lankan' in the 'Any Other Asian Backgrounds' category outside of the pre-existing categories of 'Indian', 'Pakistani', and 'Bangladeshi'. This highlights that Sri Lankans see themselves as a discrete and separate ethnic group to others presented in the survey (Aspinal, 2019).

Similarly, the 'NHS digital' database that documents health and care data for England, reports a marginalised capture of 'Sri Lankan' as a search term with 0 results, compared to other South Asian ethnic groups such as 'Indian' retrieving 26 results, 'Pakistani' retrieving 22 results, or 'Bangladeshi' retrieving 20 results as of this year (NHS Digital, 2025). Approximately 700,000 people from the Sri Lankan diaspora live in the UK (Sri Lankan High Commission in the UK, 2024), and this is not reflected in governmental reports and health research (NHS Digital, 2025; Office for National Statistics, 2021). The understanding of the prevalence of mental health problems in the Sri Lankan diaspora is, therefore, limited due to the way data is collected and reported, and their ethnic group not explicitly identified (Singh, 2019).

## 2.2 Introduction

Starting clinical training in 2022 was, without a doubt, a significant period in my career. I went through six applications to have a chance of getting a place to do the doctorate. I once thought this would not be possible and believed that the cards were stacked against me because of my cultural identity. I did not represent the right "face" of a psychologist in the UK. Seeing a *brown* face on training was not a common sight over the years I had attended psychology-based training workshops or indeed in my jobs. I grew frustrated over time with the application process and questioned whether this was really for me. This slowly changed post-lockdown when I noticed a cultural shift from clinical training programmes all over the UK. There were efforts to increase the number of spaces made available for trainees and calls for applicants from minoritised groups to apply for training. I was starting to feel heard somehow. I began getting interviews although I was still not getting on, but I knew I was good enough for training. When I reached my 6th year I was frustrated again and applied with a different mindset of – "*clinical psychology needs me*". There are real-world clinical challenges out there within mental health services struggling to engage South Asians in communities, from accessibility to initial assessments, and therapeutic engagement. The psychology workforce is not representative of the communities they represent (Ononaiye, 2024). There is a need for cultural humility training (Vekaria et al., 2023). There is still an ongoing stigma relating to talking about mental health and prioritizing wellbeing, in South Asians (Vaishnav et al., 2023). Cultural factors influenced by their upbringing, their relationships with their community, their positioning in society, their approach to day-to-day life, culminated by potential acculturation and intergenerational trauma endured, exacerbate stress on these individuals (Karasz et al., 2019; Kodippili et al., 2024). "*They need me. They need me, so I can help them."* On June 13th, 2022, I finally did it. I was offered a place to train at Southampton.

Below, I share how my empirical research came to fruition in focusing the study on second-generation Sri Lankan (SGSL) men, including: influences from my cultural upbringing,

my motivations for the research, the experience of conducting the research, what I have learned, and what my hopes for the research.

## 2.3 Context & Identity

My parents are originally from Sri Lanka and like many, moving abroad for them was a dream. Living in a new culture, finding a well-paid job, establishing financial stability, supporting their family back home, building a family of their own, and living a comfortable life, that was the dream. In the late 80s, my parents migrated over to France independently before they knew each other. They both eventually integrated into the host culture. They integrated by engaging in paid work, paying their taxes, and obtaining citizenship. They attended French classes together where they eventually met for the first time. They formed a relationship and eventually got married. After living and settling down together in France, I later came along as their first child, and not long after, my sister was born. When I was 9 years old, my family and I moved to the UK in the hope of extending my mum's hopes for me and my sister to learn English.

I was brought up as a Buddhist as this was the religion my parents practiced in Sri Lanka. My experience of Buddhism was relatively pleasant and peaceful but never consistent. We attended Buddhist temples for certain occasions in the year, often when it was new year or when a family member or friend passed away. For a short period in my early teenage years, I also attended Sunday school as a way of learning more about Buddhism. I enjoyed it initially because I made new friends in the community and embraced my religion more independently. However, this changed after a year, when I felt that the community who attended the temple were often there to gather and gossip. This felt strange to me, how a place of worship where community engagement is valued, becomes a place of speaking negatively about people. I soon informed my parents that I didn't want to continue attending Sunday school and instead would prefer going to the temple with them when we did. To my luck, they agreed.

Growing up, I remember being "coached" by my father that whenever someone asked me where I was from, that I would have to say "*I am French, but I am originally from Sri Lanka*". This

was deeply ingrained for me from a young age about my cultural identity of being positioned as French first and Sri Lankan second, despite being visibly looking more Sri Lankan than French. I also remember speaking more French at home, especially through my father, whilst my mother tongue, Sinhala was learnt indirectly through my parents' own conversations or through commands. In a later conversation I had as an adult with my mother, I questioned why I never learnt to speak Sinhala properly, and she informed me that a French hospital nurse once said that speaking Sinhala would stunt my cognitive development and that I would learn French much later compared to other children of my age. On reflection, this answer was internalized by my mother deeply because despite understanding Sinhala well, and speaking it to a certain level, I never learned to speak my mother tongue fluently.

I felt resentment as an adult because my interaction with my extended family, or the community, although we often spoke in English, felt restrictive in embedding myself *properly* into the culture because of my insufficient fluency. It was a difficult experience to go through, where I carried a lot of shame for most of my life. I compensated this feeling by engaging with my heritage culture in different ways. For example, eating Sri Lankan food being accustomed to spice from a young age, learning to cook Sri Lankan food, doing charity work for the Sri Lankan community, and learning to do *Kandyan* - a traditional style of dancing originating from Kandy in Sri Lanka. Despite all these engagements, not being fluent in Sinhala holds a heavy emotional weight of shame that I carry to this day.

## 2.4 Motivation for research

Reaching a position where I could conduct my own psychological research that could support individuals who shared a similar cultural identity and migration journey as me, gave me a lot of purpose during training. When carrying out my literature search, I noticed that Sri Lankans were not often reported in research. In fact, Sri Lankans were not identified as their own Asian ethnic group in published reports and literature. Additionally, being male and the challenges within

men's mental health, compounded by the stigma around mental health in South Asian communities, including Sri Lanka, fueled my drive to focus my research within Sri Lankan men.

My experience of shame connected to culture was an isolating experience as a SGSL man. I experienced confusion, frustration and feelings of resentment of not feeling more connected to my cultural heritage. I performed relatively well at school, and I achieved significant milestones in my academic journey and career, to maintain my value in the community, and reduce the risk of shame. Yet, the experience of shame I felt when I could not hold a proper conversation with another person in Sinhala, was heavy for me. From this, I wanted to see whether other SGSL men experienced similar difficulties.

I was introduced to Compassionate Focused Therapy (CFT) by Paul Gilbert, properly during clinical training (Gilbert, 2014). I learned that CFT was emerging as a transdiagnostic model for a range of mental health problems (Lopez et al., 2018). I learned about the three flows of compassion: Compassion from others (CfO), Compassion to Others (CtO), and Self-Compassion (SC). I also learned that CFT was based on Buddhist principles (Gilbert et al., 2024), and this sparked my interest even more because of my upbringing. I never considered compassion until the planning for my empirical research. Upon reflection, I had experienced the three flows of compassion in my personal relationships, with my family, my friends and colleagues, and until recently, self-compassion. To hear that the three flows of compassion was showing transcultural applicability (Kariyawasam et al., 2021), compelled me to explore this within SGSL men.

## 2.5 The research process

Starting recruitment for my research was both exciting and anxiety-provoking. I was excited because I was going to have the opportunity of speaking with other members of my cultural cohort and find out if there were any shared lived experiences. However, I was anxious because I didn't know who would sign up and any challenges ahead. Within a week of advertising the study, I received a message on my LinkedIn querying whether the recruitment also included

people who were Tamil men, because if so, the recruitment poster was not inclusive for people who did not identify as Sri Lankan but were originally from Sri Lanka. This brought up feelings of guilt, that I was letting my community down, because one of my values in this research was to make this study as inclusive as possible, to offer all men who were eligible to take part to sign up. From this feedback, I later amended the poster to explicitly state that all men who were originally from Sri Lanka, including Sinhalese, Tamil and Burgher could take part.

Prior to interviews, potential participants were required to confirm their eligibility for the study. One of the questions presented was "*What was the reason for your parents migrating over from Sri Lanka?*", and I could already notice a pattern forming based on their responses. All participants who identified as Sinhalese reported that their parents migrated over to the UK for "better opportunities" or "work", whereas most participants who identified as Tamil reported that their parents migrated because of the "civil war", combined with "better opportunities". This set the tone for me before meeting them, about what experiences of shame they would potentially bring to the interview.

Meeting the participants was a humble experience. I felt grateful for their willingness to be open with me, sharing vulnerable experiences of shame, and their experiences of compassion. Examples of shame-related experiences varied throughout including difficulties in engaging with their culture, not being able to speak the language, struggling to meet parental or community expectations, pressures of having to do well at school, or not progressing in careers, and also pressures of masculinity culturally and societally – all of which I resonated with. I felt heard and validated throughout my conversations with the participants. I experienced feelings of protectiveness when the participants expressed difficulties of resisting CfO, as a means of protecting their social image in the community. The narrative to not appear weak as a man was present for these participants, and I understood their determination to not let their guard down, because their sense of pride to stay strong was far greater than the repercussions of appearing vulnerable. I admired participants who expressed reflective sentiments about how far they had come to now accept compassion or to navigate situations with an openness for compassion.

This brought a lot of optimism for me regarding the support that can be available for SGSL men, and where this research could lead to.

During the analysis, I received additional supervision from another psychologist to reflect and process my own emotional journey during the data analysis process. It allowed me to pause and reflect on my initial ideas of what the data could mean, go deeper into meaning-making from the patterns I noticed, and noticing potential biases that may have arisen being SGSL myself. I felt I could have kept going with developing themes, as they often overlapped one another, however, I felt confident in capturing my interpretation of the findings accurately into the themes presented in the empirical paper.

## 2.6 What I've learned

This process taught me that my personal experiences of shame and compassion are not isolated journeys and are not linear. Whilst writing up this thesis as a trainee, I experienced several personal challenges, and faced moments of internal shame, such as not being able to complete this write-up in time, potentially being a failure, all whilst struggling to be truly compassionate with myself. Having said that, one participant shared that their ability to experience self-compassion was by being compassionate to others. This sentiment was the most profound for me because by offering this space for the participants to share their narratives and a platform to talk about their pride in culture, of their loved ones, of their passions and careers, an open opportunity to feel heard about difficult points in their lives, and space to think deeply about how far they have come – I have given them a voice. In doing so, I showed compassion to their life journeys, and in return, I showed compassion to myself in healing parts of my cultural identity, of which I held internalized shame for most of my life. I've learned to accept who I am, and to start embracing self-compassion honestly.

## 2.7 My hopes

My hope for this research is for it to go far and wide. I have plans to disseminate it in key areas that target different groups of people. This includes the individual (second-generation Sri Lankan men), communities (e.g., Sri Lankan and South Asian groups through means of social media, podcasts, community groups), researchers and clinician (through conferences, workshops and clinical services. My overall aim is to highlight awareness to this population and their experiences to further inform future policy and clinical treatment.

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# Chapter 3 Belonging as a British Sri Lankan Man: Experiences of Shame and the Three Flows of Compassion in Second-Generation Sri Lankan Men Living in the UK

**Journal Specification:** The 'PLOS ONE' journal was selected to guide the preparation for this paper. The author guidelines (Appendix C) states there are no restrictions on the word count, number of tables or figures. The guidelines request double spacing and Vancouver referencing.

**Word count: (abstract, tables, figures, and references):** 9895 words

# Abstract

The three flows of compassion (Gilbert & Irons, 2005) (6) offers a theoretical framework to understand a trans-diagnostic and transcultural framework to target in therapy. In addition, shame is considered a transcultural construct which can impact negatively on a person's well-being, no matter what their heritage. Research has shown the potential cultural applicability of the three flows of compassion in Sri Lankan nationals, when compared to a UK-based population (Kariyawasam et al., 2022) (7). In consideration of the UK, British-born 2nd generation Sri Lankan individuals need to manage their cultural identities between their parent's heritage (Sri Lankan), and their host heritage (British), which together with additional challenges, may impact upon psychological well-being and levels of shame. The aim of this study was exploring the experiences of shame and the three flows of compassion in second-generation Sri Lankan men living in the UK. A total of 12 participants took part in online semi-structured interviews. A reflexive thematic analysis (Braun & Clarke, 2022) (8) identified four themes: 'shame driven by expectations', 'living between worlds', when the three flows of compassion feels safe', and 'the emerging self'. It was recommended that future research should consider exploring the levels of the three flows of compassion in this population through standardised measures. The clinical implications include the routine exploration of shame, the person's sense of belonging in the community, masculinity, and expectations of success therapeutically.

## 3.1 Introduction

### 3.1.1 The Mental Health Picture of Sri Lankans

Sri Lanka has faced ongoing instability over the past several decades, including a 25-year civil war, a Tsunami in 2004, terrorist attacks on Easter Sunday in 2019, the COVID-19 pandemic and the ongoing economic crises (9,10,11). These events contributed to significant mental health problems, with depressive and anxiety disorders affecting 4.1% and 3.4% of the population respectively, and a national suicide rate of 14.2 per 100,000, that is substantially higher than the global average (12,11). These figures highlight the long-term psychological cost of structural and societal vulnerability. Following independence in 1948, many Sri Lankans migrated to countries such as the UK for safety, to pursue academic or work opportunities or reunite with family members (13,14). However, research has consistently shown that South Asian migrants, including Sri Lankans, often experience disproportionately high levels of mental health difficulties compared to other migrant groups, exacerbated by conflict legacies, acculturative stress, and systemic disadvantage (15,16,17,18). Understanding these historical and migratory contexts is crucial in examining the intergenerational impact of trauma, cultural expectations and emotional expression within second-generation Sri Lankan (SGSL) men living in the UK.

As second-generation South Asian immigrants, Sri Lankans may find themselves balancing conflicting cultural norms – such as collectivist values tied to family honour and emotional restraint with individualistic, Western ideals of self-expression and autonomy (19). Whilst often seen as more adjusted socially than their parents, studies suggest they may face higher rates of low self-esteem and internal conflict, partially due to intergenerational trauma and identity strain (20). As South Asian men, Sri Lankans may experience pressure to embody both traditional masculinity of inhibiting displays of emotion and modern emotional openness, leading to mental stress (21,22). In the UK, only 36% of referrals for NHS talking therapies are men (23), with South Asian men least likely to seek professional support, due to shame and

stigmatised cultural ideas that discourages emotional openness (24,18). These intersecting issues remain under-researched in relation to SGSL men.

British-born Sri Lankan individuals have been overlooked in health and psychological research. The intersectionality of being a SGSL male, highlights the impact of intergenerational trauma their parents endured, coming from a country that experienced decades worth of traumatic incidences. The role second-generation immigrants have in managing their cultural identities between their parent's heritage (Sri Lankan) and their host heritage (British), particularly when parents may push their children to retain language and practices from the heritage culture (1,2,3) can create acculturate stress and anxiety (4). Following traditional masculine norms creates a barrier in their ability to communicate their emotional difficulties, coupled by the associated stigma in doing so. Available research on SGSLs, specifically Sri Lankan Tamils, have been studied in context of the Sri Lankan civil war and its intergenerational traumatic impact on their cultural identity and sense of belonging (25). However, research on shame and the three flows of compassion in SGSLs, to date, have not been studied at all, opening the opportunity to hear novel narratives from this population.

### 3.1.2 The Three Flows of Compassion

Compassion is often conceptualised as flowing in three directions: compassion to others (CtO), compassion from others (CfO) and self-compassion (SC) (6). Initial research into SC highlighted its role in support emotional wellbeing, such as reducing self-judgement, shame and emotional reactivity (26,27). Gilbert et al. (28) argued that fully understanding compassion involves recognising how these three flows function together and independently. For instance, an individual may express compassion to others while struggling to receive it themselves or extend it inwardly (29). Shaped by attachment styles (30), developmental history (31), and cultural practices and values (32), the model has been shown to function as a transdiagnostic framework, in reducing emotional distress across different mental health problems such as anxiety, depression, trauma and difficulties rooted in shame (33,34).

Despite this, literature looking at the cultural applicability of the three-flow model remains in its infancy. For instance, individuals more likely to express SC when it fits with what their cultural and community deems valuable and acceptable (35). With compassion-based practices being influenced by Buddhist principles (36), and Buddhism being practiced mostly in Asian households (37), levels compassion across the three flows is expected to be higher amongst Asian Buddhists. Individuals in Asian countries are also based in collectivistic cultures where social connectedness and social interdependence are experienced with one another (38). However, the opposite had been reported amongst individuals from an interdependent setting like Japan, where Buddhism is the dominant religion, as self-criticism was significantly higher than those in Western societies (39). Researchers reported as self-criticism is commonplace in emotionally interdependent Asian societies, and as a key inhibitor to SC, levels of SC could be lower in Asian cultures (38,39).

One qualitative study conducted in Sri Lanka by Kariyawasam et al. identified that local students' narratives about the three flows of compassion aligned with Western definitions, whereby their experience was also influenced by culture, religion, society and their upbringing (40). Specifically, participants reported that it was harder to be self-compassionate because of high levels of self-criticism, fear of judgement and guilt, within Sri Lanka's collectivistic and interdependent society. The study reported that factors that inhibited CfO and CtO were social stigma, family expectations, and shame-based norms. This could imply that a person growing up within an interdependent community, may struggle to experience compassion across the three flows, based on internalised cultural expectations.

However, other studies reported that females usually have lower SC and higher CtO compared males in North America irrespective of ethnic groups (41), because of women's natural approach of being nurturing and compassionate to others than men (42). Kariyawasam et al.'s study was predominantly female by 70% (40), and this may have skewed the compassionate narratives of the participants towards the women. Additionally, the study was based on Sri Lankan nationals, which makes it difficult to generalise the findings to SGSL's living in the

westernised world. Therefore, exploring SGSL men's narratives on the three flows of compassion and their experience of shame is warranted.

### 3.1.3 Understanding Shame

Shame plays an important role in behaviour control and decision-making (43,44). However, shame has also been described as "one of the most powerful, painful, and potentially destructive experiences known to humans" (45). Shame, when not regulated properly through the soothing system, can become maladaptive and impact psychological wellbeing (46,47).

As a socially driven and self-conscious emotion, shame has evolved as part of our ability to navigate interpersonal relationships (48). It emerges in situations where individuals perceive themselves as failing to meet socially desirable standards around attractiveness, competence, or status (48,49,50). In this view, shame plays the role of an internal alarm system that signals incoming threats connected to our sense of belonging, in the form of criticism, disapproval or exclusion, when perceived to be inadequate, inferior or defective in the mind of the other (51,52). These feelings are deeply connected to one's sense of identity and how they perceive to be positioned within social groups (53,50).

From these definitions, the experience of shame may differentiate between external and internal shame, based on how one appraises their experience (54). Externalised or external shame is based on the fears of the self in the mind of the other, often with feelings of anger and/or contempt (49,54). This could lead to efforts of influencing others to regain their approval by means of appeasement, submission, or by avoidance (55,56). Internalised or internal shame refers to the fears of the self's inadequacies, which may include self-devaluation and self-criticism (50,57). This process of internalisation may function as a defensive strategy to protect social bonds by self-blaming before others do, however this may exacerbate emotional distress because of enduring self-criticism (56,49).Therefore, external and internal shame are interrelated, with one fuelling the other, influencing the individual's ability to regulate their emotions, perceive their value in social groups, and maintain relationships over time (56,58,52).

The links between shame and a range of psychopathologies have been reported, for instance anxiety in a non-clinical sample of undergraduate students based in US where 7% of the sample were Asian (59), anxiety and depression in a clinical sample diagnosed with social anxiety disorder (SAD) in Sweden (60), depression in a sample of US-based undergraduate students where 7% were Asian American (61), depression in a small clinical sample attending a self-help depression group in the UK (6), and depression and early shame experiences in non-clinical samples based in Portugal (62,52). The threat of shame emerging can lead to developing unhelpful coping strategies and increase competition with others in social ranking (63), which is believed to be relevant amongst men (64).

### 3.1.4 Compassion and Shame in Masculinity

Compassion towards one's own distress and seeking help is not typically associated with masculine-typical behaviours (34). Higher levels of masculine-type behaviours are associated with higher experiences of shame and lower levels of self-compassion (65). This could be exacerbated if appropriate self-soothing abilities to regulate their emotions are not in place.

Men are likely to avoid social situations that question their masculinity (66). The 'precarious manhood hypothesis' implies that as a social status, masculinity is vulnerable to threat and seeks social validation to reduce the rise of worry and anxiety (66). Individuals who engage in masculine-typical behaviours like aggression, allows their reputation status to be restored, but without potential long-term negative consequences such as feelings of anger, shame, depression and anxiety (67,68). Social safeness of being connected other people when masculinity is not under threat according to social rank theory, may lead to lower rates of anxiety, depression, hostility, shames and feelings of inferiority (69,70).

### 3.1.5 Shame and Compassion in South Asian and Sri Lankan Contexts

Shame is a transcultural construct (70). However, the majority of studies who encourage a universal understanding of shame are based on students in Westernised cultures, and so cultural applicability of shame experiences is limited (71,72). Shame is maladaptive, unpleasant

and concerned with the self in Individualistic cultures (73,74,75). In contrast, collectivistic cultures, such as Sri Lanka, shame is seen as an adaptive emotion because it motivates individuals to align with group expectations, that reflects not just on the self, but on the wider family or community (75,76).

Shame has been widely reported in South Asian women, particularly Indian and Pakistani groups, where cultural norms such as *izzat* referring to family honour influences behaviour and restricts independence (26). Women are positioned as upholders of family honour and often operate under strict social expectations to avoid shame brought to the family (26,77). While the term *izzat* is commonly associated within Indian and Pakistani norms, overlapping values of family reputation, honour, and respect may apply to Sri Lankan communities in similar terms, however this is under-researched (78). Notably, the role of shame in the lives of South Asian men, including Sri Lankan men, remains underexplored.

Limited studies have explored the experiences of compassion and shame in Sri Lankan populations. One study explored what cultural similarities and differences in the facilitators and barriers to the three flows of compassion between Sri Lankan and UK samples (7). The authors identified that native Sri Lankan participants experienced higher levels of self-assurance and self-compassion, whilst also experiencing external shame and fears of compassion (CtO, CfO), compared to UK-based participants who reported safeness in others despite individualistic cultural values (79). Whilst the paper highlights cross-cultural differences in how shame can influence a person's experience of compassion, particularly when showing or receiving compassion from others, the Sri Lankan sample is based on a native sample within a collectivistic society. This opens doors to explore whether Sri Lankans living within individualistic societies, particularly those who have been brought up in a western society, have similar experiences of shame and compassion as the UK sample or that of the native Sri Lankan sample (7).

### 3.1.6 Aims

Taken together, these studies (40,7) suggest the potential cross-cultural applicability of the three flow of compassion conceptualisation (6,28) with Sri Lankan participants. To build upon this research further, there is a need to consider the influence of gender, and the experience of shame within different groups such as SGSLs. The aim of this study therefore is to explore the narrative of SGSL men about shame in context of the three flows of compassion. This will inform the current evidence base (80,81) on whether compassion-based clinical strategies (63,33,82,83) are a culturally appropriate to improve psychological wellbeing in SGSL men.

## 3.2 Method

### 3.2.1 Design

The present study implemented a qualitative design to explore participants' experiences of how they understand the three flows of compassion, and an exploration of how they implement compassion-based practices in their lives. Recent exploratory research looking at transcultural applicability of compassion using qualitative research, reported the suitableness of its design in exploring the experiences of Sri Lankan participants (40). Reflexive thematic analysis (TA) was the chosen analysis allowing a critical reflection from the researcher during the analytical process (8). Whilst data saturation was previously considered as a marked gold standard for determining a sufficient sample size, this has recently been significantly argued against in recent years as it is based on principles by grounded theory (84). *Information power* is considered a stronger factor in determining whether sufficient data has been obtained by aligning the sample size based on the richness and diversity of the data, led by the research question (85). Nonetheless, it has been suggested that approximately 12-15 participants for a reflexive TA study would fit research design for a clinical doctorate (86). Data collection by semi-structured interviews was recommended as the most suitable approach to elicit meaningful and rich qualitative data for reflexive TA (8).

### 3.2.2 Participants

A homogenous sample of UK born and living second-generation males, from two Sri Lankan born parents, between the ages of 18-35 years ($M$ = 24.6, $SD$ = 5.5) who were not currently engaged in therapy took part in the study. Participants were purposively recruited through online social media platforms and by word of mouth. See Table 3.1 for participants' summary.

**Table 3.1 Summary of participants in the sample**

| | Participant* | Age | Occupation | Sri Lankan Ethnic Group |
|---|---|---|---|---|
| **1** | Arosha | 27 | Nurse | Sinhalese |
| **2** | Dishan | 30 | Doctor | Sinhalese |
| **3** | Nimal | 18 | Student (Engineer) | Sinhalese |
| **4** | Rohan | 28 | Engineer | Sinhalese |
| **5** | Sanjeewa | 21 | Student (Marketing) | Sinhalese |
| **6** | Arjan | 21 | Student (Engineer) | Tamil |
| **7** | Nishant | 24 | Consultant | Tamil |
| **8** | Vitesh | 20 | Student (Medical) | Sinhalese |
| **9** | Sheran | 22 | Student (Nursing) | Sinhalese |
| **10** | Krishnan | 35 | Chef | Tamil |
| **11** | Malindu | 18 | Unemployed (Gap year) | Sinhalese |
| **12** | Jathusan | 31 | Student (PhD) | Tamil |

**All participant names are pseudonyms*

### 3.2.3 Interview development

The interview topic guide was developed by the researcher to explore participant's understandings and experiences of shame in the context of the three flows of compassion, namely CtO, CfO, and SC (appendix D). The questions were based on the interview schedule from (39), and extended to include questions around migration history, and include specific cultural questions. Questions encouraged us to think of specific examples of shame

experiences (of others or themselves) to support the context of their answers. Alongside the structured questions, follow-up questions were asked as and when required.

#### 3.2.3.1 Patient and Public Involvement (PPI)

Two second-generation males of Sri Lankan heritage provided input on the development of the interview topic guide. For example, offering feedback on the questions and the order of questions, and support with piloting the questions. The two members were not included in the final analysis as they were known to the researcher.

### 3.2.4 Procedure

The study was approved by the ethics committee at the University of Southampton (Ethics Number: 92440; Appendix E). Participants informed of their consent (Appendix F) to take part in the study and agreed to be audio and video recorded prior starting the study. Registered participants went through a verification process to confirm their suitability to take part in the study (e.g. confirming they were second-generation and born in the UK – Appendix G). Interview dates and time were confirmed if participants passed the verification. Pilot interviews were conducted with the first three participants, to confirm the feasibility of the interview questions. No changes to the interview topic guide were made. Interviews lasted between 70-90 minutes on average. Participants were debriefed at the end of the interview (Appendix H). Participants were given a £50 Amazon voucher as a thank you for their participation at the end of data collection. All transcripts were then subjected to a Reflexive Thematic Analysis (TA) approach of analysis (87,3).

### 3.2.5 Data Analysis

Reflexive TA offers a flexible approach and is focused on experiential accounts and meanings, whereby language is used as a communicating tool that offers an opportunity for the receiver, in this case the researcher, to hear the ‘voice’ of individuals without interrogating the truth of the individuals’ reality (8). Reflexive TA is guided by the researcher’s subjectivity as the primary tool

for the analytical process, underpinned by their theoretical assumptions and orientation in the qualitative analysis.

An inductive 'bottom-up' approach, was implemented when analysing the data (87). The themes were generated semantically (surface-level, explicit meanings) and latently (deeper, underlying levels). Braun and Clarke reported that rather than being binary in approaches of coding styles, the semantic-latent coding levels can sit across a continuum, thereby reinforcing the privilege of flexibility in reflexive TA (8).

A critical realist ontological approach was adopted as the researcher's theoretical orientation (8), which holds the perspective that a single reality exists and is accessible from multiple lens (8). This means that participants use their words and phrases to communicate their version of reality, which is interpreted by the researcher (88).

The quality research standard of reflexive TA was reviewed (89) by going through the 20 questions highlighted by the authors to determine whether a reflexive TA has appropriately been presented and implemented in its theoretical framework, analysis and reporting. The researcher adopted a clear theoretical stance based on the research question posed. The researcher explored patterns and meanings generated from the data connected to the research question. Active reading and re-reading, annotating notes around transcripts, and jotting ideas of codes allowed the researcher to actively engage and immerse themselves into the data. Reflexive TA is an iterative process, meaning that the analytic process involves going back and forth between codes and generating themes (86) see appendix I for a sample of the coding manual).

#### 3.2.5.1 Reflexivity

Braun & Clarke highlight the importance of reflexivity when engaging in research that involves marginal or vulnerable groups (90). A reflexive stance was used in the analysis to acknowledge the researcher's influence of their perspective and reality in the research process (91). The researcher is a closely related to the sample population identifying as a second-generation male of Sri Lankan heritage (both parents from Sri Lanka), currently living in the UK. The researcher

was born in France, instead of the UK (which was the inclusion criteria for the sample). The researcher maintained the inclusion criteria to be UK-born only participants instead of European, to maintain a homogenous sample of men with shared experiences, as differences of cultural upbringing may influence varied experiences. This is something the researcher experienced themselves being French-born from Sri Lankan parents and now living in the UK for over 20 years and therefore maintaining a clearer inclusion criterion of 'British-born Sri Lankans living in the UK' felt more accessible and simpler with two clear cultural identities to consider in the research. The researcher was also aware that being second-generation, male and Sri Lankan that their own individual experiences of shame and compassion may be shared with the sample study, with potential biases. Keeping a reflective log was crucial to during the analysis to record thoughts and feelings from hearing the participants (Appendix J for a sample the reflexive diary).

## 3.3 Results

Reflexive thematic analysis (RTA) identified 4 overarching themes with 12 subthemes presented in Table 3.2 that highlight the experiences of shame and compassion in SGSL men living in the UK. The 4 themes identified were 'Shame driven by expectations, 'Living between worlds' , 'When compassion feels safe' and 'The emerging self' (see Appendix K for final thematic map). All themes have 3 subthemes each and will be presented below with participant quotes.

**Table 3.2 Summary of themes and subthemes**

| Themes | Subthemes |
|---|---|
| 1. Shame driven by expectations | - Shaped by social value<br>- Cultural disconnection<br>- Success as a generational duty |
| 2. Living between worlds | - Cultural inheritance and modern identity<br>- Learned silence in masculinity<br>- Wanting to belong |
| 3. When the three flows of compassion feel safe | - Resisting openness to compassion<br>- Relationship as a compassionate space<br>- Compassion by example |
| 4. The emerging self | - Making sense of then and now<br>- Rethinking masculinity through emotion<br>- Negotiating the inner critic |

### 3.3.1 Shame driven by expectations

This theme captures the experience of shame driven by expectations in relation to others, through community family and perceived social standards, as well as how this is felt internally through disappointment, guilt and self-criticism. Shame is revealed that it can shape and be shaped by cultural expectations. Success was also a dominant factor that was driven by the shame of failure.

***Subtheme 1: Shaped by social value***

Arosha shared how their past behaviours would influence the community's opinion about them at the time:

*In in the temple, I wasn't really the good child in the temple either…I was always staying back a year and I was always messing about…So I feel like the Aunties definitely had their opinions on me. Yeah and I never really so, I had my big friend group, my friend group would always speak with all the Aunties and everyone, but I would just kinda just stick to my own lane and just do my own thing* – Arosha (Nursing Student).

Nimal described the social evaluation that kids are subjected to by members of the Sri Lankan community, by their academic achievement, and the risk of being shamed by them:

*So I feel like in the Sri Lanka society, everyone's like every kid, every auntie for every kid had, like, every auntie sets the expectations of our kids so high because, you know, there's like the stereotypical, like Sri Lankans are smart or they stand the other in it. So I feel like every kid has the exact same pressure. That, that, that they go during exam time because all the aunties are always like especially on results day they all call up and go like, oh, how is the result you know like, you get me. They're all like that.* - Nimal (Engineer Student).

Malindu commented of the positioning that Sri Lankan men are place in wider society, comparing themselves to other ethnic groups beyond team sports:

*As a second-generation Sri Lankan man, I guess it becomes more difficult to kind of compete if you know what I mean against the next person because you know in terms of sports, they might have better genetics than you in terms of culturally. Um, I feel, I feel though in my opinion, kind of Sri Lankan men, they're kind of looked down, looked down upon more in society than maybe an African man or, a white English man. So yeah.* – Malindu (Unemployed, Gap Year).

***Subtheme 2: Shame in cultural disconnection***

Krishnan experienced shame based on how connected they were to the Sri Lankan culture because of not being able to speak their heritage language:

*Probably the fact that I can't speak Tamil is a massive I think a massive one in terms of like the amount of people that over the years have said "how can you not speak Tamil is quite a prominent one....It's like when people go: Oh, but why don't you know, Tamil? that's your mother tongue? and it's actually like it is quite shameful that I am not able to hold a proper conversation in Tamil.* – Krishnan, Chef.

Shame connected to Sri Lanka's civil war was brought up by Rohan, regarding the displacement of Tamil people:

*I guess there's like a tiny bit of shame that because of the civil war that happened and the result of the civil war, let's just say, and the displacement of a lot of Tamil people and the difficulties they went through. None of those caused by me, obviously, but the collective Sinhalese there's a bit of shame I would say like associated with that, that I was maybe, or that I have an association or I'm maybe associated with that concept of the civil war and the outcome of the civil war and some of the negative connotations and experiences that people felt as well.* – Rohan (Engineer).

Regarding the war, Nishant expressed shame about the actions that occurred by the Liberation Tigers of Tamil Eelam (LTTE) group:

*Last few years I've been educating myself on the history of Sri Lanka and what was going on with the Civil War. And I definitely, when I was younger, of course, because my parents are Tamil, I obviously was like always supporting the LTTE. Um, as I've grown up and I've learned of the actions that they have done, then I definitely sort of felt ashamed in that aspect of like, oh, you know, this might not have been the right thing to say, this might have not been the right thing to do. Um, I sort of, I don't agree with their methods that they some of the methods that I've read about, um, obviously I'm not entirely sure how much of it is true, how much of it is not true, but from what I've read and from the things I've seen, there's definitely shame in that aspect there where, you know, we are supporting what a group, a military group that used pretty horrible methods to get what they wanted. So, in that aspect, yeah, I would say that's probably the way I'd feel shame about my identity there.* – Nishant (Consultant).

***Subtheme 3: Success as a generational duty***

Nimal described success as a moral and emotional obligation to honour the sacrifices made by their parents:

*Because they've sacrificed a lot for us, I feel like. So they just want, they wanna make sure that we take full advantage of the sacrifices that they've made for us.* – Nimal (Engineer Student).

Nishant expressed success in the form of academic achievement, whereby not attaining high grades brought a sense of perceived shame to the self and parents:

*I'd say like the big, this is like the main, sort of biggest time I felt shame is during my first year of A Levels, I just finished doing a math paper and this one counted towards, um, my overall grade, so it was like a final exam. And I remember coming out of the exam and I just felt, like, awful about it. Like, I felt like I, you know, hadn't done as well as I thought I could…Um, and I definitely felt a lot of shame and a lot of guilt in that instance in that like, one, I think I failed myself, and sort of my parents, I had this, um, back then I was really hoping to get to the University of Warwick for engineering.* – Nishant (Consultant).

Krishnan shared that success by means of pursing passion-based dreams involved leaving his stable career, and experiencing shame in doing so:

*I'd say probably leaving 'cause I used to work in finance. So leaving that to chase the food dream, I think there was a massive level of shame that you. Like you worked so hard to get to a certain level and you're kind of throwing it in essence in the bin to cook for people. And like I was very adamant that I wanted to start from like the bottom. And so I got like a basic. I was in the kitchen, like at the basic like.* – Krishnan (Chef).

### 3.3.2 Living between worlds

This theme encapsulates how participants navigate their identities while positioned between two cultural worlds, i.e. their heritage culture through their parents' influence and the western norms of the society they live in. The balancing act of connecting with both cultures intertwines with their sense of belonging and emotional expression, which are reinforced by intergenerational expectations.

#### *Subtheme 1: Cultural inheritance and modern identity*

Arjan reflected on the tension between maintaining his heritage culture and his upbringing within the UK:

*Just growing up as a second generation in another country. I'm like having like having my family teach me like all like our actual like, you know, like motherland culture and heritage and stuff. While I'm also, like bringing in. Like... you know, like British culture and stuff, which like was more dominant on me, really. That was like definitely like I think about it because. Yeah, like I think it was just. Yeah, like during my younger years, like at some point, I really felt like...like, English is my main language. At first...Tamil was my main, my main language, I'd say... But now it's like English. Obviously I'm very comfortable with it. Tamil is good. I'm like I can. I can understand like everyone...Reading is very basic. Like writing, I can only do...a little bit... but when I speak. It's like a bit broken sometimes.* – Arjan (Engineer Student).

Participants also described how being connected to their heritage culture was not a difficulty for them:

*In terms of a cultural setting, I was always kind of encouraged to kind of get involved in cultural things. The music side that was never really a source of, like discomfort or anything like that* – Dishan (Doctor).

Participants shared how they embraced their heritage in different ways such as language, religion and dance:

*But language wise...I feel like I'm really good at my language, you know? Um, even my parents still praise me. Because I can read, I can write, I can speak fluently. And I'm definitely more connected to my religion now more than ever, especially with the dance side of things. I'm definitely more connected now, so I've definitely changed since I was younger.* – Sheran (Nursing student).

***Subtheme 2: Learned silence in masculinity***

Vitesh describes that learned silence is exacerbated by the way other people in the community react when men express themselves, despite efforts to support men's mental health:

*The things I always see that men are saying that no one listens and no one takes them seriously, for example. And you see all these campaigns. But then from my experiences that I've seen, when a male person tries to speak up about something, they usually do get laughed at, not*

*just by women, by other other guys. Other men as well. So that's that's another problem. And I guess that's what's causing other men to bottle it up and not talk about it.* – (Vitesh, Medical Student).

Nimal shared that emotional expression is more open in women than it is for men, and even more so when they experience shame:

*I feel like as a man like they keep it to themselves and they may and they let it build up. Whereas women like they they're more vocal with it, and if they feel ashamed, I thought they were talk to their friends. Whereas as a man, they'll keep to themselves, they'll bury it deep inside of them, and there wouldn't let anyone else find out about it.* – Nimal (Engineer Student).

Jathusan highlighted that masculinity is a barrier for men to make contact with other people, to have emotional interactions, but are being unable to:

*Maybe masculinity, like, prevents guys from, like, reaching out. You know, like, maybe masculinity prevents guys from forming like, actual meaningful connections and friendships with each other, where they're able to sort of, like, cry in front of each other. They're able to sort of, you know, like, talk about very difficult issues which, like, you know, like, has burdened them very long time. But like, they're just unable to sort of like, get out.* – Jathusan (PhD Student).

***Subtheme 3: Wanting to belong***

Vitesh reflected on how despite their experiences of shame connected to their culture, that they wished to belong in the community:

*I didn't want to look like I was just like a bad Sri Lankan, if that makes sense. It's a tough one because you want to be accepted here and over there.* – Vitesh (Medical student).

Arjan described that connecting with heritage culture has opened with opportunities to connect with others, allowing them to be compassionate to themselves:

*But I definitely found compassion for myself because it's like. That's an identity. It's a very special identity. It's something that I'm I feel I'm very lucky to the, you know, been born with invested like, you know, handed down from our family. That, like you know, I can open into*

*another like line of culture. While I'm sitting in like England, you know? Yeah, I think having that connection and relatability with others as well, because, yeah, I think having that compassion…allow me to definitely connect with a lot of other people.* – Arjan (Engineer Student).

For Krishnan, engaging with their heritage culture through their passion of food, has made them curious to learn more about cooking Sri Lankan food:

*So I've been on that side of it, but I think just kind of through cooking, it's made me want to kind of learn a little bit more about, about it. Because I feel like my parents had an orphanage in Sri Lanka and I've gone a couple of times, but. That was more of a summer holiday you go, or I've gone since. But there's a real connection and real understanding.* – Krishnan (Chef).

### 3.3.3 When the three flows of compassion feel safe

This theme explored how participants understand express compassion, shaped by their relationships, cultural norms, reflective learning. Compassion was valued and resisted at times and also flowed simultaneously across the three flows.

***Subtheme 1: Resisting openness to compassion***

Vitesh says that compassion sometimes felt uncomforting because it felt undeserving, exposing and weakening:

*I felt embarrassed about the fact that I was needing their compassion to some extent, rather than think I wanted to just do it, fix it myself. Problem myself. Go ahead and go about it myself. And then when people ask you, and then you have to tell them about your shame, and then they help you with that, you feel even more ashamed. If it's a situation that you didn't want help in, and I guess that goes back to the point that we were talking about earlier about people bossing things up and not talking about it, that when they do then receive that compassion, they might feel ashamed.* – Vitesh (Medical student).

Malindu argued that when he received compassion, that it sometimes felt like a condescending experience:

*I don't like pity. So I just feel like they're being pitiful, if that makes sense....I just feel like, they're being condescending. That's genuinely how I feel like, like the kind of like I said, being pitiful and they're talking down to me.* – Malindu (Unemployed, Gap year)

Jathusan expressed that regardless of how much they receive compassion from others, that being compassion to themselves was difficult:

*Man honestly, I don't like. I don't. I don't know. I don't have the answer for that question. I think that no matter like how hard or how much, there's like overwhelming kindness in my life with like other people, I still fall back to. I'm undeserving of this kindness.* – Jathusan (PhD Student).

***Subtheme 2: Relationships as a compassionate space***

Arosha shared that relationships, particularly friendship, were often safe and reliable spaces to experience compassion from others, through different cues only through selective individuals:

*Like when you in a time of need and you get a hug or something like this or you know someone just, you know, puts their arm around you goes, listen, look it's it's all good like I think it just help it kind of makes the situation a little bit less bad than it is uh but I think you know yeah it depends on your friendships and so on you know and how other important you have with that person.* – Arosha (Nurse).

Rohan outlined that when family and friends showed compassion to him, that he was able to show compassion to himself:

*Family and siblings help me be very compassionate because they. They know me very well; they will know me the best. So they can kind of understand me and at the end of the day, I know they they've, they've got my back. So that is always reassuring to help me be more compassionate to me, and knowing that there's other people to fall back on. Friends as well. The people who I can have those conversations with. Those people help me show that I can be more compassionate to myself because I can talk about it with someone else.* – Rohan (Engineer).

For Sheran, spending time with a loved one or showing compassion to them, brings compassion to themselves:

*Definitely, just simple things like seeing my girlfriend. I don't tell her that I'm seeing her because of me, I make it seem like she needs me and I'll go see her. Um, but yeah, I always find that like, I'll do whatever it takes to just be there with her. I'll be on like 5 miles of petrol and I'll still go to her if I have to because that's the one, like rewarding thing and just seeing her every time.* Sheran (Nursing Student).

***Subtheme 3: Compassion by example***

Jathusan spoke about how they learned more about compassion through observing others – which enables them to be show CtO:

*I would say like inspired me to be a better person in the sense that like I can like use some of the sort of like kindness and the empathy that they've shown me into how I treat other people. So I think it's just like learning process where I'm just like you know, like I maybe am not as compassionate as I think I am like when I talk to you, maybe I can like take a lot of what you're like saying or like how your friends are.* – Jathusan (PhD Student).

Nishant reported that parental figures modelling compassion to their community, has helped to practice this with their own family members:

*An example like we have like a a fair, a village fair and my mum made biryani for everyone for free, you know. So yeah, I have that, kind of sort of, my parents definitely modelled that, sort of like being helpful, give to others kind of mentality. And then I think the fact that I've been sort of the eldest in the family, when I've had a lot of younger siblings, younger cousins to take care of, definitely has helped in that sense, it's taught me a lot of patience, it's taught me, kind of taught me how to be a mentor to them and like what to say in what situations and things. Um, so and sort of how to be a sort of giving person and sacrifice the things that I'd want for them.* – Nishant (Consultant).

Rohan also spoke that seeing how others are compassionate to themselves has been useful as a model of self-compassion:

*I think seeing how other people are compassionate towards themselves when certain things happen and how other people are talking about it in general. Like again example of someone having a bad day they kind of talk it through. They do things that help reassure them. Be like having some down time to like read or whatever and I think understanding. How other people process those feelings? Helps me to understand how I could potentially process it as well in a slightly in a slightly different way. Just kind of gives a bit more understanding of the kind of feeling, even if I don't do it, just understanding how other people do it. Get over it as well. Most importantly and like kind of get on with life and reassures me that like I can also do it if someone else's experienced it and I've been OK with that.* – Rohan (Engineer).

### 3.3.4 The emerging self

The theme summarises how participants reevaluated their outlook on emotional responses, beliefs and approaches. It reflects the growth of moving away from emotional restrictions connected to shame and compassion they had initial inherited, to then developing their own sense of identity that is open-minded and self-aware.

#### *Subtheme 1: Making sense of then and now*

Nimal shared moments of reflective insight in response to personal setbacks they endured, including relational experiences:

*The past is unchangeable, so I've come to terms with that, but it's always in the back of my head. I'd always regret that last conversation....I feel like I was judgmental because I was like well why would like why? Why would you do that? Like it's it's just a phone. It's like it's not that deep that she was trying to help you for the better, like by revising. So yeah I thought like I was quite judgmental on myself from that on that part....I locked myself out from the world. I just isolate myself from everyone and everything and like really and truly I just.* – Nimal (Engineer student).

Arosha felt that after going through a difficult experience, and realising that they had support around them, e.g. parents, that they could talk to them again:

*I guess like I said, like I was able to have these conversations with my parents like now I can talk about something random or tell them how I feel about a certain situation. Uh, maybe they're not. Still a like not to the not emotional intelligence, but not to have like a conversation. But I just know that I can, you know, speak to them in the first place.* (Arosha, Nurse).

Dishan reported learning from their own past experiences by controlling their own emotions, whilst acknowledging that it may not be possible for others to do so:

*I mean it does vary. But and I've gotten definitely better at dealing with it. It was bad when I was like, much younger, but I'm sort of OK with it now and to be honest, the key thing is to learn and in my case the type of shame that I feel it can be mitigated through my, I'm in control of the circumstances which determine it. So, which is obviously a privilege that not everyone has.* – Dishan (Doctor).

***Subtheme 2: Rethinking masculinity through emotions***

Conscious efforts were made by Nishant to challenge inherited models of masculinity from the first-generation, such as not being emotionally silent to redefining their approach in being more expressive:

*I felt embarrassed about the fact that I was needing their compassion to some extent, rather than think I wanted to just do it, fix it myself. Problem myself. Go ahead and go about it myself. And then when people ask you, and then you have to tell them about your shame, and then they help you with that, you feel even more ashamed. If it's a situation that you everything didn't want help in, and I guess that goes back to the point that we were talking about earlier about people bossing things up and not talking about it, that when they do then receive that compassion, they might feel ashamed that they. Receiving that compassion.* – Nishant (Consultant).

Krishnan reported the cultural shift in talking about emotions in recent years, and having conversations with family members, that times are changing:

*The way the way it is…I'd say no now. Just 'cause I think now the culture, the community, like conversations I've had with my dad about it. Like it's, it's it's normal. Like I think if you were to ask. Come on 10 years ago. Oh, like you're going through this? Maybe go and speak to someone. No, I'm not doing it like that, stupid. That's a waste of money. That's it. But if you ask the same person now, they'll be like, yes, 'cause, I think. There's been a lot more like open conversations about.* – Krishnan (Chef).

***Subtheme 3: Negotiating the inner critic***

Sanjeewa described engaging in internal conversations, often by logic and reflection, to regulate their emotions, embracing self-compassion privately.

*For me, I know I'm a very emotional person. This like I guess, more like women are than men. I feel like when I put on my logical glasses it it helps me defend against that one powerful emotion. That's, you know, let's say I'm just happy. Now if I'm too happy, then I'm gonna miss something. You know, like a meeting or whatever. Like if if I'm not like fully judge logical, I'm just gonna forget. You know, I'm going to be living in, like a different world, basically. Of hobbies like too much happiness, that's bad. I think. Because you're just gonna do stuff that you you you should have. But because you're self-loving yourself so much, you just fire reaction. So I feel like being logical.* – Sanjeewa (Marketing Student).

Malindu spoke about being able to be self-compassionate by means of self-reassurance:

*I do try to find kind of like the silver lining in a bad performance. I think that's also important because you know you're not gonna, kind of, develop yourself, you're not gonna get better if you're always negative, so I always try to find a silver lining in something to kind of, give me the reassurance that I need that it will, it can get better.* Malindu (Unemployed, Gap Year).

Rohan reported that having a 'birds-eye' view of the problem, helps to deal with experiences of shame:

*These kind of things happen, reassure myself in that way. That is basically like life is bigger than this one individual event. There's so much more going on. There's so many other things. Let's just say there's many other like bad things going on in the world that my individual feeling or about disappointment of shame is like very miniscule in the grand scheme of other people and the world itself. So why should I basically feel bad for myself and I use that kind of logic to get over it, which is maybe like which can. Which can make something seem not as big as.* – Rohan (Engineer).

## 3.4 Discussion

The research aimed to qualitatively explore the experiences of shame, within the context of the three flows of compassion, in SGSL men living in the UK. The findings from the reflexive thematic analysis (3) identified four themes: 'shame driven by expectation', 'living between worlds', 'when compassion feels safe', and 'the emerging self'.

### 3.4.1 Shame driven by expectation

The experience of shame depicted by the participants were closely related to external pressures and internalised expectations based on how they should be seen, behave and succeed (53). Shame was often brought up to describe examples of failing to meet cultural, familial ideals, which influenced how participants would perceive themselves and their positioning in the community. Cultural examples of not being able to speak the heritage language of Sinhala or Tamil fluently, or not being familiar with Sri Lanka's historical context, often reflected an internalised negative view of themselves that threatened their social value in their community (57). Not achieving the right academic grades, and experiencing relationship breakdowns, were associated with fears of social judgement or disapproval that threatened their sense of belonging within the community, intensifying feelings of shame (50). The emphasis on social value and the emotional repercussions of not meeting expectations set by family or the community, is also in line with existing literature (92) of South Asians' context regarding reflected shame, or *Izzat*. This concept implies that an individuals' actions is perceived as

representing the reputation of the wider family or group, meaning that personal shortcomings may result in shame for not just the self but others as well.

Success was framed not only as a personal achievement but as a broader responsibility to build upon the sacrifices their parents had made, and to sustain the family's reputation in the community. For example, pursuing careers such as Medicine or Engineer in South Asian families was encouraged for the prestige of the professions (93), as a means of honouring their family's social status. Participants spoke of the pressures they experienced when wanting to make their parents proud through educational achievements or career choices, progressing forward further in their careers, or cautiously creating opportunities for themselves that is beyond parental or community expectations. This is driven by the experience of reflective shame (92), whereby they fear their actions will potentially dishonour their family's legacy in the eyes of others, affecting their social value in the community (57). Therefore, the pursuit of success in line with family honour and duty are dominant features consistent with collectivistic norms found in South Asian cultures (94).

### 3.4.2 Living between worlds

As SGSL men growing up in the UK, participants reported a rich insight into how they experienced maintaining parts of their cultural heritage, such as engaging in, whilst also upholding, their identity within an individualistic society. Participants shared their parents' motivations to migrate from Sri Lanka, and responses varied from seeking better opportunities financially and socially for their families, to fleeing from the country's civil unrest. Since moving to the UK, parental pressure to either be successful, whilst also maintaining their cultural heritage, brings internal tensions around their identity. Such tensions are based on the intergenerational impact of trauma and the acculturation stress of integrating in a foreign community from their parents' generation, and the pressure to maintain part of their cultural identity as second-generation (14). For example, participants communicated unique acculturation related stressors such as language, customs, social norms, religion and personal

beliefs that they experienced daily, creating daily stressors, such as lack of fluency in heritage language (21) caused between the two generations (14). In contrast, several participants reported a sense of cultural pride in their Sri Lankan heritage, with some engaging in cultural and community events, being fluent in either Sinhalese or Tamil, and actively practice their religious faith. This suggests potentially two subgroups of second-generation migrants, some with an 'integrated identity' that holds a balanced combination of their heritage, (based on their connection to the culture and language fluency) and mainstream culture, whilst others may have more of an 'assimilated identity', whereby the mainstream culture they are brought up in is more dominant (95).

Learned silence was adopted as a result of experiencing shame in expressing emotions with others, experiencing tension between encouragements by the media to support men's mental health, but in person not feeling supported, and masculinity being a barrier to making meaningful emotional connections. Concealment of emotional expression, shaped by traditional masculinity norms was often reported in our study, supporting previous research (16), within South Asian cultural influences (13) and through intergenerational modelling, typically from their fathers (96). Specifically, sadness, vulnerability or uncertainty was perceived as inappropriate and threatened their social value as men in society (65). Therefore, by practicing emotional restraint in public, it would avoid the risk of their masculinity being threatened. The silence was not just internalised by participants but reinforced within community and familial expectations.

Despite these experiences, participants reflected a yearning to fit in, culturally and socially. They described how prior feelings of shame shifted over time, lessened through maturity, reframes or shifts in identity. This reflects their sense of identity and their perceived value in the social group and maintain relationships (55,57,51). As a result, shame carried an emotional weight for participants that was not necessarily restricted and isolated within the individual but was also a driver to be accepted and valued in the Sri Lankan community.

### 3.4.3 When the three flows of compassion feel safe

The present findings suggest that the three flows of compassion may not be automatically embraced, and may be selective and contextually driven, alongside psychological and relational safety within the context of shame-based experiences. Participants' responses indicated that internalised self-criticism and fear of external judgement shaped their relationship with the three flows of compassion. For example, participants were readily able to show CtO if the recipient who had experienced a shame-related situation was a close friend or a partner but struggled to connect with CfO when they themselves experienced shame. These dynamics reflect prior research that individuals from collectivist cultures, including Sri Lankan populations, may experience resistance, fears or blocks in the flows of compassion, particularly if external shame is perceived (27,2).

Self-compassion for the participants was not solely as an internal resource, but shaped by cultural, relational and social learning processes. For many, reconnecting with their cultural heritage through listening to music, dancing and food, evoked a sense of cultural pride and belonging, which in turn created self-acceptance. This supports previous research that by engaging in culturally meaningful practices may enhance sense of personal wellbeing and sense of belonging (97) and promotes a greater compassionate relationship with the self (34). Additionally, participants expressed that receiving compassion from others, permitted them to extend this care to themselves. This is echoed by Gilbert who reported that when compassion is received from others that self-soothing systems can be active, facilitating self-compassion (62). Moreover, self-compassion was reportedly modelled and internalised whereby participants shared of learning self-soothing responses by observing compassionate behaviours from others. This fits with previous literature that compassion can be learned implicitly by observation, especially if individuals have not been taught self-compassion skills (98). Therefore, self-compassion in this study suggests that it is cultivated by immersing in culture, relational modelling and vicarious learning.

Nonetheless, supportive relational environments, through trusted friends, family members or partners, appeared to ease resistance of the three flows of compassion, and create a space of psychological and emotional safety for participants to express their vulnerabilities and to allow CfO (39). Participants also described that they were able to witness others show compassion to others (98,32,25). Therefore, the three flows of compassion emerged not as a universally, accessible quality, but more as a conditional, relational and at a times a socially learned experience for SGSL men in this study.

### 3.4.4 The emerging self

Participants' accounts of emotional experiences on shame, masculinity and emotional growth, revealed an ongoing process of developing their sense of identity, through self-reflection and cultural positioning. Influenced by emotional setbacks they endured, narratives shifted from harsh self-judgment to greater emotional insight. In support, they described strategies that have helped them to get through difficulties, such as listening to music, accessing compassionate spaces with trusted individuals, and engaging in self-compassion strategies in theme of forgiving themselves, adopting a growth mindset, expressing gratitude and showing generosity to others (99). This aligns with Gilbert's Compassion Focused Therapy model (62), where self-to-self relating is a central feature in understanding one's feelings, and emerging capacity for emotional flexibility (25). High levels of self-criticism and rumination has been reported to be higher in Asian collectivist backgrounds, compared to those individuals living in the West (100). Yet, collectivist cultures use self-criticism to facilitate self-improvement and maintain social harmony (101). This supports this study's findings, as participants did actively speak about improvements, they made to be self-compassionate over time, negotiating their harsh self-judgements as part of developing a more balance dialogue, and allowing emotional honesty in terms of their journey right now and where they could be moving forward.

### 3.4.5 Strengths and Limitations

The insights interpreted here are contextually confined by the characteristics of the sample. All participants were second-generation UK born Sri Lankan men, including Sinhalese and Tamil ethnic groups, with relatively homogeneous educational and socio-economic backgrounds. However, interpretations of shame and compassion among SGSL men may not extend to first-generation migrants, Sri Lankan women, older or rural populations, or those with different educational or cultural exposures. These demographic constrains limit the generalisability of the findings to broader South Asian or diaspora communities. Therefore, it is recommended that our conclusions should be culturally and contextually understood, instead of being universally applicable. This opens doors for future research to explore narratives of shame and the three flows of compassion from individuals of different genders that are second-generation Sri Lankans or other South Asian groups, as well as first-generation migrants.

Additionally, whilst the study identified evidence on the cultural applicability of the three flows of compassion in SGSL men, we did not measure how compassionate they were objectively. This offers an opportunity for future research to consider a quantitative design to measure the population's flow of compassion using a standardised measure such as the Compassionate Engagement and Action Scale (CEAS) (27), against White British men as research has previously indicated cross-cultural differences and the cultural applicability of the measure to Sri Lankan nationals against UK populations (2), but not with Sri Lankans living in western societies.

Reflexively, the researcher is a SGSL male living in the UK, which signified representation and relatability of the participants' cultural background. This enabled the researcher to have deeper understanding in certain nuances of the participants' narratives regarding their family migrate from Sri Lanka, and settling into western culture, and the pressures of acculturation being passed down. Despite this, the researcher brings their own biases into this researcher from the point of recruitment, to developing the interview schedule, to conducting the interviews, and analysing the data using reflexive TA, and interpreting themes. This means that the results are subjectively based on the researcher's point of view. It is important to note that Braun and

Clarke argue that a researcher's reflexive journey in their qualitative research is part of the analytic process (3).

### 3.4.6 Clinical Implications

The three flows of compassion continue to be a transcultural model (2) and can therefore be considered a useful therapeutic framework for second-generation Sri Lankan men. However, shame itself emerged in this study as a barrier to help-seeking, meaning that recommendations for mental health services must go beyond simply offering therapy in its conventional form. Service may need to create low-threshold, non-stigmatising entry points – for example, outreach through trusted community settings (such as religious spaces, sports groups, or cultural organisations (102), or anonymous/online consultations (103) – so that men can engage without feeling that they have failed or transgressed cultural expectations.

Co-production between services and community settings is essential to improve collaborative efforts of engaging South Asian men, as community leaders in these spaces can serve as role models (104). Disseminating service brochures and psychoeducation materials with men may support them to understand their current difficulties without accessing therapy straight away, as well as making them aware of the support available to them (105).

Within therapy, it may be important for clinicians to first provide a space for SGSL men to talk openly about themes linked to shame, including their cultural heritage and identity, their positioning within the Sri Lankan community, their masculinity, their perceived success at work or school, and expectations set by themselves or others. Participants highlighted difficulties in verbalising emotions and in accepting compassion from others. This aligns with Gilbert and Procter's (2006) observations on the fears, blocks, and resistances to compassion, where cultural and social learning can render compassionate processes threatening rather than soothing (53). Clinically, this suggests that compassion-based work should be scaffolded carefully: therapists may initially model compassion in sessions and validate cultural experiences, before gradually introducing self-compassion strategies. It may also be valuable to

ensure that clients have access to trusted individuals in their wider networks who can reinforce compassionate support outside of therapy sessions, allowing SGSL men to navigate shame-based difficulties more safely.

### 3.4.7 Conclusions

The study investigated second-generation Sri Lankan men's experience of shame in context of the three flows of compassion. The findings reported that they experience shame in different ways based on their perceived judgment from others, their level of connection to the heritage culture, their position as a man culturally and in British society, their willingness to be emotionally expressive and the cultural pressure to succeed. The findings also suggest that second-generation Sri Lankan men understand the concept of compassion and experience all three levels flows to some degree. The three flows of compassion were seen as a conditional, relational space that was shaped by trust and safety. The men reflected on their personal journeys of communicating openly about their vulnerabilities, with some suggesting that self-compassion was a new experience, but can be actively interwoven by cultural engagement, by receiving CfO, by learning through modelled examples of compassion, or by self-compassion practices. Further exploration in applying compassion-based theories and interventions in this population needs to be considered.

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# Appendix A Author Guidelines – Systematic Review

The Author Guidelines for the Clinical Psychology & Psychotherapy Journal is available here:

Clinical Psychology & Psychotherapy

# Appendix B Quality Assessment RoB 2 Tool

| Authors & Dates | Study Design | Intervention Groups | Domain 1: Risk of bias arising from the randomization process | Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) | Domain 3: Risk of bias due to missing outcome data | Domain 4: Risk of bias in measurement of the outcome | Domain 5: Risk of bias in selection of the reported result | OVERALL RISK |
|---|---|---|---|---|---|---|---|---|
| Abbas et al. (2023) | Individually-randomised parallel-group trial | CBT - Experimental group vs. Waitlist Control (WLC) | Low risk | Some Concerns | Low Risk | Low risk | Low Risk | **Some Concerns** |
| Abbas et al. (2023) | Individually-randomised parallel-group trial | CBT - Experimental group vs. Waitlist Control (WLC) | Low risk | Some Concerns | Low Risk | Low risk | Low Risk | **Some Concerns** |
| Ara et al. (2023) | Individually-randomised parallel-group trial | CBT - Experimental group vs. Waitlist Control (WLC) | Low risk | Low Risk | Low Risk | Low risk | Low Risk | **Low Risk** |
| Dawood et al. (2019) | Individually-randomised parallel-group trial | Experimental (BA-M) vs. Treatment as usual (CBT) | Low risk | Some Concerns | Low Risk | High Risk | Low Risk | **High Risk** |
| Ghosh et al. (2023) | Individually-randomised parallel-group triak | RCT – experimental version of TreadWill vs. active control vs. waitlist control. | Low risk | High Risk | High Risk | Low risk | Some Concerns | **High Risk** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Hamdani et al. (2021) | Individually-randomised parallel-group trial (Single-blind) | Experimental (PM+ plus TAU) vs. Treatment as usual | Low risk | Low Risk | High Risk | Low risk | High Risk | **High Risk** |
| Husain et al. (2014) | Individually-randomised parallel-group trial - Rater blind | Psychosocial group vs. Antidepressant | Low risk | Low Risk | Low Risk | Low risk | Low Risk | **Low Risk** |
| Husain et al. (2017) | Individually-randomised parallel-group trial | LTP+ intervention vs. TAU | Low risk | Low risk | Low risk | Low risk | Low risk | **Low risk** |
| Husain et al. (2021a) | Cluster randomized controlled trial | LTP+ intervention vs. TAU | Low risk | Low risk | Low Risk | Low risk | Low Risk | **Low Risk** |
| Husain et al. (2021b) | Individually-randomised parallel-group trial | LTP+ intervention vs. TAU | Low risk | Low risk | High Risk | High Risk | Low Risk | **High Risk** |
| Husain et al. (2023) | Individually-randomised parallel-group trial | PHP (intervention group) with treatment as usual (control group) | Low risk | Low risk | Low risk | Low risk | Low risk | **Low risk** |
| Husain et al. (2024) | a multicentre, randomised controlled trial | PHP (intervention group) with treatment as usual (control group) | Low risk | Low risk | Low risk | Low risk | Low risk | **Low risk** |
| Mishra & Singh (2023) | Individually-randomised parallel-group trial (pre-test post-rest control group design) | Community-based psychosocial group vs. control group | Low risk | Some Concerns | High Risk | High Risk | Low Risk | **High Risk** |
| Naeem et al. (2014) | Multi-centre randomised controlled trial | CaCBT-based self-help manual vs. usual care | Low risk | Low risk | Low risk | Low risk | Low risk | **Low risk** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Naeem et al. (2015) | Individually-randomised parallel-group trial (assessor blinded) | CaCBT & TAU vs TAU Only | Low risk | Low risk | Low risk | Low risk | Low risk | **Low risk** |
| Rahman et al. (2008) | Cluster-randomised parallel-group trial | Exp (THP) vs. Control (Enhance Usual Care) | Low risk | Low Risk | Low Risk | Low risk | Low Risk | **Low Risk** |
| Rahman et al. (2016) | Individually randomised parallel-group trial | Problem Management Plus (PM+) vs. EUC | Low risk | Low risk | Low risk | Low risk | Low risk | **Low risk** |
| Rahman et al. (2019) | single-blind, cluster, randomised, controlled trial, | Problem Management Plus (PM+) vs. EUC | Low risk | Low risk | Low risk | Low risk | Low risk | **Low risk** |
| Reddy & Omkarappa (2019) | Individually randomised parallel-group trial | CBT vs Control (undefined) | Low risk | Some Concerns | Low Risk | High Risk | Low Risk | **High Risk** |
| Zareen & Jahangir (2019) | Individual randomised parallel-group trial | CBT (Exp) vs. Medication (AC) | Low risk | Some Concerns | Low Risk | High Risk | Some Concerns | **High Risk** |

# Appendix C Author Guidelines - Empirical

The Author Guidelines for the PloS Journal is available here:

Submission Guidelines | PLOS One

# Appendix D Interview Topic Guide

| **INTERVIEW TOPIC GUIDE**<br>*(This interview topic guide is specified as a guide as it may be modified based on reflexive activity and participant feedback, but substantive changes will not be made without an amendment)* |
|---|
| **Research Question:** How do second-generation Sri Lankan men respond to the experience of shame in the context of the three flows of compassion? |
| **First, I would like to thank you again for taking part in this research.**<br>**Double check/ remind the participant:**<br>• **The interview will take between approximately 60-90 minutes and may be shorter than this – is that okay with you?**<br>• **Your responses will be kept confidential, quotes will be used in the results, but your name will be changed**<br>• **You can change your mind about taking part in the study and stop the interview at any point and withdraw from the study**<br>• **You can have a break if you want to at any point and, and I will ask you halfway through the interview if you would like a break**<br>• **Do you have any questions? Have you signed the consent form. (If not get them to sign at this point.)**<br><br>**The purpose of this interview is to explore whether experiences of shame in the context of compassion are understandable concepts to second-generation men originally from Sri Lanka. I am interested in whether this is influenced by things such as your family and friends, your upbringing, your religion, your cultural identity – anything like that. So, before we begin, I wanted to remind you that there are no right or wrong answers, and that this interview is about finding out about your own personal experiences and views.**<br><br>**I will now start recording. Is that okay?** |
| **To begin with, could you tell me:** |

**DEMOGRAPHICS**

| | |
|---|---|
| 1. What is your age? | |
| 2. What is your ethnicity? | |

| | |
|---|---|
| 3. What do you identify as your cultural identities? (e.g. British Sri Lankan) | |
| 4. Are you a student or are you employed? *(Prompt: if employed ask about job role).* | |

**Thank you. I will now ask about your Sri Lankan heritage.**

**SINHALA / TAMIL / BHURGER / SRI LANKAN HERITAGE**

| | |
|---|---|
| 5. Could you tell me about your Sri Lankan heritage and your parents' decision to move to the UK? | Prompts:<br>- When did they move to the UK?<br>- Why did they move to the UK?<br>What was their motivation? |

**Thank you. We will now move on to talk about compassion:**

**COMPASSION**

| | |
|---|---|
| 6. Can you tell me what the term compassion means to you? | Prompts:<br>- When you hear the word 'compassion' – what does it make you think of?<br>- It doesn't matter if you don't know the exact definition – what do you think it might be? |

**Thank you. We will come back to the topic of compassion later on. I now would like to move the discussion to the experience of shame. The first set of questions will be exploring your description of shame.**

**DESCRIBING SHAME**

| | |
|---|---|
| 7. Can you tell me what the term shame means to you? | *Prompts:*<br>- *Does not have to be the exact definition, just what you think it might be.* |
| 8. Have you ever felt or experienced shame and if so in what context? | *Note to self:*<br>- *Understand if the experience of shame comes internally (within the self) or externally (from people around).* |
| 9. Have you ever experienced shame in the context of being a second-generation Sri Lankan man? If so, how? | *Prompts:*<br>- *Cultural identity (or identities)*<br>- *Religious views*<br>- *Cultural events*<br>- *Expectations*<br>- *Language*<br>- *Community* |
| 10. How do you think shame impacts men compared to women? | |

| | |
|---|---|
| | *Prompts:*<br>- *Why do differences/similarities exist?*<br>- *Any differences between Second-generation SL men to women.* |

***Thank you. The next set of questions are going to focus on situations where you experienced shame. In the context of these situations, I will ask questions in theme of the three flows of compassion. The first section will explore how compassion is showed to other people, the second section is how other people show compassion to us, and third section is how we show compassion to ourselves.***

| COMPASSION TO OTHER PEOPLE |
|---|
| 11. So, for the first set of questions:<br><br>I would like you now to think of an occasion or two when someone you cared about was going through a difficult situation. This could be a family member or a close friend. This could be any situation but particularly a time when they had felt either (or a combination of) - shame, embarrassment, guilt or humiliation.<br><br>**<u>As a second-generation Sri Lankan male:</u>** |

| | |
|---|---|
| a) Can you tell me if you showed compassion towards them? | ➔ *If so, how and why did you show compassion towards them? OR*<br><br>*If not, why not?* |
| b) Can you tell me the things you did or said to them that indicated you showed compassion to them? | *Prompt:*<br>- *you said 'x' and about 'x', did you say or do anything else?)* |
| c) What were your feelings and thoughts towards them? | |
| d) How did your words and/or actions affect them? | |
| e) Did this have an impact on you? | ➔ *If so, how and what did you take away from the situation?*<br><br>➔ *If the same situation happened again, would you respond in the same way?* |
| f) Are there factors that facilitate or help you to be compassionate towards others? | *Prompts:*<br>- *Circumstances*<br>- *People*<br>- *Influences in life* |

| | |
|---|---|
| g) Are there any barriers that make it difficult for you to be compassionate towards others? | *Prompts:*<br>- *Circumstances*<br>- *People*<br>- *Influences in life* |
| h) Was there any moment in this experience where you or the other person felt any shame in your opinion? | *Prompts:*<br>- *E.g. when they reached out to you or when you opened up to them).*<br>- *If so, why / why not?* |

***Thank you. We are now going to talk about how others show compassion to you.***

| COMPASSION FROM OTHER PEOPLE |
|---|
| 12. I am now going to ask you to think of a time when you were going through a difficult situation leading you to experience feelings of shame. This could in any context including with family, friends, community, religious or cultural events. This could be any situation but particularly a time when you had felt either (or a combination of) – shame, embarrassment, guilt or humiliation.<br>Do you have a situation in mind?<br>**<u>As a second-generation Sri Lankan male:</u>** |

| | |
|---|---|
| a) Can you tell me if anyone showed compassion towards you? | |
| b) Why do you think they were able to be compassionate towards you? | *OR*<br>- *If no one showed compassion, why do you think that may have been the case?* |
| c) Can you tell me the things they did or said to you? | *Prompt:*<br>- *You told me about 'x' and 'x' – did anything else happen?* |
| d) What were your thoughts and feelings towards them when they showed compassion towards you? | |
| e) How did their words or actions affect you? | *Prompt: How did it make you feel?* |
| f) If the same situation was to happen again, would you want them to respond in the same way that they did? | *Prompt:*<br>- *If so, why OR if not, why not?* |
| g) Are there any factors that facilitate or help others to be compassion towards you? | *Prompt:*<br>- *Circumstances*<br>- *People*<br>- *Influences in your life* |

| | |
|---|---|
| | *What helps you to receive compassion from others?* |
| h) Are there any barriers that make it difficult for others to be compassionate towards you? | *Prompt:*<br>- *Circumstances*<br>- *People*<br>- *Influences in your life* |
| i) Was there any moment in this experiences where you or the other person felt any shame in your opinion? | *Prompt:*<br>- *For example, when [you or they] reach out to you or when you opened up to them?*<br>- *If so, why / why not?* |

***Thank you. The next set of questions will explore the third aspect which is how we show compassion to ourselves.***

| COMPASSION TO OURSELVES |
|---|
| 13. We will continue to talk about occasions when you were going through a difficult situation. You are welcome to refer to the same examples you shared already or use another example.<br><br>**<u>As a second-generation Sri Lankan male:</u>** |

| | |
|---|---|
| a) Do you think that you were compassionate towards yourself | *Prompt:*<br>- *If so, why / if not, why not?* |
| b) What were your thoughts and feelings towards yourself? | *Prompt:*<br>- *Were you kind and supportive, or judgmental and critical, or other ways?* |
| c) How did you treat yourself? | *Prompt:*<br>- *What did you do to look after yourself?*<br>- *Probe: did you do anything else?* |
| d) What led on from the way you treated yourself? | *Prompt:*<br>- *What were the consequences of treating yourself as (refer to answer from 11c).* |
| e) If the same situation happened again, would you do and think the same way about yourself? | *Prompt:*<br>- *How would you respond to the situation if it occurred again?*<br>- *If so, why / if not, why not?* |
| f) Are there any factors that facilitate or help you to be compassionate towards yourself? | *Prompt:*<br>- *Circumstances*<br>- *People*<br>- *Influences in life* |

| | |
|---|---|
| g) Are there any barriers that make it difficult to be compassionate towards yourself? | *Prompt:*<br>- *Circumstances*<br>- *People*<br>- *Influences in life* |
| h) Besides the situation itself, was there any part of the experience in how you showed compassion to yourself that made you feel a sense of shame? | *Prompt:*<br>- *Do you think shame affected any part of your experience when thinking of being compassion towards yourself?*<br>- *If so, why / if not, why not?* |
| 14. Is there anything you would like to add or comment on that you haven't mentioned in your responses regarding your experiences of shame or compassion, in general, or in the context of being a second-generation Sri Lankan man. | |

| DEBRIEF |
|---|
| *Thank participant for taking part in the interview – give debrief form.* |

# Appendix E Empirical University Ethics Confirmation

University of Southampton

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 92440.A1
Submission Title: Experiences of shame and compassion in second-generation Sri Lankan men (Amendment 1)
Submitter Name: Prashan Diddeniya

The above submission has been approved by your supervisor and has now been sent to your Faculty Ethics Committee for review. You will be notified again if they request a revision or when they approve the submission.

**If your project is Category A, this will automatically proceed to the Research Integrity and Governance team following Faculty Ethics Committee review.**

You can check the status of your study any time by going to *List my Submissions* in ERGO II. Please note the standard turnaround time for review is 10 working days and submissions should not be chased before this point.

# Appendix F Consent Form

ERGO Number: 92440
V3: 05/08/2024

University of Southampton

## CONSENT FORM

**Study Title:** Exploring how second-generation Sri Lankan men living in the UK manage experiences of shame in the context of the three flows of compassion.

**Ethics/ERGO number:** 92440

**Version and date:** V3: 05/08/2024

Thank you for your interest in this study. It is very important to us to conduct our studies in line with ethics principles, and this Consent Form asks you to confirm if you agree to take part in the above study. Please carefully consider the statements below and add your initials and signature only if you agree to participate in this research and understand what this will mean for you.

**Please add your initials to the boxes below if you agree with the statements:**

| Mandatory Consent Statements | Participant Initials |
|---|---|
| I confirm that I read the Participant Information Sheet (Version 4, 05/08/2024) explaining the study above and I understand what is expected of me. | |
| I was given the opportunity to consider the information, ask questions about the study, and all my questions have been answered to my satisfaction. | |
| I agree to take part in this study and understand that data collected during this study will be used for the purpose of this study. | |
| I understand that special category data such as my gender and age will be recorded for the purpose of this study only, and I consent to give this information about me. | |
| I understand that my personal information collected about me such as my name and my email address which was used to contact me will not be shared beyond the study team. | |
| I understand that I will be asked further questions in a follow-up email to verify that I meet the inclusion criteria to take part in the study, and I will be informed if I pass the criteria or not. | |
| I understand that my participation is voluntary and that I am free to withdraw from this study at any time without giving a reason. | |
| I understand that taking part in this study involves audio/video recording via Microsoft Teams and that the recording will be deleted immediately once the final transcription has been checked and completed. | |
| I understand that once the recording has been transcribed, I will not be able to withdraw from the study as transcripts are anonymised. | |
| I understand that I may be quoted directly in reports of the research but that I will not be directly identified (e.g. that my information will be allocated to a random number and my name will not be used). | |
| I understand that the information collected from me will be stored for future studies in the form of anonymised transcripts and I give permission to this and for my special category data (age, gender and religion) to be stored in the form of anonymised survey database as described in the participant information sheet so it can be used for future research and learning. | |

| Name of participant | Signature | Date |
|---|---|---|
| Prashan Diddeniya<br>Name of researcher | Signature | Date |

# Appendix G Verification Table

| QUESTIONS | ANSWERS |
|---|---|
| 1. **Are you male?** | YES or NO |
| 2. **Are you above the age of 18?** | YES or NO |
| 3. **Are you currently engaged in therapy?** | YES or NO |
| 4. **Do you identify as being any of the following: Sinhala, Tamil, Burgher and/or Sri Lankan?** | YES or NO *(please state)* |
| 5. **Are you a first- or second-generation Sinhala / Tamil / Burgher / Sri Lankan?** | |
| 6. **Where were you born?** | |
| 7. **Are your parents BOTH originally from Sri Lanka?** | YES or NO |
| 8. **Please provide the name of the area (city/town) where your father AND mother were originally from/grew up?** | |
| 9. **What year did your parents leave Sri Lanka?** | |
| 10. **What was the reason for your parents migrating over from Sri Lanka?** | |
| 11. **What is your favourite heritage dish?** | |

# Appendix H Debriefing Sheet

## Debriefing Form

**Study Title:** Exploring how second-generation Sri Lankan men living in the UK manage the experience of shame in the context of the three flows of compassion.

**Ethics/ERGO number:** 92440
**Researcher:** Prashan Diddeniya
**University email:** pd4n22@soton.ac.uk
**Version and date:** Version 1 - 24/05/2024

Thank you for taking part in our research study. Your contribution is very valuable and greatly appreciated.

**Purpose of the study**
The objective of the study is to understand the interplay between the notion of compassion and the personal experiences of shame in second-generation Sri Lankan men. The findings will contribute towards future studies aiming to introduce culturally sensitive therapeutic practices, using the Compassionate model, to second-generation Sri Lankan men that need support with their psychological well-being.

**What happens next?**
As mentioned in the information and consent forms, your interview recording will be transcribed and anonymised once the 7-day cooling window after your interview has elapsed. This research did not use deception, and the study will not include your name or any other identifiable characteristics.

The anonymised data will be analysed using thematic analysis to understand participants' views and experiences of compassion and shame. You may request a summary of the research findings by contacting the researcher once this project has been completed.

As a thank you for your participation, you will receive a £50 Amazon voucher. This will be sent to the email address you provided, at the end of the study's data collection process. Please note, that if you withdraw from the study during the 7-day cooling-off period after your interview, then you will not be eligible to receive the voucher.

**Support**
The questions asked in the study were not intended to cause distress. However, if you feel distressed, then we signpost you to the following resources from the Compassionate Mind website to support you:

- Audio Resources: Audio (compassionatemind.co.uk)
- Video Resources: Videos (compassionatemind.co.uk)

If you wish to seek any assistance, the following website provides a list of self-help strategies to deal with difficult situations: https://web.ntw.nhs.uk/selfhelp/

Further support, can be accessed by contacting the following organisations:

1. Samaritans (0330 094 5717)
2. NHS Helpline (111)
3. Your GP

**Further information**
If you have any concerns or questions about this study, please contact Prashan Diddeniya at pd4n22@soton.ac.uk, or Prof. Margo Ononaiye at M.S.Ononaiye@soton.ac.uk.

If you remain unhappy or would like to make a formal complaint, please contact the Head of Research Integrity and Governance, University of Southampton, by emailing: rqoinfo@soton.ac.uk, or calling: + 44 2380 595058. Please quote the Ethics/ERGO number which can be found at the top of this form. Please note that as you participated in an anonymous survey, by making a complaint, you may lose your anonymity.

Thank you again for your participation in this research.

# Appendix I Sample Coding Tracking Manual

| Coding Tracking Manual | | | | | | |
|---|---|---|---|---|---|---|
| P10947 | 23 | Think my partner is like a mix of both the element of compassion and then the element of like not making a | Pink | Compassion from Others (CfO) | Source of comapsssion from partner can be balanced. | Compassion - Friendship |
| P10947 | 23 | My own shame potentially against like a male surrounding you don't wanna feel, or I personally don't wanna feel. I don't know what's the word like, so it's not not inferior, but like that feeling of of shame around like a male population is not something I ideally like to feel, but I am OK with sharing that with my close friends. | Red, Orange, Purple | Shame-related experiences | Shame difficult to show to other male friends but is person specific and close friends can be exclusive. | Between Worlds - Learned Silence |
| P10947 | 23 | Maybe like how long someone has known me probably helps in understanding. Like who I am. How I react to things in general. Thing that helps. You have it being in person versus on my online presence or or like over the phone. | Pink | Compassion from Others (CfO) | Length of time a person knows person can help receive CfO especially in person. | Compassion - Friendship |
| P10947 | 24 | So someone who, if I say the I didn't get a job comes like ohh yeah, don't worry about it, okay, you'll get the next one. I'll like. I'd like try to cut it off before they they can kind of like offer that that level of compassion like "oh don't worry about, it's not big deal" So like I guess I'm I'm the blocker to receiving compassion. Yeah, I am the blocker at at times receiving compassion because I don't want to receive it because I think it's like not a big deal. | Red, Pink | Compassion from Others (CfO) | Blocking receiving CfO. | Compassion - Resisting |
| P10947 | 26 | In the few circumstances of like of like my parents. I would say uh, as the Asian parents their level of expectation is quite high and like they don't provide a say very emotional response sometimes it is more you know. They're going to say what they say and that can be a bit more harsh to hear and that will make me feel a bit more shame probably because my parents like: Oh you didn't get the job? Oh so you didn't hear back? So then interview didn't go well. All these kind of comments probably we feel more shame because they | Red, Orange | Cultural Identity/Expectations/Masculinity | Parental expectations can raise feelings of shame because of their harsh comments. | Shame - Social value |

# Appendix J Sample Reflective Log Diary

**04/08/2024 – Recruitment specifications**

This week I officially advertised the study on LinkedIn and Instagram on 29/07/2024. This was a success as I managed to get a lot of interest into the study. However, I did not anticipate that there would be a comment made about the recruitment which suggested to be excluding individuals who were Tamils originally from Sri Lanka living in the UK, who did not necessarily identify as being Sri Lankan. I responded to this comment by expressing my understanding in their sentiment and that the study was looking at individuals who did identify as Sri Lankan as a starting point. Another comment popped up stating that I should make it more inclusive to Tamils as it does meet the requirements of the study.

Upon reflection, the identity of 'Sri Lankan' is part of who I am as a person and as a researcher for the study. I am looking at the diaspora of second-generation individuals whose parents left Sri Lanka, and I realise that the reason for leaving will vary across the board. My own parents left for better prospects and new opportunities, whereas others left because they had no choice. They fled for their lives and most never to return due to the trauma. I feel that this is a voice that I need to acknowledge as part of the study, and especially as this is from a compassionate lens, hearing their experiences as a male and second-generation, would bring great value to the study.

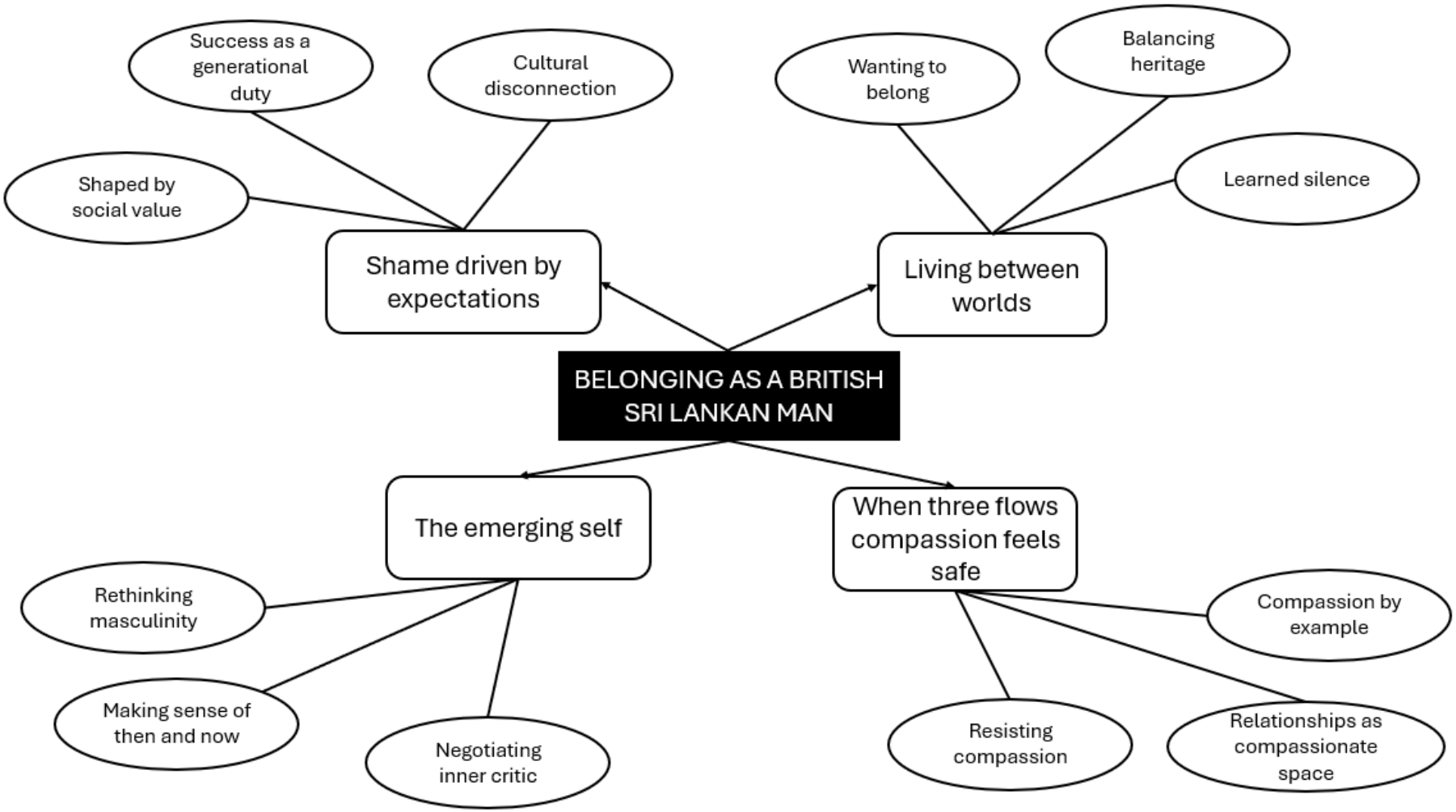
**05/08/2024 – First interview**

First interview was completed with participant 90565. It was a great interview from the participant. Their experience of shame centered mostly around their professional life as they were in a competitive field of work that was often subjected to assessments. It was a useful insight to see how the drive of a first-generation immigrants may be transferred into second-generation immigrants who pursue high paid roles in society as a measure of success and/or survival. The participant reflected that they experience a mix of internal and external shame in not wanting to express their experience with others. Fortunately, they had a group of friends they trusted enough to approach them and share their experiences, and the shame in doing so was not present. Instead, they reported feeling comfortable and open to be vulnerable about their challenges not obtaining the results they sought for in job interviews. I was also interested that his experience of self-compassion was longer lasting than experiences of receiving compassion from others, and how the drive be compassionate to others can be applied in different situations that comes along, whilst also be transferable and shared with others as perhaps a source of wisdom and experience. He identifies that Sri Lankan men are often not in a space to have open discussions and reflections of these topics, and if given the opportunity to do so, how communicative and open would they be.

**23/08/2024 – Second interview**

The second interview was completed after it was rescheduled from last week. The participant was an upcoming student starting university in September. His experience of shame felt age appropriate, regarding his GCSE results. In addition to this, there was an added layer of complexity in his experience of shame as his mother passed away at the time of his GCSEs. He shared his experience that the last conversation he had with his mum was about not spending time on his phone and instead to study. I was struck by his level of emotional growth since and his ability to reflect on his vulnerability and actions. He shared

# Appendix K Final Thematic Map



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