University of East London

Experience of Ethnicity in Therapy from the Perspective of Clients Self-Identifying as South-Asian: An Interpretative Phenomenological Analysis

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Abstract

As British society becomes increasingly multicultural, coupled with the majority of therapists identifying as Caucasian; South-Asian clients are increasingly receiving therapy from an ethnically dissimilar therapist. Within the literature on cross-cultural therapy, often individuals identified as Black and Minority Ethnic (BAME) are treated as one homogenous group. Consequently, there is a paucity of literature focusing specifically on people of South-Asian heritage and their experience of ethnicity in cross-cultural therapy. The current study aims to address that gap in the literature by exploring the experience of clients self-identifying as South-Asian who are in therapy with a therapist of a different ethnicity.

Eight clients who self-identified as South-Asian participated in semi-structured interviews and their accounts were analysed using interpretative phenomenological analysis (IPA). Four superordinate themes were identified: 1) South-Asian ethnicity and addressing stigma in cross-cultural therapy, 2) Ethnically dissimilar therapist allows for greater openness and freedom of expression, 3) Internalised racism; South-Asian therapists are 'tainted by their culture' and 4) Therapists skills and qualities are more important than their ethnicity. While some participants also spoke about previous courses of therapy with a South-Asian therapist, the majority focused on therapy with either a White or Black therapist. Links were found between participants' identification and acceptance of their own ethnicity, which seemed to be connected to their assumptions of difference in the therapy room. In addition, the role of stigma and discrimination and the impact of this on therapist choice, engagement and interaction in therapy were salient themes throughout. The therapist's competency and ability to remain open and curious about difference was seen as a key factor irrespective of their ethnicity.

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May your souls rest in eternal peace… Ameen

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List of Abbreviations

IPA: Interpretative Phenomenological Analysis

DPA: Descriptive Phenomenological Analysis

TA: Thematic Analysis

GT: Grounded Theory

APA: American Psychiatric Association

BAME: Black and Asian Minority Ethnic Groups

BPS: British Psychological Society

HCPC: Health and Care Professions Council

UK: United Kingdom

USA: United States America

ONS: Office for National Statistics

IAPT: Improving Access to Psychological Therapies

DoH: Department of Health

UEL: University of East London

CBT: Cognitive Behavioural Therapy

APA: American Psychiatric Association

CRT: Critical Race Theory

AKHB: Aga Khan Health Board

AKDN: Aga Khan Development Network

Chapter 1: Introduction

Statement of positionality

As a South-Asian girl growing up in the 1980s in Brighton and then Canada, I realised at an early age that I was 'different' to the majority. My ethnicity, the colour of my skin and my cultural background was different to those around me, and I generally felt uncomfortable if I addressed this. I felt that I did not fit in, and so attempted to assimilate myself with the majority as much as possible. I denied any experience of racism, as I learnt it was a taboo and not to be spoken about. More recently, I was working in a secondary care psychology team, and had an interesting experience which inspired me to undertake the current study. A South-Asian client refused to be seen by myself (a South-Asian woman) and instead requested to be seen by a White colleague. After I got over my initial feeling of rejection, I was intrigued to learn why she did not want to be seen by someone of a similar ethnicity to her. This experience inspired me to read previous literature in the field of cross-cultural counselling and clients' experience of it. Interestingly, I too have chosen a White therapist for my personal therapy, and I have shared my personal reflections on this in this study.

My training journey has been experienced through my individual cultural lens. As a South-Asian trainee on a professional doctorate programme in the UK, I bring my ethnicity and cultural heritage into an academic institution whose foundation is built on British culture. The British culture, coupled with the fact that my cultural heritage is South-Asian, means there is an inherent cross-cultural element to my training. This has been an invaluable experience for me, as counselling psychology involves many cross-cultural relationships between clients and therapists.

The current rise in cross-cultural therapeutic relationships is mainly due to increased globalisation; it has become extremely easy for different cultures to come together following the movement of people around the world (Helman, 2007).

Despite the rise in cross-cultural therapeutic relationships, there continue to be challenges in how difference is approached in the therapy room by clients and therapists alike (Pilgrim, 1997). Training programmes stress the importance of therapists being culturally aware, in order for them to be competent to address difference in the therapy room (James, 2016). In reality, though, therapists often feel anxious and uncomfortable when discussing ethnicity with their clients (Patel, 2014).

Previous research on the experience of clients in cross-cultural therapy has been mixed. Laungani (2004) posited that many South-Asian's do not feel the need to access therapy as they feel their close-knit families provide sufficient support. Equally, many South-Asian's assume that they will not be understood by a White therapist, and believe they may impose their own Westernised values onto their clients (Laungani, 2004). In therapeutic encounters where the client and therapist do not share the same ethnicity, language, social norms and assumptions, often misunderstandings can occur (Laungani, 2004). However, there is also evidence to suggest that South-Asian clients may have a preference for a White therapist rather than a South-Asian therapist due to the stigma attached to accessing therapy (Gurpinar-Morgan et al. 2014). The role of shame and stigma in the South-Asian community is an important issue, as the shame of being assigned a diagnostic label or called 'mentally ill' often prevents many South-Asians from accessing therapy (Gilbert et al., 2004). If those clients do seek therapy, research suggests they may often prefer to be seen by an ethnically dissimilar therapist to avoid this stigmatisation (Gurpinar-Morgan et al. 2014). Previous research combined with my own

experiences led me to become interested in more fully understanding clients' experiences of ethnicity in cross-cultural therapy.

Overview

According to the most recent census from the Office for National Statistics (ONS, 2011) 14% of the UK population identify as belonging to an 'ethnic group'. The number of people identifying themselves as belonging to an 'ethnic group' more than doubled in recent decades (8.7% in 2001 and 5.9% in 1999). With the emergence of globalisation both clients and therapists in the UK have been impacted by its effects (Lago, 2006). This increasing trend of expanding 'ethnic groups' in the UK is likely to continue. In the therapeutic domain of psychology, ethnic differences between the client and therapist have long been considered important factors affecting the therapy relationship (Helmes & Cook, 1999; Jones, 1978). A survey carried out in 2016 from the division of counselling psychology in the BPS found that 95% of counselling psychologists in the UK identified as being White (Jones-Nielsen and Nicholas, 2016). Therefore, given the statistics, it is more likely that South-Asian clients will be allocated to a White therapist given the ethnic make-up of services currently (Jones-Nielsen & Nicholas, 2016). Naturally, these figures are reflected in therapeutic encounters. Sue et al. (1996) stated that increased cultural diversity in the UK population has resulted in a greater need for cross-cultural therapy.

Interestingly, the 2011 census showed that over half of those who identified as belonging to an 'ethnic group' identified as 'Asian/Asian British' and the second most prevalent ethnicity after 'White' was 'Indian' (with 1.4 million people identifying as Indian) (ONS, 2015). It is unfortunate that this group is not prominently represented in research; the majority of research in this area has focused on BAME groups more generally.

Relevance to Counselling Psychology

Research has repeatedly demonstrated that there is a lack of focus and inadequate coverage of ethnicity and cross-cultural in higher education at graduate and post graduate level (Laungani, 2004). Ethnicity has not been given the focus it deserves, and this has affected how therapists *address* or *fail to address* it in the therapy room. If counselling psychologists are not given the space and support to explore their own ethnicity and that of their clients, how can therapists be expected to be culturally aware? Many therapists avoid addressing ethnicity from a fear of 'saying the wrong thing' or being accused of being racist or offensive (Patel, 2014). This then, impacts the experience of ethnicity in the therapy room for clients (Patel, 2014).

According to the Practice Guidelines for Psychologists (BPS, 2017) and the Standards for Proficiency for Practitioner Psychologists (HCPC, 2015), therapists are required to practice in a non-discriminatory manner, be aware of stereotypical beliefs, acknowledge the history of racism, and respect their clients' ethnicity and cultural beliefs by tailoring their approach accordingly. The guidelines address how to work effectively with clients from diverse backgrounds; however, they seem to fail to address cross-cultural aspects of the therapy process. For example, there is limited guidance on addressing cultural difference between the client and therapist, and how this might contribute to the clients' experience of ethnicity in therapy. A review of previous literature will now be explored.

Chapter 2: Literature Review

Overview

First, I offer a summary of significant terms related to the current study, followed by an overview of findings from previous research pertaining to cross-cultural counselling and clients' views on ethnicity in the therapeutic relationship. I critically evaluate the findings by discussing their strengths and weaknesses, thus highlighting a research gap. On this basis, I argue that there is a need for more qualitative research to be undertaken in the UK with South-Asians, as the majority of previous research is quantitative, has taken place in the USA, and has involved BAME groups in general rather than focusing on South-Asians. In addition, there have been many inconsistencies in previous research which warrant further study. This chapter will conclude by offering a clear rationale for my proposed research study by describing its relation to the field of counselling psychology, culminating in an illustration of my aims and research questions.

Literature search strategy

To carry out a comprehensive literature search I searched several electronic databases (PsycINFO, PsycARTICLES, EBSCO, Scopus and Google Scholar) using a variety of key words, including 'ethnicity', 'South-Asian', 'BAME', 'psychological therapy', 'multi-cultural counselling', 'cross-cultural counselling', 'ethnic-similarity', 'ethnic-dissimilarity', 'ethnic-matching', 'client's experience', 'race', 'culture', and 'mental health'. Papers were initially chosen by reading their titles and abstracts. If they were related to cross-cultural therapy, ethnic matching, or psychological therapy with South-Asians, they were selected for inclusion in the literature review. I then manually performed snowball searches, reviewing reference lists to find additional related papers. There was a lack of research undertaken in the UK and with South-Asians; therefore,

research carried out in the USA and with BAME groups in general were included. To complement the literature search, relevant books were found by accessing the University of East London (UEL) library repository. In addition, websites including those of the Office for National Statistics (ONS), and The Health and Care Professions Council (HCPC) and British Psychological Society (BPS) were also used for reference.

Constructions of race, culture and ethnicity

Before embarking on a review of the literature in the field of cross-cultural counselling, and to fully understand discussions in this study, it is important to understand the meaning of the terms race, culture and ethnicity, which are often incorrectly used interchangeably. It is also fundamental to understand these constructs, as they influence how we view our identity and how we view others.

Race has been defined on the basis that people can be separated into categories constructed around their physical appearance, including facial features, skin colour, and hair colour, which is perceived to be permanent and genetically determined (Fernando, 2010). But race is not a scientific concept and arguably does not exist in any kind of biological sense. Instead, perhaps, it exists only as a social and political construct— though of course one with real-world implications (Fernando, 2010). Race has been used for thousands of years to create unjust hierarchies (Durrheim et al., 2009). Racial categories have been defined as groupings formed on the basis of shared physical characteristics (Lago, 2006). The most recent 2011 census included the following racial categories: White, Asian, Asian British, Black, African, Caribbean, Black British, Mixed, Multiple ethnic group and other ethnic group (ONS, 2011). The term 'South-Asian' is used to identify a group of people whose cultural and/or familial backgrounds originate from the Indian subcontinent, Pakistan, Bangladesh, Sri Lanka, and East Africa (Dobbs

et al., 2006). The term 'White' is used to identify a group of people of European decent (Tuckwell, 2002). The acronym 'BAME' stands for 'Black and minority ethnic group' and is used to refer to ethnic groups in the UK who do not identify at White (Stevenson, 2010).

Culture can be defined as behaviours and attitudes that are social and changeable, including social norms and rules for living. Culture is assumed to have been passed down from generation to generation; however, one's culture is changeable and dictates how one lives (Fernando, 2010). Culture has been defined as a dynamic process which is influenced by social, political, and historical factors (Whaley & Davis, 2007).

Ethnicity has been described by Fernando (2010) as one's sense of belonging and sense of identity, which is perceived as psychosocial and partially changeable. He posits that ethnicity reflects how people see themselves, in terms of their background and cultural heritage (Fernando, 2010). Therefore, ethnicity has an impact on how people see themselves and how they relate to others. I will use the term ethnicity in this study, as it encapsulates both race and culture (Fernando, 2010). In relation to ethnicity and psychological therapy, it is important to understand the concept of cross-cultural therapy. Cross-cultural therapy, also known as multicultural therapy, takes place when the client and therapist identify as having different ethnicities to one another (Palmer, 2002).

Racism and racial prejudice

Fernando (2010) mentioned that it is important to highlight the distinction between 'racism' and 'racial prejudice'. Racial prejudice is a psychological state, attitude or feeling which is expressed, whereby a person believes that other racial groups are not equal to them. This may entail overgeneralising the negative attributes of a few people to

the whole group. Racism can be recognised by the derogatory way in which a person behaves or stereotypes another (Fernando, 2010).

Calvin (1997) stated that we make sense of others and their differences by organising new information into categories and applying this knowledge to future situations, thus forming stereotypes. Eleftheriadou (2006) believes that people form stereotypes when they feel anxious about interacting with other people from different ethnic groups. In addition, Eleftheriadou (2006) asserts that people form stereotypes by having a narrow ethnocentric worldview. In essence, this refers to the fact that people use their own ethnicity or cultural background as 'the norm' that other groups are compared against.

Racism in psychology

There are different types of racism in psychology including *overt racism* and *covert racism* (Lago, 2006). An example of overt or intentional racism is a therapist who refuses to see a client based on their ethnicity. An example of covert or unintentional racism would occur if a counselling service expected their clients to complete standardised psychological tests which do not take into account cultural differences (Lago, 2006).

Racism is often conceptualised on an interpersonal level between people or institutions; however little is known about internalised racism which takes place within an individual (David et al., 2019). According to Williams and Williams-Morris (2000), internalised racism refers "to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves" (p. 255). Speight (2007) argues that the internalising of racism can cause even more harm than if it were coming from someone else. The dominant group's beliefs, social norms and ideals assume a superior position, becoming the norm, whereby all other minority group's beliefs, social norms

and ideals are viewed as inferior Speight (2007). There is a lack of research in the UK in relation to internalised racism amongst South-Asian's, however there is one doctoral research which has been conducted by Parakrama (2012) in the USA. Parakrama (2012) explored the phenomenon of internalised racism among South-Asian clinicians, working with South-Asian clients. In relation to the therapy dyads, Parakrama (2012) found salient themes including: 'disclosure of racial identity' and 'discussion of racism'. Although these findings are interesting they were not focused on South-Asian clients' experience of internalised racism towards South-Asian therapists.

In addition, therapy models are based on Western, Eurocentric culture, which is a worldview that is predominantly based on the premise that Western civilisations are superior in relation to Eastern culture. Such therapy models are individualistic in nature, but they are expected to be helpful for people of different 'non-Western' backgrounds (Orlans & Van Scoyoc, 2009). It can be argued that Western therapy models fail to consider Asian and other 'non-Western' groups that are predominantly collectivist in nature (Sue et al., 1996). Pilgrim (1997) argued that by not considering different ethnicities, therapy models are unintentionally racist—which is as harmful as intentional racism. This is all relevant when thinking about therapeutic relationships between the client and therapist. It can be argued that we all have preconceived assumptions, judgements, and stereotypes about ourselves and others; however, the extent to which they affect our relationships depends on our understanding of them and whether we feel comfortable having an open, honest conversation with the other person in cross-cultural therapy (Palmer, 2002).

Ethnicity and access to mental health services

Research has shown that BAME groups are considered to be at increased risk of psychological distress compared to the general population (Bhui & Mackenzie, 2008), however they are less likely to access mental health services than the majority population (Steel et al., 2006). Recent figures from the National Health Service (NHS) Psychological Therapies Report on the use of Improving Access to Psychological Therapies (IAPT) services reported that BAME clients were 64.3% less likely to complete therapy than their White British counterparts (Health and Social Care Information Centre, 2018). This disparity is surprising given the prevalence rates of mental health difficulties are reported to be higher among the BAME population compared to the White majority (Department of Health, 1999; National Institute for Mental Health in England, 2003).

Specifically regarding South-Asians and access to mental health services, Moller et al. (2016) explored beliefs and attitudes of second-generation South-Asian woman in Britain in relation to their likelihood to seek help by accessing counselling. Eighty-two women, most of whom had not experienced therapy, responded to a qualitative survey. The authors found an overarching theme of generalising and stereotyping of therapy itself and of White therapists, which acted as barriers to access therapy (Moller et al., 2016). Although studies such as that of Moller et al. (2016) are useful in helping us to understand South-Asians' beliefs related to accessing therapy, there is also a great need to understand the subjective relationship between ethnicity, mental health, and cross-cultural therapy to ensure that clients make the best use of therapy and support positive outcomes (Department of Health, 2005).

South-Asian migration history to Britain

To understand current cross-cultural therapeutic relationships, it is important to have a historical understanding of South-Asians' experience of migration to Britain. In the 1950s many South-Asians from India, Pakistan, South Africa, East Africa, and the West Indies migrated to Britain in search of a new life and job opportunities (Laungani, 2004). Since the establishment of the East India Company South-Asians from the Indian Subcontinent migrated to Britain for work (Visram, 2002). However in the 1960s, Britain decided to close their *open door policy* due to fears of too many *third world people* infiltrating their country. In the 1970s, many South-Asians were forced to leave Uganda, as they held British passports many of them migrated to Britain, Canada and USA (Laungani, 2004). The first migrants to Britain were considered first generation, many of whom arrived with their families and had children in Britain, who would be known as second generation (Laungani, 2004). This led to an increase in multiculturism and a rich ethnic tapestry, which forms present day Britain (Laungani, 2004).

Theoretical Models

The Critical Race Theory (CRT)

When researching the field of cross-cultural therapy one cannot ignore the CRT, which was developed by Delgado and Stefancic (2001). The CRT posits that cultural and racial differences can be attributed to one's social constructions which develop over time (Delgado and Stefancic, 2001). The CRT was developed in response to the 'colour-blind' ideology in relation to race. According to Holt Barrett and George (2005) the 'colour-blind' ideology in relation to race was often used by White people who claimed there were no differences between people, to make them feel less uncomfortable. The APA rejected this ideology on the grounds of racism in 2002. Holt Barrett and George (2005) claimed that being ignorant about actual racial differences between people, encourages

discrimination and racism. Support has been offered by Erskine (2002) who proposes that therapy is never conducted in a *neutral race environment*, thus there will always be differences between the client and therapist. Erskine (2002) recommends in order to prevent discrimination, racial differences and their social influences should be discussed openly.

Ethnic-matching and cross-cultural therapy

The importance of ethnic matching, and whether it is helps the therapeutic relationship between clients and therapists, is related to many factors (Palmer, 2002). In the therapeutic domain of psychology, ethnic differences between clients and therapists have long been considered important factors affecting the therapy relationship (Helmes & Cook, 1999; Jones, 1978).

Karlsson (2005) suggested that the most popular question in this area is whether clients prefer therapists who are of the same ethnicity or not. The literature on ethnic matching of clients and therapists remains inconclusive. Eleftheriadou (2002) explored this and suggested that a therapist with the same ethnicity as their client may facilitate a positive therapeutic alliance as they have shared cultural norms and values. However, there are also drawbacks, as they may over-identify with each other, or may not prescribe to presumably shared norms (Eleftheriadou, 2002).

The 1960s saw an increase in interest of cross-cultural therapy among counselling psychology researchers (Moodlye, 2007). As Britain's society has become more multicultural, it is becoming more common to have clients and therapists of different ethnicities in the same therapy room (Clarkson & Nippoda, 1997).

The HCPCs standards of proficiency for practitioner psychologists and BPS guidelines stipulate that mental health practitioners should consider the ethnicity of the client and its impact on their psychosocial wellbeing (BPS, 2017; HCPC, 2015) and potential interventions (BPS, 2017). However, there is a body of literature that suggests therapists often struggle to achieve this. For instance, Knox et al. (2003) carried out a qualitative study to explore the views on cross-cultural therapy of 12 psychologists with different ethnic backgrounds. They found that many therapists were uncomfortable addressing ethnicity, and therefore refrained from talking about it with their clients. Perhaps this outcome should be expected, given how little training on ethnicity is included in most courses.

In support of Knox et al (2003), another study by Patel (2014) found consistent results. Patel (2014) interviewed White therapists about their experience of working with clients of different ethnicities, and found therapists struggled to talk about the ethnic differences between themselves and their clients. Therapists also reported feeling anxious to talk about ethnicity in the therapy room with their clients. This finding highlighted a barrier in the therapeutic relationship. However, it is important to note in such situations the client will eventually express their difficulties, irrespective of whether they are related to ethnicity or not (Eleftheriadou, 2002). This would then help the therapist to get a better understanding of their clients' ethnicity and whether they attach importance to it or not. Although it is useful to understand the therapist's experience of cross-cultural therapy (Knox et al., 2003; Patel, 2014), this evidence suggests that it is fundamental to explore clients' views on ethnicity in therapy with particular reference to cross-cultural therapy. A better understanding of clients' experience of ethnicity in therapy will result in better engagement, therapy relationships, and outcomes (Lanugani, 2004).

Quantitative studies on ethnic matching and clients' views

Quantitative studies reflect a positivist epistemological approach, founded on the assumption that the truth is objective and statements about the world can be tested through experimentation and observation (Larsson, Brooks & Loewenthal, 2012). Although quantitative research can be generalizable to large populations and have statistical power, this approach is not aligned with the humanist position of counselling psychology, which posits that clients are subjective experts in their experience and a source of rich narratives (Cooper, 2009). Although there have been more quantitative than qualitative studies in this area, their results have been inconsistent, suggesting a need for further research in the field.

For instance, Cabral and Smith (2011) carried out a meta-analysis of 81 quantitative studies in America. They were particularly interested in three main aspects: clients' preferences for a therapist of their own ethnicity, clients' perceptions of their therapist's ethnicity, and therapy outcomes. The findings suggested clients had a moderately strong preference (Cohen's $d = 0.63$) for a therapist of their own ethnicity. Clients also had a tendency to perceive therapists of their own ethnicity slightly more positively than other therapists (Cohen's $d = 0.32$). The authors also found almost no benefit of ethnic matching of clients with therapists for treatment outcomes (Cohen's $d = 0.09$).

The meta-analysis by Cabral and Smith (2011) is consistent with other findings that client's ethnicity had an effect on therapist preference. This is supported by previous studies such as that of Proctor and Rosen (1981), who found that both Black and White male veterans preferred therapy with an ethnically similar counsellor. A major weakness of Cabral and Smith's (2011) meta-analysis is that the majority of studies involved participants who were not actual clients, but instead members of the public who were

asked their preferences on the ethnicity of their therapist, if *they were* to access mental health services. In evaluation this study can be critiqued as it is an assumption to infer members of the public would be able to accurately imagine what their experience would be if they were to have therapy.

Another meta-analysis carried out by Shin et al. (2005) yielded results that disagree with those of Cabral and Smith. Shin et al. (2005) looked at 10 studies between 1991 and 2001 of ethnic matching between African American and Caucasian American therapeutic dyads. They investigated the effectiveness of ethnic matching in terms of retention rates and number of sessions attended. They found no significant differences between ethnically matched and ethnically unmatched dyads of clients and therapists (Shin et al., 2005).

There is some evidence to suggest positive outcomes of ethnically matching clients with therapists. Sue and Zane (1987) found that the therapists get more credibility from their clients during the initial stages of therapy when they are ethnically matched. In addition, ethnic dissimilarity between clients and therapists has been thought to cause miscommunications, misunderstandings, and cultural biases resulting in greater client drop-out rates (Erdur, Rude & Baron, 2003). However, Erdur et al. (2000) did not find significant effects of ethnic matching in a study of the working alliance and counselling outcomes of Asian American, African American, Hispanic and White clients in ethnically matched and non-matched counselling dyads in data obtained from 42 university and college counselling centres (Erdur et al., 2000).

The studies discussed above highlight inconsistencies in findings. Penderson et al. (1989) said that more questions are raised than answered in the field of ethnic similarity, as these

studies only focus on clients' race. Thus, they proposed it is important to explore other factors, such as the client's social class, racial identity, and the style of counselling they prefer. Penderson et al. (1989) further said that these factors are more likely to have an effect rather than these studies that solely look at race.

It should be noted that the studies discussed above were carried out mainly in Canada, and therefore their findings are not representative of clients and therapists in Britain. Another limitation has been outlined by Karlsson (2005) and Sue (1998), who posited, many of the quantitative studies described above lack reliability and validity, as they have implemented client records or they have asked students to role-play scenarios. In such instances, real-life clients have not been approached and asked about their own experiences of ethnic similarity in therapy. Although the effects of ethnic matching of clients and therapists has proven to be important in the field, not many studies have investigated actual clients in therapy (Erdur et al., 2003). These factors have motivated the present study.

Qualitative studies on ethnic matching and clients' views

Qualitative research believes the truth is subjective and multi-faceted; therefore, all individuals have their own truth and perspectives, which are equally valid (Vishnevsky & Beanlands, 2004). Only two relevant qualitative studies were found in this review of the literature.

A qualitative study of 23 BAME clients carried out by Chang and Yoon (2011) investigated the effect of race in cross-cultural therapeutic relationships, examining clients' perceptions of working with a White therapist. They found that most clients felt that the White therapist could not understand key aspects of their experiences, and

therefore the clients avoided discussing issues pertaining to their ethnicity. However, many clients felt that racial differences were minimised if the therapist was kind, accepting, and felt comfortable addressing racial issues. Conversely, a small group of clients found benefits in a racial mismatch and perceived disadvantages from racial matching. Conflicting findings suggest the construction of one's South-Asian ethnicity is multi-dimensional, and further research is required in the field (Chang & Yoon, 2011). Although this study is useful in that it gave a qualitative account of clients' subjective experience, reflecting counselling psychology's humanistic stance (Cooper, 2009), it only considered ethnic minorities in America, not Britain. Although research in this area in Britain is scarce, a few studies have been carried out.

Gurpinar-Morgan et al. (2014) conducted a British qualitative study focusing on the views of five BAME adolescents engaging in cognitive behavioural therapy (CBT) on ethnicity and how this affected the therapeutic relationship. The authors used interpretative phenomenological analysis to find four main themes. The most interesting theme was related to having an ethnically dissimilar therapist; all participants had worked with an ethnically dissimilar therapist and reported therapy was beneficial (Gurpinar-Morgan et al. 2014). These findings are consistent with the quantitative findings of Cabral and Smith (2011) that therapeutic outcome is unrelated to ethnic similarity between client and therapist.

Like Chang and Yoon's (2011) finding, the majority of clients felt White therapists could not understand key aspects of their experiences and therefore clients avoided discussing issues pertaining to their ethnicity, Lago (2006) highlighted the challenge many therapists face in such situations. Lago proposed that all therapists should be trained to understand how their own ethnicity and cultural background affects how they perceive their clients'

distress and difficulties. According to Lago (2006), if therapists understand how their own ethnic background affects how they perceive their clients' difficulties, they will feel more comfortable talking about differences in the therapy room, resulting in a more positive experience for the client.

There is much debate as to whether ethnically matching clients to therapists is effective in fostering a positive therapeutic alliance. Cabral and Smith (2011) stated that attempting to ethnically match clients and therapists is not feasible. If psychology teams in the USA and UK were to enforce ethnic similarity, it might produce unintentional negative consequences (Alladin, 2002). Indeed, therapists working with only one ethnic group may fail to develop competencies across different ethnic groups. They may also fail to acknowledge that within-group differences can be greater than between-group differences (Cabral & Smith, 2011). In addition, there are not enough BAME therapists, according to the American Psychiatric Association (APA) census in 2005, to match them with BAME clients. Similarly, according to research by the Health and Social Care Information Centre in 2013, only 9.6% of psychologists were from BAME backgrounds.

The results of Cabral and Smith's (2011) meta-analysis suggest that therapists working with clients from different ethnic backgrounds they should not be fearful, but optimistic, as generally ethnic matching has no impact on therapeutic outcomes. Other results suggest therapists should apply multicultural competencies to encourage positive client experiences in therapy (Sue et al., 1992).

Rationale

In evaluation of previous studies I have found three main gaps in the research. Quantitative and qualitative studies on cross-cultural therapy and clients' preferences remain inconclusive (Karlsson, 2005). In the studies reviewed, there are many inconsistencies as to whether clients prefer to be matched or whether they prefer to be seen by an ethnically different therapist. The second gap is that there is a lack of qualitative research, therefore the depth and richness of accessing clients' experiences have not been captured effectively. The third gap in the current field of research is the lack of studies carried out in Britain with South-Asian's. D'Andrea and Heckman's (2008) forty-year review of multicultural outcome research made some recommendations for future research in this growing field. They have insisted that more qualitative research be carried out as quantitative research methods are 'are not always the most respectful, effective, valid or reliable' (D'Andrea & Heckman, 2008, p.361). In addition, as mentioned earlier there is a great need to understand the subjective relationship between ethnicity, mental health and cross-cultural therapy to ensure that clients make the best use of their therapy (Department of Health, 2005). Palmer and Laungani (1999) have mentioned in their book of the lack of research into cross-cultural counselling in Britain and have said that more research is required. This lack of relevant qualitative studies further highlights the need for research using qualitative methodology, as it is a true reflection of the values most cherished by counselling psychology (Cooper, 2009).

An overview and critique of the findings from previous research into cross-cultural therapy have been provided and the rational for the current study was discussed. The aims and research questions are as follows:

Aims of study

The current study aimed to explore South-Asian clients' experience of ethnicity in cross-cultural therapy. It included clients who self-identified as South-Asian and addressed their subjective experience of ethnicity in therapy. More specifically, it focused on their experience of having therapy with a therapist who had a different ethnicity to themselves.

Research questions

1. How do South-Asian clients experience ethnicity with an ethnically dissimilar therapist?

2. What are client's views on ethnic similarity/dissimilarity and do they feel it effects the therapeutic relationship?

3. Are there other factors which are important to think about in relation to ethnicity and therapy?

Chapter 3: Methodology

Overview

This chapter begins by exploring the methodological, ontological and epistemological approaches adopted in the study. It will provide a rationale for the qualitative methodology adopted in this study, specifically interpretative phenomenological analysis (IPA) and address the operationalisation of this methodological approach, including the study's choice of participants, recruitment, materials, procedures and analysis. This chapter will then discuss reflexivity and the validity of the research and conclude by addressing ethical issues.

Research paradigms in counselling psychology

The starting point of any research project in this field begins with the counselling psychology researcher's set of philosophical assumptions and research paradigms about knowledge and the nature of how we acquire knowledge (Willig, 2012). Research paradigms have been defined as "basic belief systems based on ontological, epistemological and methodological assumptions" (Guba & Lincoln, 1994, p.107). It is imperative that the researcher is aware of the paradigmatic assumptions that underpin their study, including their ontological and epistemological positions, which forms the foundation for their research and influences their methodological choices (Morrow, 2007). It is important to note that different theorists frame epistemology differently; these differences will be clarified here to avoid confusion.

Ontology, epistemology, and axiology

Ontology is concerned with the nature of existence (i.e. "what is there to know?"), epistemology is concerned with finding out how we know whether something exists (i.e. "how do we know what we know?") and axiology is related to the role of the researcher's values (Willig, 2012; Ponterotto, 2005). Willig (2012) proposes that one's epistemological stance can be positioned on a continuum: realist, phenomenological, and social constructionist. Ponterotto (2005), in contrast, argues that one's epistemological stance should sit on the following continuum: positivism, post-positivism, constructivism, interpretivism and critical theory.

Realism is a philosophical framework where, applied to research, the researcher takes participants' accounts of events that actually took place at face value (Willig, 2012). In essence, this perspective encourages the researcher to take a passive role and simply record participants' accounts (Willig, 2012).

Critical realism is different from realism, in that it is a position where the researcher does not believe that knowledge is generated directly from the participant, but that it is a product of the researcher's interpretation of a participant's account (Willig, 2012). The researcher takes more of an active role if they adopt a critical realist position as opposed to a realist position (Willig, 2012).

Relativism is a position where the researcher searches for a deeper understanding; they do not take the participants' account at face value, instead they are interested in how the participant is "constructing meaning" (Willig, 2012, p.11) in relation to their experience.

Constructivism, interpretivism and social constructionism

Constructivist and interpretivist epistemological paradigms can be aligned with relativism (Ponterrotto, 2005). In terms of epistemological positions, authors who assume a constructivist and interpretivist position assert there is no single truth, rather there are multiple truths, which are equally valid. The philosophical assumptions underpinning constructivist and interpretivist paradigms inform phenomenology (both the philosophy and its application). Social constructionists also assert truth cannot be found 'out there', rather it is constructed by an individual, however these authors place emphasis on language, culture, time and other factors mediating experience (Willig, 2012). Researchers ascribing to this perspective appreciate participants' knowledge production is context dependent and can only ever be understood as such (Willig, 2012).

Positivism and post-positivism

Positivists adopt a realist ontological position. Positivists assert truth exists independent of the knower and can be attained or arrived at in some conclusive way, whereby causal, generalisable claims can be made (Ponterotto, 2005). Applied to research, the researcher might be viewed as a detective trying to find reality by being as objective as possible, to avoid 'contaminating' the data with their own perspectives (Lyons & Coyle, 2016). A major strength of quantitative research is that it can be generalisable to large populations (Fossey et al., 2002). However, a major criticism of the positivist paradigm is that it is reductionist; it reduces complex human experiences to simple data and does not acknowledge the researcher's subjectivity as a meaning-making agent (Fossey et al., 2002). Therefore, it can be argued that the positivist paradigm is not aligned with the humanist position of counselling psychology, which values individual differences and subjectivity, positing participants and their experiences are a source of richness (Cooper, 2009).

Post-positivism was developed as a reaction to the dissatisfaction with the positivist approach. Post-positivist theorists assert true reality cannot fully be attained. They acknowledge the researcher has limits in perceiving reality *fully* (Guba & Lincoln, 1994). Both the positivist and post-positivist approaches believe that there is a cause and effect relationship that can be tested and generalised, a stance that generally lends itself well to quantitative research methods (Ponterrotto, 2005). The field of psychology has developed over the past decades and has been dominated by the positivist and post-positivist paradigm (Larsson et al., 2012). The majority of research in the field of cross-cultural therapy has taken place in the quantitative arena, and such studies reflect a positivist epistemological paradigm.

Theoretical basis for IPA (phenomenology, hermeneutics and idiography)

Phenomenology, hermeneutics and idiography are central tenants to IPA (Smith at al., 2012). Phenomenology is the study of experience and the structures of consciousness (Heidegger, 1962). It is concerned with how we are in relation to others and is founded on the concept of intentionality. Intentionality, as defined by Husserl, is a term used to "describe the relationship between the process occurring in consciousness, and the object of attention for that process" (Smith et al. 2012, p.13). Thus, from a phenomenological perspective, *experience* is always the awareness *of something* in relation the researcher's acknowledgement of the phenomena (Smith et al. 2012). Phenomenology espouses that we come into being with our relationships with others and relationships exist before we come into being (Smith et al., 2009). It focuses on the relationship we have with ourselves as well as with others. In the case of the present study, phenomenology emphasises my active role in the relationship with my participants (Smith et al., 2009).

Phenomenology proposes that to truly understand concepts one must closely examine and interact with the lived experience (Smith at al., 2012). In terms of the application of phenomenology as a research method, it aims to access the participants' experience of the phenomenon under study (Willig, 2012). There are two main sub-types of phenomenology; descriptive (Husserlian phenomenology) and interpretative (Heideggerian phenomenology) (Willig, 2012). Descriptive phenomenologists take participants' accounts at face value, not going beyond the data, and asserting it is possible to 'bracket' one's own assumptions, biases and beliefs (also referred to as epoché) (Willig, 2012). In contrast, interpretive phenomenological researchers assert it is never possible to 'bracket' assumptions, biases and beliefs as a researcher, and that while it is important to attempt to do so, it is only in the attempt that we can being to uncover the structures of experience of a given phenomenon. For instance, the interpretive phenomenological researcher, after initially looking at interview transcripts, would use their own interpretations to give meaning to their participants' experiences and concurrently reflect on their own subjective positioning within the research (Willig, 2012).

Heidegger (1962) recognised the importance of interpreting participants' narratives which are influenced by the researcher's own thoughts and beliefs, thus producing the 'double hermeneutic' (Smith et al. 2012). The double hermeneutic takes place when "the researcher is making sense of the participant, who is making sense of x" (Smith et al. 2012, p.35). The double process captures the participant's *meaning-making* of a particular phenomenon through the lens of the researcher's *sense-making* process, which is influenced by their own assumptions, values and beliefs (Smith et al. 2012).

The hermeneutic circle is a method of making sense of a participant's experience that has been described as "the dynamic relationship between the part and the whole, at a series of levels" (Smith et al. 2012, p.28). The hermeneutic circle describes the interpretative process implemented in IPA.

Idiography espouses the idiographic approach which focuses on the specific rather than the general (Smith et al. 2012). It aims to explore each participants experience in detail before moving onto the next case, thus making comparisons between the cases to get an understanding of shared experiences of the participants (Smith et al. 2012).

My ontological and epistemological position

The ontological and epistemological position of the researcher can strongly influence on their research (Willig, 2012). I adopt a relativist ontological position and a constructivist epistemology, and I contextualise this within an interpretivist theoretical framework. Hence, my values align with the philosophical underpinnings of my research. In the present study, I believe that knowledge is co-constructed between my participants and myself as the researcher (Creswell & Poth, 2018). I also consider the phenomenological approach is particularly useful when studying experiences, and I subscribe to the Heideggerian tradition. In addition, I subscribe to the notion of the double hermeneutic, which further substantiates that IPA is the most appropriate methodology for the present study.

Qualitative research

Morrow (2007) posited that qualitative research is interested in discovering answers to questions such as 'How?' and 'What?', and in studying people's experiences using language. The choice of qualitative methodology is in line with counselling psychology's

humanistic values, which appreciate the person as a whole and delves deeper into the meaning people attribute to their experiences (Douglas et al., 2016). Interviews are the most popular qualitative research method, as they allow participants to describe and explore phenomena and the researcher to make sense of their experiences (Willig, 2008). Qualitative research values the role that the researcher plays, so reflexivity is fundamental (Willig, 2008). The aim of my research is to explore participants' subjective experiences, which lends itself well to a qualitative approach, as it appreciates individual differences (Willig, 2008). This is particularly important as the South-Asian population in the UK have not had their individual experiences appreciated or represented in previous research.

Choice of IPA over other methodologies

Interpretative phenomenological Analysis (IPA)

Smith et al. (2009) proposed that IPA is based on three central tenets: phenomenology, hermeneutics, and ideography. Phenomenology, as mentioned above, refers to the study of human experience (Smith et al., 2009). By its nature, IPA takes into account the relationship between the researcher and participant. It acknowledges my voice as I attempt to make sense of my participant's understanding of their experience, known as the double hermeneutic (Smith et al., 2009). IPA is also idiographic in nature, which means that is strives for detail and depth of analysis by focusing on a particular phenomenon (Smith et al., 2009). For this reason, IPA implements a purposive, homogenous sample—that is, a group of similar participants who have experienced a similar phenomenon (Smith et al., 2009). IPA is the most appropriate methodology for this study I am interested in my interpretation of my participants' experience of ethnicity in cross-cultural therapy.

A limitation of IPA is that although it is used to describe lived experiences, it does not make any claims around explaining lived experiences (Willig, 2008). However, my research aim was not to explain but to examine participants' experience of cross-cultural therapy. There are some instances where it can be helpful to explain lived experiences if one is interested in finding cause and effect relationships. An example could include the factors that contributed to positive therapy outcome in cross-cultural therapy.

I did not consider a quantitative research method appropriate as it would not have met the research aims. It would not have given voice to the participants' experiences and would not have accounted for my interpretation and influence. Thus, I decided upon a qualitative research method. I considered a few other methodologies before choosing IPA; descriptive phenomenological analysis (DPA) and grounded theory (GT).

Descriptive phenomenological analysis (DPA)

DPA involves staying very close to the participants accounts of their experiences and aims to purely capture and represent their material (Willig, 2012). I initially considered using DPA; however, I decided it was inappropriate as I did not agree that my participant's accounts should be taken at face value and I did not want to purely describe their experience. Instead, I wanted to delve beneath the surface and create meaning from their experiences. This allowed me to consider their accounts through my own lens, through my interpretations, which has given my analysis a deeper level (Willig, 2012).

Grounded theory (GT)

GT involves "a process of testing emerging theoretical formulations against incoming data, thus moving between developing and testing theory as the research progresses towards saturation" (Willig, 2012, p.8). The aim of the current study was not to

understand *the cause* of South-Asian's experience of ethnicity in cross-cultural therapy by testing theory, therefore GT was not chosen as the methodology.

Sample

The phenomenon of South-Asians who have experienced psychological therapy with an ethnically dissimilar therapist was the topic of study. Thus, recruitment involved identifying and inviting people who have had this experience to participate. Once ethical authorisation was granted by the University's Psychology Ethics Board (Appendix A, B and C), recruitment began. Participants were recruited by using purposive, opportunist and snowballing sampling techniques in accordance with the IPA guidelines stipulated by Smith et al. (2012). This was done though advertising via a research poster (Appendix E) and on social media (Facebook). I recruited two participants via social media. Lack of response may have been due to the stigma often associated with South-Asians accessing psychological therapy. Additionally, some South-Asians may have been reluctant to contact me as I am also South-Asian, and they may have been concerned about their community finding out that they are either in therapy or had therapy in the past. The remainder of participants were recruited via snowballing (Coolican, 2004).

Inclusion and Exclusion Criteria

A relatively homogenous group of participants were recruited, as advised by Smith et al. (2012) using specific inclusion and exclusion criteria (Robinson, 2014). The following criteria were observed:

- Over 18 years of age
- Self-identified as South-Asian (Indian, Pakistani, Bangladeshi, and/or Sri Lankan)
- Fluent in English language

- Either currently engaging in psychological therapy and received a minimum of six sessions or completed a course of therapy no more than six months ago with an ethnically dissimilar therapist

- Participant's therapist should be at least two years post qualification and registered with their governing body. They should be either a clinical psychologist, counselling psychologist, counsellor, or psychotherapist.

- Not experiencing a mental health crisis

Research Participants

Initially I recruited ten participants; one was the pilot participant, one withdrew, and eight took part in the research study. The inclusion/exclusion criteria mentioned above were met in all cases. Additional characteristics, such as age and gender were left open in line with previous IPA research. All participants were female, aged between 27 and 59, and all identified as South-Asian (Indian). Six participants had a White British therapist, one participant had a White Polish therapist, and one participant had an African American therapist. Pseudonyms were assigned to all participants to respect their confidentiality (see Table 1).

Table 1: Participants' Demographic Details

Participant Name	Age	Gender	Ethnicity	Therapist Gender	Therapist Ethnicity	Therapist Role
Kierendeep	25-30	Female	Indian	Male	White British	Counselling Psychologist
Taslim	50-55	Female	Indian	Female	White British	Counsellor
Nureen	55-60	Female	Indian	Female	White British	Counsellor
Jasmine	55-60	Female	Indian	Female	White British	Counsellor
Lilly	55-60	Female	Indian	Female	White British	Counsellor
Mamta	40-45	Female	Indian	Female	White British	Psychotherapist
Farah	35-40	Female	Indian	Female	White Polish	Clinical Psychologist
Selena	50-55	Female	Indian	Female	African American	Psychotherapist

Procedure and Materials

Ethical approval was sought from the University Ethics Committee. Once ethical approval was obtained, I advertised my study by uploading my poster to social media (Facebook). I ensured that I did not include my personal email address or phone number on the poster. I used my university email address and a separate sim card used only for research purposes to ensure I respected personal boundaries. Initially, I was unsure whether I would be able to recruit enough participants, so I completed an 'Ethics amendment form' to request interviewing participants online (via Skype) if required. This amendment was approved; however, I did not require the use of video conferencing as I was able to meet all participants face-to-face. When potential participants contacted me,

I had an initial conversation with them over the phone to ensure they met the inclusion/exclusion criteria, answered any questions they had, and arranged to meet them in person for the interview. I emailed the participant information letter (Appendix F), consent form (Appendix G), and demographic form (Appendix H) ahead of our meeting to allow them to read it if they wished to.

Before meeting with the eight participants in the study sample, I conducted a pilot interview to determine whether the questions in the semi-structured interview were phrased coherently and framed in such a way that they might elicit material aligned with the research question. Feedback from the pilot was that the interview questions were good and, and no changes were required. The pilot yielded rich data therefore no changes were made to the interview questions.

I met all eight participants in person, either on university property or a local library. The interviews were conducted in a pre-booked room and I clearly put a sign on the door reading 'do not disturb'. When I first met each participant, I introduced myself and offered them a drink to try ease any initial anxiety. I explained the whole process, including how long we would be there. I checked in with them to ensure they could stay for the full hour. We read through the participant information sheet together, and I asked them to read and sign the consent form and the demographic form if they were satisfied and consented to take part. Before I began audio-recording, I asked if they had any questions for me. I then started audio-recording on two devices to limit the possibility of a missed recording; I always carried extra batteries for the same reason. I then proceeded to ask my interview questions (Appendix I). During the interviews I was attentive to the participant. I followed their narratives and allowed the space for them to express their experiences, remaining curious and trying not to make any assumptions.

After the interview was complete, I stopped recording and facilitated a de-brief with my participant. I asked about their experience of the interview with me and I answered any questions they had. I provided all participants with a debrief sheet (Appendix H), which included information about where they could get further assistance if required. I also emailed the debrief sheet to them after the interview. I transferred the audios to my laptop, which was password protected, and then deleted it from my audio-recording devices to ensure the audio was not lost in the event of theft or damage. Participants had two months after their interview to withdraw. Two months following each interview, I transcribed the audio myself to become familiar with the material (Smith et al., 2012) into a password-protected Microsoft Word document and thereafter began the analysis stage. I read and re-read the transcripts according to the guidelines for IPA (Smith et al., 2012), making some initial notes alongside the transcript. I made descriptive, linguistic, and conceptual comments. I then noted emerging themes. I then structured the analysis by clustering themes with shared meanings, and finally, searched for connections between different themes before moving to the next participant. Once each participant's interview was analysed, I looked for patterns between different participants and created themes (Smith et al., 2012), which will be discussed in the subsequent chapter.

Validity and the analysis process

Smith et al. (2009) recommended following the guidelines proposed by Yardley (2000) to ensure that the study met validity and reliability criteria for qualitative research. Yardley's four principles and a brief description of my attempts to follow them can be found below.

Sensitivity to contexts

Qualitative research is said to be valid and reliable if it is sensitive to context, including sensitivity to the literature, ensuring the recruitment is purposive, and that the interaction between the participant and researcher respected as it demonstrates sensitivity to the participants' material (Smith et al., 2009; Yardley, 2000). In this study, I aimed to acquire and develop a deep understanding of cross-cultural counselling and ethnic similarity and dissimilarity in the therapeutic relationship, as I have shown in the introduction and literature review.

Commitment and Rigour

Yardley (2000) proposed that commitment to the research can be shown in the amount of attentiveness displayed by the researcher during the interview itself. I tried my best to 'be with' my participants and made every effort to give them my undivided attention. I also engaged in reflexivity to further explore how I may have been influencing the participant in the room. This allowed me to become more aware of my blind spots, and thus ensure my participants' voices were heard.

Rigour has been described by Yardley (2000) to mean the completeness of data collection and analysis. To increase the validity and reliability of my research, I ensured that all participants met the inclusion/exclusion criteria; I carried out a pilot interview; and I ensured that my sample were relatively homogenous, thus meeting the criteria for IPA methodology (Smith, 2012). In addition, I ensured that (to the best of my ability) IPA guidelines were strictly adhered to, from transcription through coding and the development of themes.

Transparency and Coherence

Yardley (2000) also mentioned that transparency is essential in qualitative research. I believe I have been transparent throughout my research study. I have demonstrated this by being open and honest during the whole research journey. I have also used examples from the participants' transcripts in my analysis section. I have attempted to make it easy for the reader to clearly follow how I analysed the participants' material and how my final themes were formed (Yardley, 2009).

Coherence in qualitative research refers to the clarity of an argument (Yardley, 2000). Coherence in qualitative research suggests there is synergy between the research question, the method of investigation, and analysis which has taken place (Yardley, 2000). I believe that my research question, epistemological stance, research aims, and methodology are aligned in this research study.

Impact and Importance

The impact and importance of qualitative research are concerned with the research study's contribution to the field of knowledge and its practical implications. This current study explored South-Asian clients' experience of psychological therapy with an ethnically dissimilar therapist. Findings from this study can guide therapists, as well as clients, and may encourage them to think more intently on the impact of multicultural therapy. The findings may help therapists who do find themselves sitting opposite an ethnically dissimilar client and help them to explore more beneficial methods of discussing ethnicity in therapy room. Thus, I believe this research project is important and will be valued in the field of counselling psychology.

Reflexivity

Qualitative researchers should continuously engage in reflexivity to be aware of their own preconceived assumptions and biases. There are two main types of reflexivity: personal and epistemological (Willig, 2008). Personal reflexivity has encouraged me to think about my own values, beliefs, and experiences and how they may impact my research. Epistemological reflexivity has encouraged me to reflect on my ontological expectations, including what I anticipated to find in my research project (Willig, 2008). IPA highlights the importance of reflexivity and believes the researcher takes a central role, though it does not suggest a method for integrating myself with the research process (Willig, 2012). However, it has been suggested in qualitative research that an effective method of engaging in reflexivity is to keep a research journal (Morrow, 2007).

I have been keeping a research journal from the beginning of my research journey and have noted my experiences, learnings and reflections. I have also been attending regular peer research supervision groups to share my experiences with my peers. In addition, I have been reflecting on my research journey with my research supervisor and personal therapist, which has helped me to take a step back from my research. I have been aware of my own ethnicity (I identify as South-Asian) and what effect this has had on my participants. During the interviews, I was aware of how the participants may have been feeling when they were speaking with me (someone who is ethnically similar to them) about their therapist (who is ethnically dissimilar to them).

When the participant left the room, I immediately wrote my reflections down; how I felt it went, how I felt in relation to the participant, how I was feeling internally, what impact I thought I had on them, etc. I noticed that some participants seemed to be over-identifying with me. For example, they might include me in their narrative and say, 'you know how

we do things' or make reference to places of worship or certain religious festivals and assume that I was aware of them. I had to ask them for clarification to ensure that they shared their experiences and their interpretation of the phenomena in question. When I noticed this, I asked them to explain what they meant, to ensure I could stay with their experience and try my best to not make any assumptions. Although we may share the same ethnicity, we may have quite opposite views on issues related to cross-cultural therapy.

I have also reflected on my own experience of having therapy with an ethnically dissimilar therapist and why I became interested in this research topic to start with. When choosing my own therapist, I consciously chose a therapist who did not share the same ethnicity as me. I wanted to ensure that there would be some distance between us. I did not want the therapist to be Asian, as it would have felt like they were a member of my community and that would have reminded me of the stigma and discrimination attached to accessing therapy within my community. I wanted to have the chance to explain my interpretation of my ethnicity, my culture, and my religious beliefs, and I did not want my therapist to already have assumptions and judgements of my background. I thought this type of judgement was more likely if they were Asian. I think I would have held back and not been as open as I would like to be with an Asian therapist. I also wanted my therapist to offer a different perspective to my own. I am aware that many of these points reflect my own biases and assumptions regarding Asian therapists, which is why it is imperative that I am aware of them in relation to my interpretative process during the analysis stage.

Ethical Considerations

The ethical guidelines stipulated by University's (2013) 'Code of Practice for Research Ethics' and the British Psychological Society's (2018) 'Code of Ethics and Conduct' state that the researcher should practice in a professional manner that protects the integrity of the establishment and the field of psychology by advancing the field of knowledge and causing any harm to participants.

Ethical approval was granted by Ethics Committee prior to any data collection. I ensured that all participants were fully informed about the possible impact of taking part, what the aim of the study was, who I was, where the findings would be published, and only then asked for participants' consent to participate. All participants were made aware that they could stop the interview at any time or withdraw from the study within two months of their interview (up to the point of data analysis). All participants were given pseudonyms to protect their identity. All recordings and transcripts were protected with a password (Willig, 2012).

All participants were de-briefed (given a debrief sheet) after each interview and were sign-posted to helpful services should they require them. After each interview, I asked how they found the experience and if they had any questions. None of my participants became upset; however, if they had, I would have explored that with them. I would have mentioned that they could get in touch with myself or with my supervisor after the interview if they wanted. If they were still in therapy, I encouraged them to speak with their therapist. If they wanted to know where they could access further support, I informed them of relevant services.

Analysis

I began the process of analysis following the six stages recommended by Smith et al. (2012). The goal was to produce themes by capturing the lived experience of cross-cultural therapy amongst South-Asian clients as well as my interpretation of what the participant was trying to convey (in accordance with the double hermeneutic process) (Smith et al. 2012). According to Smith et al. (2012) there is no single 'correct' method of carrying out IPA analysis and they encourage flexibility when producing relevant themes. As an example of each stage of the analytic process, I have included an excerpt of Kierendeep's transcript in Appendix K.

Stage 1: Reading and re-reading

In order to immerse myself in the data, I personally transcribed each interview into a Microsoft Word document. The process required that I listen to the audio recordings several times during the transcription process. Having listened to the audio recordings multiple times, I developed a sound understanding of my participant's perspectives which gave me a good sense of what they were trying to communicate to me. I then read and re-read the resulting transcripts line-by-line. This process allowed me to familiarise myself with the written data (Smith et al. 2012).

Stage 2: Initial notes

For this stage, I inserted the transcripts into a table in Microsoft Word. Each transcript was in a separate column on the left of the document. I made exploratory comments of three types—descriptive, linguistic, and conceptual—in the middle column, and noted emergent themes (Smith et al. 2012) in the right-hand column. Descriptive comments (**in bold**) constituted my initial thoughts and observations of the content of the transcripts. I noted key words and described those I thought were important to the participant. The

linguistics comments (*in italics*) included notes on the language used by the participant and the underlying meaning I thought they were trying to convey. I noted fluency of speech, hesitations, repetition, tone of voice, use of pronouns, and laughter. The conceptual comments (underlined) represented the start of the interpretive process; in those comments I started to include elements of personal reflection and questions that came into my mind (Smith et al. 2012).

Stage 3: Developing emergent themes

In the previous stage, I created detailed and comprehensive notes in order to accurately reflect the participant's account. This helped me to generate themes that represented the participants' narratives. To identify emergent themes from the transcript, I repeatedly changed my focus, zooming into specific parts, and then expanding my lens to include the whole transcript, thus engaging in the hermeneutic circle (Smith, 2012). This process allows the transcript to be divided into parts, which are then brought together as a whole after the analysis process (Smith, 2012). The themes consisted not only of my participants' original words, but also included my interpretation and understanding of their experience, representing "a synergistic process of description and interpretation" (Smith, 2012, p. 92). An example of developing emerging themes can be found in Appendix L.

Stage 4: Searching for connections across emergent themes

In this stage, I looked for connections between the emergent themes in each transcript. To organise the themes into clusters corresponding to the research question, I implemented Smith et al.'s (2012) concepts of abstraction, subsumption, polarization, contextualization, numeration, and function. To assist me in this process, I typed, printed, and cut out all emergent themes before physically reorganizing them. Visualising their

physical representations and the ability to move them around helped me to search for connections. Each cluster then became a superordinate theme. An example of searching for connections amongst emerging themes can be found in Appendix M.

Stage 5: Moving to the next case

Each of the stages outlined above was repeated for each of the eight participants. I tried to treat each new transcript as a separate, unique account by bracketing (as much as possible) previous transcripts. I also attempted to bracket my own previous experiences and assumptions as much as I could. I found it helpful to write about my previous experiences and reflections in my research journal (an example from my research journal can be seen in Appendix O). However, it is important to note that it is not possible to entirely bracket previous experiences or knowledge of previous transcripts (Smith et al., 2009).

Stage 6: Seeking patterns across cases

After analysing all eight transcripts, I explored the themes and continued the hermeneutic circle by merging, deleting, or renaming the themes, resulting in a list of subordinate themes. I then clustered the groups of subordinate themes under specific superordinate themes (Smith et al., 2012). I then explored each superordinate and subordinate in turn by assigning a narrative and using excerpts from the transcripts for transparency. According to Smith et al. (2012), the purpose of this stage is to demonstrate a combination of the shared phenomena experienced by the participants as well as their unique individual experiences.

Chapter 4: Analysis

This IPA study posed the research question *'How do South-Asian clients experience ethnicity with an ethnically dissimilar therapist?'*. Eight semi-structured interviews were conducted and the data was analysed. This chapter outlines the findings. Data analysis generated four superordinate themes and fourteen subordinate themes *(see Table 2)*. It is important to note that my interpretations throughout the entire analysis process (from noting initial comments and emerging themes, to forming subordinate themes and superordinate themes) was heavily influenced by my own preconceptions and experience of cross-cultural therapy. This will influence my understanding of the participants understanding of their experience which is also known as the double hermeneutic circle (Smith, 2009). I therefore acknowledge that my interpretation and formation of subsequent themes is purely one way to analyse the data and another researcher may analyse the transcripts differently, based on their subjective interpretation.

Table 2: Overview of Themes

Superordinate Themes	Subordinate Themes
1) South-Asian ethnicity and addressing stigma in cross-cultural therapy	1.1. Navigating my ethnicity in therapy; which box do I tick? 1.2. A 'Mishmash' of ethnicity in therapy: South-Asian ethnicity understood in the context of different identities coming together. 1.3. Self-stigma in therapy
2) Ethnically dissimilar therapist allows for greater openness and freedom of expression	2.1. 'The freedom in therapy to share my interpretation and perspective of ethnicity, culture and religious festivals'. 2.2. The therapist offering a fresh and objective perspective on my difficulties. 2.3. Therapist's openness and curiosity in the face of difference.
3) Internalised racism; South-Asian therapists are 'tainted by their culture'	3.1. Clients' prejudice towards South-Asian therapists. 3.2. Client's feeling judged by South-Asian therapists. 3.3. Client's lack of trust; their South-Asian therapist would not maintain confidentiality. 3.4. Client's expressions being hindered by a South-Asian therapist due to over-identification.
4) Therapists skills and qualities are more important than their ethnicity	4.1. Individual qualities of the therapist 4.2. Therapists experience 4.3. Therapist's non-verbal communication 4.4. Therapist taking an interest in client

The next section will discuss the superordinate and subordinate themes in greater detail.

Superordinate Theme 1: South-Asian ethnicity and addressing stigma in cross-cultural therapy

Overview

Participants, all of whom identified as South-Asian, described their ethnicity and what it meant to them in relation to their experience of ethnicity in therapy. They spoke about their culture, family values, and religion as being part of their ethnicity. They spoke about their place of birth and their parents' place of birth and reflected on whether they identified as British or with being 'Indian', 'Asian' or 'East African' and how this impacted their experience of therapy.

The first subordinate theme addresses the struggle of some participants with the experience of 'being put into a box' or 'given a label' in therapy. They seemed to be able to speak freely about how they chose to self-identify their ethnicity during the interview. The second subordinate theme addresses how all participants believed their ethnicity comprised a combination of different cultural backgrounds. The third subordinate theme acknowledged self-stigma which became apparent in therapy by all participants.

Table 3: Key for excerpts:

…	Significant pause
[ ]	Material omitted
[*I:*]	Interviewer speech

Subordinate Theme 1.1: Navigating my ethnicity in therapy; which box do I tick?

How to identify ethnicity in and of itself was an issue that all participants grappled with in therapy. Ethnicity in contemporary society is oftentimes presented as a nebulous concept, as the ways in which we define ethnicity are revising and updated, according to how meaning around ethnicity is constructed at a given historical moment. At times, this is linked with political correctness and shifting understandings of different ethnicities, as well as ethnicity as an overall concept. Yet, when individuals are asked about their ethnicity, for example in equal opportunities monitoring forms in therapy (including in NHS settings), lists of ethnic groups (usually defined by government bodies) are how individuals are positioned to define their own ethnicity. It is in this way that defining ethnicity becomes a 'tick box' exercise, selecting how one defines one's ethnicity on the basis of restricted choices and pre-determined categories. The phenomenon of the experience of ethnicity in therapy from the perspective of clients self-identifying as South-Asian can be understood as a multifaceted and rich experience that cannot be defined by such restrictive categories. Yet this phenomenon is perhaps more complex than highlighting the deficit of contemporary definitions of ethnicity. This is because oftentimes, such categories are what is immediately to hand when considering ethnicity and therefore are used, despite their apparent inadequacy, to communicate ethnic identities. The relationship between the terms available to describe ethnicity is an ambiguous and conflictual one; on the one hand the terms are restrictive and insufficient to describe the richness of how meaning is constructed in relation to ethnicity and on the other hand, such 'box' terms are necessary so that something can be communicated about how ethnic identities and experiences are communicated and represented to others.

Pre-determined categories for ethnicity are perhaps used but not necessarily agreed with. In this way, there is possibly a sense of needing to 'fit into a box' to communicate meaning

making around ethnic identities however these boxes do not fully capture how ethnicity is understood and finding other, self-defined ways of communicating ethnic identities also appears important. Kierendeep spoke about 'ticking a box' in relation to her ethnicity in therapy:

> *"Uhm…I would describe it as uhm…Asian or British Asian….that's usually like the box that I tick when if I am doing forms and things…uhm..but yeah…Asian Indian"* (Kierendeep, p. 1, lines10-11).

When Kierendeep identifies herself as 'Asian-Indian' it seems she has expressed her ethnicity through her own lens and perspective, rather than fitting into a pre-prescribed box.

The use of pre-defined categories used to describe ethnic identity is necessary to communicate. Moreover, there appears to be a way in which participants not only use such pre-determined labels to express ethnic identity, but the adjective becomes an expression of self. Here, ethnic identity is no longer an external category others have created but it becomes 'who I am'. In this meaning-making venture voiced by Farah, the self *becomes* the category:

> *"I always find this question really hard….and I know that sounds silly to say…I think technically the answer is that I am a …….British..Asian……British Indian"* (Farah, p. 135, lines 9-10).

Adopting a passive role in the description of one's ethnicity in therapy renders them to adopt a position of powerlessness. This can be understood by exploring the wider social and historical context. An example of this has been expressed by Lilly:

"Uhm…well my father came from India…uhm and we came from Africa….. I was born in Africa, but because my father was Indian, we are classed as Indians" (Lilly, p. 101, Lines 25-26).

Lilly's mention that her family are 'classed as Indians' suggests that she ascribes to herself the passive role of *being classified as* 'Indian'—thereby allowing the classifier to hold the power. The use of pre-defined categories to describe ethnic identity is necessary for communication; however, it also does not allow individuals to truly express themselves subjectively in relation to the ethnicity they feel most aligned to. There appears to be an inherent conflict in using pre-defined ethnic categories: while they can be helpful to facilitate communication and understanding, they do not allow individuals to express themselves by providing a sense of their *unique blend* of ethnicity, as described by Jasmine:

"I'm British Asian…I'm a Muslim….and what does it mean to me? It's just an identity…I'm very cultured, I value my culture" (Jasmine, p.72, lines 9-10).

The antithesis expressed by Jasmine, gives the impression that her ethnicity and culture are very important to her, though at the same time her reference to them as 'just an identity' is echoed in statements by other participants.

How ethnic identity is categorised might lead one understands it as compartmentalised, forcing one to choose one or another. However, it has become apparent that ethnic identity in therapy can be better understood as fluid and changeable, which allows for individuality. This recognition acknowledges that some South-Asians may identify more strongly with certain parts of their ethnic makeup than others. Selena, for example, identifies more with her British rather than her Indian ethnicity:

"Uhm…I describe myself as British Asian….obviously…my ancestors, my forefathers were from India, [I: Okay]…via East Africa…uhm and I feel quite African in some ways..or at least I very much appreciate the African culture and ..the…Zanzibar …from where my parents came from..uhm…in terms of you know, our language and food …..and I love you know… I love the vibrancy of Africa…..I don't call myself Indian ..Indian …because it's..I wasn't brought up there and I think there is a difference..perhaps a different mentality…so I prefer British Asian" (Selena, p. 153, lines 12-21)..

To summarise this theme, it seems that many participants struggled to identify their ethnicity in therapy and tended to describe it using the type of pre-prescribed categories that commonly appear on forms. Thus, defining ethnicity becomes a 'tick box' exercise, where one's identity is chosen from among pre-determined categories. Participants' use of pre-determined categories highlights how much of an influence external factors have in shaping internal perceptions of ethnicity.

Subordinate Theme 1.2: A 'Mishmash' of ethnicity in therapy: South-Asian ethnicity understood in the context of different identities coming together

The South-Asian ethnicity constitutes a combination of ethnicities and cultural identities. This indicates inter-connections between various different facets of how individuals may experience their ethnicity in therapy – it is difficult to speak about one of these facets without the others, as they are closely intertwined. Not one participant spoke about themselves in a unilateral manner; the phenomenon of the experience of ethnicity in therapy from the perspective of clients self-identifying as South-Asian can be understood as multifaceted, multi-layered and unique. The degree to which individuals identify with their place of birth, their parents' places of birth and the country from which their ancestors descend varies from person to person. Each country and the associated cultural, social norms and traditions affect one's sense of ethnicity in therapy. One's sense of ethnicity is also related to childhood experiences and upbringing. If a South-Asian person is brought up in a predominantly White area and is subject to racism, their experience of ethnicity in therapy will depend on whether they have strong family social support or not. If they have a supportive family network, they may feel more aligned with their South-Asian ethnicity, as they may feel uncomfortable with difference in therapy. However, if they do not have family support, they may attempt to align themselves more closely with the majority, and adopt social norms consistent with British culture and ethnicity in an attempt to 'fit in'. Individuals' sense of ethnicity seems to be strongly related to where they were born and spent most of their formative years. In addition, sense of ethnicity also seems to be passed on from parents and their place of birth. Notably, several influential factors, such as language and favourite foods, seem to be learned from one's parents. A sense of this unique blend or 'mishmash' has been described by Farah and further emphasises that one cannot be constrained within a simple ethnic 'box' in therapy.

"I feel like my ethnicity is a mishmash of Indian …East African and British culture. [I: Mhmm..would you mind going into it a bit with me?] Yeah…uhm…so….I was born and brought up here, so a lot of my..ethnicity stems from British culture…I was raised here, I went to school here, but my parents were both born in East Africa and my grandparents were in East Africa as well….and I think a couple of generations before that…so there are definitely elements of East African culture, East African Indian culture that have come over with them….uhm…and then, obviously, way, way, way back….uhm…the Gujarati kind of traditions that my ancestors will have had…some of them have come down. [I: Hmm…and what aspects of which culture do you feel are..part of your mishmash?] (laughs) So, I think that sometimes I struggle between aspects of all of them…." (Farah, p. 135-136, lines 11-29).

It seems that, for Farah and many other participants, their ethnicity and cultural background constitute a *unique blend*. Farah identifies with a combination of British, East African and Indian cultures. When she laughs in response to my question, it seems that she realises the complexity and richness of her background, and how that impacts her life currently.

Similarly, Mamta spoke about a combination of British, African and Indian heritage in therapy here:

"Okay. So I would say..uhm I'm…uhm…Asian background, so Indian heritage [I: Okay.] Uhm…and so that for me, that means my grandparents..uhm.. and great grandparents were from India….they travelled to East Africa…and uhm…then my

parents travelled to the UK separately and then met in the UK…and I was born

in the UK…" (Mamta, p. 118, lines. 9-15).

This rich blend is characteristic of many of the participants which took place in the study. Many of their ancestors followed a similar migration route, originating in India, passing through East Africa, and finally residing in the UK. Taslim recounted her family's migration route. She mentioned she feels she comprises a combination of cultures which constitute her British Asian ethnicity in therapy:

"I classify myself as a British Asian…[I: Mhmm]..via East Africa…..uhm because my parents were born in East Africa..I was born in London…but my great grandparents are from India originally" (Taslim, p. 18, lines 9-14).

Taslim explains how she 'likes being Indian' here:

"I like being Indian…I like the history that …that being Indian has…we have a civilization and a culture that goes back many years and it's important to me! Uhm..I don't shy away from that…." (Taslim, p. 19. Lines 47-49).

Taslim refers to 'not shying away' from her Indian identity in therapy, which suggests that she feels comfortable with and proud of her ethnicity. This shows growth on her part, as she mentioned that she was less open about her identity in the past. However, she may have felt more comfortable disclosing this with me, a fellow South-Asian woman compared to her White friends. Taslim speaks of having a harmonious combination of cultures (British, East-African and Indian), which she strongly values in therapy.

However, this does not seem to be the case for Nureen, who seems to identify more with her British culture and less with her African and Indian cultures:

"I was born in Uganda, came here at the time of the expulsion, so..uhm…I don't feel any loyalty towards Uganda at all" (Nureen, p. 38. Lines 9-10).

Nureen, her family and her community were forced to leave Uganda in the 1970s under the reign of Idi Amin. They were targeted because of their Asian ethnicity, so it is understandable that although Uganda is her place of birth, she does not feel attached to it, and instead identifies with British culture:

"Uhm…I think because I've been here for such a long time….Uhm… know for a fact that a lot of my Asian friends or acquaintances even …felt that I was a bit westernized…" (Nureen, p. 39, lines 43-44).

It seems that Nureen is proud of identifying most strongly with her British culture and this may be why she feels so comfortable engaging in cross-cultural therapy with a White therapist. She also mentions that she has noticed a shift in her allegiance to her Indian identity after visiting India, where she noticed many commonalities between their food, culture and language and her own. She also noticed a shift in her thinking in relation to her Indian identity here:

"Gujarat…[..]..I think because…I never thought of it…and I uhm…went to see my mum's roots…and asked my uncle…her brothers about whether we had any family etc….and they gave me details and didn't have any numbers…..we literally went into this village and asked around…. And it was just amazing…really….and

they were so hospitable…..It was so welcoming. [..]…I felt guilty for never been

interested before […] I feel like good …I'm glad I went I feel like I've connected

with my history..if you like.." (Nureen, p. 40-41, lines 67-88).

Nureen's shift from identifying predominantly as British to becoming more accepting of her Indian culture demonstrates how fluid and unique an individual's experience of their ethnicity in therapy can be.

The subordinate theme discussed above offers an account of my interpretation of the participants experience their South-Asian ethnicity in therapy. It has illustrated how South-Asian ethnicity is multi-faceted and multi-layered; fluid, rather than easily fitted into categories; and unique to each individual which affects clients experience of ethnicity in cross-cultural therapy.

Subordinate Theme 1.3: Self-stigma in therapy

Stigma around 'mental illness' and talking in psychological therapy has deep roots in the South-Asian community and has unfortunately been present for generations. Many people who identify as South-Asian do not believe that 'depression' and 'anxiety' exist. Instead, they may attribute their mental health difficulties to physical ailments. In addition, many South-Asians do not believe distress should be discussed with anyone who is not part of their family. Thus, they avoid psychological therapy, and some may wait until the situation becomes serious before accessing any help. Those who do access therapy may struggle with being honest in therapy due to a cultural lack of belief in the effectiveness of therapy. There are some South-Asians who do access therapy and who feel comfortable to talk about their distress, but they are a minority.

The theme of stigma and prejudice became apparent in all participants' narratives. It took the form of internalised negative assumptions and judgements towards themselves for accessing therapy, their family's judgement of therapy, or participants' own biases toward South-Asian therapists. All participants spoke about stigma in one form or another, and stigma appeared to have wide consequences, including effects on their perception of themselves, and their conceptualisation of 'mental illness' and cross-cultural therapy.

Growing up in a South-Asian community and being exposed to discriminatory and prejudicial social, cultural and familial influences in relation to 'mental illness' may cause one to view oneself in the same way. Many South Asians may struggle to ask for help, access therapy, and believe that struggling with one's mental health is a sign of weakness. This may influence whether they access therapy, whether they decide to engage in cross-cultural therapy, how comfortable they are being honest during their sessions and may have an impact on their experience of ethnicity in therapy. Many participants mentioned that they felt more comfortable with an ethnically dissimilar therapist because they were judging themselves and they did not want their therapist to judge them as well. This seemed to have been the case for many of the participants in therapy. In many narratives, participants shared their negative assumptions, prejudices and stigmatisations towards themselves for being weak and not being able to cope with their difficulties and therefore struggling to express themselves in therapy.

Nureen mentions how other people's perception of her seemed to influence her perception of herself here:

> *"I think the misconception really is that if you're smart enough ..if you are a professional…you do your own thing, …that you should be able to handle things …in some ways, you know? Uhm…but then things happen, which….which throw*

people….So…uhm…and I think since then, I've realized that actually, everybody goes through that because I've just opened up to anybody and everybody now …it's like, I've had it….and I'd recommend it for anything…and then people open up a lot more" (Nureen, p. 51, lines 352-357).

There seems to be an expectation that if someone is a 'professional' then they cannot be affected by mental illness. The excerpt from Nureen above highlights how she initially refrains from using personal pronouns when she mentions 'which throw people', instead of referring to herself. This may suggest that she is uncomfortable owning the fact that she has also struggled. However, she later uses personal pronouns and refers to herself. This reflects the journey she has made—from initially distancing herself from her struggle due to shame and stigma, to eventually accepting that everyone can struggle, and it is acceptable to express feelings.

Similarly Jasmine viewed herself as 'weak' due to the stigma attached to being in therapy, as she mentions here:

"Uhm….a sign of weakness because I think I felt that…that I wasn't seen… I cant cope with it. I can't go and tell anybody I cant cope with it..they will think I'm weak..they will think that" (Jasmine, p. 99, lines 732-733).

The self-stigma Jasmine inflicts upon herself in relation to being in therapy shows that she struggles to open up. She experiences this as a sign of weakness which impacts her experience of ethnicity in therapy as she spoke about feeling judged by a South-Asian therapist.

Some participants also felt that if they had a South-Asian therapist and they spoke freely in the session, their therapist would perceive them to be weak. Nureen shared her experience here:

"Whereas I think with an Asian person. I would have probably thought…she's just gonna think I'm a wimp…yeah" (Nureen, p. 48, lines 283-284).

Nureen said that she would not feel able to 'open up' with an Asian therapist from fear of judgement that she is not strong enough to manage her own difficulties. It seems that although participants recognise that South-Asian therapists are trained professionals, they are unable to see past their ethnicity due to a fear of judgement.

Being perceived as 'weak' prevents many South-Asians from even accepting that they may have a 'mental illness', much less accessing therapy. Many fear bringing *shame* on the family. Thus, if they do decide to engage in therapy, they may choose an ethnically dissimilar therapist to limit the likelihood of being judged by other members of the South-Asian community.

Amongst the South-Asian community there is an unwritten, unspoken, but strong rule related to 'mental illness' – that it simply does not exist. Many South-Asians believe that 'mental illness' is a product of Western philosophy that is not relevant to them. A common belief is that any difficulty can be overcome through prayer, rituals, and either keeping issues within the family or simply ignoring them. The worst thing one can do is talk about their difficulties with people outside their family, as this would 'bring shame'

on the family. It seems that accessing therapy is not part of South-Asian culture, though in British cultures it is normal and common to access therapy as Jasmine mentions:

> *"I've got English friends ...I've got Asian friends ...I've not just in the Ismaili community...I have Sikh friends...I have got Hindu friends...and the White ones don't hesitate to go to counselling...the minute they've got a little bit of a problem ...they are there for whatever reason...whether it helps them ...I don't know yeah.... drinking problem...they are there...violence....they are there...whereas I've got friends who just suffer .. suffer..suffer... abuse from in laws ...abuse from this, that and the other and they...they just don't go and talk about it."* (Jasmine, p.98, lines 694-700).

It seems that one of the main reasons South-Asians may avoid psychological therapy is because they are worried they will be viewed as 'weak' – not strong enough to cope with their difficulties themselves.

The concept of 'izzat', also known as family honour or *saving face*, is part of every fibre of the rich tapestry that is South-Asian culture. There is substantial pressure within the community to be successful, financially stable, and honourable. Many in the community strive to show each other that they are doing well—if they are not, many strive to hide the nature of their distress from fear of judgement or *losing face*. For this reason, many South-Asians do not show weakness or give any indication when they are struggling. There is a long list of factors from which comparisons are made amongst each other including career, salary, marital status, physical/mental health, attractiveness, ability to have children, ability to raise respectable children…the list can seem endless. Many in the South-Asian community feel judged if they show any sign of weakness. Indeed, Farah

spoke about her family not really accepting her mental illness and asking her to *brush it under the carpet*, as they feared judgement from others:

> *"I first struggled with depression, it wasn't really…..talked about….especially in my culture…and when I told my family… it was very much like……don't tell anyone..uhm….dont talk about it….uhm…just..think of all the starving children in Africa…that kind of mentality…"* (Farah, p. 149, lines 405-407).

Farah's use of her family's metaphor here, comparing her mental illness to 'starving children in Africa', portrays a clear example of how her family and community minimise and dismiss the importance and severity of mental illness. The message this sends to Farah is that South-Asians do not acknowledge the existence of mental illness, and thus are not supportive of those who experience it. As a result, it seems logical that she prefers a White therapist, who is understanding of her mental health needs and validating of her difficulties.

Similarly, Nureen mentioned how she initially felt compelled to keep her family's 'secret' but when her therapist normalised her experience and helped Nureen to realise that it was a natural process she felt more comfortable. This may have also changed the way Nureen viewed therapy, making it more acceptable to express her true life experiences in therapy:

> *"I felt uhm…relieved that I sort of hidden something which I felt was a private family thing which should always, which should never be brought up…..and she highlighted that this is actually part of your grieving process…and this is part of you needing help,…until you accept that…and then the next session we talked about just that"* (Nureen, p. 64, lines 714-717).

Similarly Selena also spoke about her culture not accepting mental illness as a 'real condition':

"in Asian culture..its something we don't talk about…mental health outside is only being recognized now.. let alone in our community ..where it is a taboo….[….] unconscious reason for not wanting an Asian person is because in our community it's never talked about recognized acknowledged…and it's seen as bit of a ….Oh God, we don't need outside help sort of thing…so perhaps subconsciously its a safer thing to just steer clear from it" (Selena, p. 170-171, lines 488-496).

The above excerpt is a prime example. It shows how Selena's family does not acknowledge the validity of mental illness, does not encourage people to talk about their problems outside the family, and does not encourage therapy. Selena also reflected on her experience of not being understood and accepted by her family, and said this may be why she was drawn to a White therapist, who was more accepting and understanding of her difficulties. It seems her choice of a White therapist was an *unconscious* decision. This is an experience shared by many participants. They did not consciously choose a White therapist however upon further reflection they seemed to be drawn to them for one reason or another.

The excerpt below from Kierendeep is an example of the notion many South-Asians have in relation to keeping secrets within the family, and also about her apprehension concerning maintaining her family's honour:

"I think that I might be seen in a bad light or that my family might be seen in a bad light because I would disclose things about my family that you know are generally only kept within small family" (Kierendeep, p. 9, lines 279-281).

In addition, Taslim also spoke about how she was worried about feeling judged by her friends and family for accessing therapy:

"when I first started therapy..there was a lot about judgment and...and feeling judged and like this whole thing about...I am too cool for that...you know..that kind of thing...its like..what is someone gonna say about that..and how are they going to respond...to me" (Taslim, p. 27-28, lines 334-338).

It seems for Taslim, she also did not feel comfortable within herself that she was accessing therapy. She seemed to become more comfortable with time and as he accepted it she felt more able to communicate this to others.

In summary, self-stigma of South-Asian clients effects their experience of ethnicity in therapy as it impacts how comfortable they feel talking about their difficulties. The participants preferred therapy with an ethnically dissimilar therapist as they felt more able to express themselves due to the notion that their ethnically different therapist did not subscribe to the same stigmas that the participants did.

Superordinate Theme 2: Ethnically dissimilar therapist allows for greater openness and freedom of expression

Overview

Cross-cultural therapy with an ethnically dissimilar therapist can give South-Asian clients a space where they may feel able to express how they are feeling by narrating their experience of life without the fear of judgment which tends to take place with other South-Asian's in their social circles. All participants had therapy with an ethnically dissimilar therapist (seven with a White therapist and one with a Black therapist) and all reported feeling understood and respected by their therapist. Cross-cultural therapy facilitates dyads whereby the client becomes aware of differences between themselves and their therapist allowing them to feel more comfortable to be honest about their difficulties. South-Asian's in particular seem to be more forthcoming when their therapist does not remind them of a family member. This could be understood in the context of when people of a similar ethnicity may identify with each other and where they may at times over-identify and assume they know the others person's perspective, which may discourage South-Asian clients from truly expressing their experience. The differences present in cross-cultural therapy seemed to help clients feel more able to speak freely. Participants assumed White therapists would maintain confidentiality and remain objective and fair, while South-Asian therapists might struggle to maintain an objective, non-judgmental position. This may be attributed to participants feeling judged by other people in their families. Indeed, in an attempt to protect their family honour, participants may struggle to share their difficulties with a South-Asian therapist from fear that someone they know will find out.

In order to understand the phenomenon of interest for the current study (South-Asian clients' experience of ethnicity in cross-cultural therapy) the following subordinate themes emerged; 'The freedom in therapy to share my interpretation and perspective of ethnicity, culture and religious festivals', 'The therapist offering a fresh and objective perspective on my difficulties' and 'Therapist's openness and curiosity in the face of difference.'

Subordinate Theme 2.1: 'The freedom in therapy to share my interpretation and perspective of ethnicity, culture and religious festivals'

When people talk about their experiences with others, they tend to tailor their content and make certain adaptations depending on whom they are speaking to. If both people share the same ethnicity, they are more likely to share similar languages, culture and religious festivals. They are therefore more likely to make assumptions about each other and may not feel as able to express themselves if their experience is not consistent with the 'norm'. If both people are of different ethnicities, they are less likely to make assumptions about each other. They may, therefore, take more time to explain their perspective and experiences. This is what has tended to happen with the participants. Many of the participants have spoken about the *freedom* they felt when engaging in cross-cultural therapy. They felt comfortable sharing their interpretations and experiences without the worry that their therapist is judging them. Nureen speaks about this when asked about her experience of cross-cultural therapy:

> *"I can actually talk about certain things without feeling…oh I shouldn't, because it's embarrassing, or because you'll judge me for it, or to judge the person I'm talking about…..uhm so it was it was liberating"* (Nureen, p. 65, lines 734-737)..

The theme of freedom during therapy with an ethnically dissimilar therapist was shared by many. This gives the impression that Nureen may view therapy with a South-Asian therapist as suffocating as she does not feel able to express herself freely. Kierendeep also speaks about her experience of freedom in cross-cultural therapy:

"yeah…quite freeing..uhm..I think I am less worried about what it is I am going to say next or whether or not I should or shouldn't say something…uhm…yeah…I think that's.. the main thing I worry less about…how I am going to be perceived" (Kierendeep, p. 8, lines 249-251).

Kierendeep mentions how she worries less about how she is being perceived by her White therapist than by a South-Asian therapist. This reiterates the notion of being judged by an ethnically similar therapist and being *accepted* by a White therapist.

Lilly mentions how she found therapy helpful, as she was able to speak freely with her White therapist:

"I felt really at ease with her…uhm and I could talk to her…quite freely, more than the other therapists that I've seen….that did really help me a lot" (Lilly, p. 104, lines 101-102).

The prominent theme of *freedom* when engaging in cross-cultural therapy that many of the South-Asian participants acknowledged suggests that they felt able to express themselves freely without worrying about being judged. They were able to talk about the nature of their distress and not be ashamed of it. They were able to share their

interpretation of their experience of ethnicity, culture, and religious festivals and not feel that their therapist would come with their own assumptions regarding said culture and religious festivals.

Subordinate Theme 2.2: 'The therapist offering a fresh and objective perspective on my difficulties.'

Engaging in therapy with an ethnically dissimilar therapist can provide a helpful distance between the client and therapist. It can also offer an alternative perspective in making sense of the client's difficulties. Many South-Asians seem to prefer some distance from their therapist, to allow them to feel comfortable and open up. Many South-Asians believe that having an ethnically similar therapist is too close to home or that they share too many similarities. Farah speaks about her experience of her White therapist offering a fresh perspective here:

> *"I loved it to be honest, like therapy for me was like…it was like someone showing me what else the world could be like…uhm…and it really opened my eyes to things and gave me a lot of..uhm…clarity on different aspects of my life"* (Farah, p. 142, lines 200-202).

It seems as if Farah may have felt *stuck*; however, engaging in cross-cultural therapy has illuminated an alternative perspective and given her some clarity. Nureen shares a similar experience:

"Yeah....she didn't judge me at all...neither of them did...but it was like a eureka moment! ..yeah, great...and you...you literally feel (exhales in relief) ...yeah, this is fine" (Nureen, p. 64, lines 727-728).

Nureen expresses the relief she experienced at being offered a fresh perspective by her White therapist. She did not feel judged by them, which may have had something to do with the distance she felt between them.

Farah also speaks about feeling validated by her White therapist. Her family had not accepted her mental illness and made every effort to conceal it from friends and family.

"I think that maybe there was an element of relief at having someone who wasn't in my ethnicity... who could reassure me and tell me that... you're not making this up..... it's a real thing." (Farah, p. 149, lines 408-410)

Nureen comments further on the distance she felt from her therapist, and explicitly says she is "glad" she could not relate to her therapist. This suggests that engaging in therapy with a South-Asian reminds Nureen of a family member, which may discourage her from being open and honest due to feeling judged:

"I was glad that it wasn't somebody that I could relate to or that they would know a bit about my culture. And, and I think that because she was about my age, maybe a few years older, she'd probably experienced similar things not only in her own life, but also through work....uhm..and I think that... had that been somebody with...an Asian woman, for example, I think I would probably not have opened up so much" (Nureen, p. 47, lines 260-265).

Nureen mentions that she would not have "opened up" if she had a South-Asian therapist. This finding is consistent with statements from many other participants. An ethnically dissimilar therapist offers a fresh and objective perspective that is welcomed by many South-Asian clients. Many South-Asians have experienced family members comparing them against others since childhood, and thus may view people from their culture as judgemental. By engaging on cross-cultural therapy, it seems the South-Asian clients were given the opportunity to explore their difficulties from a different prospective which they found helpful.

Subordinate Theme 2.3: Therapist's openness and curiosity in the face of difference

Cultural competence and maintaining a position of openness and curiosity are signs of a containing therapist. A therapist with the confidence, understanding and foresight to address difference in the therapy room in relation to ethnicity can offer a powerful experience for the client. Addressing difference in the therapy room highlights that the therapist is reflective and to a certain degree feels comfortable with their own ethnicity. They are confident enough to ask about difference and to enquire about their client's religion, faith, and social norms if they are unsure. There will always be difference between the therapist and client, in terms of gender, age, or ethnicity, to name just a few possibilities. What clients seem to find helpful is being given the opportunity to address these differences and to reflect on how they feel about them and whether or not they impact the therapeutic relationship. When therapists do not address ethnic differences in cross-cultural therapy, they fail to address the *elephant in the room*, which indirectly communicates a message to the client—that it is not appropriate to discuss the ethnic differences between them.

Many of participants have expressed that they found it helpful when their ethnically dissimilar therapist was open-minded and curious about difference. Lilly portrays this here:

> *"And she was like, okay…now I understand from your culture, where you're coming from, what do you think about life? How do you perceive it?...and she was like…very open minded"* (Lilly, p. 106, lines 134-135)..

Lilly's White therapist seems to have made a real effort to understand Lilly's perspective by considering her culture and background, and avoiding assumptions. This has really helped Lilly to feel comfortable expressing herself in therapy. Similarly, Nureen shares how her White therapist encouraged her to explore her own culture and she did not feel judged by them:

> *"So…, for me,… I felt she made me look deeper into what was needed without judging me or my culture….and then she explored it more to say…you need to get over this…, which you're just aware of and you never experienced if you like"* (Nureen, p. 64, lines 721-723).

It seems that Nureen found her therapists position refreshing and helpful. By offering her a new perspective Nureen's therapist was able to help her to overcome a difficulty. In contrast, many participants assumed that their South-Asian therapists would not be able to stay with their narrative and would instead assert their own assumptions.

South-Asian clients may struggle when broaching topics which are considered taboo in South-Asian cultures with an ethnically similar therapist. They may decide to not discuss such topics all together. For instance although inter-marriages and inter-relationships are becoming more acceptable there is still some stigma amongst members of the South-Asian community. Farah spoke about her relationship with her partner who is from a different culture from her own and said that had her therapist been South-Asian she would have struggled:

> *"it was useful to have someone of a different ethnicity…uhm…was…uhm…talking about relationship.. so I was just engaged to Chris… and so, you know, talking to some of my own ethnicity can be, it can be harder to talk freely about that kind of stuff than talking with a …..uhm…someone of a different culture…uhm…and I also felt she was really uhm…open-minded to my culture…she met my Dad and had a talk with him…..and she also met Chris and had a talk with him…so she was…was very respectful of…of…me and my culture in every way"* (Farah, p. 144, lines 250-256).

Farah's White therapist has shown that she is respectful, open and curious of Farah's ethnicity and cultural background. By meeting with Farah's partner and father (two key people in Farah's life) she was able to understand where Farah was coming from. By having an "open-minded" approach Farah's therapist seems to have helped her in her therapy journey and positively impacted her experience of therapy with an ethnically dissimilar therapist which is the phenomenon of interest in the current study.

Jasmine had a similar experience, where her White therapist despite not knowing very much about her culture, showed curiosity and took on board what Jasmine was saying:

"And she didn't …. I mean, she was ignorant. I mean, ignorant is a strong word by she didn't have the awareness of my…my culture….my community…my… my faith or anything like that….she had no awareness of it….but she listened…uhm…whether she went away inspired …curious…..whatever, I don't know. ..but to me, I felt like she listened because she did draw on it" (Jasmine, p. 87, lines 420-424).

Jasmine felt her White therapist "listened" which seems to have really added to her experience of therapy with an ethnically dissimilar therapist. This thread of being listened to and accepted seems by a White therapist is a salient point that many of the participants mentioned. Taslim reflected on her experience of not being understood or accepted by the White majority during childhood and there being something powerful of being accepted by her White therapist:

"back then…there was …there was lack of understanding….and maybe a little bit of non-acceptance and this time….its completely different…you know there is understanding…there is acceptance.." (Taslim, p. 29, lines 386-388).

Additionally, Nureen mentions about how her White therapist shows cultural competence by asking whether her family are also accessing therapy and whether engaging in therapy was something that was acceptable in her culture:

"she did ask about how uhm…the rest of my family were coping with the same thing……..whether culturally….uhm…it was something it was normal to go for therapy….and I think unfortunately…[…] very few Asians will go for help…[…]

I think it's important to ask for help. I think a lot …of a lot of it is …we shouldn't be airing our views outside and we should help ourselves and talk to people within but I find I found that talking to a stranger who didn't know anything about me… helped…and the fact that she was better for me, to be honest…. I think that had it been…another Asian woman….with a similar background to me….and maybe I would have found it more difficult to talk to…" (Nureen, p. 47, lines 246-254).

Nureen very openly discussed how if she were to have a therapist with a "similar background" she would have struggled to talk. This reiterates the concern that many South-Asian clients face in relation to their fear of being judged negatively by an Asian therapist.

White therapist's making self-disclosures in order to bridge the gap by maintaining an open position of curiosity. It seems that Nureen's therapist made a comparison between Nureen's Muslim faith and her own Christian faith in relation to the significance of the first forty days after a loved one passes away. This seems to help Nureen feel understood:

"40 days is a very important time in a lot of religions…not just ours…..and she actually acknowledged that…and as Christians we have this…and she just said we have this and she just expanded on it… which was good…..because it made me feel like …..yeah..that's nice that we can make comparisons…" (Nureen, p. 62, lines 654-658).

It seems that some participants preferred distance but on this occasion Nureen appreciated some similarities or touch points to help her to relate to her therapist.

In summary, it seems that all the participants appreciated their therapist to be open-minded and curious about difference. It gave them the chance to share their unique individual perspective and not feel judged as they may have felt if they had therapy with a South-Asian therapist.

Superordinate Theme 3: Internalised racism; South-Asian therapists are 'tainted by their culture'

Overview

Internalised racism refers "to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves", (Williams & Williams-Morris, 2000, p.255). In this context internalised racism refers to South-Asian clients expressing their biases towards South-Asian therapists.

Although the focus of this study was concerned with cross-cultural therapy it was not surprising that ethnic-matching was also discussed by the participants. There are mixed views in relation to ethnic-matching between South-Asian clients and therapists. Some clients prefer to have therapy with a therapist who shares the same ethnicity as they may share similarities including language, culture and social norms. These similarities may help the client feel more comfortable. Many South-Asian's initially think they would prefer a South-Asian therapist for the reasons mentioned previously however they change their mind once they begin to think about it in greater depth. The majority of participants in the current study seem to be against ethnic-matching and have a preference for therapists who do not share the same ethnicity. Interestingly, the theme of internalised racism towards South-Asian therapists arose, subtly on many occasions. Many found that they struggled to be honest in therapy due to the fear of being judged by South-Asian

therapists. They also worried about saving their family *honour* and feared that their family secrets could become known in the wider community. Many worried about the ethnically similar therapist making assumptions on their behalf which may stifle their narratives. In addition, some fear that their therapist would not maintain confidentiality and other members of their community may find out that they are struggling and accessing therapy which is considered a taboo.

Many participants felt that there would be an over-familiarity and over-identification if they were to have a South-Asian therapist. Participants said they would view a South-Asian therapist as a family member and therefore not feel able to express themselves openly from fear of judgement.

This superordinate theme comprises of three subordinate themes; 'Clients' prejudice towards South-Asian therapists', 'Client's feeling judged by South-Asian therapists' , 'Client's lack of trust; their South-Asian therapist would not maintain confidentiality', and 'Client's expressions being hindered by a South-Asian therapist due to over-identification'.

Subordinate Theme 3.1: Clients' prejudice towards South-Asian therapists

Many participants made negative assumptions in relation to South-Asian therapists. It seemed that the participants harboured discriminatory and prejudiced views towards South-Asian therapists. Although they acknowledged that all therapists are professional when delivering therapy, they could not seem to separate South-Asian therapists' clinical skills from their ethnicity.

It is important to address participants' social and cultural prejudices regarding South-Asian therapists. Many participants questioned whether South-Asian therapists could be trusted to maintain confidentiality and whether they could remain non-judgemental towards their clients in therapy. Participants based their concerns on a previous course of therapy with a South-Asian therapist or on their assumptions of how a South-Asian therapist might practise.

As mentioned earlier, it is common for South-Asians to judge and compare themselves against each other. This seems to hold among the participants as well. Whether they were voicing their assumptions or speaking from past experience, many seemed unable to separate the professional from their ethnicity. Nureen mentions this here:

> *"Yeah, I felt…..and yet you think well, you know, if it was an Asian woman, she's obviously been trained…she would have had the same training as anybody else…but I think you know, some kind of something would have crept in for me…"* (Nureen, p. 48, lines 289-291).

It seems that Nureen and many others struggle to accept that South-Asian therapists are able to maintain their professionalism and bracket their judgements and assumptions of their clients. Farah also expresses similar concerns when reflecting on how her White therapist was able to take an objective position. She a South-Asian therapist could probably do the same but she is aware of her own judgements:

> *"that's not to say that someone who wasn't Asian couldn't have done that, but from my own perspective… my own judgment..in essence, I would have felt more*

comfortable at that stage talking to someone outside of my culture" (Farah, p. 149, lines 411-413).

Similarly, Farah has been able to reflect on her biases and assumptions when engaging with a South-Asian therapist. She appreciates that South-Asian therapists are competent and capable of practicing professionally and adhering to the same confidentiality guidelines as their White counterparts, however it would still negatively impact her experience of ethnicity in therapy and the amount of progress she makes:

"Yeah, I do…I think I would have been much less open …I would have, I probably would have…uhm…progressed less quickly..uhm…and perhaps in a different way….but I don't think that's necessarily a reflection on the therapist….it's more my perception of how I should act in front of a therapist or what they might be thinking... rather than what they actually were thinking" (Farah, p . 150, lines 419-423).

As mentioned in superordinate theme two there is a lot of prejudice and stigma associated with 'mental illness', accessing psychological therapy and expressing one's self in therapy amongst the South-Asian community. There are many people in the South-Asian community who question the existence of 'mental illness' and believe any form of psychological therapy is a sign of weakness. Many South-Asian's experience of growing up has involved some form of judgment or comparison with other people around them. For this reason, they may view a South-Asian therapist who is in a position of power to make judgments.

Kierendeep speaks about how she specifically chose a White therapist rather than a South-Asian therapist as she felt that South-Asian therapists were "tainted by their culture" and therefore more likely to pass judgment:

> *"I just tend to find that ...yeah...it's just having someone who is going to deal with culture...who is so curious about it... is really useful and I think someone else who is not ...sounds strange....someone else who is not been tainted by the culture...in terms of they don't have you know the ...expectation that I should be a certain way...or that there is this kind of standard and idea of what an Indian woman should be because he is not part of that culture"* (Kierendeep, p. 15, lines 495-500).

Kierendeep speaks of being judged against a set of "standards" or ideals that many South-Asian's ascribe to such as being respectful, educated, marry young, have children etc. She did not wish to be compared against this list of expectations so decided to engage in cross-cultural therapy instead.

All the participants said they would feel judged by a South-Asian therapist which says a lot about where they are coming from irrespective of whether or not that would take place in actuality. Nureen said if she were to have a South-Asian therapist she would also feel judged:

> *"I would have been scared about them judging me"* (Nureen, p. 66, line 760).

Many others, including Kierendeep mentioned they would feel judged by a South-Asian therapist which is interesting as they base this view mainly on their assumptions of the therapist, so in essence they are judging the South-Asian therapist.

"the comparison was that with the Indian therapist I had there was a lot of kind of...assumption that she knew what I was talking about and I knew what she was talking about...uhm in certain things...whereas with a male White therapist there was no assumptions....uhm.,..it means I need to be more explicit in the way that I explain things to him...and explain you know...small things about these traditions and stuff...uhm that I maybe didn't have to explain to another therapist but...it is useful in a way because I then get to tell him what I see that tradition as rather than going off of what someone else's assumed experience is..." (Kierendeep, p. 6, lines 179-186).

In summary, many participants expressed negative assumptions in relation to South-Asian therapists despite their realisation that all therapists are professional. Perhaps the participants struggled to separate South-Asian therapists' clinical skills from their ethnicity. In addition, it was further substantiated that a large number of South-Asian's do not accept that 'mental illness' exists and those that do usually view it as a sign of weakness. Many believe that problems should be discussed within the family and not with an outsider or therapist. For those who do access therapy they seem to prefer an ethnically dissimilar therapist due to the stigma and prejudice surrounding mental illness in the South-Asian community. Thus further highlighting client's prejudice towards South-Asian therapists.

Subordinate Theme 3.2: Client's feeling judged by South-Asian therapists.

The South-Asian community can often be judgmental of each other, whereby they have high standards and expectations of one another. There is a lot of competitiveness to portray oneself as being successful in life. This unfortunately seems to have also transpired into therapeutic relationships; where South-Asian clients feel judged by ethnically similar therapists. The clients fear of being judged prevents them from expressing their difficulties and showing their vulnerable selves.

The majority of the participants who either reflected on their experience with an ethnically similar therapist or shared their views about ethnic similarity mentioned their reluctance to divulge their difficulties due to the fear of being judged by a South-Asian therapist. Kierendeep shared her experience of feeling judged by her previous South-Asian therapist:

> *"Yeah…yeah…or things that would just kind of like unspoken….I think…you feel….or I certainly felt as though I was potentially was a lot more…going to be judged by a therapist who was the same ethnicity as me…that they may potentially may be this unspoken thing like…you know…I'm a parent and you know that's the way that things should be…and yeah…I don't know if it was my assumption …of what it was …but yeah I don't have that with a White therapist…I think there is more kind of like curious questioning…uhm…yeah…yeah…* (Kierendeep, p. 6-7, lines 196-202).

Kierendeep was able to reflect on the notion that feeling judged by an ethnically similar therapist was her 'assumption', however it was enough to make her feel uncomfortable. Feeling judged by one's therapist does not foster a positive therapeutic relationship.

Similarly, Farah mentioned that she was also very aware of how she acted in therapy with a White therapist and how she would have acted differently had they been South-Asian. She was aware of her assumptions and how this impacted her experience of ethnicity in therapy:

> *"Yeah, I do…I think I would have been much less open …I would have, I probably would have…uhm…progressed less quickly..uhm…and perhaps in a different way….but I don't think that's necessarily a reflection on the therapist….it's more my perception of how I should act in front of a therapist or what they might be thinking… rather than what they actually were thinking" (Farah, p. 150, lines 419-423).*

It seems Farah is very aware of how she is perceived by others and how she would be 'expected' to behave in front of a South-Asian therapist given her cultural norms and expectations.

In summary, the excerpts explored above have provided some examples of when participants have felt judged by South-Asian therapists. This judgement, whether assumed or actual affects the participants what the participant experience of ethnicity in therapy.

Subordinate Theme 3.3: Client lack of trust that their South-Asian therapist would maintain confidentiality

There is a proverb known in many South-Asian communities; 'everyone knows everyone's business' suggesting that many people like to gossip and divulge information even if it is derogatory in nature. This coupled with the social norm of comparing one another to protect 'honour' is a concoction resulting in a lack of trust in keeping information confidential. This may be the reason that many participants have expressed a concern, questioning whether a South-Asian therapist can maintain confidentiality. There seems to be a huge anxiety amongst the participants that if they engage in therapy with an ethnically similar therapist, their friends and family may find out they are struggling with their mental health (which is a sign of weakness) and a source of shame. This worry has been described by Taslim:

> *"Just that they don't maintain the confidentiality…and I know that is a really..bad kind of judgement to make about somebody…who is a professional…they are meant to do that…uhm..yeah…that's not very good…"* (Taslim, p. 33, lines 521-523).

Taslim acknowledges that she in fact is judging the *hypothetical South-Asian therapist* however she struggles to separate the therapist's 'professionalism' with their 'ethnicity'. Nureen also expressed similar concerns:

> *"Confidentiality would have been an issue for me….uhm….[…] yeah, then I think I would… I would have known them. Yeah."* (Nureen, p. 49, lines 310-311).

Nureen's worry about other people that she knows finding out that she is in therapy seems very worrying as she may feel ashamed for engaging with therapy.

Some participants said they may contemplate having a therapist who is South-Asian but from a different community or belonging to a believing in a different faith to them as this would make them less likely to know their friends or family. Selena mentions that as her family are well know and respectable in her community she would not consider a therapist from her community but may contemplate a therapist from a neighbouring community:

> *"It might make me think twice…I certainly wouldn't have a therapist, from our community..[…] for obvious reasons…it's too close. And also…members of my family are well known in the community, therefore, I wouldn't want the two and two to be put together for their… their confidentiality and anonymity as well as mine….[I: Sure. Okay.] So I definitely …categorically wouldn't do that within the community"* (Selena, p. 171-172, lines 517-527).

Selena's use of language when stating that she would "definitely", "categorically" not see a therapist from her community reinforced her strong decision against ethnic-matching. Selena seems to want to protect not only herself but her family as well, engaging in therapy and admitting she has been struggling with her mental health can *bring shame* on the whole family.

Subordinate Theme 3.4: Client's expressions being hindered by a South-Asian therapist due to over-identification

Clients naturally look for similarities or differences between themselves and their therapists. They can become curious about their therapist and may make assumptions based on their physical appearance. If the client and therapist share a similar ethnicity, the client is more likely to view the therapist as a close friend or family member. If this takes place they may not feel comfortable to open up depending on the nature of their distress. This may also exacerbate their worry about confidentiality. Many participants expressed this concern, including Taslim who viewed her previous South-Asian therapist as her daughter, given their age difference:

> *…because I was almost her mum's age…probably…obviously we didn't talk about her family at all…but I was visualising her going home and saying… oh, I had such and such a lady and she reminded me of you…. or how would you deal with x, y and z… happened to you?...whereas I think the white lady ....would probably not have that same experience going home"* (Taslim, p. 59-60, lines 594-599).

As Taslim viewed her previous South-Asian therapist as her daughter she, struggled to open up as felt the young therapist would not be able to cope. When Taslim said "*I was visualising her going home and saying",* this reflected Taslim's assumptions of her therapist breaking confidentiality and talking with her family about her clients.

Other participants also made reference to South-Asian therapists reminding them of their family which inhibited them in some way. Kierendeep reflected on her experience with a previous South-Asian therapist who therapy in her home:

"I am not entirely sure why…I think it had something to do with feeling a little bit too much like I was…sat in my own home….and therefore had to be a lot more careful about what I say because that's how I feel when I am at home around loads of family…I feel quite …diplomatic about what I say whereas my White male therapist I see in an outside therapy space…(gestures a big box with her hands) which is very different …it's not..that's kind of my place that I associate therapy….whereas being in someone's home is a very different experience…."

Kierendeep mentioned how she felt like her previous South-Asian therapist's home reminded her of her own home and how this prohibited her to open up, as she would not have a voice at home. When she gestured "a big box with her hands" in response to her White therapists therapy space it seemed she was communicating that she had a lot of space and felt able to express herself more openly with him.

In summary, it seemed that viewing a South-Asian therapist as a friend or family member, by their appearance or therapy room had an inhibiting effect. Many participants struggled to speak openly with a South-Asian therapist and this may be due to the stigma and shame associated with having a 'mental illness' and accessing therapy.

Superordinate Theme 4: Therapists skills and qualities are more important than their ethnicity

Overview

All therapists attend the same training courses irrespective of their ethnicity; therefore one could argue they all have the necessary therapeutic skills to deliver effective therapy. However how culturally competent they are depends on their level of personal reflection and understanding of culture. Many training courses do not provide enough of an emphasis on culture and diversity. Clients' experience of ethnicity in therapy will substantially depend on their therapists' therapeutic skills, experience and cultural competence.

Some of the participants mentioned that their experience of ethnicity in therapy did not have anything to do with the therapists ethnicity. They said that the therapists ethnicity was irrelevant, what was important was their experience and their clinical skills. If the therapist was able to develop a strong therapeutic alliance with their client by showing empathy, good listening skills and experience then it is more likely that the client will have a positive experience of therapy. It can be argued that therapists who show cultural competency will leave clients with a positive experience of their ethnicity in therapy, thus allowing them to feel comfortable to share aspects of their ethnicity.

The subordinate themes which became apparent were 'Individual qualities of the therapist', 'Therapist's experience', 'Therapist's non-verbal communication' and 'Therapist taking an interest in client'.

Subordinate Theme 4.1: Individual qualities of the therapist

The therapists individual and unique qualities have a huge impact on how clients feel in the therapy room. If the therapist is able to put their clients *at ease* then they will have a more positive experience of therapy generally. Whether the therapist is able to facilitate a discussion with their clients about their ethnicity and the ethnic differences between them, will have an effect on their clients experience of ethnicity in the therapy room. For example, Lilly mentioned how her experience of ethnicity in therapy depended on the "actual person" rather than their ethnicity.

> *"I think……it depends on the actual person…because the last therapist I had, I felt really comfortable with her….and it wasn't because of any religion basis. It was just her personality. So, you know, at the end of the day, I could have somebody from my same religion, but I don't feel comfortable with that person. So, it's the actual person then, okay, that is more important than the religion basis"* (Lilly, p. 114, lines 361-365).

Lilly has made reference to her therapist's "religion", but she may have been using the term "religion" to encompass her ethnicity. She made reference to "feeling comfortable" to the person and she prioritises this above their ethnicity.

In addition, Taslim mentions her therapists qualities and how they contributed to her experience of ethnicity in therapy here:

> *"I think uhm…its down to not just me as the client..but I definitely think its down to the quality of my therapist…"* (Taslim, p. 35, lines 591-592).

Nureen commented on positive qualities of her White therapist which seemed to provide a positive experience of therapy for her:

"She was very professional in that sense. She was well prepared. She asked the right questions, I think at the right time…" (Nureen, p. 46, lines 232-233).

"as an individual, she was very warm…uhm…lots of positive vibes from her…" (Nureen, p. 59, lines 577-578).

It seems that the above comments from Nureen in relation to her White therapist's qualities had less to do with her therapists' ethnicity and more to do with her inherent qualities as a therapist.

Subordinate Theme 4.2: Therapist's experience

The therapist's experience has an impact on how comfortable they feel when addressing difference in the therapy room. For those therapists who are experienced they are more likely to be sensitive and attuned to difference in ethnicity between themselves and their clients.

Nureen reflected on her experience of ethnicity in therapy with a White therapist; she said she felt comfortable talking about her ethnicity and she made reference to her therapists experience:

"Uhm….no I don't think there was anything that I felt I couldn't talk to her about. There was nothing that made me feel uncomfortable with her about talking about my own ethnicity, my own background, things that had happened…and I think

she's, she'd been through….she'd helped other people through all this before,….white and non-white. So I think she was very experienced, and she knew how to draw the right information out of you" (Nureen, p.67, lines 786-790).

Nureen gave a good example of how an experienced therapist was able to show cultural competency and facilitate a space where their client felt comfortable to address their differences in relation to their ethnicity.

Subordinate Theme 4.3: Therapist's non-verbal communication

Nureen also speaks about her therapists empathy and use of body language which helped give her the experience of acceptance and support:

"There was a lot of sympathy…there was a lot of empathy. The body language was right. She didn't. I didn't feel uncomfortable or judged by her…she accepted things about me my background, the way I was feeling, without flinching and I think that's part of their training that they're not supposed to show a lot of emotion but I felt very much at ease with her" (Nureen, p. 67, lines 806-810).

When Nureen mentioned her therapist accepted her "without flinching" she may have been expecting them to react in such a way, however their lack of affect at this time seemed helpful for her.

In addition Nureen and Lilly mentioned that their therapists' body language and facial expressions helped put them at ease during their therapy sessions which enhanced their experiences of ethnicity in therapy:

"Uhm…I think she nodded at the right places and made the right sounds in the right places. And she didn't give any advice at all. She hardly spoke. But she did finish with saying something about what to prepare for next time, say, which helped……and maybe I'm just mental I don't know, maybe, maybe an Asian woman would have been just the same. But then maybe I think I wouldn't have opened up …she would have had to work harder for me to open up to her….I think…I just felt that there was …there was no fear of anybody judging me…" (Nureen, p. 48, lines 274-279).

"And she nodded a lot in the right places" (Nureen, p. 68, line 824).

"Uhm…I just think the way they come across, it's totally different ..the …maybe the body language….the some people you feel comfortable with some people you don't…uhm…and it was just you know…uhm..just the body language I suppose..not too sure…" (Lilly, p. 111, lines 280-282).

Nureen mentioned how she would not have opened up with a South-Asian therapist which says more about Nureen's assumptions than a South-Asian therapist's ability or skills to provide an open and safe therapeutic space. It seems that Nureen's assumptions are based on the belief that she may be judged by a South-Asian therapist. This could have stemmed from her previous relationships with other South-Asian people who were judgemental towards her.

When therapist's are able to recall what their clients spoke about in previous sessions, it really helps the client feel that they are respected and truly listened to. Nureen shares her experience:

"she made me feel very…very comfortable..with her questions… and she explained things..uhm…so it was very good…and then when we met the following, every time we met the following week, she'd always remember and that I thought was very important…she never made notes…there was no pen or paper or anything…but she maybe made the notes after I left…. I don't know. But I always felt… God she's listening to me….because she remembered …Oh, gosh, you remembered,… you know… (Nureen, p. 54-55, lines 456-461).

Being kept in mind by her therapist seemed to really make an impression on Nureen. Her choice of words including "God", "Oh, gosh" and her repetition of the word "remembered" several times communicated her surprise that her therapist cared enough to keep her in mind and validate her experiences by remembering what she talked about in therapy.

Subordinate Theme 4.4: Therapist taking an interest in client

Many South-Asian's choose to speak with other South-Asian's as they share a similar language, social norms and beliefs. Therefore, they feel more comfortable and trust that they will be able to understand each other. They believe that people who are from another ethnicity will not understand where they are coming from. Some South-Asian clients prefer to see an ethnically similar therapist for this very reason. However, for some, the perception seems to change when it comes to engaging in psychological therapy. Some South-Asian clients initially believe they would prefer a South-Asian therapist, however, change their mind before starting therapy. This was Kierendeep's experience:

"its quite funny cos when I first went into therapy I assumed off the bat for myself that oh I will have an Indian female therapist and they will be the only person that I will talk to because they will be the only person that will understand me…uhm and actually then when I went and looked around and thought about it…and started speaking to people..that I actually realised that …that just wasn't something that was gonna work for me…" (Kierendeep, p.14, lines 449-454).

This change in perception was characteristic of a few of the other participants. Although all the participants had expressed a preference for an ethnically different therapist, a few of them did mention that having an ethnically similar therapist could be helpful as they would be more understanding and able to relate to their clients. Taslim voiced her views:

"I think she would be able to relate to a lot of things…" (Taslim p. 59, line 594).

There were not many comments similar to Taslim's above. The majority of clients felt that although a South-Asian therapist may be able to relate, they were not particularly looking for that in therapy. Instead they preferred to engage with cross-cultural therapy where they would get a fresh, alternative perspective.

Jasmine expressed how her ethnically dissimilar therapist was interested in her and this helped give her a positive experience of ethnicity in therapy:

"that comes across instantly…uhm and she was actually interested. She asked about our parents. She asked about my background she ….she was interested…and she made me feel she was interested so it wasn't a problem. I

mean, you can sometimes have people that asked for the sake of asking…uhm but

I felt like she was interested" (Jasmine, p. 83, lines 298-301).

This genuine interest from her therapist has little to do with ethnicity but more to do with the therapist's qualities and how they are able to help their clients feel comfortable in the therapy room.

Similarly, Kierendeep mentioned how her White therapist was curious about her ethnicity which greatly improved her experience of ethnicity in therapy:

"I just tend to find that …yeah…it's just having someone who is going to deal with culture…who is so curious about it… is really useful" (Kierendeep, p. 15, lines 495-496).

When the therapist is interested in their client and the client feels understood by their therapist, it creates a good therapeutic alliance. Taslim mentions how her White therapist 'gets it' which helps her to feel understood:

"it feels great…cos it just makes the relationship …it just…it makes it even deeper…you know…it …you have that uhm..you have that openness anyway…but there is no barriers then…you know…it makes it really easy to then talk about whatever it is you want to talk about…..which is the whole point of therapy…you should be able to do that….and I feel that I can because she gets it…and its something that is really important to me ..that she gets it" (Taslim, p. 27, lines 320-324).

Taslim's therapist 'gets it' which suggests that she feels accepted in therapy which therefore allows her to be more comfortable talking about her ethnicity in therapy.

In addition, Jasmine mentioned how her therapist's curiosity encouraged her to feel comfortable to open up in her sessions:

"She was curious about me .....and then from just getting me to talk.....she gauged what I was all about" (Jasmine, p. 85, lines 369-370).

In summary, it seemed there were more cons than pros of ethnic-matching in therapy with South-Asian clients, according to the participants in the current study. Although some of the participants mentioned that a South-Asian therapist could have a better understanding of where they were coming from and therefore offer more support, it seemed that they were actually looking for an ethnically different therapist who would be able to provide another perspective. The participants did not seem able to put their assumptions aside to ascertain whether or not a South-Asian therapist would be able to remain objective, offer an alternative perspective and provide a safe, containing space.

Chapter 5: Discussion

Overview

This final chapter will discuss the findings from the analysis section by contextualising them in previous literature, with particular reference to South-Asian clients experience of ethnicity in cross-cultural therapy. This will be followed by a critical evaluation of the study in relation to Yardley's (2000) quality criteria. The strengths and weaknesses of the study will be discussed. I will then explore my personal, ontological, epistemological and methodological reflections in relation to this study. The chapter will conclude with the study's contribution to the field of counselling psychology and suggestions for future research.

Summary of findings

The findings from the current study addressed the research question in relation to South-Asian experience of ethnicity in cross-cultural therapy. The participant's experience of ethnicity in therapy seemed to be attributed to many factors in relation to themselves and their therapists. Factors relating to themselves included childhood experience of ethnicity and diversity, self-reflection and the degree to which they ascribed to the stigma around 'mental illness' and accessing therapy in the South-Asian community. Factors relating to the therapists, included their level of cultural competency, ability to address difference in the therapy room, experience and therapeutic skills. It seemed that participants who grew up in predominantly White areas and had exposure to people of different ethnicities felt more comfortable with ethnically dissimilar therapists. The participants who grew up in areas with a large South-Asian presence either thought they did not need therapy as they were able to speak with family or they reported a huge concern engaging with South-Asian therapists. The concern was surrounding the fear of being judged and seen to be weak and unable to cope. All participants mentioned how shame affected their therapy

journey negatively; whether it delayed when they sought help, or whether it prevented them from talking in therapy. Many of the participants preferred having therapy with an ethnically dissimilar therapist due to the shame of being in a vulnerable position, viewed as *being weak* whilst engaging with an ethnically similar therapist. In relation to the ethnically dissimilar therapists, it seemed that those who felt comfortable to address ethnic differences in the therapy room showing openness, curiosity and by staying with their clients experiences' facilitated a supportive therapeutic environment. Those therapists who were experienced and who had good therapy skills also added positively to the participant's experience of ethnicity during therapy.

The findings suggested that all the participants were 'listened to' and 'accepted' by their ethnically dissimilar therapist. By approaching difference with openness and curiosity, the ethnically different therapist was able to encourage the client to express their individual experiences. The participants were not judged in therapy and found it refreshing to be able to voice their experiences without the fear of someone from their community finding out that they are engaging in therapy. Due to the *stigma* and *shame* of, firstly struggling with one's mental health and secondly accessing therapy within the South-Asian community, many of the participants appreciated the 'distance' they experienced with their therapist. The awareness that their therapist was not part of their community seemed to encourage them to be open in therapy. Many of the participants reflected on previous courses of therapy with an ethnically similar therapist or they spoke about their assumptions of how they would experience ethnicity in the therapy room. Many participants mentioned that they would feel uncomfortable or not able to express themselves as fully as they would like, with an ethnically similar therapist. Some participants said they would view a South-Asian therapist as friend or family member which may lead to over-identification. This may inhibit the participant from sharing their

perspective as assumptions will be made by both parties, which is a natural process. There was also a worry amongst the participants that a South-Asian therapist would not remain confidential. The participants worried that their friends or family would find out there were in therapy. The shame attached to accessing therapy therefore caused some anxiety. It is interesting as these fears are based on the assumption that a South-Asian therapist is not able to conduct themselves in a professional manner and practice ethically. A few participants were able to recognise and reflect on their assumptions but they still preferred to engage with cross-cultural therapy despite this. A few participants reflected on a shift in their thinking; initially thinking they would have preferred to have a South-Asian therapist but then realising that they in fact preferred a White therapist.

In addition, some of the participants believed that their experience of ethnicity in therapy had very little to do with the ethnicity of the therapist but more to do with their experience and clinical skills. If the therapists took a genuine interest in their clients, came across as experienced, exhibited comforting non-verbal communication and had the 'right' qualities as a therapist the participants seemed to feel comfortable to talk about ethnicity. This seemed to enhance their experience of ethnicity in cross-cultural therapy. This finding would argue that that the ethnicity of the therapist is not as important compared to their personal attributes in the therapy room.

Through the process of conducting the interviews, transcribing and analysing the data, I have noticed a theme of 'power'. It seems as though the participants have favoured their White therapists, idealising them and rating them above South-Asian therapists. They have reflected on their biases and judgments towards South-Asians. This could be explained by childhood experiences of being misunderstood by the majority White population and then as adults engaging in cross-cultural therapy, being understood by a

White therapist could act as a validating process resulting in a reparative relationship. For example Taslim recounted how her White school friends did not understand her culture when she decorated her hands with henna or when she was not allowed to eat pork for religious reasons. At the time she felt they did not understand her. However, by engaging with a White therapist she was able to express her interpretation and experience. Through this process she was accepted and felt for comfortable to identify with her ethnicity. Whether this shift took place consciously or unconsciously it seemed to add to her experience of ethnicity in cross-cultural therapy.

The difference in power and status given to White and South-Asian therapists by South-Asian clients could also be understood in the context of internalised racism. It seemed as though the participants had prescribed to the notion of internalised racism which has been directed towards the BAME community and South-Asians more specifically for decades. It is likely that this process was unconscious, but it seemed as though the participants viewed White therapists to be superior and South-Asian therapists to be inferior. They did not think that a South-Asian therapist would be able to separate their professional role from their cultural influences.

Contextualising the findings in the literature

According to Palmer and Laungani (1999) there is a lack of research into cross-cultural counselling in Britain, therefore the current study was undertaken. The current study yielded four superordinate themes which were developed from the data: 'South-Asian ethnicity and addressing stigma in cross-cultural therapy', 'Ethnically dissimilar therapist allows greater openness and freedom of expression', 'Internalised racism; South-Asian therapists are tainted by their culture' and 'Therapists skills and qualities are more

important than their ethnicity'. These themes will now be discussed taking into consideration previous literature.

Superordinate theme 1: South-Asian ethnicity and addressing stigma in cross-cultural therapy

The first superordinate theme addressed the participants experience of their ethnicity in therapy and what it meant to them. They all identified as South-Asian, and spoke about how it consisted of their culture, family values, and religious beliefs. They also spoke about their place of birth and their parents' place of birth and reflected on whether they identified as British with either an 'Indian', 'Asian' and/or 'East African' influence. This was consistent with South-Asian migration pathways described by (Laungani, 2004). In addition many of the participants reflected on their childhoods. It seemed that those who grew up in predominantly White areas were more aware of their assumptions and biases towards South-Asian therapists compared to those participants who grew up in more multicultural areas.

The first theme focused on addressing stigma in relation to cross-cultural therapy in the South-Asian community. It addressed the notion that many South-Asian's do not believe that 'depression' and 'anxiety' exist and instead attribute their difficulties to physical ailments. The theme also found that many South-Asians do not believe they should speak about their distress with anyone who is not part of their family. For this reason, they do not access psychological therapy at all, and some may wait until the situation becomes serious before accessing help. This finding was consistent with previous research which found that South-Asians are less likely than the rest of the population to access therapy (Steel et al., 2006). For those who do access therapy they may struggle with being honest in therapy due to their cultures lack of belief in the effectiveness of therapy. There are a

small number of South-Asians who do access therapy and who feel comfortable to talk about their distress, but they are a minority. For this reason many participants said they would be reluctant to engage in therapy with a South-Asian therapist. In addition, my findings were consistent with previous research by Moller et al. (2016) in relation to stereotyping and South-Asian women's views around this.

The current study agrees with Palmer's (2002) notion that we all have preconceived assumptions, judgements, and stereotypes about ourselves and others; the extent to which they affect our relationships depends on our understanding of them and whether we feel comfortable having an open, honest conversation with the other person in cross-cultural therapy.

Superordinate theme 2: Ethnically dissimilar therapist allows for greater openness and freedom of expression

The second theme addressed how cross-cultural therapy allowed for freedom of expression. The participants mentioned they were able to express how they felt by narrating their experience of life without the fear of judgment which tends to take place with other South-Asian's in their social circles. This main finding was consistent with previous research by Gurpinar-Morgan et al. (2014). Gurpinar-Morgan et al. (2014) conducted a British qualitative study focusing on the views of five BAME adolescents engaging in CBT on ethnicity and how this affected the therapeutic relationship. Gurpinar-Morgan et al. (2014) found that all the participants preferred engaging in cross-cultural therapy and reported it to be beneficial for the client.

Unlike previous research, the current study found (on many occasions) that White therapists were able to successfully encourage their South-Asian clients to speak freely about their ethnicity. Previous research by Chang and Yoon (2011) found, the majority of clients felt White therapists could not understand key aspects of their experiences and therefore clients avoided discussing issues pertaining to their ethnicity. This may be a reflection of the time between the two studies; Chang and Yoon's (2011) study is currently nine years old, therefore advancements have been made in multiculturism, pluralism and cultural competence in therapeutic practice since then.

In addition, further support has been offered by Gurpinar-Morgan et al. (2014) who also found, of those clients who do seek therapy, they often prefer to be seen by an ethnically dissimilar therapist to avoid the stigma associated with other South-Asian's discovering out they are struggling with their mental health.

All participants had therapy with an ethnically dissimilar therapist (seven with a White therapist and one with a Black therapist) and all reported feeling understood and respected by their therapist. This theme found that cross-cultural therapy facilitates dyads whereby the client was able to adopt distance from their therapist allowing them to feel more comfortable and honest about their difficulties. South-Asian's in particular seemed to be more forthcoming when their therapist did not remind them of a family member. This could be understood in the context of when people of a similar ethnicity may identify with each other and where they may at times over-identify and assume they know the others' perspective. This may discourage South-Asian clients to truly express their experience.

Although the current study did not explore how therapists understanding of their ethnic background affects how they perceive their clients' difficulties, Lago (2006) found that

such therapists were better able to talk about differences in the therapy room. Thus it can be argued, as the participants in the current study were able to address differences in in the therapy room, their therapists also had a good understanding of their own ethnicity. It shows that the therapists in the study were culturally competent (ref). This is a reflection on how education has improved over time to include more of an emphasis on ethnicity and diversity.

In addition, it seems the current study is consistent with Lago (2006), who posited that therapists who understand their own ethnic background, understand their clients' difficulties and feel comfortable talking about differences in the therapy room, thus resulting in a more positive experience for the client.

Superordinate theme 3: Internalised racism; South-Asian therapists are 'tainted by their culture'

The third theme addressed the internalised racism expressed by the participants in relation to ethnic-matching between South-Asian clients and therapists. All the participants mentioned that they preferred to have therapy with an ethnically different therapist. Many participants said they would struggle to be honest in therapy due to the fear of being judged. They would also worry about saving their family *honour* and their family secrets becoming known in the wider community. Many worried about the therapist making assumptions on their behalf which may stifle their narratives. This finding is in accordance with Eleftheriadou (2002) who also found that ethnically similar therapist and clients may over-identify with each other which is not always helpful. In addition, fear that their South-Asian therapist would not maintain confidentiality and other members of their community may find out that they are struggling and accessing therapy which is

considered a taboo. The clients may also be worried about the therapist disclosing what they talked about in therapy.

This theme also discussed the social and cultural prejudices which were brought to the surface in relation to South-Asian therapists. Many participants questioned whether South-Asian therapists could be trusted to maintain confidentiality and whether they could remain non-judgemental towards their clients in therapy. The participants based their concerns on a previous courses of therapy with a South-Asian therapist or on their assumptions of how a South-Asian therapist may practise. Internalised racism seems to be taking place; the participants have internalised the dominant groups biases and assumptions where they view South-Asian therapists as inferior in comparison to White therapists. This finding is consistent with Speight's (2007) claim that the internalising of racism can cause even more harm than if it were coming from someone else.

Although there is not very much research concerning the phenomenon of internalised racism amongst South-Asian's, Parakrama's (2012) doctoral research has offered some support. Parakrama (2012) explored the internalised racism among South-Asian clinicians, working with South-Asian clients. In relation to the therapy dyads, Parakrama (2012) found salient themes including: 'disclosure of racial identity' and 'discussion of racism'. Although these findings are interesting they were not focused on South-Asian clients' experience of internalised racism towards South-Asian therapist. Further research is required in the field of internalised racism.

This finding of internalised racism is not consistent with previous research by Cabral and Smith's (2011) meta-analysis of 81 quantitative studies in America. Cabral and Smith (2011) found clients had a moderately strong preference (Cohen's $d = 0.63$) for a therapist of their own ethnicity, a tendency to perceive therapists of their own ethnicity slightly

more positively than other therapists (Cohen's $d = 0.32$). However, the degree to which this meta-analysis can be compared to the current study is questionable as there are many key differences; it is a meta-analysis of quantitative studies carried out in the USA and included clients of different ethnicities (Asian America, African America, Hispanic and White).

Superordinate theme 4: Therapists skills and qualities are more important than their ethnicity

The fourth theme addressed factors other than ethnicity, which was a finding which was not expected. Many of the participants mentioned that the therapists skills, experience and personal attributes were more important than their ethnicity. They said their experience of ethnicity was enhanced if their therapists could show genuine interest in their clients, adopt warm and engaging non-verbal communication showed experience and understanding in cultural competence.

Interestingly this finding was unexpected and there is a lack of previous literature in this area. Previous studies either focussed on ethnic-similarity or dissimilarity between clients and therapists and findings focused on how ethnicity impacts the therapeutic relationship, experience of therapy or outcome of therapy (Helmes & Cook, 1999; Jones, 1978; Palmer, 2002; Eleftheriadou, 2002).

This finding offers support to The HCPCs standards of proficiency for practitioner psychologists and BPS guidelines which stipulate that mental health practitioners should consider the ethnicity of the client and its impact on their psychosocial wellbeing (BPS, 2017; HCPC, 2015) and potential interventions (BPS, 2017) irrespective of their own

ethnicity. It seems that more research is required in this area to explore the factors other than the therapists ethnicity. In summary, it is promising that participants can have a positive experience of ethnicity in therapy, irrespective of the ethnicity of their therapist as this will be helpful in terms of clinical implications. In the NHS where free therapy is provided, it is very unlikely that clients will be given the choice to choose the ethnicity of their therapist. Therefore, it is reassuring to know that all therapists are able to foster an open therapeutic space for clients to feel able to express themselves and their ethnicity, irrespective of the therapists ethnicity. The findings from the current study suggest there is more to do with the participants perceptions, assumptions and biases of their therapist which impacts their experience of ethnicity in therapy, rather than the actual ethnicity of their therapist.

Critical evaluation of the study

Yardley's (2000) criteria for critically evaluating qualitative research were outlined in the methodology and followed throughout the current study. These were sensitivity to contexts, commitment and rigour, transparency and coherence and impact and importance. These will now be explored in relation to the current study.

Sensitivity to contexts

I ensured the current study addressed sensitivity to contexts at all stages from the literature review, semi-structured interviews and the analysis stage. When conducting the literature review I ensured that I selected relevant studies related to the phenomenon of interest; South-Asian's experience of ethnicity in cross-cultural therapy. As studies in this area were lacking, I extended my search to include BAME clients in general. I ensured that the literature search focused on my research question in order to maintain sensitivity to contexts.

In order to ensure that my semi-structured interviews followed the sensitivity to contexts criteria by Yardley (2000) I had a minimum number of questions open questions, which allowed the participants to express their experiences of ethnicity in therapy. During the interviews I tried my best to stay as close to the participant's accounts as possible by bracketing my own assumptions and experiences. If they assumed I knew about certain aspects pertaining to their faith or ethnicity I asked them to explain, even if I was aware of the phenomena as I wanted them to share their unique experience. I also used my personal therapy sessions and my reflective journal to process and think about my own feelings and experience of the interviews. This helped me to be more aware of my own biases and assumptions when during the interviews.

Commitment and rigour

Commitment and rigour were maintained throughout the current study in order to maintain the integrity of the research during the data collection stage and analysis. In order to ensure the data was collected in a safe, confidential environment I booked rooms in advance, I put a 'do not disturb sign' on the door to prevent interruptions and I also recorded on two devices to ensure all interviews were recorded to a good standard. In accordance with Willig's (2008) recommendations, the development of subordinate and superordinate themes was checked regularly by my director of studies and changes were made as a result of regular discussions. It was useful to have an outsider's perspective in order to help me find my blind spots. Although it was helpful having regular discussions with my director of studies it was important for me to stay close to my subjective interpretations of the participants experience, as recommended by IPA guidelines (Smith et al., 2009). In addition, I chose to transcribe all the recordings myself, rather than use a computerised software, in order to give myself the best chance of immersing into the data.

Transparency and coherence

I have remained transparent throughout my research journey and documented everything from start to finish. I have ensured that I included all relevant documents in the appendices including my ethics forms and ethics amendment forms. I have added examples of each stage of the analysis process in the appendix to show transparency. I have submitted all the transcripts separately and have saved the audio recordings securely, so I can provide them if required. I have been open and honest about my epistemological position and my experience of ethnicity in personal therapy with an ethnically dissimilar therapist.

Impact and importance

The potential impact and importance of the current study was considered throughout. It can help current trainees, counselling psychologists and therapists to have a better understanding of South-Asian clients experience of ethnicity, thereby encouraging them to facilitate more positive therapeutic alliances with their clients. The current study also emphasises to trainees, counselling psychologists and other therapists, the importance of self-awareness in relation to their own ethnicity and how they view difference. The more comfortable they feel in relation to their ethnicity, the more likely they will be to facilitate a discussion with clients.

In terms of disseminating my findings, I will be presenting my findings to the psychologists in the NHS trust I work for, in our quarterly meeting. I also endeavour to publish my findings in 'The Psychologist' and the 'Counselling Psychology Review', both published by the BPS. The findings can also be published in other peer rated journals which have an interest in ethnicity and cross-cultural therapy. In order to broaden the scope and disseminate my findings to the general public, I have decided to present my

findings to South-Asian's in my own community. I hold an honorary position as a board member with the Aga Khan Health Board (AKHB) who work closely with the Aga Khan Development Network (AKDN) which is a charity organisation. I believe by disseminating my findings to South-Asian's, I will be able to dispel some of the stigma surrounding 'mental illness' and accessing psychological therapy. This is a huge area of passion for me personally and I really hope that I can make a positive difference in one form or another.

Strengths and limitations of the study

A strength of the current study was mentioned above; the degree to which Yardley's (2000) guidelines were followed, ensured the study met validity and reliability criteria for qualitative research. The study also followed the IPA guidelines in accordance with Smith et al. (2009). The use of IPA encouraged the participants to speak openly about their experience of ethnicity in cross-cultural therapy. In addition, my interpretations added a unique richness to the analysis which would have been missed if other methodologies had been chosen. The study answered the initial aims and research questions.

I believe being an insider researcher added value and context to my interpretations and analysis, however this also created a few challenges. During the interviews with my participants, there were times where I noticed myself over-identifying with them. I noticed a desire to relate to them and connect with them as I shared many of their experiences; where their parents were born, their faith and religious ceremonies. It was a struggle to completely stay with their experience as I was noticing different feelings in my body. For example when they spoke about South-Asian therapist's not being able to maintain confidentiality or not offering an open, safe space in therapy I noticed myself feeling angry. I noticed my thoughts becoming somewhat defensive; I know that I being

a South-Asian therapist maintain confidentiality and try my best to stay with my clients' experiences rather than assert my own. However, regular journaling and on-going discussions in personal therapy gave me an outlet to express my anger. I therefore tried my best to stay with the participants experience during the interview and was more aware of my interpretations during the analysis stage.

During the analysis stage, I initially struggled in maintaining a balance between knowing how much I needed to stay with the participants' experience and how much I needed to offer my interpretation. After discussing with my director of studies I became aware of the importance of my interpretation by using the participants quotes to further substantiate my interpretations. The subjective nature of IPA infers that every different researcher will have different interpretations from the same data, thus true representation is impossible (Smith et al., 2009). My interpretations are based on my experience of being a South-Asian client engaging in therapy with an ethnically different therapist.

More generally, a good number of participants were recruited, all of which were female, which met IPA's criteria of homogeneity, who had a shared experience of engaging in cross-cultural therapy with an ethnically dissimilar therapist (Smith et al., 2009). All the participants had therapy with an ethnically dissimilar therapist, where seven were White and one was Black. Another factor which was not entirely consistent, was the 'role' of the therapist; they were either counselling psychologists, clinical psychologists, counsellors or psychotherapists. As the therapist 'role' was not the focus of my study, it was acceptable to include a variety. Future research could include one type of therapist to find out whether this had any effect on the results.

Reflexivity

According to BPS Code of Ethics and Conduct (2018), reflexivity holds a central role in the field of counselling psychology and is greatly encouraged in all aspects including clinical and research work (BPS, 2018). Therapy is an intersubjective venture which takes place between two people, in which each person affects the other (Douglas et al., 2016). According to Willig (2008) the role of reflexivity and the relationship between myself as the researcher and the participants is an important one to explore. During the interviews with my participants I was aware of the impact I had on my participants and how they impacted me. I was aware of my ethnicity, my skin colour, my verbal and non-verbal communication. Some of the participants mentioned that they felt comfortable to talk to me as they felt I could understand where they were coming from. Other participants apologised when they mentioned their beliefs about South-Asian therapists in a derogatory sense as they were aware that I was a trainee. This made me curious about the interaction I shared with each participant, which effected how I felt in the room thus having an effect on their responses during the interview. This most likely influenced the analysis of the transcripts at some point during the research journey; either during the initial coding phase or in the latter stages of developing themes.

Personal reflexivity

Given the reflective nature of IPA, it is fundamental to consider the reason why I chose to conduct this research and how I have impacted my research at various different stages. This section begins by highlighting my personal reflections of being an insider in my study. I self-identify as a British South-Asian woman currently engaging in cross-cultural therapy with a White therapist. Being reflective and reflexive has help me to become aware of my assumptions and biases and how they have impacted my research journey.

I identify as a South-Asian British woman, and I believe ethnicity is very important to me. I identify with my Indian heritage, my parent's East-African heritage and my British heritage. My grandparents were born in Gujarat, India. They migrated to East Africa; my mother was born in Uganda and my father was born in Tanzania. My mother was forced to leave Uganda and her family settled in the UK in the 1970s. My father moved to the UK in the 1980's. My parents met in London and I was born in the 1980s. Having grown up in predominantly White areas in the UK and Canada I was quite used to being around White people, however I was always aware of the differences between myself and them. I felt that it was not acceptable to address the differences between, therefore I assimilated myself with the Western culture.

I myself chose to engage in cross-cultural therapy with a White female counselling psychologist and I think it is important to share my reasons for doing so. I chose a White therapist because I honestly felt more comfortable with a White person in a therapy setting. Growing up, I felt judged by many other South-Asian's. The reason for this is I am an Ismaili Shia Muslim, which belongs to a minority Muslim sect. I believe if I would have had therapy with an ethnically similar therapist I would have felt judged by them. Similarly to the participants, I wanted a chance to express my perspective and experience of my life rather than have my therapist making assumptions of me. By having a White therapist, I was able to have healthy distance and space to address my concerns. I feel it was also helpful to see my therapist's perspective which was different from my own. My experience of ethnicity in the therapy room was very positive. I was able to discuss aspects of my religion, culture and family dynamics. My therapist was very accepting, open and curious when she was unsure about something. We spent many sessions talking about my research, my views on cross-cultural therapy and I how I felt in the room with her. It is interesting as it seems that my experience of cross-cultural therapy was similar

to that of my participants. I was conscious of this during the interviews, therefore I made an effort to stay with their experiences as much as possible.

It was interesting for me to hear the participants accounts of their ethnicity as there my history follows a similar trajectory. On a few occasions the participants referred to 'us' as some of them were aware of my history or they made assumptions based on my appearance. This was interesting to note that although I made every effort to encourage them to share 'their' experiences with me, they made assumptions and over-identified with me which inferred that we had 'similar experiences' based on our ethnicity. I believe having some shared understandings helped the work. An example of this was when Taslim mentioned 'Khushiali' which is an Ismaili religious festival. She assumed that because I am also an Ismaili Muslim I was aware of it; which I was however as I was trying to stay as close as possible to her experience I later asked Taslim to explain the festival to me. It was useful for me to have an understanding of the festival, however in my opinion this can become a trap that one can fall into when two people of the same ethnicity are together discussing a particular topic. In accordance with my epistemological stance and IPA's position, we all have unique experiences of a phenomenon and even though we both know of Khushiali our experiences may be different. I made every effort to stay with Taslim's experience during the interview, however during the analysis phase I added my interpretation, according to IPA's guidelines (Smith, 2009). Having an insiders position for the current study has allowed me to have sound understanding of where my participant may be coming from, but I have also tried my best to stay with their experience.

Methodological/epistemological reflexivity

The role of reflexivity is also fundamental in qualitative research and IPA; the double hermeneutic being a prime example of this (Smith et al., 2009). Also being constantly aware of my epistemological stance has helped me to ensure all aspects of my research are aligned.

The nature of qualitative research and the use of IPA has encouraged me to have an impact of my entire research journey; from participant recruitment, formulating research questions, carrying out interviews, my behaviour when engaging with participants, transcribing and my subjective interpretation of the data.

My relativist ontological position and constructivist epistemological stance set within an interpretivist theoretical framework lead me to believe that knowledge is co-constructed between my participants and myself as the researcher (Creswell & Poth, 2018). I also consider the phenomenological approach is particularly useful when studying experiences, and I subscribe to the Heideggerian tradition. In addition, I subscribe to the notion of the double hermeneutic (Smith, 2009). My position has greatly impacted my research journey. The participants and I co-constructed meaning together in a reflexive process. My interpretation of their accounts was guided by my experience of ethnicity in cross-cultural therapy and my cultural beliefs in relation to this phenomenon.

Contributions and clinical implications in relation to counselling psychology

This research project is relevant to the field of counselling psychology as it has the potential to inform training programmes: from curriculum design (including lectures pertaining to ethnicity, coming to terms with one's own ethnicity and feeling comfortable working with clients of similar and dissimilar ethnic backgrounds) and delivery

(providing the space for discussion and reflection). It has been found that therapists who reflect on their own ethnicity and its impact in the therapy room were more able to discuss ethnicity with their clients (James, 2016). Therefore, the importance of identifying with one's own ethnicity needs to be addressed by trainees in personal therapy and supervision. It may also help inform therapists when thinking about appropriate allocations. If they are aware of client preferences and if clients will benefit from either seeing a therapist who is ethnically similar or dissimilar to them, this can be advantageous. However, this can only be offered if it is feasible given the resources available in the team. Also, in the therapy room, it may enhance therapeutic alliance if the therapist is able be more aware of their own ethnicity and how it affects the client and their process.

According to the Practice Guidelines for Psychologists (BPS, 2017) and the Standards for Proficiency for Practitioner Psychologists (HCPC, 2015), therapists are required to practice in a non-discriminatory manner, be aware of stereotypical beliefs, acknowledge the history of racism, and respect their clients' ethnicity and cultural beliefs by tailoring their approach accordingly. Thus, the current study can provide therapists a valuable understanding of their South-Asian clients experience of ethnicity in the cross-cultural therapy.

Recommendations for future research

The current study has highlighted an area for future research. The concept of internalised racism was an interesting finding and further research could be undertaken in order to discover more around the topic. In order to research this, a group of South-Asian clients could be asked about their experience of ethnicity whilst in therapy with a South-Asian therapist. The results from this study would be interesting as it would be based on actual ethnically matched therapeutic relationships. It should be noted however, that it may be

difficult to find enough participants for this study, therefore enough time would be needed to allocate to participant recruitment. In addition, further future research could focus on aspects other than the therapists ethnicity as this seemed to be an overriding factor for many of the participants, which impacted their experience of ethnicity in therapy.

Conclusion

The findings from the current study addressed the research question in relation to South-Asian's experience of ethnicity in cross-cultural therapy. The participant's experience of ethnicity in therapy seemed to be attributed to many factors in relation to themselves and their therapists. Factors relating to themselves included childhood experience of ethnicity and diversity, self-reflection and the degree to which they ascribed to the stigma around 'mental illness' and accessing therapy in the South-Asian community. Factors relating to the therapists, included their level of cultural competency, ability to address difference in the therapy room, experience and therapeutic skills. All participants mentioned how shame affected their therapy journey negatively. Many of the participants preferred having therapy with an ethnically dissimilar therapist due to the shame of being in a vulnerable position, viewed as *being weak* whilst engaging with an ethnically similar therapist. In relation to the ethnically dissimilar therapists, it seemed that those who felt comfortable to address ethnic differences in the therapy room showing openness, curiosity and by staying with their clients experiences' facilitated a supportive therapeutic environment. Those therapists who were experienced and who had good therapy skills also added positively to the participant's experience of ethnicity during therapy.

The study addressed the aims and research questions outlined in the beginning which was to explore South-Asian clients' experience of ethnicity in cross-cultural therapy. The original contribution of the study is that it addressed the gaps outlined at the beginning.

The study provided much needed qualitative research in the UK for South-Asian clients experiencing cross-cultural therapy rather than looking more generally at BAME groups in the USA. Lastly, the study was able to encourage South-Asian's to share their experience of ethnicity in cross-cultural therapy.

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Appendices

Appendix A: Original letter from ethics committee

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Miha Constantinescu

SUPERVISOR: **Claire Marshall**

STUDENT: Zara Kanji

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: Subjective Experience of Ethnicity in Psychological Therapy of Clients Self-identifying as South-Asian: An Interpretative Phenomenological Analysis

DECISION OPTIONS:

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

Approved

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the <u>researcher</u> to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

☒
LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*:   Dr Miha Constantinescu

Date: 26.04.2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Appendix B: Ethics amendment form 1

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

 FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

Complete the request form electronically and accurately.

Type your name in the 'student's signature' section (page 2).

When submitting this request form, ensure that all necessary documents are attached (see below).

Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk

Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

Recruitment and data collection are not to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.

Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.

A copy of the approval of your initial ethics application.

Name of applicant: Zara Kanji

Programme of study: Professional Doctorate in Counselling Psychology

Title of research: Subjective Experience of Ethnicity in Psychological Therapy of Clients Self-identifying as South-Asian: An Interpretative Phenomenological Analysis

Name of supervisor: Dr Claire Marshall

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
I would like to be given permission to carry out interviews via skype if face-to-face interviews are not feasible.	This will hopefully increase my chances of recruiting enough participants.
I have updated my social media advert and included a poster *(please find attached).*	The new poster will help to attract more attention from prospective participants and thus help with recruitment.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	/	

Student's signature (please type your name): Zara Kanji

Date: 05/07/2019

TO BE COMPLETED BY REVIEWER 132		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 5.7.19

Appendix C: Ethics amendment form 2

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

 FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk)

HOW TO COMPLETE & SUBMIT THE REQUEST

Complete the request form electronically and accurately.

Type your name in the 'student's signature' section (page 2).

When submitting this request form, ensure that all necessary documents are attached (see below).

Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk

Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

Recruitment and data collection are not to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.

Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.

A copy of the approval of your initial ethics application.

Name of applicant: Zara Kanji

Programme of study: Professional Doctorate in Counselling Psychology

Title of research: Subjective Experience of Ethnicity in Psychological Therapy of Clients Self-identifying as South-Asian: An Interpretative Phenomenological Analysis

Name of supervisor: Dr Claire Marshall

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
I would like to change the title of my thesis from 'Subjective Experience of Ethnicity in Psychological Therapy of Clients Self-identifying as South-Asian: An Interpretative Phenomenological Analysis' to the following: 'Experience of Ethnicity in Therapy from the Perspective of Clients Self-Identifying as South-Asian: An Interpretative Phenomenological Analysis'	The reason I would like to make this change is that I believe the new title describes my study more succinctly and in greater detail.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	/	

Student's signature (please type your name): Zara Kanji

Date: 24/08/2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 1.9.20

Appendix D: Research integrity certificate of achievement

CERTIFICATE of ACHIEVEMENT

This is to certify that

ZARA KANJI

has completed successfully

Research Integrity Modules

29 January 2019

End of course quiz - Social and Behavioural Sciences Grade: 75.00 %

Are you having psychological therapy with a therapist who has a different ethnicity to you?

Do you identify as South-Asian?

Would you like to share your experience of therapy?

If you answered YES then please get in touch!!

Zara Kanji, Counselling Psychologist in Training
E-mail:

I am in the second year of my Doctorate in Counselling Psychology at UEL.
I am interested in the field of multi-cultural therapy from the client's perspective.
My study will **include clients who self-identify as South-Asian** and will ask
about their subjective experience of ethnicity in therapy.

Appendix F: Participant information sheet

PARTICIPANT INVITATION LETTER

Researcher:
Zara Kanji, Counselling Psychologist in Training,
University of East London, E15 4LZ

Supervised by **Dr Claire Marshall**, Counselling Psychologist and lecturer,
University of East London, E15 4LZ
E-mail: C.marshall@uel.ac.uk, Tel: 020 8223 4680

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in my research project.
The project is being conducted as part of my Professional Doctorate in Counselling Psychology at the University of East London.
My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Project Title
Experience of Ethnicity in Therapy from the Perspective of Clients Self-Identifying as South-Asian: An Interpretative Phenomenological Analysis

Project Description
My project aims to explore the field of multi-cultural therapy from the client's perspective. It will include clients who self-identify as South-Asian and will ask about their subjective experience of ethnicity in therapy. More specifically it will focus on their experience of having therapy with a therapist who has a different ethnicity to themselves.

Who Can Take Part?
I am looking for participants who self-identify as South-Asian and are having psychological therapy or recently finished therapy with a therapist of a different ethnicity to themselves.

What Will You Be Required To Do?
If you decide to volunteer, you will be asked to complete a short demographic sheet and sign a consent form. We will then meet at UEL or a more convenient library where we will have a face-to-face interview lasting approximately 60-90 minutes. The interview will be recorded and transcribed by me and all data will be anonymised and stored securely. I will ask you questions about your experience of having therapy with therapist who has a different ethnicity to you. I will ask you how you found it and what

your experience was like. I will not be asking about the nature of why you attended therapy or the content of what you discussed during your sessions. You do not have to answer all the questions and will not be forced to discuss anything you feel uncomfortable with. The discussion will be audio recorded to enable me to transcribe it afterwards.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

Benefits
Your participation will help enrich the literature in the field of multi-cultural therapy and will help us to understand South-Asian's experience of therapy with an ethnically dissimilar therapist. A greater understanding in this area may help therapists be more aware of ethnic dissimilarity in the therapeutic relationship.

Risks
You will be asked about your experience of therapy and not about the nature of what brought you to therapy therefore risks are minimal. However if something distressing does come up for you and you wish to end the interview your wishes will be respected. There will also be a debrief at the end where I will sign-post you to teams where you can get further support and I will be happy to answer any questions you may have.

Confidentiality of Data
Your privacy and safety will be respected at all times. I will ensure that we meet in a booked room with no interruptions. Your name or identifiable information will not be on any of the transcripts or final write-up. I will use a pseudonym (false name) which you can choose if you wish. You do not have to answer all the questions if you do not want to and will have the choice to withdraw at any time with no explanation required. Apart from myself, my supervisor and examiner will see the anonymised data which may also be published in academic journals. After the study has been completed, the data will be stored securely for two years and then deleted. Your contact details will be deleted at the end of the study.

What Happens Next?
If you agree to take part I will send you the consent form, information sheet and demographic sheet for you to read before we meet. When we meet I will ask you to sign the consent form and complete demographic sheet before we commence the interview.

What If You Want To Withdraw?
You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw after two months from your interview date I would reserve the right to use material that you provide.

Thank you for taking the time to consider your participation in my study. Please feel free to get in touch with me if you have any questions.

Appendix G: Participant consent form

Consent to Participate in a Research Study

Experience of Ethnicity in Therapy from the Perspective of Clients Self-Identifying as South-Asian: An Interpretative Phenomenological Analysis

1. I have the read the information page relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.
Please tick box ☐

2. I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.
Please tick box ☐

3. I hereby freely and fully consent to participate in the study which has been fully explained to me.
Please tick box ☐

4. Having given this consent, I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw two months after my interview date, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher
Please tick box ☐

By only ticking all of the above boxes this be taken as consent to participant in the research study

Participant's Name (BLOCK CAPITALS)
……………………………………………………………………………….

Participant's Signature
……………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)
…………………………………………………………………………..

Researcher's Signature
………………………………………………………………………………….Date: ....

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Appendix H: Participant demographic form

Demographic Information Sheet

1. **Name:**

……………………………………………………………………………

2. **Gender:**

……………………………………………………………………………

3. **Date of Birth:**

……………………………………………………………………………

4. **Your ethnicity:**

……………………………………………………………………………

5. **Your therapist's ethnicity:**

……………………………………………………………………………

6. **Your therapist's role: (please circle)**

Counselling Psychologist / Clinical Psychologist / Psychotherapist / Counsellor

Other:……………………………………………………………………..(please specify)

7. **Are you currently having therapy? (please circle)**

Yes / No

8. **Do you know the modality of your therapy? (please circle)**

CBT / Psychodynamic / Counselling /
Other:…………………………..(please specify)

9. **If you are currently in therapy how many sessions have you had?**

…………………………………………………………………………….

10. **If you have finished therapy, how long ago was your last session?**
…………………………………………………………………………….

Thank you for completing this form.

Appendix I: Interview schedule

Interview Schedule

1. How would you describe your ethnicity and what it means to you?
2. How would you describe your therapist's ethnicity?
3. What is your experience of having therapy with a therapist who has a different ethnicity to you?
   a. Anything that has been going well?
   b. Anything that has not been going well?
4. Is there anything else you would like to add in relation to this topic?

Appendix J: Participant debrief sheet

<u>Debrief Sheet</u>

Thank you for taking the time to partake in my research project.

As discussed the aim of my project was to explore the field of multi-cultural therapy from your perspective. It asked about your subjective experience of ethnicity in therapy. More specifically it focused on your experience of having therapy with a therapist who has a different ethnicity to yourself.

If you found the interview uncomfortable or distressing in any way please feel free to discuss this with my supervisor or myself.
If you are still in therapy I would encourage you to speak with your therapist.
If you have completed therapy but would like to access more support please contact the following agencies where you can get more information:

Mind
https://www.mind.org.uk/information-support/helplines/
15-19 Broadway, Stratford, London E15 4BQ
T: 020 8519 2122, F: 020 8522 1725
E-mail: supporterrelations@mind.org.uk

Improving Access to Psychological Therapies (IAPT)
https://www.nhs.uk/Service-Search/Psychological%20therapies%20(IAPT)/LocationSearch/10008

Samaritans
https://www.samaritans.org/

If you have any further questions and wish to get in touch please do so:

Zara Kanji, Counselling Psychologist in Training,
University of East London, E15 4LZ

Supervised by **Dr Claire Marshall**, Counselling Psychologist and lecturer,
University of East London, E15 4LZ
E-mail: C.marshall@uel.ac.uk, Tel: 020 8223 4680

Appendix K: Example transcript with comments

Original Transcript: Kierendeep	Exploratory Comments: **Descriptive**. *Linguistic* and <u>Conceptual</u>	Emergent Themes
P: Yeah,...a very interesting experience…I think partly because the therapist that I had before …..the Indian woman…she used to work out of her home…and she would only take *specific* clients who she would see at home…but ..again I think that made me feel **strangely more uncomfortable…** I: Right	<u>It seems that she feels judged by her South-Asian therapist….could this be her own feelings of being judged</u> by family members and due to having a similar physical appearance or skin colour she may view her therapist as her family rather than an 'objective therapist' *Use of the word strangely, maybe she was surprised?*	South-Asian therapist viewed as judgmental
P: Uhm I am not entirely sure why…I think it had something to do with **feeling a little bit too much like I was…sat in my own home**….and therefore had to be a lot **more careful about what I say** because **that's how I feel when I am at home around loads of family**…**I feel quite …diplomatic about what I say whereas my White male therapist I see in an outside therapy space**…<u>(gestures a big box with her hands)</u> which is very different …it's not..that's kind of my place that I associate therapy…..whereas being in someone's home is a very different experience…. […] I: Yeah…what was it like to share this with your	<u>Did she view her previous South-Asian therapist in a motherly role, reminding her of her own mother?</u> <u>She is noticing too many similarities with her South-Asian therapist –</u> **she is over-identifying with her therapist** <u>Use of gestures symbolises free space to express herself without judgement with her White therapist</u>	Viewing South-Asian therapist as her mother Over-identifying with South-Asian therapist

therapist….this information about being treated differently to your brothers? How did you feel when you shared it with your therapist?	*She uses the word 'freeing' many times suggesting she feels comfortable to be herself with the White therapist*	Freedom of speech
P: Uhm……I think **quite freeing** in a way…uhm…I think because when I shared these things I kind of got a response back was that these that…these…that was really unfair and it wasn't just me…kind of being really dramatic about it…uhm…so yeah…it was quite a good reaction…**I felt as though he kind of got…the position that I was coming from**….in the context of the story….yeah..	**Feeling understood by White therapist** **Able to express her perspective**	Freedom to share her interpretation and experience

Appendix L: Development of emergent themes

Emergent Themes							
Kierendeep	**Taslim**	**Nureen**	**Jasmin**	**Lilly**	**Mamta**	**Farah**	**Selena**
Religions influence on ethnicity is important	British Asian ethnicity	British Asian	British Asian	Indian	British, Indian Asian (East African- but not much)	British Asian mishmash of East African and Indian	British Asian
Tradition/culture related to ethnicity	Ethnicity as being an identifer	Lacks sense of belonging but identifies more with Indian and British culture	Ismaili Muslim	Indian/African	Mums family is Muslim, Fathers family is Jain Hindu, Father is Atheist	Indian culture focused around family	Assimilate more with British and African culture rather than
Shame for not being a 'proper indian'	Importance of Indian/British culture and Islamic religion on her ethnicity	Woman are strong and independent in her family	East African and Indian culture	Muslim religion very important	Life split into separate compartments and did not feel she belonged anywhere	Protective parents affected self confidence growing up	Three strands of ethnicity; British, Asian and African
Gender inequality – Male dominance	Ethnicity is important Indian culture including language, food and music forms part of her identity	Comfortable in her own skin but constantly aware of difference in ethnicity	Proud of her ethnicity	African/Indian culture	Therapist is White British Anglo Saxon	Therapist White British/Eastern European	Indian values of respecting elders is important
Over-identification with similar therapist		White therapist	White therapist	Respectful of other religions	Client chose a White therapist but did not think about race- just gravitated towards her	Mixed experience of therapy	Mixture of Indian, African and British
close identification with Indian therapist from both therapist and client	Combination of British, Indian and East African culture	Therapist was well prepared and made me feel comfortable	Previous therapy with a White male not good experience due to his gender and	White therapist open to ask questions about religion and faith	Did not choose an Asian therapist as unsure if they would have understood her more	Ethnically different therapist helped to push me to see a different perspective	Black American therapist
Non-verbal gestures and judgment from an ethnically similar therapist	Transition from not embracing her ethnicity as a child to feeling proud about it as an adult.	Positive helpful experience of therapy White therapist was culturally sensitive and curious of difference	Preference for a female White therapist calm friendly and put client at ease	White therapist open-minded and non-judgemental White therapist respectful and listening	Has not discussed ethnicity very much in therapy Aware of White privilege and not comfortable to talk about it with White therapist	Negative having ethnic difference as they did not understand the importance of family to me I felt challenged sometimes in a good way and sometimes in a difficult	Initial surprised when I found out my therapist was Black after having two White therapists Competent Black therapist
Asian therapist viewed as a family member	Asian ethnicity not being accepted as a child						
Preference for a White therapist	White Irish therapist	Stereotype that Asians should not seek therapy	White therapist showing an interest in		Nervous about how a White therapist may feel if she talks	Another perspective helped me to feel relief and	My therapists professional ability and

Appendix M: Connections amongst emergent themes
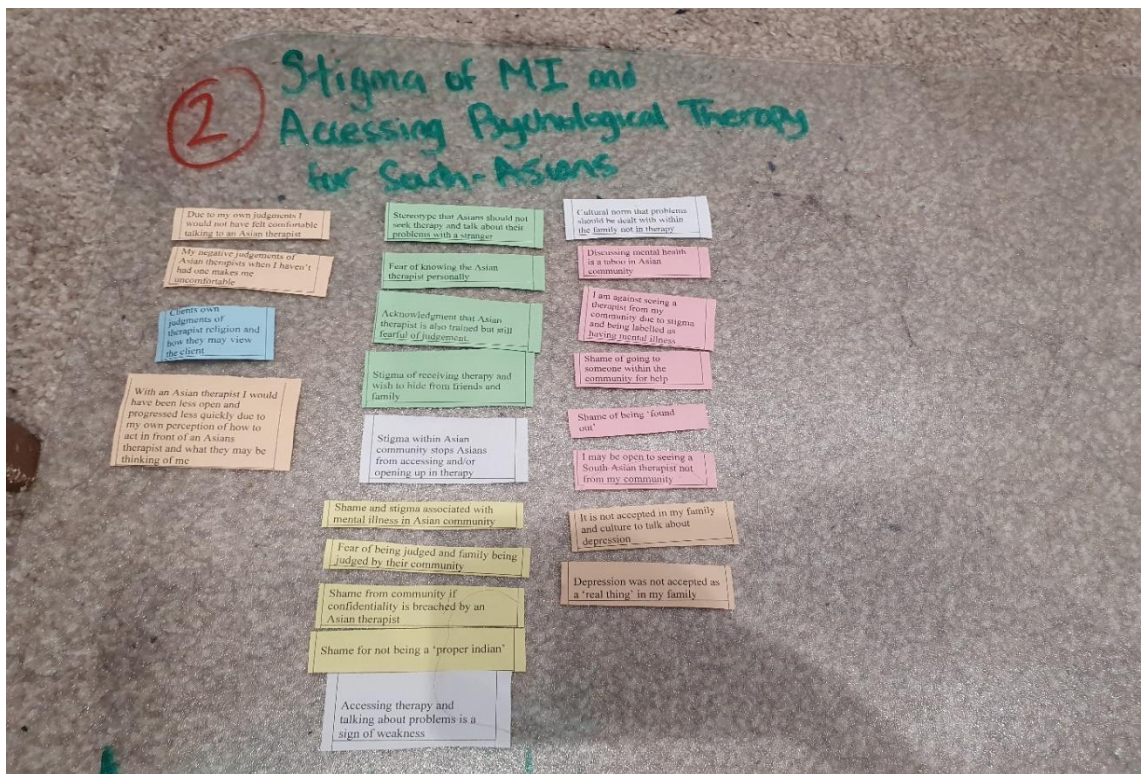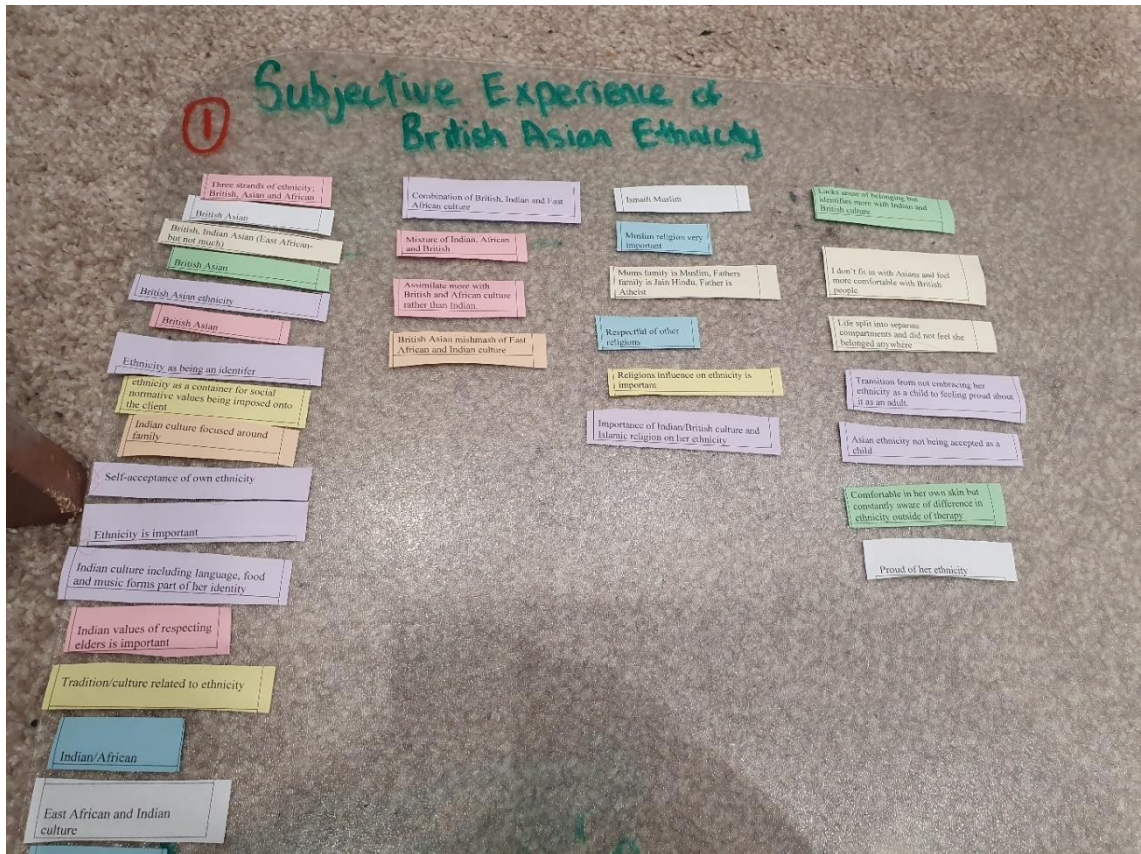
③ **Therapy With an Ethnically Dissimilar Therapist**

Key:-

Kieran - yellow
Lilly - blue
Nureen - green
Taslim - purple
Serena - pink
Jasmine - white
Farah - salmon
Mamta - pale

④ **Psychological Therapy With An Ethnically Similar Therapist**

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Appendix N: Superordinate and subordinate themes

Superordinate Themes	Subordinate Themes
1) South-Asian ethnicity and addressing stigma in cross-cultural therapy	1.1.'Navigating my ethnicity in therapy; which box do I tick?' 1.2. A 'Mishmash' of ethnicity in therapy: South-Asian ethnicity understood in the context of different identities coming together 1.3. Self-stigma in therapy
2) Ethnically dissimilar therapist allows for greater openness and freedom of expression	2.1. 'The freedom in therapy to share my interpretation and perspective of ethnicity, culture and religious festivals'. 2.2. The therapist offering a fresh and objective perspective on my difficulties. 2.3. Therapist's openness and curiosity in the face of difference.
3) Internalised racism; South-Asian therapists are 'tainted by their culture'	3.1. Clients' prejudice towards South-Asian therapists. 3.2. Client's feeling judged by South-Asian therapists. 3.3. Client's lack of trust; their South-Asian therapist would not maintain confidentiality. 3.4. Client's expressions being hindered by a South-Asian therapist due to over-identification.
4) Therapists skills and qualities are more important than their ethnicity	4.1. Individual qualities of the therapist 4.2. Therapists experience 4.3. Therapist's non-verbal communication 4.4. Therapist taking an interest in client

Appendix O: Reflective journal entry

Dear Diary

I have been in the analysis stage of my research, after spending forever transcribing my eight interviews. Although it took a long time to transcribe I am pleased I transcribed manually rather than use some automated software. Transcribing manually has really helped me to get close to my data as it forced me to listen to the interviews over and over and over and over again! I am trying to stay as close as I can to my participant's material but am also adding my interpretations. As this is the first time I am undertaking qualitative analysis I am a little unsure of how much I include my interpretations. After reading books on IPA and have a few discussions with my director of studies I have realised the true importance of my interpretation. Initially I was unsure how much of 'my voice' to add. I think it is helpful to start with the participants experience (in the transcription stage) then slowly start to add my comments and thoughts as the analysis progresses. I think I am starting to realise the value my subjectivity is adding to the research. Still a long way to go, so keep going!

Best wishes,

Zara