Extending Counselling Psychology practices and theories when meeting a client's and a service user's therapeutic needs

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Declaration

I also grant powers of discretion to the University Library to allow the thesis to be copied in whole or in part without further reference to the author.

Extending Counselling Psychology practices and theories when meeting the therapeutic needs of clients and service users

Introduction to the portfolio:

As Counselling Psychologists and academic researchers in the field of Counselling Psychology, we constantly look to ensure that we evolve and move forward with the practices and theories surrounding the discipline. This is done to ensure that the breadth of knowledge we hope to obtain along the way allows us to work with clients and service users who present with a wide variety of presenting problems and who come from diverse cultural and religious backgrounds and life experiences. Competency and the ability to look to new research, theories and clinical practices to ensure that we meet the needs of our clients and services users have been well documented and are highlighted as vital in establishing a well-rounded skills set in this profession (e.g. Sue, 1998; Heppner, 2006).

Thematic Connection:

There are two overarching themes reflected in this portfolio.

1. To centrally highlight the importance for Counselling Psychology to evolve in clinical practices, training and teaching to ensure that we meet the needs of a range of clients and service users. Therefore, the items in this portfolio encourage readers to gain insights into service users' experiences of their therapeutic needs as being met or not met, and also highlight how mental health organisations and therapists experience facilitating strategies within their clinical work to try and meet their clients' needs.
2. The implications for clinical practice and the attitudes of clients/therapists when the process of 'matching' or 'non-matching' presents itself in the dynamic. Matching is understood to be the process whereby the therapist and client are matched on religion, gender, ethnicity and language. The first piece, the critical literature review, reflects this by conveying how 'non-matching' between professionals and individuals from the South Asian community can cause a barrier and the development of negative attitudes towards seeking psychological support. The second piece, the research, shows the understanding of South Asian therapists when clinically matched to their clients on the basis of gender, ethnicity, language and religion. This piece explores the

construction of experiences and the development of attitudes that South Asian therapists have towards their work when working in this way. The final piece, the clinical case study, explores the facilitation of therapeutic work between a client and therapist working in a 'non-matching' dynamic and thus the therapeutic relationship that is developed through understanding the differences in their relationship. This piece of work highlights that whilst 'matching' of demographics is not present, the 'matching' of the client's and therapist's core beliefs and less obvious aspects of their relationship can still be beneficial for counselling.

Presentation of Portfolio:

The portfolio is presented in two parts. The first part encompasses a direct focus on the therapeutic needs of the South Asian community and is conveyed through two pieces of work: a critical literature review and a piece of qualitative research. The critical literature review highlights the experiences and attitudes of the community towards counselling and their therapeutic needs and therefore signifies clients' and service users' experiences. The qualitative research follows on with this community and explores the other side: South Asian therapists' experiences of working with this community to meet clients' therapeutic needs though therapist-client matching. The second part of this portfolio presents a clinical case that brings together therapists' and clients' experiences of working collaboratively to 'meet the needs'. The case study examines my own experiences as a trainee Counselling Psychologist, as well as the client's experiences in our work together in terms of facing challenges in meeting the client's therapeutic needs when working with social anxiety and CBT.

Detailed introductions to each part are given below, conveying their connection to the theme and presenting brief outlines of what they bring to this area of Counselling Psychology.

Part one: Focus on the needs of the South Asian community

Throughout my training, I have been deeply interested in how our current mental health services, both in the voluntary sector and the NHS, manage to meet the needs of the South Asian community. Being part of the community myself, I used my personal experiences, and interest developed during my clinical placements, as a basis to explore this community through examining current literatures. I also made the community the focus point of my own research.

The South Asian community is known to be fast-growing in the UK (Census, 2001); as such, with literature documenting the high rise in mental health problems faced by the community (e.g. Bhugra & Bhui, 2003; Fazil & Cochrane, 2003; Anand & Cochrane, 2005), there is a need for a space to review and develop the way we as therapists work and meet the needs of the community.

I was able to explore this through the following two pieces of work:

1. ***What are South Asian people's attitudes towards Counselling Psychology and mental health services?*** *A critical literature review with implications for understanding the South Asian community's thoughts towards therapeutic support and preferences for alternative ways of coping with emotional, mental and psychological distress*.

The critical literature review encompasses studies that convey the attitudes of the South Asian community towards counselling. Studies are drawn from both the USA and UK and highlight various factors that contribute to the community holding both positive and negative attitudes. The review concludes that positive attitudes are held by those who have received education and awareness around what counselling is, what psychological symptoms can be, and how seeking help through professional psychological support is beneficial (e.g. Netto, 2006; Bhugra & Hicks, 2004). Furthermore, generational and gender differences are found where second-generation and South Asian females regard counselling with more positive attitudes as a help-seeking behaviour, compared to the first-generation and South Asian males (Goodwin et al., 1998; Panganamala, 1998). Negative attitudes are found due to the expectation and fear that they would be shamed, outcast, unaccepted and misunderstood in counselling (e.g. Bhugra & Hicks, 2004; Meltzer et al., 2002; Newham Innercity Multifund and Newham Asian Women's Project, 1998). Whilst holding these attitudes, many South Asians look for alternative ways of coping, such as religion, family and friends (Hussain & Cochrane, 2003). Overall, the review contributes to understanding the needs, fears and expectations of the community when considering counselling as a help-seeking behaviour.

2. Qualitative Research: ***A qualitative study exploring how South Asian therapists experience working in a therapist-client matching service for South Asian users.***

The basis of the research stemmed from the use of therapist-client matching services in the UK as a way to meet the needs of minority groups (Flaskerud, 1990; Fernando, 2005;

Farsimadan et al., 2007). The process entails the therapist and the client being matched to clinically work together, based on shared facets of identity. It was noted that such a strategy has been put in place to provide minority groups, such as the South Asian community, with a space in which to be able to 'self-disclose' comfortably and to feel they are being understood (Fernando, 2005). The literature review focusing on this aspect resulted in mixed reviews from services users when describing their experiences, outcomes and uptake of services that carried out matching based on ethnicity, religion, language, gender and sexual orientation (e.g. Farsimadin et al., 2007; Liddle, 1996; Netto, 2006. It was also highlighted that there was at present a gap in the literature exploring the therapists' experiences of matching (e.g. Iwamasa, 1996; Maki, 1990).

Following findings from the review, I aimed to explore South Asians therapists' experiences of matching in their clinical work. Interviews were conducted with 8 South Asian therapists.

The research followed Charmaz's (2006) Grounded Theory and social constructivist stance and produced a model conveying the many complexities involved in working in a therapist-client matching service. Three lower level themes were found, namely (1) reasons and justifications; (2) constructing the value of therapists' work through clients' experiences; and (3) support. Three higher level core themes emerged too: (1) acknowledging self-processes; (2) level of experience; and (3) experiencing internal conflicts.

The findings of this study have implications for Counselling Psychology with regard to training and teaching in the subject, and the support and developmental needs for therapists working in these settings.

Part two: Clinical Case Study

Social Anxiety Disorder: Meeting the client's needs: An advanced case study looking at ways to evolve therapeutic practice in Cognitive Behavioural approaches (CBT).

The clinical case study explores my work with an older adult client, Mary, in a secondary care psychological service. The case study describes the challenges faced in meeting her therapeutic needs whilst working with social anxiety. It explores the steps taken through the support of supervision and clinical learning in adopting third-wave CBT approaches,

Acceptance and Commitment Therapy (ACT), in order to work with the client to achieve her therapeutic goals.

Challenges and learning in theory, therapeutic processes and relationships are explored along with discussion on my development as a Counselling Psychologist.

The reason for including this piece in the portfolio is due to my own journey through clinical practice of working to push the boundaries of Counselling Psychology to meet the therapeutic needs of my clients. I was particularly interested in including this piece as it portrays my ability to work with meeting the needs of a client group other than South Asian. This particular case study involved my work with an older adult Caucasian woman. Therefore, this illustrates my commitment and ability to raise awareness and work therapeutically in this way for a range of clients.

My Personal Journey:

The development of each of these pieces and their subsequent write-up has taken place throughout the course of my training. I believe each piece demonstrates my personal journey through training, the knowledge gained, self-development, ability to reflect and, most of all, my underlying passion for this area of Counselling Psychology.

I am aware that my portfolio largely mirrors my personal background and who I am. I believe this has provided me with the overall strength and determination to become inquisitive, curious, and take up the position of both the clinical practitioner as well the academic researcher wherever appropriate. Furthermore, as I come to qualify and reflect on my aims to present the work in this portfolio, I am fully committed to and passionate about continuing to develop my ability and to extend my learning and breadth of knowledge of Counselling Psychology. In this way I hope to continue to understand and learn ways to meet the needs of my clients in whatever clinical setting I embark upon after qualification.

My personal journey through this training has also encompassed therapy and supervision. Having this experience has allowed me to explore my personal beliefs, struggles and has helped me raise awareness of myself and how I have impacted on my clinical work and

research in different ways. I hope that my learning and development and the values discovered are conveyed throughout the different pieces included in this portfolio.

Finally, I am thankful that my portfolio has allowed me to include reflections at every stage and bring together my thoughts and continuous growth as a Counselling Psychologist throughout my training. I am overwhelmed by the depth of learning and knowledge gained at every stage. The ability to constantly review and revisit the needs of my clients, and to explore and surround myself with the ever-evolving theories and clinical practices involved in allowing us to work with a range of clients, have been key learning points for me during my training. Furthermore, seeking support through supervision and also giving knowledge to others about the areas of Counselling Psychology I have learned about are invaluable aspects that have underlined my own development during this journey in Counselling Psychology.

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Part One

1. Critical Literature Review
2. Qualitative Research

What are South Asian people's attitudes towards counselling and mental health services?

A critical literature review with implications for understanding the South Asian community's thoughts towards therapeutic support and preferences of alternative ways of coping with emotional, mental and psychological distress.

1. Introduction

It is estimated that approximately 2,331,423 British Asians (Census, 2001) are living in the UK and in the past eleven years the population has increased (Stillwell & Ham, 2010). With this growing population, South Asian immigrants are still moving to the UK; as such, the process of adapting, rebuilding and becoming familiar with the systems in the UK can be challenging. Along with the people, the NHS, and particularly the mental health system, continues to struggle to provide this ethnic group with services that are easily accessible and that meet the group's needs (Netto, 2006).

In a bid to lessen these challenges, an increased understanding of the lifestyle of this community and the South Asian culture is being called for, especially in relation to the community's mental health needs. It has been documented that there has been a rise in suicide rates, self-harm, depression and anxiety in this community (Bhugra & Bhui, 2003; Fazil & Cochrane, 2003; Anand & Cochrane, 2005).

A number of studies are now taking place to make efforts to understand the help-seeking behaviours of the South Asian community and to assess whether these people depend or call upon the mental health services when in mental distress, by exploring their attitudes towards services such as counselling. Furthermore, comparisons have been made to assess whether this community accesses services in the same way as Caucasian communities, and if a gap is found, what is it that mental health professionals need to learn or understand about South Asian people that would help to bridge this gap. Various conclusions have been made from studies that have been conducted.

Finally, other factors to consider here are the cultural differences between South Asian people and the Western mental health system. In exploring attitudes towards counselling as a help-seeking behaviour, we must also think about the ways in which the South Asian community traditionally copes with emotional and psychological distress and what seeking help in the NHS means to that community. Through exploring the studies covered in this review, insight is gained into whether help-seeking through mental health services in the NHS is useful for the community. Furthermore, other help-seeking behaviours that are considered more helpful and which are in line with traditional values of the community (family systems, religious beliefs) are found and discussed.

2. Rationale for the review

2.1 Growing South Asian communities in the UK and USA

Since 2000, both the UK and the USA have seen their populations become more diverse. According to the 2001 Census data, the UK was home to '2,331,423 British Asians' that year. In the USA, the situation was similar; according to the Census Bureau (1992), 4.7 million Asians comprised 1.9% of the total USA population.

The South Asian population is a broad category and can be described as people whose 'culture or familial backgrounds originate from the subcontinent of India, Pakistan, Bangladesh and Sri Lanka also including people from East Africa' (Marshall & Yazdani 2000).

Therefore, taking into account the fast-growing South Asian communities in the UK and the USA, one can say we have now entered a stage of a 'new world of multiculturalism, political correctness and racism' (Laungani, 2004). In light of this, Sheikh and Furnham (2000) suggested that with the changes in multiculturalism come struggles to adapt and, hence, some of those who immigrated to another country and from a different cultural background are vulnerable to experiencing some level of mental distress. This can begin with a struggle to adjust to a different way of living, being away from traditions, and the conflict between the Western and Eastern world (Anand & Cochrane, 2005; Bhugra & Bhui, 2003). Furthermore, taking into account the growing number of communities in question, we must not ignore the increasing concern that, currently, these communities under-utilise the services available to them in the UK and USA, and that known barriers are in place in reaching out to these

individuals (Leong & Lau, 2001; Bhugra & Bhui, 2003). Therefore, this calls for a closer look at the mental health care system and how best both the UK and the USA can make attempts to reach their ethnic communities. A way to facilitate this and gain insight would be to explore the current attitudes and coping strategies of the South Asian community.

2.2 Mental health problems in the South Asian community

Research has been conducted that looks into the mental health of South Asian immigrants coming to the UK and the USA. The UK has taken a significant approach in addressing the mental health needs of such a community with the introduction of 'Delivering Race Equality: A Framework for Action' (Anand & Cochrane, 2005), which was taken from the 2003 Department of Health report. In a literature review written by Anand and Cochrane (2005), evidence reported in the article conveyed a 'high prevalence of mental health problems' within the female population in the South Asian community in the UK. There was a special request to address presentations such as 'depression, suicide, deliberate self-harm and eating disorders' in the community, which have been reported to be in high numbers (Bhugra & Bhui, 2003; Fazil & Cochrane, 2003). It is important to note that, according to the literature, within the South Asian population, especially in the UK, Pakistani (Muslim) women in particular appear to suffer more from depression than other South Asian women (Creed et al., 1999).

The USA has also realised the need for providing mental health care and emotional support to those in the South Asian community. The nature of immigration and the upheaval of moving your whole life to a different country can be difficult in itself and can cause feelings of alienation and isolation (Sodowsky & Carey, 1987), potentially resulting in depression and anxiety, especially when there is a lack of family support (Hussain & Cochrane, 2004). Particular studies conducted in the USA have looked at why people in the South Asian communities may underuse psychological services available to them (Panganamala & Plummer, 1998; Leong & Lau, 2001). Factors such as stigmatisation and different cultural values have been named as barriers for this population group when attempting to either access counselling services or contemplate using them, and the main aim is to find a way to educate this group of people, consequently 'refuting previous negative stereotypes' (Panganamala & Plummer, 1998).

Other help-seeking behaviours have also been identified as being used by South Asian communities as way of coping with a level of mental distress (Leong & Lau, 2001; Sheikh & Furnham, 2000; Wynaden et al., 2005). Help-seeking behaviours, alternative attitudes and service use will be further explored throughout the literature reviewed here.

3. Relevance to Counselling Psychology

The points discussed under the 'Rationale' section help to create an insight into why this review is vital for Counselling Psychology. With the number of South Asians increasing each year in the UK, it is important that Counselling Psychologists and allied mental health professionals take an approach in their clinical work that is one of acceptance, openness and sensitivity to the needs of all clients, including those of this community (Bhugra & Bhui, 2003; Fazil & Cochrane, 2003; Anand & Cochrane, 2005).

Having an understanding of the attitudes of individuals from the South Asian community towards counselling and learning of any potential fears and/or barriers towards counselling will allow psychologists, counsellors and similar professionals to become better equipped to work therapeutically with them, thus improving the uptake of services available to them (McKenzie et al., 2007).

Furthermore, the counselling skills related to multicultural counselling are well embedded within the core competencies of all trained therapists and psychologists. Therefore, the need to exercise these skills is heightened with the increasingly diverse populations found in the UK (Sue, 1998; Ibrahim, 1985). The motivation to encourage psychologists to universally approach multicultural counselling is growing. In order to encourage and help facilitate this practice, such literature reviews can help provide insight into the current tensions and concerns faced by the community and contribute to training, learning and understanding in this area of Counselling Psychology (Fukuyama, 1990).

4. Aim for the review

This review is being written with a view to finding out what attitudes South Asian people adopt in relation to counselling services and mental health care, and if negative attitudes are in place, what coping strategies they rely on instead.

In reviewing a number of studies, I hope to explore the following questions:

- If positive attitudes are found, then why is there hesitation in accessing services; also, what external barriers/factors are faced?
- In cases where counselling is not an option as a coping/help-seeking strategy, what coping strategies do people from this community use?
- Is there room for, and could we consider integrating some of, the internal strategies with counselling to close the gap between psychological services on offer and the needs of the South Asian community? This will be discussed in detail in the conclusion.

Before beginning the review, it is important to explain the important factors that have contributed to the formation and style of this review. Furthermore, special efforts have been made to outline a specific area of literature that this review aims to analyse. It is possible that due to the substantial amount of literature that has been discussed in relation to the South Asian community and mental health, that there are a number of avenues within this area that could be discussed throughout this review. One area which has provided a useful contribution to counselling is the literature which explores the practices of multicultural counselling (Kareem, 1992; Speight et al., 1991; Sue, 1998; Netto, 2006). Multicultural counselling has been used as a way of bridging the gap between the community and mental health support, and the underuse of services available to the community. Literature has also explored the following factors: (1) mental health illness arising in the South Asian community (Rait & Burns, 1998; Hussain & Cochrane, 2003; Netto, 2006; Fenton & Sadiq-Sangster, 1996); (2) how the community defines mental health (Fenton & Sadiq-Sangster, 1996; Krause, 1989); (3) what professionals believe the needs are for this ethnic community and the current barriers (Johnson & Nadirshaw, 1993; Panganamala & Plummer, 1998; Sue et al., 1982; Sue, 1988; Ibrahim, 1985; Wynaden et al., 2005); and (4) the experiences and attitudes of the community towards mental health services, including counselling (Netto, 2006; Bhugra & Bhui, 2003; Anand & Cochrane, 2005).

Taking this into consideration, as well as the different avenues and sections this review could cover, I will explore factor number (4) shared above: 'the experiences and attitudes of the community towards mental health services, including counselling'. Loya et al. (2010) and Sue et al. (1982) have stated that there is a call for further analysis of the literature exploring the attitudes of South Asian community so that areas for further investigation can be highlighted. This would then be useful in helping us to gain knowledge regarding not only

understanding help-seeking behaviours but also the current barriers that prevent individuals from the community from accessing services. Therefore, the opportunity is taken to highlight particular papers and studies that are specific only to exploring the attitudes of the South Asian community, as this is currently under-researched. However, Sheikh and Furnham (2000) conveyed that whilst literature is limited, findings are highly significant in this area. The decision to discuss particular papers has been done on the basis of their findings and how strongly the papers relate to the topic at hand. Other papers related more loosely to the topic have also been mentioned where appropriate. Note that the studies reviewed take into account the ethnic community's expectations of and attitudes towards counselling and mental health support in general, irrespective of whether members of this community have experienced counselling or mental health support or whether they have experienced emotional and psychological distress. Care has also been taken to include studies from the USA. Whilst the UK and US mental health systems are very different, it is useful to include research from the USA, due to the lack of understanding and research in the UK. Furthermore, looking specifically at this area alone, reviewing literature from the USA still provides a further opportunity to learn about and understand this community.

5. **Reviewing the literature and presentation**

The review will be presented in two main sections. The first section aims to explore positive attitudes of individuals from the South Asian community towards counselling and mental health care services, and takes special care to convey what can help to produce such positive attitudes. The second section will review studies that explore how the South Asian community uses alternative coping strategies over seeking help through more formal channels such as counselling. I have chosen to present studies one by one by incorporating other relevant findings matching the study. I do this with the aim of not only critically evaluating literature in this area but also providing a thorough analysis and sharing in detail significant findings that contribute to this complex area.

6. Positive attitudes towards counselling

6.1 Education around counselling leading to positive attitudes

Netto (2006) – A qualitative study of the cultural sensitivity of counselling provision in the voluntary sector in the UK

A study conducted by Netto (2006, pg. 1) assessed 'the accessibility and appropriateness of counselling service provision' for South Asian people in the UK. Interviews were conducted with 38 participants; all identified as having suffered from anxiety and depression. The interviewer wanted to find out more about the nature of counselling services provided; the context in which the service was offered; the measures that had been taken by these services to make them more accessible for Asian people; how flexible these services were in meeting the requirements and needs of South Asian people; the way service uptake and use was ethnically monitored; arrangements for the training and selection of the counsellors; and the extent to which they were supported for working in a culturally diverse population.

An important finding was that participants who were current service users viewed counselling as a positive step in addressing their psychological distress and did not find other strategies that would be seen as more helpful than counselling for them. On the other hand, participants who were not service users and, thus, had not received any counselling had very little knowledge about counselling. Therefore, they were unaware of the purpose of these services and were uncertain of what help they would be. Whilst one may say this is not a surprise, Netto (2006) argued that for those not engaging in services, simply providing knowledge and education would change the attitudes and, hence, individuals would be more aware of services available and how they could access the help and support. Furthermore, this was demonstrated by Netto (2006) in her findings, as once participants (who were not clients) had received information about counselling, interest in receiving therapeutic help increased. It was also found that due to lack of awareness around counselling services for the South Asian community, the service lacked numbers in self-referrals from this ethnic minority group, further supporting the idea that a lack of education or knowledge led to few individuals in the community reaching out to services. It was also found that counselling services reported having trouble meeting the needs of South Asian people as they were not able to offer a multi-ethnic team and there was a call for more multicultural training for trainees. Clients

also reported that they felt more comfortable when receiving therapy from somebody of a similar or the same ethnic and cultural background.

Strengths:

This study was vital in highlighting the role of providing knowledge and education to the South Asian community on counselling, and the benefits of engagement when in mental distress. With this realisation, the study also highlights the importance of the individual's GP's role in providing information about counselling, as, for many, the GP is the first port of call when 'ill'. This has been supported by other literature carried out by Wynaden et al. (2005). Wynaden et al, (2005) conveyed the importance of health care professionals such as GPs in advocating mental health support for those in the community that may have difficulty in understanding what services are available to them. Furthermore, the study also contributes to other literature highlighting alternative forms of coping for individuals in the South Asian Community. Netto (2006) finds that those not actively engaging in mental health services often seek support from their family and community network; this has also been found and discussed by Atkins and Rollings, (1992).

A further strength of the study was its use of the method of 'triangulation' whereby Netto (2006) 'compared data collected by one method to similar data collected by another' (pg. 3). This enabled Netto's findings to be further strengthened. Morse (1991) also discussed that this method is known to be desirable for those wishing to achieve validity and reliability of checks, as well as adopting a comprehensive approach to data collection.

Weaknesses and Limitations:

Whilst Netto's (2006) study provides us with valuable insights in comparing the attitudes of those who are already using counselling and have knowledge of the service with the attitudes of those who are still contemplating the idea (and thereby highlighting the importance of education), her study also has limitations and weaknesses in relation to the design and method. Netto (2006) does not disclose how the severity of depression and anxiety the client defined themselves to have, when participating in the study, was measured. In addition, no information is given regarding the type of treatment the 'clients' were receiving or had received, and for how long. Kearney et al. (2005) explained that a sufficient number of sessions, together with stable input from therapists, can over time help break down possible stigma attached to therapy for South Asian clients. This also raises another question: Were

positive attitudes found on the basis that clients found counselling useful due to the characteristics of their counsellor and the approach used by the counsellor? Would positive attitudes still have been found with those who were not receiving multicultural counselling? Sue (1988) argued that multicultural counselling and therapy provided by certain therapists who are mindful of ethnicity and cultural needs will lead to positive outcomes. Thus, the number of sessions and type of input given are vital information if we are to really see what Netto's (2006) findings of positive attitudes towards counselling were based on. Furthermore, by being informed further of what the process of counselling entailed and the severity of presentations, this would allow the study to gain in validity. At present, conclusions and findings from this study come with a set of limitations.

Bhugra and Hicks (2004) – Effect of an educational pamphlet on help-seeking attitudes for depression among British South Asian women

Following from the conclusions made about the previous study, Bhugra and Hicks (2004) concluded that education through pamphlets and advertising of counselling services could also lead to positive attitudes being generated towards seeking help through therapeutic interventions. This study involved handing out an educational pamphlet on suicide and depression to 180 British South Asian women.

Participants in the study identified themselves as out-patients and were recruited from South Asian communities in London. Participants' ages ranged from 15 to 75 years. The pamphlet used for the study was developed from focus groups and highlighted the importance of recognising depression and the risk of suicide; preventing suicide attempts; treating depression; using various coping mechanisms; and finding sources of help for the South Asian community. Participants were given the pamphlet and a questionnaire to fill out. After 4–6 weeks, another questionnaire was sent for them to fill out which assessed the long-term effects of the pamphlet and its impact on help-seeking behaviours.

Strengths:

The strength of this study lies in the design of the pamphlet that was generated as a resource to be used for data collection. Bhugra and Hicks (2004) found that the educational pamphlet proved to be a vital technique in helping individuals from the community realise what depression/suicidal symptoms looked like, thus allowing them to identify symptoms within

themselves. Bhugra and Hicks (2004) found that their pamphlet caused women to alter their current help-seeking behaviours, as after reading the pamphlet, women were more likely to report their feelings to a health professional, for example, by visiting their GP and attending counselling. With the first questionnaire, 38 women had reported that their views had not changed, but after 6–8 weeks, this number had fallen to 13, which meant more would seek counselling/mental health care help if available to them.

Another significant strength of the study is in the process of the production of the pamphlet, which was facilitated through an integrated approach of using focus groups, along with assessing the acceptance of qualitative exploration with patients. The use of focus groups allowed for discussion and exchange of ideas in relation to South Asian women's views of depression and suicide. Kitzinger (1995) states that the use of focus groups allows communities to get together to comment on experiences in a valued and accepting space. This then allows for rich, collective views to be used for data, which might have been limited had the researcher used direct one-to-one interviews.

Weaknesses and limitations:

Whilst accepting the importance of the study and the strengths that stem from the use of focus groups, limitations and weaknesses can be also seen. The findings cannot be extended to the whole community as only female participants took part. Whilst some would say that having a sample that contained a broad age range of women was a good way to see if the pamphlet would be well received by all ages, Bhugra and Hicks (2004) did not account for this by analysing generational differences. Studies such as those by Panganamala and Plummer (1998) and Goodwin and Duncan (1998) conveyed that attitudes towards mental health in general vary significantly between first-generation immigrants and second-generation immigrants. Therefore, studies exploring attitudes of South Asian women should take into consideration age and immigration as contributing factors to how one may view the mental health system. In addition, another limitation of the study is found, since Bhugra and Hicks (2004) reported their sample was not randomly selected and participants opted in to take part. Collier and Mahoney (1996) discuss the problems that occur in qualitative research such as predictable outcomes and systematic error that can be caused by self-selection bias; hence, in relation to this study, women who participated in the study may well have had a personal interest for taking part. It was also reported by Bhugra and Hicks (2004) that, initially, 298 South Asian women were invited to take part in the study; however, only 180 agreed to

actually take part. Information regarding the drop in participants is not found; this information may provide us with some understanding of the motivations for those who did participate and the reasons why some did not. In further highlighting the impact of this as a weakness of the study, Orne (1962) discussed in his paper the impact of participants' motivation to engage in psychological research. He discussed the concerns behind goal-focused behaviour in answers and the impact of this on the overall results. Orne (1962) shared that whilst this cannot always be accounted for, it does contribute to reducing the validity of a study. Furthermore, with this study, participants were recruited from general clinics, but were not specifically asked or questioned beforehand about their experience of depression or suicidal feelings and the severity of these feelings and symptoms. It has been noted that the understanding of depression within the South Asian community does not always match the understanding of depression under the criteria of the DSM-IV (Hussain & Cochrane, 2004). Therefore, diagnosis of depression in line with the DSM-IV could be questioned. Whilst we conclude from the findings that the pamphlet led to positive attitudes and changes in help-seeking behaviours, no actual follow-up was facilitated to support this.

A summary of both of these studies highlights the importance of education and raising the awareness of counselling and mental health services. It has been suggested that providing education can lead to positive uptake of services. This has been echoed in other areas related to general health care; when education has been provided around the importance of attending doctor's appointments and check-ups related to care needed with diabetes, increases in attendance of support groups and positive attitudes towards care were found (Somannanver et al., 2008). Furthermore, when education and awareness of health care support was given, it was regarded highly as a help-seeking behaviour for men faced with alcoholism and women seeking infertility advice and support (Morjaria & Orford, 2002). However, a weakness of Morjaria & Orford (2002), which limits the validity of their findings, was the use of a small sample. The authors further discuss the limitation of their study in not being able to achieve respondent validation. If achieved, this would have allowed their findings to be strengthened even if data was collected from a small sample. Finally, a study by Syed et al. (2012) supports the study by Netto (2006) discussed above; they conveyed that those of the South Asian community born and brought up in the UK who had significant awareness of mental health and related services held more positive attitudes towards seeking help through counselling than those living in India who had immigrated, who had no awareness or education around services available to them. A strength of this study was the sample size and

nature of participants; this was a well-conducted study conveying attitudes of men and women from India, British-born Indians as well as white British, and hence gave varied insight into attitudes held by mixed ethnicities towards counselling. Syed et al. (2012) also support Netto's (2006) and Bhugra and Hicks' (2004) findings, as they also found that once individuals engaged in counselling, they held more positive beliefs about it.

The above calls for a need to increase the ability of services to provide information within South Asian communities to increase the uptake of services and to further allow individuals to question and correct any misinformation or preconceptions they may have with regard to accessing such help.

6.2 Gender differences in attitudes towards seeking help psychologically

Soorkia, Snelgar and Swami (2011) – Factors influencing attitudes towards seeking professional psychological help among South Asian students in Britain

A recent study has identified the existence of gender differences when evaluating attitudes towards seeking help through psychological interventions. Soorkia and colleagues (2011) carried out a quantitative study where 148 South Asian students completed a survey that measured the association between attitudes towards seeking help and variables such as Asian values, cultural mistrust and ethnic identity.

Soorkia and colleagues (2011) found that overall, female participants hold more positive beliefs and attitudes towards seeking psychological help compared to males. Furthermore, it was also found that attitudes were predicted by the relationship between psychological help and its adherence to one's cultural values, therefore suggesting that the more counselling was seen as a process that involved or was committed to cultural values shared by the person, the more positive the attitudes held by the individual. This has been further supported by a number of papers that discuss the importance of therapists and counselling being able to work using multicultural counselling practices in order to help understand cultural values and beliefs clients may hold (Sue, 1988; Betancourt & Lopez, 1993; Patterson, 1996). Finally, Soorkia and colleagues (2011) also reported this pattern to be very similar for all Pakistanis, Indians and other South Asian descendants, conveying homogeneity between the communities.

Strengths:

This study does well to use quantitative methods in support of its findings; research carried out by Hamid et al. (2009) has found that matching therapists to clients on the basis of gender for the South Asian community may be a useful way to encourage more positive experiences and attitudes towards counselling. Positive experiences may be found as matching of gender could lead to reduced worries of being judged or misunderstood for clients. Furthermore, stigma attached to men accessing mental health services is widely found within the community. However, a concern and possible weakness to be mindful of with regard to this process of therapist-client matching would be potential assumption-making and over-identification, which would need to be monitored and reflected upon (Hamid et al., 2009).

In addition, the study gives vital insights into the considerations needed for practitioners when working with South Asian people and the importance of inviting culture and ethnic values into the process. The study gives significant support to arguments put forward by those who encourage the process of multicultural practices and the training of therapists to work with diverse cultures and ethnicities and to thereby bridge the gap between the community and mental health (Sue et al., 1982; Sue, 1988; Ibrahim, 1985).

Weaknesses and limitations:

When assessing the validity of this study, some limitations are found. A possible limitation is that whilst we are able to conclude gender differences, we are limited as to how far we can extend the findings to all ages and ethnic and cultural backgrounds within the South Asian community. Furthermore, other research has found differences in responses to treatment within the South Asian communities due to the diverse cultural presentations within them. They discussed that in-group differences are widely found within the South Asian community and these should be taken into account when working within a multicultural counselling framework (Ibrahim, 1985; Betancourt & Lopez, 1993). One would ask if these findings are purely a representation of South Asians who have been educated in the UK and, therefore, may have very different cultural and religious values to those who are older and/or are first-generation immigrants.

In addition, the study only incorporated selected variables. It would have been insightful, and would have increased the usefulness of the findings, if a wider selection of variables, such systemic influence, had been included. This is supported by research (Cardol, et al., 2005),

where it has been discussed that the impact of systemic/family background has a significant contribution on the development of attitudes towards help seeking behaviour.

6.3 Positive attitudes found with second-generation South Asians

Goodwin and Duncan (1998) – Attitudes towards marital counselling and the Family Law Act (1996) in a British Asian community

In 1998, Goodwin and Duncan published a study that looked at the attitudes of South Asian Indian couples living in the UK towards marital counselling. 70 married couples aged between 23 and 74 gave their consent to participate and were selected by scanning the electoral register and randomly selecting entrants with Hindu-Gujarati names, or through posters and leaflets. A structured interview was conducted and interviews were done separately with each person in the marriage. Interviews were conducted in English and Gujarati and the interviewer was always the same sex as the respondent to ensure gender differences did not impact the interview.

Goodwin and Duncan (1998) found that there were two very distinct responses to the use of marriage counselling and the idea of divorce. The older participants, who were first-generation immigrants, felt that divorce and counselling would not be an option, and the influence of culture meant they felt they should not discuss problems; they simply had to 'get on with it'. The attitudes of the younger and middle-aged participants (under 30 years), who identified themselves as second-generation immigrants, were very different: 80% of the respondents reported they would attend counselling if all other strategies failed. It was interesting to discover that awareness of formal support and counselling was found amongst participants, but their knowledge about particular services was vague, and only a third (31%), which is lower than the white population, were aware of particular services. The use of religious leaders (priests and caste leaders) was rejected as they felt this would destroy the anonymity of their identity and the process of confidentiality, which was so vital for them.

Strengths:

The method used for this study was rigorous with three stages to refine questions and alter the interview structure. The use of a consultation and pilot allowed for the researchers to query any areas that posed problems and concerns. Furthermore, the pilot stage allowed for refinement of the semi-structured interview schedule. Sampson (2004) states that pilots, especially in social science research, are often under-utilised due to the fear researchers have

of intervening in pure data collection. However, as shown by Goodwin and Duncan (1998), pilot and consultation periods allow room to consider problems that may arise. Furthermore, pilots and consultations can be seen as procedures that are necessary and can underpin the process of focusing on validity and ethics in research. Hence, the process of data collection here informs many researchers of the benefits of adopting this design method.

Results from this study are promising and support other literature exploring generational difference. It has been found that those from second-generation immigrant families have had the opportunity to gain more knowledge, having been born and brought up in a society where mental health is more accessible (Anand & Cochrane, 2005; Shariff, 2009). This also supports previous arguments that the education and knowledge second-generation individuals may have obtained can lead them to hold positive beliefs about counselling as a help-seeking behaviour (Netto, 2006; Bhugra & Hicks, 2004).

Weaknesses and limitations:

Whilst the study is supportive of other relevant research, limitations are present. The study's sample was only taken from a specific group in this community: Indian Hindus. Although there may have been specific reasons for this, it prevented the authors from generalising their findings to the whole South Asian community. Once again, this raises the argument discussed previously of in-group diversity found within the community (Ibrahim, 1985; Betancourt & Lopez, 1993), thus making it difficult to present the findings as a representation of the whole community. Although the study's sampling methods were thorough and the authors made every attempt to reach out to a number of Hindus in the South Asian community, there could have been some response bias. Respondents who agreed to take part in the study could have had personal interest in taking part; for example, wanting to find out more about counselling due to maybe having experienced problems in their marriage, and seeing this study as a way to explore what they could do. This also supports comments made previously with regard to qualitative research, and the concerns of goal-focused responses from participants, therefore leading to negative implications on the validity of findings (Orne, 1962).

Panganamala and Plummer (1998) – Attitudes towards counselling among Asian Indians in the United States

In the USA, Panganamala and Plummer (1998) conducted a study that produced results which went against a hypothesis they were testing. They investigated the attitudes of South Asian Americans towards counselling as a coping strategy when in psychological distress, specifically looking at immigrants from India. Panganamala and Plummer (2008) predicted that attitudes would be fairly negative due to lack of understanding and the possible stigma attached to speaking to an unknown person about personal problems and, hence, respondents would dismiss counselling as a coping strategy.

101 participants for this study were recruited from Asian Indian social organisations and also from Asian Indian youth meetings and university classes. The survey addressed three main topics: attitudes towards counselling, counselling behaviours and demographics.

Factor analysis was carried out to analyse the responses from the survey questions. Results showed that Asian Indians in the United States do hold neutral or fairly positive attitudes towards counselling and that Asian Indians who had migrated to the USA at a younger age were able to hold more positive attitudes towards counselling than those who had migrated at an older age. The researchers also note that Asian Indians who had more prestige in the community (i.e. had studied and been educated in the USA) also had better opinions of counselling than those who had not (the older age immigrants). Results enabled the authors to report a heterogeneity of attitudes towards counselling amongst this specific population in the South Asian community, with younger Asian Indians holding positive attitudes compared to negative attitudes held by older Asian Indians.

Strengths:

The strength of this study is in the questions it leaves for researchers interested in this area. The results and design of the study laid a foundation for additional exploration using factor analysis to further develop the findings related to positively held values of counselling within the Asian American community. The findings lend strong support to other literature discussed in the review and further support the findings of Goodwin and Duncan (1998). The findings also contribute to the discussion made by Abouguendia and Noels (2001), who argue that the attitudes of second-generation immigrants towards counselling may account for their unique experiences of being born in a ‘western’ society with more awareness and education,

compared to those of their parents and first-generation immigrants. Experiences of education, way of life and settling in another country need to be accounted for.

Weaknesses and limitations:

Although Panganamala and Plummer (1998) were able to support their predictions and found valid results, the study still presented many limitations. The survey included a 5-point Likert scale: strongly agree, agree, neither agree nor disagree, disagree and strongly disagree. By having the option of selecting neither disagree nor agree, participants can avoid answering the question. This could be the reason why Panganamala and Plummer (1998) found that most Asian Indians' attitudes were neutral and, hence, allowed a large proportion of respondents to avoid addressing the question at hand entirely. Whilst the Likert scale is a well-tested attitudinal instrument, Garland discussed in his 1991 article that the use of a 5-point scale can lead to distortions within the results as respondents who want to socially be seen as 'acceptable' or please the researcher are more 'likely' to use the mid-point on the scale as their answer. The survey was also handed out to a wide variety of Asian Indians, some of whom immigrated at a young age and who thus went through the American schooling system, and others who immigrated at much later stage and, therefore, might not have received the same quality of schooling. This resulted in a difference in literacy skills. This could have influenced their understanding of the study and what was being asked of them.

Overall, generational differences and the influence of being brought up in the UK/USA have a significant impact on attitudes towards seeking help professionally through mental health services (Netto, 2006; Bhugra & Bhui, 2003; Panganamala & Plummer, 1998). This highlights the need for health professionals to ensure that focus is given to older South Asian individuals and first-generation immigrants. This idea is supported by Pilkington et al.'s 2012 study, which reported that British-born Muslims were more likely to use psychological help due to awareness and education, whereas those who immigrated still held onto ideas of shame and stereotypes of seeking help outside of the family. Overall, this conveys that generational differences certainly exist. These findings are supported by a study which shows that first-generation South Asian immigrants also find it hard to be compliant with regard to medication, doctor's advice and self-care, leading to negative attitudes towards seeking help through the NHS, as they believe that the traditional ways of coping through cultural remedies are more beneficial and that taking advice from someone outside of the family system is secondary to family advice and ways of coping (Gerrish, 2001). However, it is vital

to note the limitations of these findings. Discrepancies were found in the number of participants used as some were observed and interviewed twice. In addition, the information regarding their ethnic background was not acknowledged, which neglected the fact that inter-group differences within the south Asian group can exist. This leads us to question how far one is able to generalise the findings as a whole.

7. Negative attitudes/expectations towards counselling – preferences of alternative coping strategies

7.1 Explorations of alternative coping strategies

Hussain and Cochrane (2003) – Living with depression: Coping strategies used by South Asian Women, living in the UK, suffering from depression.

Hussain and Cochrane published a vital study in 2003 which helps us to understand some of the coping strategies used by the South Asian community when dealing with depression. Ten South Asian women from the Indian subcontinent who were either first- or second-generation immigrants participated in the study. They had all received treatment from mental health services for a clinical diagnosis of depression within the last year. The researcher, who was Asian too, used topic guides to interview them about their experience. Some of the topic guides used were: available support structures within services; individual coping strategies; and reasons behind choice.

Hussain and Cochrane (2003) reported findings that provide an insight into some internal coping factors used by people in the South Asian Community. Grounded Theory was used to identify the strategies. Religion and praying was identified as the main coping strategy. Another coping strategy was seeking help by going to see a 'peer or Guru' who was regarded as a religious healer in the community. Crying and self-harm were also seen as a way of alleviating feelings of stress and helping ease the burden of challenges faced in life. In addition, medications such as sleeping pills were seen as a coping strategy. When participants were asked questions in relation to using services such as counselling that were available to them, many of them felt it was their problem and not anyone else's. They were also scared that if they were seen getting external help, their needs would not be treated with

confidentiality and they feared being blamed for not being able to cope. They also felt they could not approach such services as they could not speak English and they had no support from the family to help/encourage them. This also led to participants holding the belief that mainstream services could help them as professionals could not speak their language and, thus, their cultural and linguistic needs were not going to be met.

Whilst the primary aim of presenting this paper as part of this literature review, has been specifically due to the direct aim of exploring other help-seeking behaviours compared to counselling with regard to attitudes, the findings from the study have also been documented in other literature. It has been discussed that religion, family and culture are widely used in situations of distress and challenges in the South Asian community (Lee, 1996; Bhugra & Hicks, 2004; Morjaria, 2002). This has been attributed to the cultural preferences of the community (Sue, 1988) and the belief that traditional ways of coping through seeking advice and support from family are more beneficial than seeking support from external agencies (Wynaden et al., 2005). The attitudes towards counselling and mental health and the differences in cultural understanding or misunderstanding have led to the development of other help-seeking behaviours and negative attitudes towards counselling and mental health.

Strengths:

As well as its contribution to this area of counselling psychology as shared above, the study used robust data collection methods. A vital data collection method, involving the research assistant being able to conduct interviews in the same language, without the use of interpreters, was seen here as key in allowing rich data to be collected. One can question whether the same richness and insight would have been obtained with interpreters. Kapborg and Berterö discuss the concerns with validity when using interpreters in their 2002 paper, particularly the problems around losing valuable information via misunderstandings and the interpreter and participant attributing different meanings to words. This process of data collection supports the idea of promoting cultural competence in research and being able to be seen as an 'insider' to the phenomena you are investigating.

Weaknesses and limitations:

The study does well to produce useful insights; however, limitations are found. It would have been interesting and useful to find out more about the women and their background, as religious and individual differences would have had some impact on findings and this was not

accounted for. Hussain and Cochrane (2003) included information on general demographics but failed to give information regarding the participants' treatment history. This would have had some impact on their overall experience of counselling and shed light on why they still preferred other coping strategies compared to receiving therapeutic support. Furthermore, there should have been an attempt to acknowledge that religion and culture can hold many different meanings for individuals. Betancourt & Lopez, (1993) report that when conducting research that aims to explore culture, race and impact of this on human behaviour and preferences, researchers must take time to understand the terms. It is argued that meaning constructed by participants for these words will have derived from their own psychology of their relationships, identity and actions/beliefs. Furthermore, the dual process of seeking help through therapy and adopting self-coping strategies would have been useful to explore further, as it remains unclear to what extent coping strategies are used or adopted as an alternative to service input.

7.2 Stigma, shame and fear-expectance barriers towards seeking help through counselling

Conrad and Pacquiao (2005) – Manifestation, attribution and coping with depression among Asian Indians from the perspectives of health care practitioners

Conrad and Pacquiao (2005) devised a study to specifically look at how Asian Indians' cultural identity influenced their perception of depression and what care outcomes they had. Structured interviews with 23 multidisciplinary mental health professionals and 20 medical records were reviewed. The health care professionals all had experience of looking after people in this cultural group. Within the notes, factors to consider were: admission history; progress; and psychological evaluations. The informants were all staff members (physicians, psychologists/counsellors and nurses) at a large acute psychiatric hospital.

Medical notes revealed that many of the Asian patients delayed seeking help even though some stated they had been 'crying on and off for a few years'. Stigma attached to seeking help and speaking to someone outside of the community and the fear of being questioned and confidentiality being broken leading to being shamed in the Asian community were noted as reasons that led to the denial of an illness and failure to seek help through counselling. This

has also been reported by Sue (1998), where she discussed the delayed approach from individuals from the South Asian community in reaching out for support when in distress, due to the fear of experiencing shame that they cannot cope.

Conrad and Pacquiao (2005), also revealed a lack of trust in the process of counselling, as patients believed that it would not help them in any way. There was a deficit of understanding about what care could be offered from the staff at the hospital and no knowledge about what counselling was and could offer them and, hence, it was almost always rejected. Language was also found to be a barrier in providing the best care for the patients. Patients were also scared to reveal their true feelings in fear of it being shared with family members.

Strengths:

A valuable insight from this study is that it helps us gain understanding of how medical health professionals experience providing care to individuals in this community. Findings from this study have been supported by Gilbert et al. (2004). They found that South Asian women were reluctant to trust health care professionals, with the concern that confidentiality would not be upheld. Furthermore, health care professionals found that honour and respect were very strong factors and individuals from the South Asian community felt they would risk losing honour and respect from the community if they engaged with mental health services.

In addition, from this study, one is able to acknowledge and be in a position to further investigate how important it is for medical heath care professionals to promote cultural competence not only amongst peers but with patients too, to help break down barriers and misconceptions. Campinha-Bacote (2002) discusses the value of approaching working with those from a different ethnic background through a health care model. The model invites practitioners and health care professionals to engage in thinking about; 'Cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desires'.

Weaknesses and limitations:

Whilst Conrad and Pacquiao (2005) were able to highlight a number of factors that explained negative attitudes towards counselling, limitations of the study can be seen in several areas. Some of the health care practitioners interviewed were from a South Asian background themselves and this could have influenced how they perceived the situation with their patients and may have also meant that they made assumptions based on their own cultural

beliefs. Also, as informants were all professionals speaking about the attitudes of South Asians, we are unable to get first-hand accounts or insights and so form conclusions based on secondary information and perceptions. This limitation is supported by Taylor and Bogdan (1984), who argued that using medical records in research can lead to selection bias, misunderstanding and ambiguity. This can decrease the validity and strength of results.

Cinnirella and Loewenthal (1999) – Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study

Cinnirella and Loewenthal presented a study in 1999 that compared the understanding of mental illnesses and help-seeking behaviours across three cultures: South Asian, Caucasian Christian and African. The main aim was to convey the differences in the beliefs of these groups and how these beliefs influenced help-seeking behaviours and their preferences and attitudes towards external support, specifically, counselling.

The study involved 52 female participants from the ethnic backgrounds stated above. Qualitative thematic analysis was used on open-ended-style questions following an interview. Participants were recruited through a snowball approach where participants found other participants, and some were recruited through convenience sampling, where the authors had mainly targeted religious places. The interviews used three questions in which participants were asked about symptoms of depression, what depression was, and possible treatments.

This study's findings were useful and revealed a number of things. In all groups, there was a lack of understanding in relation to what mental health care was and what was available to them. Very few could differentiate the roles of psychiatrist, psychotherapists and psychologists. This prevented them from realising that different help was available in different ways. Many mentioned that if they were to have a negative experience with one professional, they would not see any others as they believed they all did the same job. Religion as a coping strategy was preferred in all three groups but more in the South Asian groups and, in particular, with Muslim women, who declared that religion could give answers as well as help with the illness. Religion was also preferred over going to see a mental health professional as it was seen as more private than counselling. Concern regarding stigma within the community was also more prevalent in the South Asian participants than the other two ethnic groups. There was a large amount of concern that going to a counselling or mental

health care service in the community would mean that people would label them 'mad' and, consequently, family respect would be tarnished. Holding these beliefs led to negative attitudes towards seeking help through counselling. Finally, there was fear of being misunderstood; the South Asian participants conveyed their fears that the health professional would misunderstand the importance of family input and culture in treatment.

Strengths:

The study helpfully conveys how important it is to understand the part that religion and culture play in coping with depression and the need for health care professionals to take account of the fears of being judged or misunderstood. This study also provided insights into the need for trans-cultural counselling and training for all mental health professionals so that barriers can be broken down. The findings support vital literature found on cross-cultural counselling and promoting cultural competency in therapy (Sue, 1988; Laungani, 2004)

Weaknesses and limitations:

One limitation found for this study comes from the recruitment process. Most of the participants were recruited from religious places and, thus, prayer as a coping strategy would be most likely, given the sample base. Here one can argue about the validity of the study as it may be possible that systematic errors were found due to non-random sampling.

Findings from the above two papers can be supported by other literature that has explored shame, feeling judged and non-acceptance in the community with regard to reaching out, irrespective of counselling and attitudes towards counselling. Newham Inner City Multifund and Newham Asian Women's Project (1998) found that the fear of details being disclosed by the GP was the main reason behind non-attendance of appointments and check-ups; furthermore, Meltzer et al. (2000) also found that many South Asians avoid GP appointments and hospital visits due to the fear of being seen or 'found out', which could be perhaps also due to their belief that symptoms will just go away and should not be made a big deal of. Pilkington et al. (2012) have also discussed the idea of 'izzat', meaning self-respect. This, along with the feeling of shame, is seen as being the main predictor in reasons for British Muslims accessing psychological help. Finally, Netto et al. (2006) have also suggested that lack of awareness, understanding of health care and external support, and the collective belief and stereotype of the system are all reasons for lack of uptake of support groups, health care support and mental health support.

7.3 Cultural differences – negative attitudes towards counselling compared to the Caucasian ethnic group

Lavender et al. (2006) – Understandings of depression: An interview study of Yoruba, Bangladeshi and White British people

Lavender and her colleagues conducted a study with King's College London to explore the views of South Asian people (specifically, Bangladesh origin) towards depression in comparison to the Caucasian community and how useful counselling was as a help-seeking behaviour. Participants were recruited from general practices and they came forward as volunteers for the study. People from Nigerian, Bangladeshi and Caucasian backgrounds were involved. Sixty people came forward for the study and none of them had experienced depression before. The study used semi-structured interviews and they were conducted after each participant was shown a vignette of a person diagnosed with having a major depressive episode. The vignette matched the participant's age, gender and family-structure background. The interviewer explored three main themes: causes of depression; attitudes towards depression; and the means of coping with and treating depression.

Lavender et al. (2006) found that most participants wanted to explore what the causes for depression might have been for the person in the vignette. When it came to how one would cope with depression, there was a lot of variation amongst all three groups. It was interesting to find that one of the major differences came from the Bangladeshi group, who revealed that to get emotional help, they would use religious prayers. However, it has been reported in an earlier paper by Hussain and Cochrane (2003) that individuals from the South Asian community are more inclined to use praying and religious support as an alternative coping behaviour. However, it is important, as discussed earlier, not to take this paper and its findings at face value, as the study did not seek to gain understanding of the backgrounds of the women involved. One of the reasons for seeking religious support is that it is more socially accepted in the community and also seen as more useful (Gilbert et al., 2004; Sue, 1988; Netto, 2006). Counselling and seeking therapeutic support was not described or mentioned as a possible coping strategy by any of the cultural groups. Furthermore, Lavender et al. (2006) also concluded that people from the Asian background in this study turned to more social (religious/community) and moral support from family, rather than turning to biological and treatment-focused help, compared to people from the Caucasian ethnic

background, who spoke about treatment and medication as possible options to cope. In further adding some insight to these findings, it has been found that when clients from a South Asian background are 'matched' to therapists of the same religion or ethnicity, positive beliefs are held about seeking help from health professionals. Reasons for this may be that clients from the South Asian background feel more able to use their religious and cultural beliefs within the support they receive from professionals (Farsimadin et al., 2007). Therefore, could matching or multicultural counselling be useful in providing a bridge between individuals from the South Asian group seeking cultural and religious understanding of their coping ability and access to help from health professions? (Ibrahim, 1985)

Strengths:

The study is interesting as it a comparison study, revealing how South Asians may react differently to those from a Caucasian background to depression. Therefore, the researcher's ability to include a varied ethnic sample selection accounts for the rich and interesting data. Allowing a mixed ethnic sample has elicited a variety of responses, hence increasing the validity of the analysis and overall results.

Weaknesses and limitations:

Although the study does well to provide various cultural insights towards attitudes and preferences for coping, there is one possible limitation. The interviewers were all from different backgrounds and also occupations. The Caucasian ethnic interviewer was a GP who had previous experience in eliciting information in this way, and the other interviewer was a male of Bangladeshi origin who worked in the community. These two interviewers may have influenced the respondents. Taylor and Bogdan (1984) discussed that different interviewers will elicit different responses due to their own personal characteristics. Furthermore, interviewers would have developed varying interpretations. This would have led to some bias in findings found. Some participants may have wanted to please the Caucasian interviewer and, on the other hand, withhold information when talking to the Bangladeshi interviewer due to the fear of being 'labelled' in the community. Preferences of not wanting to speak to someone from the same community when discussing personal difficulty, due to possible fear of being judged, stigmatised and becoming an outcast, are well documented in the South Asian community (Netto, 2006; Chan & Quinn, 2009).

8. Summary

The studies reviewed provide us with various insights into the preferences and attitudes of South Asians with regard to seeking help when in emotional mental distress.

Where positive attitudes are found towards counselling and making use of psychological services available to them, it has been found that, in most cases (Netto, 2006; Bhugra & Hicks, 2004), a lack of education around services and locating appropriate services has prevented people from actually making use of them. Generational differences are also highlighted in the discussion of heterogeneity within the South Asian community in relation to their attitudes. Those that emigrated at a younger age are more positive about contacting counselling services than those who are a lot older (Goodwin & Duncan, 1998; Panganamala & Plummer, 1998). Therefore, a lack of education and understanding of what counselling is; where to locate such services; the role of the GP; generational differences and their influence along with education of the individual all play vital roles in placing barriers for people in the South Asian community to undertake counselling and seek help from mental health services, even when positive attitudes towards such services are in place.

Whilst the literature enables us to explore the above, concerns regarding how studies have been conducted have also been found. Studies looked at specific groups within the South Asian community; for example, Goodwin and Duncan (1998) and Panganamala and Plummer (1998) both looked solely at the Indian population, which made it harder to generalise the findings to the whole South Asian community. Studies have also not made attempts to discuss in-group diversity within the South Asian community. Both Bhugra and Hicks (2004) and Goodwin and Duncan (1998) failed to assess their respondents. Bhugra and Hicks (2004) failed to assess how clinically depressed their respondents were and what their understanding of depression was, whilst Goodwin and Duncan (1998) also did not assess the level of distress in the couples' marriages at the time. Both these reasons could have influenced the findings and meant that individual differences were not accounted for.

Reviewing literature that explores other coping strategies over counselling and mental health services used by the South Asian population, Hussain and Cochrane (2003) found that the idea of religion as a coping method for dealing with mental illnesses was particularly prominent in the South Asian population compared to other ethnic groups (Lavender et al., 2006). The fear of being stigmatised also contributed to the negative views of attending

counselling or attempting to seek help from mental health services (Conrad & Pacquiao, 2005). This was also supported by other literature that has reported that shame, honour and wanting to be accepted by the community are important factors in what support people access when in distress (Gilbert et al., 2004). There is also a lack of understanding and knowledge about the differences between psychiatrists, psychologists and counsellors (Cinnirella & Loewenthal, 1999). All of the above reasons lead us to conclude that due to fear of being stigmatised in the community, fear of being misunderstood and fear of private information being disclosed to the community, many South Asians favour and prefer private coping strategies to deal with mental distress and so reject the idea of counselling. Instead they use crying, turning to family members and keeping it within the family, prayer, turning to a religious priest for support and advice, and/or not accepting distress or symptoms in the first place (Meltzer et al., 2000; Newham Inner City Multifund and Newham Asian Women's Project (1998). In addition, stigma and stereotypes of mental health services are characteristic of some cultural backgrounds, and the type of stigma attached in this community is related to being 'black marked', left as an outcast and, in some families, disowned (Netto, 2006).

Implications for further study

For the purpose of exploring this area, I feel that significant findings have been revealed through the studies reviewed. As commented earlier in this literature review, a lot of the studies reviewed combined causes of mental illnesses and the use of psychological services. For the aim of answering the literature review question, I only focused on studies that explored attitudes towards mental health services, for example, counselling, hence limiting the focus of the review. Whilst this was considered a limitation, it also made me realise that many gaps are present in this area of research, as it appeared there were very few articles looking directly at the attitudes and expectations of South Asians with counselling, especially in the UK. Possible further areas of exploration are therefore considered.

The male population – what are their attitudes?

Many of the studies conducted with South Asian communities have been carried out with the female population more than the male. Specific literature reviews (Anand & Cochrane, 2005; Hussain & Cochrane, 2004) have also been written looking only at the female population in this community and how they deal with mental illnesses. Most of the studies reviewed in this

literature also only take into account the female population, and this has been a source of criticism as it means the findings of the studies cannot be generalised to the whole population (Hussain & Cochrane, 2003). There is room for further research to be conducted here as no real efforts have been made, apart from the research by Soorkia et al. (2011), to find out exactly where the male community stands regarding their views and attitudes. We cannot make assumptions, and gender differences do need to be accounted for. The authors suggest possible research should now aim to look at the male population, for example, replicating Bhugra & Hicks (2004) by using the education pamphlet on South Asian men to give us a better idea of how the pamphlet works for the whole community. If finding male participants is difficult, then single case studies could be carried out to generate themes and conclusions.

Counselling for South Asian communities in relation to specific areas

One of the studies included in this literature review, that of Goodwin and Duncan (1998), looks at marital counselling specifically. This is an innovative study and provides insight into the counselling needs of the South Asian community in relation to specific areas that are the cause of psychological distress. Possible areas to review are racism and the prejudice that South Asian people may face when moving to this country and also domestic violence. The author of this review understands that there are many more areas, but these two seem most pressing for the community, as it has been well documented that there is a significant amount of concern for the community with regard to these two areas (Merchant, 2000; Chew-Graham et al., 2002; Laungani, 2004). Possible research could involve analysing how needs are met for those who are victims of domestic violence and finding out what coping strategies are adopted and whether counselling can be one of them. Domestic violence would undoubtedly be related to culture and family dynamics, and so this would help us further our knowledge of this community and help find ways to meet their needs in other areas of psychological concern. This would also be a pathway to more detailed research within this community, allowing us to explore important areas that cause the rise in suicide rates, self-harm, depression and anxiety.

Attitudes and beliefs held by services and practitioners towards the community – Trans-cultural counselling and training

There is a lack of literature exploring providers' experiences of working with the South Asian community. Throughout the studies reviewed, barriers such as expectations of being misunderstood, stigmas, labels and fear of personal disclosure have all been described. Therefore, insight into how services, counsellors, psychologists and similar mental health professionals work with this, or what they understand of these attitudes, fears and beliefs, would be interesting to obtain. Discussion and conclusions around this could influence training for professionals, facilitations of support groups for professionals working with the community and, overall, could help inform services to be able to meet the needs of the South Asian community.

Final thoughts

My aim was to review the attitudes of the South Asian community towards counselling and the mental health system and the positive and negative factors affecting these views. There still remains a gap between the South Asian community and the use of mental health services; although positive attitudes are held, barriers to the use of services available exist, and where internal coping strategies are firmly in place, counselling is rejected. What can be done to bridge this gap? Could we bring internal coping strategies to the counselling room? Can we break down the external barriers by encouraging education and knowledge? Many questions have been produced as a result of the literature review, creating a path for further investigation.

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A qualitative study exploring how South Asian therapists experience working in a therapist-client matching service for South Asian users

Abstract

This research study aimed to investigate the experiences of South Asian therapists who work with South Asian clients in a therapist-client matching service**.** Current literature around matching resulted in mixed reviews on therapeutic outcomes and clients' and service users' experiences. An absence of literature exploring therapists' experiences of matching was noted. Eight therapists from South Asian counselling organisations who worked with matching were interviewed. Using an abbreviated and a social constructivist approach of Grounded Theory (Charmaz, 2006; Willig, 2008), therapists' narratives were collected and a model conveying the experiences of therapists emerged. 'Reasons and justification', 'constructing the value of their experience through understanding their clients' experiences' and 'support' were identified as lower level themes. Higher level core themes also emerged and these were: 'acknowledging self-processes', 'level of experience', and 'experiencing internal conflicts'. Analysis and reflections on the themes and model that emerged are provided. Finally, implications and contributions to Counselling Psychology are discussed and explored with regard to teaching, training and guidance for counselling organisations working with matching.

Chapter one: Introduction to Research – Literature Review

It is estimated that approximately 2,331,423 British Asians (Census, 2001) are living in the UK, and it appears that in the past eleven years, the population has increased (Stillwell & Ham, 2010). Within this growing population, the mental health system in the UK struggles to provide this particular ethnic group with services that are easily accessible and that meet its needs (Netto, Gaag, Thanki & Bondi, 2001). The British government has, however, recognised this struggle and special steps in providing funding for the voluntary sector have been taken. This is to establish trans-cultural counselling services that can provide the

cultural, linguistic and religious understanding needed to help provide appropriate counselling for this specific population (Netto et al., 2001; Nelson-Jones, 2002).

Voluntary services in areas with high concentration of South Asian communities within the UK have started and are continuing to adopt a 'therapist-client matching' approach which enables people of South Asian descent to receive counselling from a therapist who is familiar with or shares the same culture, religion and language (Flaskerud, 1991; Fernando, 2005; Farsimadin, 2007). The 'matching' process has facilitated and created space for South Asian people to be able to 'self-disclose' and feel that they are being understood by their therapist (Fernando, 2005).

Whilst this process attempts to bridge the gap between mental health systems and the needs of the South Asian ethnic minority group, a closer look at the process that is facilitated between the South Asian therapist and client does raise some concerns. It has been found that the process of therapist-client matching can also lead to a number of risks in the therapeutic relationship, including: over-identification with the clients; therapist self-disclosure; maintaining therapeutic boundaries; and hindering sound ethical decision-making (Eleftheriadou, 2003; Maki, 1990; Iwamasa, 1996). Therefore, by matching South Asian therapists to South Asian clients, are we dismissing the actual needs of the South Asian therapist and undermining or misrepresenting a level of 'empathetic and understanding' therapy alliance?

Hence, whilst research carried out by Fernando (2005), Netto (1991) and Netto et al. (2006) reported that the overall therapist-client matching service has proven to provide many benefits for the clients, it also appears that a large focus of the research carried out has been placed on understanding clients' experiences alone. Therefore, other questions remain unanswered by the literature, for example, what is the effect on the South Asian therapist who is being matched to their client on numerous levels? How do they, the therapist, feel about this, and how do they interpret this unique counselling experience?

1.1 Aims for the literature review

In line with the above introduction, the literature review here attempts to provide a summary of studies that explore counselling where therapist-client matching is offered on either one level or more (a level being 'matched' on gender, religion, ethnicity, sexual orientation and/or

language). It is important to state that whilst the above introduction and the research itself is primarily focused on South Asian therapist-client matching and, in particular, attempts to examine therapists' experiences, I will try to broaden the boundaries of the literature review to explore experiences where matching has occurred on any one level. These levels will be irrespective of the South Asian community and will convey many different examples of matching. One of the reasons for doing so is because, presently, there is limited literature on South Asian matching. Therefore, a broader insight will allow us to appreciate and understand matching on the whole and the impact the process has on a range of therapeutic relationships, including the experiences of both clients and therapists. I finally hope to achieve a solid foundation in understanding therapist-client matching from all perspectives that have been researched, thus opening the platform to then focus on the current gap in the literature; the impact of multiple levels of matching that is carried out for this specific ethnic minority group; and, in particular, the experiences and thoughts constructed by the South Asian therapists who are employed within services that offer this way of working.

The following review begins with a discussion of matching on the basis of (1) ethnicity, followed by (2) gender, (3) religion, (4) language and (5) sexual orientation. In 1.10, I focus on the South Asian ethnic community. Whilst there is a noticeable gap in the literature that conveys South Asian therapists' experiences of counselling regardless of matching, a number of research articles have explored South Asian service users' experiences (Netto, 1998; Goodwin & Duncan, 1998; Bhui & Sashidharan 2003). Therefore, I endeavour to review how South Asian service users experience counselling and explore their attitudes with the hope that some understanding of either side (therapist or client) within this ethnic group is gained. In concluding the topics discussed, the eighth section will highlight therapists' competencies and the skills needed in working with clients from ethnic minorities regardless of the therapist's own personal background. This will provide some insight into whether successful therapeutic work with clients from an ethnic minority background is dependent on therapist-client matching conditions. Finally, I will draw conclusions on the main body of this review and highlight the aims and purpose of the qualitative research study that follows this chapter.

1.2 Introduction of therapist-client matching and its relevance to Counselling Psychology

As the mental health system does all it can to improve its services to the public, issues regarding discrimination with reference to age, race, gender, disability and many more areas are still being faced. Whilst this challenge persists, people continue to feel discouraged to use such services and, hence, can feel isolated within their own problems (Clarke, 2003; Sue & Sue, 1999). Since the NHS and mainstream mental health services struggle with this, we are currently facing a climate where voluntary organisations are being set up to try to fill this gap and meet the needs of minority populations (Netto, 1998).

Voluntary organisations that are pushing forward to be better equipped to serve minority populations are progressing and reviewing their services to make them more accessible for these users. Therapist-client matching has now been adopted by many organisations to meet the needs of minority populations that are unable to access mainstream services (Fernando, 2005). The matching service allows users to work with therapists who share similarities with them, for example, both client and therapist may be of the same religion, and therefore religious understanding becomes the basis of their relationship. The user here will be able to explore their problems in the context of their religion, if they wish to, without feeling misunderstood or compelled to explain themselves. Matching such as this can operate on many levels, such as sexual orientation, gender, ethnic background, language and religion. It has been reported by Reitz (1995), who reviewed a number of studies (Sue et al., 1992; Flaskerud & Lie, 1991 Snowden et al., 1995a), that being matched on these levels caters for a more comfortable relationship to be formed where empathy and understanding is at the basis of the alliance. It is important that the matching is only done when the user requests it, which is often the case for many minority populations (Fernando, 2005).

1.3 Terminology and definitions

Part 1

Terms such as ‘matching’, ‘therapist-client matching’, ‘therapeutic dyads’, ‘similarities shared’ and ‘matching on levels’ are used interchangeably. This has been done to express the

numerous ways in which matching can and has been defined and understood in Counselling Psychology literature.

The term ‘matching’ defines the process of the client/patient being allocated to a particular therapist on the basis of sharing a common aspect of identity, whether this is ethnicity, gender, language spoken, religion and/or their sexual orientation. When I speak of organisations that carry out this ‘matching’ process, I aim to speak about counselling services that use this process to assign specific therapists to clients on the basis of shared identity aspects.

Part 2

Whilst taking time to define terms for the review, I felt it was also important to understand and explore the meanings of ethnicity, race and culture. The rationale for doing so is that going forward; I will be exploring the tensions, barriers and challenges faced by the South Asian community in the critical literature review. Writing this section, I have come to understand these terms from many viewpoints and perspectives. Furthermore, Betancourt & Lopez, 1993) reported that culture and related concepts form an imperial part of human behaviour and the psychology behind how one may understand their relationships, identity and actions/beliefs. Therefore, when facilitating psychological research, one must take time to define or understand these terms within the phenomena they are researching.

I have outlined below definitions of these terms using discussions from literature to support my own understanding. I want to emphasise here that I accept that these terms can be defined in many ways and, therefore, are by no means reduced to how they are conveyed below.

Race: There has been some consensus found in obtaining a definition for ‘race’. Leech (2005) defined ‘race’ as a group of people who may share similar physical characteristics such as skin colour, although not always exclusively. In sharing the same definition, Jones (1991) argued that ‘race’ is also known to signify characteristics such as skin colour and facial features which may be known to a particular geographical group. However, Zuckerman (1990) argued that one must not forget that within-group differences can occur and, thus, ‘race’ cannot explicitly be labelled as a ‘similar group of people’.

Wilson (2006), in his chapter on 'The sociology of racial and ethnic relations', discusses the difficulty in obtaining an agreed definition due to changes in the world that we have come to live in. Wilson argues that the meaning and understanding of 'race' continually changes and has moved from a biological scientific fact to a social interaction based meaning. A contributing factor to the difficulty in having a set definition stems from the changes and developments in the social, economic and political world we live in. He describes how the movement from 'classical theories and perspectives' (p.238), 'post-civil rights controversies' (p.240) to inequality in the 21st century have led to theorists continually questioning the definition of 'race'. In conclusion, Wilson states that due to these changing trends the understanding and meaning of 'race' will evolve over time too.

Ethnicity: It is reported that ethnicity is heavily related to the meaning of culture, as it is also seen as a process of thinking and of traditions passed on through generations (Betancourt & Lopez, 1993). Ethnicity can also be seen to stem from one's nationality and where one may have been born. Another definition given is common history or culture shared through heritage and generations, which can be established and possibly stem from a place of country (Craig et al., 2012).

Culture: There has been common understanding that to achieve a consensus in agreeing the definition of culture is nearly impossible (Segall, 1984). However, it has also been shared that a common understanding is not needed to make some attempts to create a general definition of the term (Betancourt & Lopez, 1993). An early school of thought is that culture is manmade and socially driven, whereby systems of ways of living are created and passed down by generations (Rohner, 1984; Herkovits, 1948). A more recent school of thought shares similar thinking regarding the underlying process based on community practices, ways of thinking and acting, and traditions passed on that extend to beliefs and attitudes (Craig et al., 2012).

When taking the time to review literature and making attempts to define the terms above, I have gained some valuable insight that these terms can be understood in many ways. Furthermore, I understand that these terms carry a lot of weight and can be politically understood. It is also said that the ability to be able to identify race, ethnicity and culture stems largely from one's personal experiences of life, as well as social constructions of one's history, and family background (Morning, 2001). Furthermore, it has been argued that each term can hold various different meanings and individually are politically charged to drive

certain thoughts and opinions (Leech, 2005). On the other hand, it has been reported that these terms can be used interchangeably and collectively to convey a school of thought. Furthermore, they represent an identity; over generations and with evolving communities, geographical representations and religion, these terms have become more embedded within discourse. It is further noted that it can be an unrealistic expectation that one fits in to a certain 'group' (Ballard, 2002).

Overall, I feel it is important to be able to take time to share this section as part of the research and gain understanding of what these terms mean and how I integrate them in to my research. Whilst my research does not aim to provide definitions, some insight into how therapists view their ethnicity, race and culture will be discussed or explored. McKenzie and CrowCroft (1996) discussed in their paper that when conducting research using these terms, it is important that the researcher is able to understand what these terms can mean and how they wish to express them in their research. Furthermore, they advise researchers to be mindful that research into cultural or ethnic grouping can be reduced to tensions and arguments in being able to produce the 'appropriate' terminology. Therefore, researchers should stay objective and make attempts to gather as much information as possible with regard to these terms from their participants. Following this, I feel it is important for me and for my readers to be mindful of how these terms have been defined in the literature as shared above. That said, going forward, I wish to also allow the meanings of these terms, and contributions to what these terms may mean, to evolve through the narratives and participants' own understanding of their identity. Bhopal and Donaldson (1998) believed that researchers should avoid labelling and grouping. Furthermore, continuous research into cultural, ethnic groups themselves is the most important step in allowing us to be able to gain insight into what these terms can mean and allow the researcher to then actively conceptualise definitions of these terms.

1.4 Therapist-client matching based on ethnicity

Mixed reviews

It is found in research that when both the therapist and client share the same ethnic background, the service user feels more comfortable in sharing his/her problems. This helps to facilitate more understanding and a safer counselling space. It can also encourage better

levels of a working alliance and treatment engagement on the whole (Fernando, 2005; Rastogi & Wieling, 2005).

However, it also emerges from the literature that impact on treatment outcomes and facilitation of therapeutic process by ethnic matching or sharing similar racial aspects of identity can be unproductive (Care Services Improvement Partnership, 2007, 1 and 2).

Clients' positive impact/experience of ethnic matching on treatment outcomes, engagement and perceptions

Studies by Ricker, Nystul and Waldo (1999) and Flaherty and Adams (1998) both argued that positive outcomes are achieved when clients are matched to a therapist of the same ethnicity. Flaherty and Adams explained further that there is also a decline in the number of ethnic minorities that terminate their counselling when placed in a matching pair. They concluded that when ethnic minorities are clinically matched to their clients, there is no significant difference between white and ethnic minorities in treatment outcomes and both do equally well, thus supporting the idea that ethnic matching is beneficial.

Further exploring the impact and experience of ethnic matching for ethnic minorities throughout his work, Morrison (1977) has suggested that ethnic minority therapists create a trusting space based on the fact they have shared background experiences and, furthermore, can overlook cross cultural stereotypes. This notion is further supported by research carried out by Farsimadin et al. (2007), who argued that clients from the ethnic minority community achieve higher positive performance outcomes on measures of treatment compared to those who are not clinically matched to their therapist based on ethnicity (Brief Symptom Inventory, Derogatis & Melisaratos, 1983).

A recent study by Chang and Yoon (2011) examined the perceptions and attitudes of 23 ethnic minority clients on receiving therapy from a white therapist. What emerged from their investigations were a number of important observations. One finding was that clients did fear that the therapist would not be able to understand their background and experiences regarding their culture and race and so did not go on to talk about their experiences in sessions. However, another finding suggested that some felt that these worries could be eliminated if the therapist portrayed an effective, compassionate and inviting therapeutic relationship. Furthermore, some also expressed their preference for mismatching and held some beliefs related to the disadvantages of being clinically matched to their therapist based on

ethnicity/race. These findings encourage us to look at both sides of the story, as impact is not wholly deemed positive when ethnic matching occurs.

No impact on therapeutic outcomes for clients

Whilst the above seems positive, other studies have reported that, at times, ethnic matching does not always lead to better therapeutic outcomes (Sterling, Gottheil, Weinstein & Serota, 2002). A study carried out by Mollersen, Sexton and Holte (2005) acknowledged that ethnic matching did not improve treatment outcomes but may have some impact on the type of service that was given. This study also reports that shared ethnicity led to an actual decrease in counselling and became more medical. They go on to suggest that the roles of therapists in this dyad may be affected by this matching process; and, hence, further insight and thought should be given to how the therapists view their role and their position in this process.

Karlson (2005) also suggested that more may be going on, as he reported that ethnic matching unaccompanied did not impact or reduce dropout rates for clients and therefore advocates overall that it would be difficult to establish whether any impact did actually occur. He further reported that supplementary investigation needs to be undertaken in this area as ethnic matching is a plausible factor in psychotherapy but only when considered with other factors. His thoughts are similar to those of Sterling et al., (1998), who concluded that matching was not related to treatment outcomes, and that this factor is not alone significant in improving therapeutic outcomes. Nonetheless, some impact could occur when accompanied with other levels of matching.

Findings such as the above which have shown no improvement or effect in treatment outcomes have now been discussed when matching has been offered. What is interesting is that no improvement in treatment was experienced even when ethnicity matching was preferred and requested by clients themselves (Erdur, Rude, Barón, Draper & Shankar, 2000). This was shown in a study carried out by Cabral and Smith (2011), who conducted a meta-analysis review on perceptions, preferences and outcomes. They found that, on the whole, individuals evaluated therapists who shared the same ethnic background more highly than other therapists and also preferred receiving therapy from them. However, regardless of preference and positive impact and experiences, they still reported that ethnic matching provided advantages with regard to treatment outcomes and overall progress in therapy.

Clients' preferences for and against ethnic matching

A number of studies have investigated whether service users themselves are seeking ethnically matched counsellors/therapists in order to receive a specific service over a general, mainstream counselling experience. It was found by Knipscheer and Kleber (2004) that the majority of the ethnic minorities that took part in their study believed that having a therapist ethnically matched to them was vital and that this conveyed a therapist's ability to empathise in the counselling process. These findings have been further supported by research carried out by Redfern, Dancey and Dryden (1993), who argued that levels of empathy are regarded to as higher by a service user when receiving counselling from an ethnically matched therapist. Therefore, in order to achieve shared understanding, ethnically matched therapists were preferred. Preference for ethnic matching has also been found in the Caucasian ethnic community (Fuertes & Gelso, 1998) and thus brings to our attention the idea that ethnic matching should not only be considered for black ethnic minority (BME) populations but can be relevant to a number of ethnic backgrounds.

Widening the breadth of the exploration, Chan and Quinn (2009) investigated whether adolescents showed any preference for receiving counselling from a counsellor of the same ethnic background. They reported that there was no significant difference between white, BME and/or other ethnic minorities in showing any preference over seeing an ethnically matched therapist; however, the majority of the BME students from their sample did state they would prefer *not* to see someone who shared the same ethnicity as them due to the fear of speaking to someone from their community. These findings are echoed to some extent by Netto et al. (2006), who found that some UK-based Asians' unwillingness to see another Asian therapist due to the fear of being judged and not accepted led to reluctance to share authentic thoughts and feelings. The South Asian women's community has been further looked at by Shaft (1998), who found that the South Asian women who she herself had treated reported that having a racially, ethnically matched counsellor was not an essential need or preference; instead, qualities such as warmth, respect and genuineness were considered more desirable, thus conveying that matched ethnicity may not be as preferred or desired by clients from all backgrounds as one might have thought.

Therapists' experiences and the need for cross-cultural competency

In reviewing the literature found, it is important to point out the scarcity of research that aims to understand the experiences of therapists who are ethnically matched to their clients.

However, research carried out by Iwamasa (1996) and Maki (1990) provides some insight. Iwamasa (1996) found that ethnic matching did advocate high levels of trust and understanding in therapists' therapeutic dyads. These findings are in contrast to Maki's (1990) findings, which highlighted the idea that matching could be unhelpful as it promotes the process of making assumptions, thus causing problems in the dyad.

In further exploring therapists' experiences of matching, some literature focuses on therapists' ability to work with culture and ethnicity in a therapeutic dyad and, therefore, addresses the skills needed to achieve a level of cultural competency in counselling. Overall, a general consensus is found when discussing cultural competency in literature (Alladin, 2002; Sue, 1998). The consensus is that for therapists who do work with clients of a similar ethnic background, a greater understanding should be given to their own internalised structure and understanding of self-beliefs, morals and identity in order to avoid making assumptions and mis-stereotyping (Ho, 1995). Alladin (2002) echoed the dangers involved in ethnic matching, arguing that inflexibility in matching could lead to segregation for both therapists and clients and that neither matching nor non-matching can be picked over the other as research has resulted in such varied findings and has left more questions for researchers than answers.

Overall, literature reviewed in this area calls for a greater level of cultural competency for those training in counselling, irrespective of ethnicity, to be well equipped to work with clients from any ethnic background (Bhui & Morgan, 2007; Sue, 1998), and that gaining cultural competency will prevent 'cultural blind spots' and assumption-making processes (Neville, Worthington, Duran, Lee & Browne, 2000).

1.5 Therapist-client matching based on gender

Impact of gender matching in client disclosure, therapeutic outcomes and perceptions

Literature exploring gender matching has revealed that female users feel a higher level of satisfaction and understanding when sharing the counselling experience with a female therapist. However, this is not the case for male service users (Flaherty & Adams, 1998). Another study carried out by Pattee and Farber (2008) investigated gender and gender roles with 223 patients by understanding their experiences of self-disclosure in therapy. Through factor analysis of the Disclosure to Therapist Inventory-IV they reported that, on the whole,

female patients who were seen by female therapists experienced a greater level of distress in disclosure than male patients did with female therapists. Furthermore, therapists that were perceived as flexible in relation to identifying specific gender roles achieved higher levels of openness with clients than those who were identified with traditional gender roles. In conclusion, Pattee and Farber called for further in-depth discussion into gender role influence in therapy, stating that there are still a lot of inconsistencies and it is not as clear-cut as people may perceive the process to be.

In contrast, Blow et al. (2008) have discussed the notion that some straightforward clarity can be gained and that gender-based matching simply has no impact on the therapeutic process, outcomes or the perceptions made by clients about their therapists. Throughout their review, they reported that, on the whole, research fails to attribute any positive outcomes to gender matching in therapy at all (Sterling, Gottheil, Weinstein & Serota, 1998) and they explored these findings through a number of studies. A study carried out by Okiishi, Lambert, Eggett, Nielsen, Dayton and Vermeersch (2006) showed that in the treatment outcomes of 5000 clients seen by 71 therapists, there was no indication of gender-based matching as a contributing factor to progress and successful treatment outcomes (cited in Blow et al., 2008). These findings are strongly echoed by Vociscano et al. (2004), who found that progress in treatment outcomes was in actual fact due to the process of the therapists discussing the therapeutic relationship with their clients, rather than the fact that clients shared the same gender with their therapists (cited in Blow et al., 2008). This goes on to support the proposal for a greater need to investigate variables surrounding gender matching, because when gender matching is co-facilitated by another variable, some impact is found on treatment outcomes.

Whilst on most occasions gender matching is hypothesised not to have an impact on process, outcomes or perception, many are still convinced that for female clients who have been sexually abused or for those who are victims of domestic violence, gender matching can prove to be vital. This consideration has been investigated by Wagner, Kilcrease-Fleming, Fowler and Kazelskis (1993), who explored therapeutic relationships through the study of the process and therapeutic outcomes for girls who had been assigned to male therapists compared to girls who were assigned to female therapists. They found that there were no preferences or differing views in perceptions between the two genders and both were equally effective in providing counselling for the clients, thus creating doubt about the assumption that gender matching is fundamental in cases of domestic violence or abuse.

Mixed stances and beliefs on the impact of gender matching

Overall, there seems to be a mixed stance on matching based on gender, and it is believed that gender matching does not always lead to high satisfaction rates amongst clients of the service they are receiving, nor does it necessarily mean the client rates his/her therapist's competence level any higher (Redfern et al., 1993). However, Blow et al. (2008) have suggested that gender matching may be of importance in creating an effect on the therapeutic process, but, interestingly, only when considered with other variables, such as race.

1.6 Therapist-client matching based on religion

Clients' preferences, experiences and impact on therapeutic outcomes

Worthington (1988) has provided some narratives contributing to the literature in this area and accommodates thoughts on two potential hypotheses. He commented that clients who come from a religious background will construct a religious evaluation of their problems and experiences in counselling compared to those who do not come from such a background. Due to this, religious matching must have some degree of impact on the therapeutic process and work carried out, because the client's religious evaluations will impose on perceptions, attitudes and constructs formed in counselling between themselves and the therapist, regardless of the therapist's religious beliefs. Therefore, matching on this level may be of some therapeutic use. Furthermore, empirical research has been carried out to test these assumptions. Kelly and Strupp (1992) found that by studying 32 dyads within which the therapist and the client shared similar religious values, client therapeutic improvement was found (Worthington et al., 2005). As such, they suggested that matching on religion, religious beliefs and/or values can be an effective factor in determining progress in counselling.

With the aim of understanding whether positive treatment outcomes are found when religious beliefs are matched based on preference, findings by Ripley, Worthington and Berry (2001) are explored. This study investigated the preferences of Christian service users when accessing a psychological service. Their first preference was to be counselled by Christian therapists using Christian practices and their last preference was to be counselled by a non-Christian therapist using psychological practices only. Hussain and Cochrane (2002) also found that South Asian women who were diagnosed with depression felt that in order for the treatment to succeed, it was important to have a therapist of the same religion who was able to understand their presenting problems within a cultural and spiritual context.

Bringing religion into the 'room': Introducing religion into counselling interventions

There is minimal literature looking at therapist-client religion matching, but there is some that explores religion explicitly by both therapists and clients, regardless of a clinical match. There is a call for all therapists and clinicians to be trained on understanding and being sensitive to all religious backgrounds, thus enabling those clients who have strong religious beliefs from using counselling services even if they do not have access to a therapist of the same religious background (Worthington, 1988; Kelly & Strupp, 1992).

Schaffner and Dixon (2011) conducted a study in which a number of students were interviewed regarding their preferences for using religiosity in counselling. Their hypothesis was that students with higher religiosity values and beliefs would prefer a counsellor to incorporate religion and explore beliefs and values within a counselling framework; this was supported by their findings. Furthermore, they found that gender contributed to their findings and reported that females had stronger preferences for religious counselling than men.

Findings by Schaffner and Dixon (2011) are supported by earlier findings by Mayers, Leavey, Vallianatou and Barker (2007), who explored help-seeking behaviours of religious and spiritual clients. They found that clients incorporated their faith into their coping strategies, which they then utilised alongside therapeutic support. Although no significant results were found for the need to match on the basis of religion, it was reported that, on the whole, religiosity should be integrated into counselling (McCullough 1999).

Religion and Culture:

Whilst reviewing literature in this area, a number of empirical studies have highlighted the importance of understanding (1) the relationship between religion and culture; (2) the therapist's own understanding of their own culture and religious beliefs held; and (3) how culture and religion is identified in their training and clinical work, thus influencing them in their therapeutic interventions with religious clients (Walker et al., 2004; Wolf and Stevens, 2001; Constantine et al., 2000). Having this insight encourages us to think about the possible relationships between the two factors (religion and culture) and the overall influence both factors would have on the therapeutic process.

1.7 Therapist-client matching based on language

Impact on treatment outcomes for clients when language is matched:

Flaskerud and Liu (1991) reported that having the therapist and the client matched on the basis of language was a significant contributor to providing clients with a positive therapeutic experience; their findings showed that the number of sessions a client had with their therapist increased when they shared the same language. However, the dropout was not significantly affected by language.

In a review by Flaskerud (1990), he suggested that a lack of a common language between the therapist and client can create problems when giving a diagnosis, particularly due to a decrease in disclosure. However, in his review, Flaskerud (1990) commented that no significant support can be found for positive therapeutic outcomes when the client and therapist are matched on language; I hypothesise that this is due to the use of other interventions to help support the process, such as using an interpreter.

Positive impact of language when ethnicity matched:

Language matching seems to go hand-in-hand with ethnic matching. This was a conclusion drawn by Sue et al. (1991), where it was found that service users continued longer with counselling when language matching was offered to them in a language other than English, in addition to being matched on ethnicity. These findings were also shared with Ziguras, Klimidis, Lewis and, Stuart (2003), who found that, when counselling was offered to ethnic minority service users in their mother tongue, better outcomes with treatment were found.

1.8 Therapist-client matching based on sexual orientation

Clients' preferences and seeking behaviours

Positive experiences and evaluations of receiving counselling and treatment have been found when homosexual and bisexual clients are matched to their therapist on the basis of sharing the same sexual orientation. Clayton (2006) reported that the sexual orientation of the therapist is never seen as a 'neutral' factor when counselling homosexual and bisexual clients and that this factor is deemed vital in facilitating progress and positive treatment outcomes. This is supported by an empirical study carried out by Liddle (1996), who asked clients (gay,

lesbian and bisexual) to describe their experiences with their therapists. It was found that homosexual therapists and female heterosexual therapists were more helpful than heterosexual male therapists. However, it was found that therapists' clinical practice was still seen as more of a contributing a factor when accounting for helpfulness as opposed to their demographics. In another study by Liddle (1997), where she investigated therapist-seeking behaviours of gay and lesbian clients, she reported that 41% of the therapists seen were gay, lesbian or bisexual, thus conveying the need and match-seeking preferences of gay, lesbian or bisexual clients.

1.9 Matching literature and demographic variables

A significant amount of literature on matching has been based on the levels explored above: religion, language, ethnicity, sexual orientation and gender. I find it interesting that there is a lack of research on matching that contains levels such as personality matching, whether clients and therapists are married, share life experiences, and have children and so on. It allows me to question what motivation there is for literature on matching to be primarily based on demographic levels and personal attributes. Bernier and Dozier (2002) suggested that demographic variables are the most influential in determining the success of therapeutic outcomes and have a significant influence on other possible matching variables, including coping styles, life experiences and personalities, and therefore should be considered more fully. I also individually acknowledge that in a political climate where our population is so vast and varied with many from differing backgrounds, carrying out research based on demographic details such as those explored in this review is of vital importance in order to understand our society and the culture we live in.

1.10 The views, attitudes and experiences of South Asian service users towards counselling and 'matching'

Throughout the literature, a number of studies have highlighted that positive attitudes towards counselling and engagement with services, whether through matching or not, can be found. It has been suggested that a lack of education around what counselling is, the benefits of therapeutic support, and difficulties in locating appropriate services has prevented South Asian people from actually making use of them (Netto, 2006; Bhugra & Hicks, 2004). Once those in the community are educated about counselling, positive evaluations and engagement of services are found. This is shown by a study conducted by Netto (1998), who found that

once service users were educated in what counselling could offer through appropriate resources and communication, they seemed very much interested in engaging. Furthermore, Netto's study (1998) also supported ethnic matching as a condition for ensuring positive experiences for service users. It was found that clients reported positive experiences and felt more comfortable in therapy when they were allocated to a therapist of similar or same ethnic background. It was found, in response, that services in highly populated South Asian areas found it hard to meet this need as they were not able to present a multi-ethnic team at all times. The study therefore called for more multicultural training for trainees to make some attempts to overcome this limitation.

Generational differences leading to split views and attitudes towards counselling are also highlighted within the South Asian community. Those that migrated to the UK at a younger age are more positive about contacting counselling services than those who arrived when they were much older (Goodwin et al., 1998; Panganamala, 1998). This suggests that clients who have an understanding of what counselling is, where to locate such services and the role of the GP make positive moves to engage in services compared to those of older generations who may not have this understanding. Consequently, this shows that a generational difference itself can be an external barrier in accessing services, even when South Asian clients of the older generation feel positive about attending counselling.

When exploring negative attitudes and experiences of South Asian service users, Bhui & Sashidharan's (2003) study reported a number of important factors to consider. This study explains that being misunderstood or not understood culturally is a pragmatic factor that contributes to a client's negative experience of counselling. Bhui & Sashidharan (2003) reported from their research that whilst many mental health professionals feel that the needs of South Asian service users are met, service users, on the other hand, can feel extremely unhappy with the service they receive. Many of the users they interviewed expressed a preference for seeing professionals of the same 'race' or those that spoke the same language in order to avoid being misunderstood or stereotyped. They also felt that in therapeutic relationships where religious beliefs were not commonly shared, there was no opportunity for service users to explore their own beliefs in relation to their experiences or presenting problems. This seems to signify that positive experiences of counselling can be constructed if ethnic and religious matching occurs between South Asian users and their therapists.

Experiencing problems of being misunderstood and showing preference for 'similar' therapists and matching is also discussed in a study by Bowl (2007), who interviewed South Asian women who had received psychological assessments from psychiatrists. He outlined in his research that 'cultural' exclusion (Bowl, 2007, p. 9) was experienced by many of his participants, who felt that they were not understood as English was not their first language. Interestingly, Bowl (2007) also identified in his analysis that participants commented on problems with psychiatrists who were of the same ethnic background but did not speak the same language and that this also intensified miscommunication; therefore, matching on language was preferred over ethnic matching to ensure a positive experience for the participant being assessed for psychological treatment.

A study by Hussain and Cochrane (2003) conveyed another side to the story, explaining that matching is not always beneficial for users, and that many tend to use alternative coping strategies outside of counselling. They found, through their Grounded Theory analysis of ten interviews with South Asian women, that crying, praying and religion were used instead of reaching out to appropriate services when feeling depressed or emotionally distressed. Many also reported that when thinking about accessing services, they feared that their problems might not be treated with confidentiality and that speaking to someone 'outside' of the family was still seen as confiding in someone who was part of the 'community'. Therefore, speaking to someone of the same or similar ethnicity could bring shame upon them and their family.

Further, supporting the idea that South Asian women feel shame and fear when accessing psychological support from South Asian services, a study carried out by Newham Innercity Multifund and Newham Asian Women's Project (1998) found that clients feared that speaking to a therapist/GP about accessing counselling services would not be treated confidentially, especially if the GP was of the same ethnic origin, hence conveying that ethnic matching can be more problematic than helpful in allowing users to access appropriate services for help.

In concluding this section, one can see that there are mixed views and attitudes on matching in counselling. Some factors are highlighted that enable service users to experience positive evaluations of counselling where education and validation of needs is met. There are still mixed thoughts and findings on whether South Asian service users find matching on some level, whether that is ethnicity, language and/or religion, useful. In order to develop a body of evidence further research is required in this area.

1.11 What are the current thoughts with regard to multicultural counselling? Also, does matching permit the process for equal understanding in a therapeutic relationship?

I have touched upon the practices of multicultural counselling in the above sections, when sharing thoughts about the benefits and need for therapists to be aware of ethnic communities and of the need for cultural competency (Sue, 1982). However, I feel it is important to summarise some of the literature that discusses the work facilitated in this way, as matching is seen as an integral part of multicultural counselling practices (Speight et al., 1991). Furthermore, much of the literature around multicultural counselling informs the practices and need for the matching model to be used in mental health services.

The multicultural counselling movement has been well supported in helping therapists work with clients whose culture is different to their own. The motivation behind such a movement stems from the thinking shared by Sue et al. (1992): How can therapists work with clients who are culturally different from themselves, and can this work be effective? From this stems the additional thinking that differences can then also occur in different gender client-therapist dyads, different language-speaking dyads, and so on. Thus, the principles and practices of multicultural counselling have been applied to all therapeutic relationships where distinct differences in characteristics and demographics can occur. Pedersen (1988) argued that if this is the case, then every encounter in counselling is 'multicultural' as all therapists and counsellors work with differences and, hence, should have developed these skills as the foundation to their training. Furthermore, one is trained in counselling to work with such differences as these form the basis of the work and differences are not going to be limited (Patterson, 1996). Speight et al. (1991) argued that even with this known, multicultural counselling has become an independent skill and a specialist training. Literature in this area discusses the benefits of such training and sensitivity in this area. Fukuyama (1990) argued that at one point, specific sensitivity around cultural diversity was needed in counselling. With evolving communities, ways of thinking and developments in culture, there was a real sense of reality that such diverse populations and cultures existed. The multicultural counselling movement has been known to be supported by the cognitive development theory by William Perry (1970) (Fukuyama, 1996). The theory argues that struggle is experienced when one moves from dualistic thinking to multiplicity. Therefore, in relation to multicultural counselling, the struggle is experienced by counsellors to move from known cultural beliefs

to the many existing cultures and communities and ways of thinking (Fukuyama, 1996) that may be experienced in a multicultural counselling dyad. Hence, counsellors are continually encouraged to think about the components needed in specialist training or counselling techniques to help with the development of multicultural counselling. The matching model is seen as a way of facilitating this.

Concerns with multicultural counselling and matching

The motivation behind the movement of multicultural counselling has been explored and thoughts have been shared on the working principles of this movement and the process of matching. In drawing some preliminary conclusions on the literature reviewed so far with multicultural counselling, I begin to question the extent to which matching provides or facilitates a shared 'complete' understanding in the therapeutic relationship. I also question whether matching is needed to achieve successful therapeutic experiences for either the therapist and/or the client when clients are from ethnic minority groups. Furthermore, and, more importantly, I wonder how successful multicultural counselling is when working with cultural and racial differences and the usefulness of the core competencies when therapists work with clients who do not share the same aspects of each other's identity.

There is a school of thought that suggests that adequate training should enable therapists to work with all client groups (Truax & Carkhuff, 1967). It is also suggested that all counsellors and therapists should possess genuineness, warmth, be non-judgemental and express empathetic understanding (Truax & Carkhuff, 1967, p. 1).

This school of thought is further supported by Sue (1998), who also suggested that whilst ethnic/racial and linguistic matching can be favourable and lead to better treatment outcomes and perceptions of sessions, cognitive matching is just as vital, if not more so. She further suggested that cognitive matching (thinking in the same way) should be at the forefront of all therapeutic dyads and, therefore, it would not matter if ethnic matching occurred, as all therapists could be trained to adopt this skill and to utilise it in understanding all clients from a vast range of ethnic backgrounds.

Knipscheer and Kleber (2004) also found that ethnic matching or having similar therapeutic dyads was not deemed to be important in creating successful therapeutic outcomes. Instead, they suggested that the therapists' expertise, therapeutic skills and techniques based on

evidenced-based theories, along with sharing a worldwide view of experiences, was important in creating effective therapeutic relationships.

In addition, it is also thought that matching is not necessarily a condition needed for successful dyads in therapy, as the therapists should sustain a level of competency allowing them to work in the clients' frame of reference in relation to cultural and personal contexts, regardless of their own background (Constantine, 2002; Kareem, 1992).

Furthermore, Iwamasa (1996) suggested that where matching does occur, therapists should take care in deconstructing what similarities they share; one should not take for granted individual differences even in 'similar', 'matched' therapeutic dyads. On the other hand, Rogers (1951) explained that it is desirable for the counsellor to hold some understanding and experiences of their clients' cultural or specific personal contexts. This idea is supported by studies discussed earlier that convey positive treatment outcomes when ethnic, gender, language and sexual orientation matching occurs. Furthermore, an article by Sue, Stanely and Nolan (1987) conveyed the difficulty psychotherapists face when working with clients from ethnic minorities. They discussed that even when cultural sensitivity is applied, there are situations when treatment procedures and specific techniques are used on the basis of **assumed** cultural values of the clients and, hence, are not always appropriate or deemed suitable for the client. They highlighted that additional research is needed to assess the impact of culture, religion and language in psychotherapy and especially in training and clinical practices as, currently, psychotherapists who do not share the same aspects of identity fail to meet their clients' needs.

Exploring the literature that supports the work of matching, Reid (2010) showed that a complex but helpful process is found in a client-matching dyad. She concluded from her qualitative research that through matching, therapists sometimes do become open to the risk of over identification and face challenges in assuming knowledge about their clients. However, the similarities shared also facilitate openness and encourage therapists to develop strong coping strategies. She also concluded that matching can be useful when differences are highlighted as well as similarities, allowing a rounded approach to be maintained in the therapeutic process. Furthermore, supervision is vital for therapists working with matching, as it encourages therapists to explore their own personal experiences and provide the appropriate guidance when working with this process.

Finally, in exploring some of the literature that documents the principles and practices of multicultural counselling, it has been highlighted that some literature fails to understand the true meaning of ethnic and cultural differences and, furthermore, disregards the fact that in-group differences can occur (Ibrahim, 1985; Speight et al., 1991; Sue et al., 1992; Sue, 1998; Casas, 1985; Patterson, 1996). Moreover, Sue (1998) highlighted that multicultural counselling goes further and deeper than simply highlighting differences in ethnic background and cultural identity. Thought should be taken when identifying what the meaning of ethnicity and culture is for both the therapist and client. In addition, effort to match on shared understanding and perception of this should be facilitated. In support of this argument, further discussions are made for a more integrated and universal approach to working with ethnicity and cultural differences (Vontress, 1988; Ibrahim, 1985; Draguns, 1989). This entails the thinking put forward by Kluckhohn and Murray (1953), who argued that people can be alike and different, and that the uniqueness of individuals as well as the 'sameness' should be accounted for and explored in the counselling process, in the name of a more universal approach.

1.12 Conclusions

Firstly, it is clear by reviewing the literature that there are contradictions and differing schools of thought as to whether or not therapist-client matching is effective in therapeutic work. Secondly, when reviewing different levels where matching can occur, I acknowledge that further literature is found which focuses on ethnic matching compared to other levels. This is further conveyed through studies reviewed throughout this literature. The review of literature presented in this chapter, also described varied attitudes of the South Asian population towards matching and counselling. Furthermore, some attempts were made to examine literature that looks at whether a shared and equal understanding in a therapeutic dyad is achieved through matching only; once again, diverse reviews are found.

Finally, I acknowledge a gap in the literature that draws on therapists' experiences of matching, more specifically, experiences of South Asian therapists, and a gap in the research that investigates the effectiveness and experiences of multiple levels of matching in a therapeutic dyad.

When considering the studies that focused on ethnic matching, a number of observations can be made. Firstly, a strong consensus is shared amongst one school of thought: ethnic matching is effective in therapy (Ricker et al., 1999; Flaherty & Adams, 1998) and many individuals from different ethnic communities have compelling preferences to be allocated to an ethnically similar therapist (Chang & Yoon, 2011). It has been reported by studies discussed in this literature review (Ricker et al., 1999; Chang & Yoon, 2011) that ethnic matching allows better performance outcomes and a reduced number of drop-outs; this could be because many individuals accept as truth that being ethnically matched to their therapist allows a trusting and non-stereotyping space to be created to which both the therapist and client can have easy access within the therapeutic process (Morrison, 1977).

On the other hand, a number of studies reviewed support the notion that ethnic matching is not always beneficial. It is suggested that ethnic matching does not significantly improve therapeutic outcomes (Sterling et al., 2002; Mollersen et al., 2005). Interestingly, it was also reported that ethnic matching could, in fact, have a profound negative influence on the style and working ability of therapists and that further thought and research should be conducted to explore this (Mollerson et al., 2005).

Considerations were also given to expectations of therapists' competency in working with clients who were not ethnically matched to them. Individuals from the ethnic community were reported as seeking out counsellors/therapists who were of the same cultural/racial and ethnic background with the expectation that ethnically matched therapists would consider South Asian clients highly with regard to empathy and understanding (Knipscheer & Kleber, 2004a; Redfern et al., 1993). These preferences were not only found in ethnic minority groups, such as African Caribbean and Asian, but, according to Fuertes and Gelso (1998), also in the Caucasian community. However, in contrast, some research commented that individuals from the South Asian community feared receiving treatment from the same ethnic community due to worries of being judged and not accepted (Netto et al., 2006).

When trying to understand therapists' experiences of ethnic matching, it was reported that, for some, matching can allow room for understanding and trust, thus creating a better therapeutic process (Iwamasa, 1996). In contrast, however, some advocate that being ethnically matched could promote assumption-making and, hence, be disruptive (Maki, 1990). Furthermore, being in tune with one's own internalised structure and beliefs is vital for

therapists working in a matched pair, and risks such as segregation and frustrations have been highlighted (Alladin, 2002; Sue, 1997).

In contrast to ethnic matching, distinctive views are found when considering matching based on gender. It has been reported that gender has no implication or impact on the therapeutic process (Blow et al., 2008; Okiishi et al., 2006; Vociscano et al., 2004). Literature suggests that the impact of gender may be significant when in place with another level of matching, such as ethnicity.

When considering matching based on religion, findings are also similar to those found for language, highlighting that this level of matching is also seen as effective for service-user satisfaction and therapeutic outcomes. It has been suggested that religion can be the basis of formulating our values and understanding of the things around us; hence, this level must have some weight in the therapeutic process between a client and therapist (Worthington, 1988; Ripley, Worthington & Berry, 2001). With this in mind, and through a review of numerous studies, I was able to establish the significance of using religion in counselling interventions in order to allow clients who have strong preferences for using spirituality in session to be supported. Thus, research does not directly promote religious matching, but does give way to the idea that religion and spirituality are vital in a therapeutic relationship; and whilst some may have preferences to be matched (Ripley, Worthington & Berry, 2001; Hussain & Cochrane, 2002), all therapists should receive training to understand all religious backgrounds (Worthington, 1988; Kelly & Strupp, 1992). It is also important to highlight that when religion and culture, are matched together; this is seen as highly significant as both tap in to unique aspects of self and, thus, multiple matching in this way could be considered useful.

Matching based on language is also considered to be effective in therapeutic outcomes (Flaskerud & Liu, 1991), as a lack of common language results in a decrease in disclosure during a session and a higher level of misunderstanding. Having a shared common language could facilitate honesty, feeling comfortable and being able to express yourself freely (Flaskerud, 1990) and, therefore, language matching is considered valuable. As with religion and gender, language is considered a useful level to match alongside ethnicity. It has been reported that ethnic minority groups, particularly those where English is not their mother tongue and language matching is facilitated, experience better treatment outcomes and

require less contact from other professionals (GPs) as therapy itself is intensively used (Stuart, 2003; Sue et al., 1992).

Literature covered and reviewed when exploring the views of South Asian service users in relation to counselling and matching shows mixed experiences and attitudes. It was found that once education and space are given to explore what counselling can offer individuals, generally, most South Asian service users feel positive about engaging in services (Netto, 2006; Bhugra & Hicks, 2004). Furthermore, generational differences in attitudes are encountered. Second-generation South Asians are more likely to engage in counselling compared to those of the first generation, and this could be because the first generation lacks understanding and education about what counselling can offer. This is where Netto (1998) believed matching would be considered appropriate to facilitate trust in the counselling process, bridge the gap and provide first-hand education and understanding.

Negative attitudes were found when service users felt they were misunderstood, especially in therapeutic assessments where a more medicalised approach was taken, rather than providing space to explore cultural beliefs within problems presented (Bhui & Bhugra 2002). This supports the notion that matching could possibly help address these problems. Therefore, the need for appropriate assessments and counselling interventions to be used with regard to South Asian culture, language and ethnicity is indicated, as this is preferred by South Asian service users. Bowl (2007) showed that language and ethnic matching were preferred when a client was being allocated to a professional and, interestingly, language was deemed more important than ethnicity in eliminating the process of being misunderstood.

On the other hand, studies have also shown that matching is not necessarily important or effective for South Asian service users. Many users feel that other coping strategies, such as praying, family support and talking to outsiders, can be used; moreover, speaking to someone outside of the family who was still part of the community can create a fear of being judged and lead to a breakdown in trust in confidentiality (Newham Innercity Multifund and Newham Asian Women's Project, 1998).

In addition to reviewing literature that discusses matching on different levels, I went on to explore whether appropriate research could offer some insights into whether matching is a suitable measure of a 'shared' and 'equal' understanding between a therapist and a client. I

began this exploration by questioning what matching entailed and whether matching was seen as the most important condition needed to create an effective therapeutic alliance.

The literature reviewed strongly suggests that all therapists trained in this area of work should possess skills, abilities and competencies to work with any client, regardless of race, language, gender and sexual orientation (Truax & Carkhuff, 1967; Sue, 1998; Knipscheer & Kleber, 2004). Therefore, whilst we have seen that matching can be effective and be a cause for positive and progressive treatment outcomes, it is not necessarily needed to create an effective working therapeutic alliance. Skills such as empathy, being genuine and non-judgemental were equally, if not more, important (Sue, 1998). Whilst this is evident, literature still supports the idea that matching provides some degree of bridging between certain client groups and therapeutic services, especially for ethnic minorities. Acknowledging this process can provide some insight into the inequalities faced by such communities when trying to access mental health services (Alladin, 2002).

In addition, I believe that having an understanding of therapists' experiences of matching would allow us to have a more complete picture and understanding of this unique process. It would also allow us to understand therapists' experiences of training and their perception of their professional self in comparison to their beliefs of their self-identity. I am also intrigued about the process of multiple levels of matching; it has been highlighted numerous times that many levels of matching, when co-represented, influence each other immensely with regard to treatment outcomes and engagement in therapy. Exploring this would enable us to be in a position to make more definite comments.

1.13 Where do we stand – Researcher's aim for the qualitative study

Recognising the gaps in this area of research opened up an opportunity for me to explore unknown territory and expand on the research already undertaken. I hope to firstly explore what experiences are held by therapists who carry out therapist-client matching: what perception do they have of this method of being matched to clients? What does this process bring for them and how do they make sense of/manage this experience? Secondly, I have two independent interests: (1) exploring the process of matching within the South Asian community; and (2) investigating the experience for a therapist who works with clients where multiple matching has occurred. In allowing both of these to be explored, I will use semi-

structured interviews with South Asian therapists working in services where they are clinically matched to their clients on multiple levels of their identity.

I will use Grounded Theory to explore therapists' experiences through their own narratives and the process of how their experiences are constructed to understand how they perceive matching. By using Grounded Theory, I hope to formulate a model that would be accessible to all organisations working with multiple levels of matching, especially for South Asian services users, to help provide guidance on training and care for therapists working in this area.

1.14 What I hope the research will contribute to Counselling Psychology and the rationale for exploring South Asian therapists' views

In the current climate, we are faced with an increased number of ethnic minorities now accessing mental health services, especially the South Asian ethnic population. The need for the mental health system to work and address this therefore now seems essential. Hence, we see the increased promotion of multicultural services as they move from voluntary organisations to mainstream services. With this development, the phenomenon of 'therapist-client' matching has already proven to be of some importance to the counselling world.

In relation to this specific research area, I believed that understanding the thoughts and feelings of South Asian therapists regarding this matching process would provide an insight into what is the impact on a therapist, be it positive or negative. Furthermore, so far, through the literature review and critical literature reviewed, I feel that I have gauged an understanding of the tensions, challenges and barriers and, thus, the overall attitudes of South Asian service users towards mental health services. This insight includes service users' mixed attitudes towards receiving therapy or treatment from South Asian therapists where matching of some levels would occur, and this has been documented (Flaherty & Adams, 1998; Morrison, 1977; Farsimadin et al., 2007; Netto, 1998). Having this insight for me initiated the question as to how therapists view this unique process for themselves. Whilst it is known why South Asian service users may reach out for such therapy, what is it that leads therapists to want to work in this way? Do they encounter similar thoughts and feelings to those documented by South Asian clients/service users?

Exploring the thoughts and attitudes of South Asian therapists and having insight into the above questions would be vital in helping us shape the future of services and advancing therapy techniques. Understanding this would allow voluntary organisations and the NHS mental health services which provide this service to review the avenues that enable them to assist and further develop the system whereby therapists are matched to clients. In addition, the research gathered provides some perspectives not only on South Asian trainee/counselling psychologists but on all trainees/qualified therapists who are wanting to work in, or have an interest in working in, a trans-cultural service where matching is offered to service users on the basis of gender, ethnicity, language and sexual orientation.

I also felt a personal motivation to seek therapists' perspectives of this type of work. Reflecting on my experiences leads me to use myself as an instrument in helping to motivate the research question; I feel my own experiences are the springboard from which to investigate this under-researched area.

Chapter 2: Methodology

2.1 Introduction

Throughout this project, I have subscribed to working within a social constructivist framework. By doing so, I was able to explore narratives of South Asian therapists who work with South Asian clients in a range of therapist matching services. By applying this framework to a qualitative design, I was able to explore therapists' understanding of their lived experience and reality within their social context (working with 'matched' clients). The main aim was to reach depth and to capture meaning embedded within an individual's narratives. I strove to achieve this by conducting semi-structured interviews and then applying the principles of Grounded Theory, as modified by Charmaz (2006), to analyse them.

2.2 Research aim and development of question

The research question developed from the interest and experiences I gained from the professional work I had carried out during my training. Working as a South Asian therapist in a therapist-client matching service with South Asian clients gave rise to some personal challenges, new ways of thinking and an interest in how therapists similar to me also found this way of working. I was aware of the uniqueness of this therapeutic process and was eager to learn more.

My aims were namely: (1) to explore the effect of therapist-client matching on therapists; and (2) to look at the effect of matching a client to a therapist on a number of multiple levels. Therefore, I propose to explore this within the context of the South Asian community. Literature explores the challenges and barriers this community faces in accessing counselling services (Hussain & Cochrane, 2002; 2003; 2004). This has been recognised, and the number of organisations attempting to meet the needs of the South Asian community using therapist-client matching is certainly considerable. Hence, exploring therapist-client matching in this area would open doors to not only building knowledge on the experiences of the therapists but also their experience of matching when it is carried out on a number of levels, which is commonly done in organisations to cater for the needs of South Asian clients.

Therefore, I attempted to concentrate on this area, an area which is under-researched, by using Grounded Theory. Grounded Theory will enable me to explore how South Asian therapists working in the voluntary sector understand their moment-by-moment experience of counselling South Asian clients who have been 'clinically matched' to them and their service on a number of levels, such as ethnicity, religion, language and gender. Grounded Theory was applied in order to attempt to create a theory from the ground upwards based on the data collected. This theory will then be shared by a number of South Asian therapists.

In the development of the question, I consulted lecturers and my supervisor about the question at hand and discussed the appropriateness of using the question to successfully target my aim. As suggested by Willig (2008), I was careful to ensure the question was realistic and did not expand to areas which I was incapable of investigating due to time pressures and limited resources.

In following guidelines by Glaser and Strauss (1967), the research design which emerged ensured that it allowed flexibility but was grounded and attentive to the phenomenon it was investigating.

2.3 Use of self in research

From the commencement of this research, I was fully aware of the position I took in the process as a 23-year-old British Indian trainee Counselling Psychologist who had experience in the realm of what was being explored. In line with Charmaz (2006, p. 16), my prior knowledge helped guide the process as my 'background assumptions and disciplinary perspectives' allowed me to attend to certain possibilities within the data collection process. This position also helped to intensify my ability to pursue different ideas and concepts, whilst I also stayed open-minded and grounded within the participants' narratives.

Another reason to outline the position I held was significant when introducing participants to the research. Madil, Jordan and Shirley (2000, p.10) discussed the inevitability of the impact of one's personal and cultural perspectives on the project and further stated that this process creates empathy based on shared humane and cultural understanding which then facilitates an 'important bridge between me and the participant' and can be a useful analytic resource. This

is something I experienced and found to be a functional tool in allowing narratives to unfold in the data collection stages.

Being able to use myself in the research, I ensured that, from the outset, I was able to outline what were my assumptions and preconceived ideas about the research area and about the therapists I was going to interview. As Hurst (1999) suggested, this enabled me to ensure that my knowledge about the research was in line with my epistemological stance and also the impact my assumptions would have on the data collection, analysis and overall research process.

The assumptions and preconceived ideas that I held were:

1. Therapists who were going to be interviewed all held different ideas about what being 'clinically matched' to their client meant and the notion of similarity. Their ideas and thoughts were constructed thorough their own clinical and personal experiences.

2. Therapists who were being interviewed were all willing to share the experiences of their work and their reality with me. They were all aware of the aims and would be open to talk about their personal constructions of the reality they lived in when working in the therapist-client matching service.

3. The theory that would emerge from the research would be beneficial to the world of Counselling Psychology and would be of interest to fellow therapists who worked in a setting where they were matched to their clients on more than one level.

4. My position and identity would influence how interviewees felt discussing their experiences and, hence, would impact the concepts and theory that would subsequently emerge. Also, capturing the reflection on what was constructed from what was heard would be fundamental to the trustworthiness of the analysis.

5. By using Grounded Theory, I would be able to construct an overall theory that would encompass the dominant narratives at the data collection stage and would detail relationships between concepts and categories that emerged. The theory would then be accessible to all those interested in the phenomenon.

Reflexivity: use of self in research

I felt it was imperative that I was able to be realistic about my position in this research. I do believe that, on setting out, I was naive about how much impact I really would have on my chosen topic and research question. I was aware that my passion for this community, due to my own ethnic background and my own clinical experiences, was my driving force in conducting this research. Acknowledging that this passion and stance are important and much needed in completing doctoral research, I was also aware that by using Grounded Theory, I needed to pay particular care to how much I used my 'self' as a South Asian therapist and how much I used my 'self' as a curious human being, as an academic researcher.

Whilst planning my method and analysis process, I was keen to follow Grounded Theory principles and therefore knew that it was important that the theory emerged solely from the interviews and not from my personal point of view. Therefore, accepting who I was and what I was bringing to this research and stating it explicitly took some tension away around hiding it or ignoring it. I also believed that being honest and acknowledging what I was feeling and what I might assume about this topic in hand showed maturity and realism about my position in this research process.

Adopting a reflective stance

I chose to adopt a reflective stance throughout the process of carrying out the research. I was aware of the emic vs. etic culture and, hence, was considerate that whilst participants could hold an emic stance, they were South Asian therapists who worked with South Asian clients and so were seen to be part of the phenomenon being investigated; as such, they could also present themselves as etic. In other words, they were willing to be the observer on the outside of the phenomenon, who was 'stepping' into the phenomenon to observe certain realities and experiences held by South Asian therapists. In exploring this, I came to an understanding that holding either stance would not be possible; instead, therapists were presented along a continuum between the two stances and so needed to be consciously aware of what position they held and when, in minimising bias. Taking this position and being reflective of this and the overall process, I believed they were able to attend to their experiences, thoughts and pre-

existing beliefs about the phenomenon under investigation. Being able to be critically reflective helped me to consider their position throughout the research and the impact they may have on the process.

Therefore, by using the space to be reflective, and by using supervisory discussion and attention to the data being collected, I was able to minimise the impact of bias in the analysis of the data as I became more conscious of 'bracketing' myself from the process itself and only using my own beliefs to spark curiosity and exploration of the theory that was emerging.

Reflections were documented in the form of reflective diary entries. These were used in supervisory discussion and as a way of outlining assumptions, preconceived thoughts and ideas I may have held.

2.4 My epistemological stance

To be able to gain an in-depth understanding of how South Asian therapists make sense of their therapeutic work in relation to matching with South Asian clients, I proposed to apply a social constructivist framework to a qualitative research design. Qualitative research is seen to be the 'best and richest for theorizing about social structures and social systems' (Glaser & Strauss, 1967, p. 17). Therefore, I felt that qualitative research would allow me to retrieve depth in the data obtained and understand the 'social' structures therapists apply within the experiences of their work.

Willig (2008), Charmaz (2006) and Goodman (1978) all concurred that by holding a position as a social constructivist researcher, you strive to understand that there is no one absolute *'knowledge'* but rather, there are a number of '*knowledges*' and that these are drawn from human experiences. Therefore, holding this position is then concerned with exploring ways in which individuals are able to construct their 'knowledges' within the reality they live in. Experiences such as the culture they adopt, the language they speak and the emotions they feel can all be socially constructed from their own interpersonal relationships and understanding of their very own reality (Willig, 2008); as such, according to Charmaz (2006), all humans are active and reflective in retrieving and producing meaning to the world they live in, and from this meaning, knowledge of who they are, what they think and feel is constructed (Willig, 2008).

Consequently, by using Grounded Theory, I applied a social constructivist stance on my research and endeavoured to understand one's experience of a reality that is observed and shared by many.

Reflexivity: my epistemological stance

I was keen to take a position in this research where I was able to explore the realities lived by South Asian therapists. I felt comfortable knowing that taking a social constructivist stance would allow me to immerse myself in this process. I also believed that taking this stance would allow me to highlight the impact of social interactions (through therapist-client but also interviewer and interviewee) and how each individual makes sense of these encounters.

I knew throughout these interactions (interviewer-interviewee) that I ran the risk of exerting an 'expert' view on the topic or making assumptions, thus preventing interviewees from fully exploring. I therefore chose to document and bracket through reflections and memos. In addition, I felt comfortable realising that in my own clinical work I hold the responsibly of assuming things about my clients, but I have developed skills to work through and manage this. Therefore, I felt confident that using my therapeutic skills to form strong relationships to gain permission into their realities, with my own passion included, would facilitate a strong interviewer-interviewee relationship.

2.5 Grounded Theory

It was Glaser and Strauss (1967) who first systematically assembled Grounded Theory methodology and, since then, it has been commented on and developed by many (Corbin & Strauss, 2008; Charmaz, 2006). Grounded Theory is seen to allow a theory to emerge from the data, hence ensuring the theory is solely embedded in the data collected. The method is carried from a constructivist perspective, which allowed me to start from the beginning with no previous analysis. Space is created for a 'comprehensive and systematic framework for inductively building theory about a phenomenon' (Strauss & Corbin, 1998). Willig (2008) described how Grounded Theory facilitates the process of identifying the meaning from data, creating codes for this and placing them in categories. The process of understanding these

and investigating the relationships between them then go on to form a framework of the overall theory.

A grounded theorist integrates and systematically carries out comparisons between data to inform emerging theories. Data is typically collected through interviewing methods and then coded. Analysis is then developed by grouping information and frequently occurring codes to form categories. These categories are constantly reviewed and compared with newly merging categories from continuous data collection. Categories identified at the end of the grouping codes process form the basis of the overall emerging theory based on the phenomenon (Glaser & Strauss, 1967). The method is recognised as fundamentally interactive and an annotative method; hence, using this method allows me to remain active and fluent throughout the stages of analysis with freedom to be reflective and take notes of thoughts, ideas and challenges with the process (Charmaz, 2006). Overall, Grounded Theory is best conceived as a method that is integrative, interpretive and interactive.

Social constructivist perspective

As previously noted, Grounded Theory has been adapted and reviewed many times as new theorists come to use and adapt the principles originally stated by Glaser and Strauss (1967). For the purpose of this research, I followed the principles laid out by Charmaz (1990, 2006) and therefore followed a social constructivist adaptation of Grounded Theory.

The social constructivist adaptation concurs that Grounded Theory allows the examination of human portrayal of experiences and that any knowledge is socially constructed. Therefore, Charmaz (2006, 2009) conveyed that the process and practices entailed in using Grounded Theory are also impacted by me and the participants' social interactions and knowledge. Charmaz (2006, p.16) also stated that allowing prior knowledge that I may have will guide the research process as their 'background assumptions and disciplinary perspectives' allows the grounded theorist to attend to certain possibilities and processes within data being collected. My interest here not only intensifies their interest in the topic, but I also strongly believed that my knowledge would help me to pursue different ideas and concepts within the interviews, and as long as they remain open, I would be able to stay 'grounded' in the narratives.

Therefore, in line with the above explanation and understanding put forward by Charmaz (2006, 2009), I felt that this best fit with my epistemological stance and understanding of my

position within the data and how I was able to make sense of and construct my own understanding of the phenomena I was about to investigate.

Traditional version vs. abbreviated approach of Grounded Theory

Due to the time pressure and limited resources, I became concerned about how effectively I would be able to use the traditional version of the Grounded Theory that involved seeking out categories and theories until development of these become saturated and/or dense. Therefore, I followed what Willig (2008, p. 39) stated as an 'abbreviated version of Grounded Theory'. This meant that I was only concerned with original data collected. All analysis followed the traditional principles of Grounded Theory: initial coding, focused coding, and so on, to allow a theory to emerge. The abbreviated approach was used when, instead of committing to the traditional process of theoretical sampling and saturation, the saturation stage was artificially imposed on the data collection process. Also, as Willig (2008) suggested, I dedicated my collection process to data that emerged from semi-structured interviews.

Reflexivity: use of abbreviated version of Grounded Theory

I am aware that committing more time to the analysis and data collection process would have allowed me to develop a more robust and comprehensive theory.

With more time, I acknowledge that some possible themes could have emerged from the data set. I do feel frustrated at the thought that, by conducting only eight interviews due to course restraints, I may have missed out on further in-depth insight. I accept this as a downside and as a possible future recommendation.

2.6 Grounded Theory: Rationale for choice of methodology

Outlined below are my explanations for the use of Grounded Theory as a qualitative method compared to the use of other qualitative methods.

Research Question – striving to explore in-depth meaning

The research question aimed to explore South Asians therapists' understanding of the meaning of their lived experiences of counselling South Asian clients, and how they worked

with ‘matching’ on multiple levels. Grounded Theory enabled me to examine ‘novel understanding’ of these experiences and capture *how* therapists understood their reality, thus allowing the theory to materialise (Stern, 1994 cited in Strauss & Corbin, 1998, p. 11).

Understanding their ‘in the moment’ reflections

By using Grounded Theory as a method of analysis, I was able to explore the ‘what is, not what should, could, or ought to be’ (Glaser, 1999, p. 840). Hence, I was exposed to the present, in-moment experiences lived by South Asian therapists. This provided a rich, deep and accurate understanding of their reality of their experiences, and what it meant for them to experience it.

Grounding a theory based on the narratives explored

I desired to use the data obtained to produce a theory based on the information revealed by the analysis of data collected. Producing this theory would then bring together a broad understanding of the shared reality of South Asian therapists’ experience of working in therapist-client matching services. Strauss and Corbin (1998) stated that Grounded Theory is able to create this ‘space’ for a ‘comprehensive and systematic framework’, which will facilitate the building of a theory about a phenomenon. Therefore, therapists’ understandings and meanings could be merged together to outline a phenomenon. This phenomenon would be ‘grounded’ within the narratives, and accurately represented and shown within the categories that uphold the theory.

2.7 Methods of Data Collection

In-depth semi-structured interviews

Semi-structured interviews were favoured as the method to collect data for analysis. In line with the research question, I had entertained the idea of using recorded sessions and/or focus groups. However, both were deemed inappropriate as methods, following Flick (1956, 2009), who argued that, with recordings, researchers are placed in a position where they are asked to deduce meanings and, hence, could paralyse the process of pure exploration with the participant. Focus groups were also ruled out as I felt that this could hinder a natural exploration process, as there was a fear that the participants who were therapists may withdraw from exploring truthfully whilst in the presence of their peers. This has been noted

by Litosseliti (2003), who suggested that there are possibilities of peer pressure to reach consensus in discussions and to not voice opposing views due to fear of standing out.

I felt that using semi-structured interviews would allow me to achieve natural, open and subjective narratives that would provide a rich and detailed account of the participants' experiences in relation to the research question. Conducting the interviews with a degree of structure enabled a level of focus in the interviews and provided a foundation upon which discovery and exploration then grew. Willig (2008) expressed that the benefit of using semi-structured interviews is that they are able to achieve an appropriate balance between flexibility within exploration of the narratives and the research area and a degree of focus and boundary within the interview itself. I also felt confident about using semi-structured interviews within Grounded Theory as they both had a common interest in exploring the reality of the interviewee. Charmaz (2006) also stated that an interview provides the space for participants to construct or reconstruct their reality in which they live and, thus, allows narratives to be fully grounded within their subjective experiences.

Finally, I was interested in using a method in which researchers were able to exercise their counselling skills in order to facilitate a natural and comfortable environment for the participants being interviewed. This was achieved by using the interview to allow space for participants to also question the actual research question being put to them, and then ask any question or express any worries they may have had about the interview. By using empathy and the counselling skills I possessed, I was able to create an atmosphere that was comfortable. Willig (2008) mentioned that being able to create such an atmosphere is crucial to the success of gathering rich data.

Research interviews began in March 2012 with a total of eight participants. Each interview lasted between 45 and 60 minutes and was recorded for the purpose of analysis. I was able to take notes of any further observations and changes, such as emotions and comfort level. Wilson et al. (2002) suggests this practice as taking notes allows the researcher to increase and validate the credibility and trustworthiness of the data collected.

Interview schedule

To provide direction to the interview, an interview schedule was used (Appendix Five). The interview schedule contained open-ended questions and refrained from the use of leading questions that could influence the interviewee. The interview schedule attempted to outline

points that were the most obvious to explore in the first interview, and then changed to outline points for interviews thereafter. The schedule was extremely helpful in giving me confidence to explore certain topics and areas within the therapists' narratives. It was also used to help prevent an absence in focus occurring, where I could easily get distracted in wondering what questions to ask (Charmaz, 2006) and subsequently lose the opportunity to gain valuable data. I was open to changes, and as data collection progressed, interviews became more focused and structured to allow theoretical data collection and to fill in conceptual gaps that were emerging.

I found on many occasions that participants unexpectedly answered questions that were part of the interview schedule, and on these occasions, as suggested by Fylan (2005), I changed the course of questions accordingly in order to adapt to the stage the participants were at in exploring their experiences. At certain points in the interview, I used 'cues' as the data collection progressed and I found myself becoming more focused and connected to the participants' experiences. This enabled further grounded examples to emerge from each individual's experiences. Examples of such cues were: 'Could you give me an example to describe that?'

Non-verbal cues, such as nodding, smiling and maintaining eye contact, were also established as a way of facilitating a rapport to build upon and, as expressed by Barker et al. (2002), these were helpful in allowing participants to feel understood and welcome to share their experiences, intimate feelings and thoughts in a safe and accepting space.

I felt that having the openness and flexibility to change the interview schedule highlighted my willingness to stay in tune to the theory and concepts that were emerging in the data collection process. Being able to commit to this process was crucial in allowing concepts to be grounded in narratives shared by the participants during their interview (Charmaz, 2006).

2.8 Research Participants

Sampling characteristics

I used the process of 'purposive sampling' to recruit participants for the data collection. Purposive sampling is a sampling method whereby certain cases are handpicked that present the desirable characteristics needed to gain relevant information for the topic under

investigation (Charmaz, 2006). Therefore, I used sampling to find South Asian therapists working in organisations where counselling is provided to South Asian clients and who were 'matched' to their clients on the basis of more than one of the following: religion, language, ethnic background and gender. Recruiting was restricted to London and selected surrounding cities; this was due to the limited financial resources to which I had access.

In total, eight participants were interviewed, and the interviewees consisted of ten females and two males ranging from the ages of 25 to 66. In line with the research question being asked, all participants needed to be able to identify themselves as (1) a therapist and (2) South Asian in order to meet the 'inclusion criteria'. In line with theoretical sampling, I ensured that all participants were able to identify with what was being asked in the research question and were able to share experiences directly in exploration of what I desired. All participants spoke fluent English and were able to read and write. This was an important element of the inclusion criteria, as it ensured that all participants were able to provide me with informed consent to take part in the research.

All participants worked or had worked in an organisation that clinically matched their clients to the therapists based on gender, age, religion, culture and language. Therapists were specifically chosen if they had direct experience of working with clients who had been matched to them on numerous levels, specifically to allow full exploration into the chosen research field.

Recruitment process

Therapists were contacted through their organisations, using the search engine Google. I sent out an invitation letter (Appendix Two) along with information about the research (Appendix Three) and the proposed consent form (Appendix Four), which they would need to sign should they wish to take part. Contact details were provided on the invitation letter. On all occasions, invitation letters were received by the manager or director of the organisation, who then passed on details to the counselling team. If no contact was made after this, I withdrew that organisation from the potential recruitment list.

On all occasions, therapists that took part initially contacted me via email to show interest in taking part, having read the invitation letter. Once contact details were shared, I contacted the participants by phone to arrange a suitable time and place to meet in order to conduct the interviews. This was recorded on the interview log and also sent to my supervisors to ensure

they were aware of my location when interviewing. Also, at this stage, any initial worries or questions regarding the interview were also addressed.

2.9 Overall Interview Process

For each interview conducted, I followed the same procedure each time to ensure that all ethical considerations were followed throughout (Willig, 2008). Before starting the interview, I would read through the information sent out in the initial contact again to ensure that the participant had full understanding of why the interview was being conducted. Following on from this, if the participant had any questions regarding the interview, I gave space here to answer and discuss these. Once the participant was happy to continue, I talked the participant through the consent form and asked the participant to sign their signature and the date. A copy of the consent form was given to the participant and one kept for me. The audio recorder was then placed and switched on and the interview was carried out by following the interview schedule.

Interviews lasted 45 to 60 minutes. The interview schedule was followed in order to provide focus; however, flexibility was adopted to allow participants to freely explore what they wished in relation to the research questioned being asked. If at any time the participants did not wish to answer questions or did not pursue further exploration, I respected this. Whilst all interviews were audio-recorded, I also kept notes throughout the interview. These notes consisted of any non-verbal observations, such as the participant's body language. These notes formed part of my interview memos (Appendix Seven).

Following ethical guidelines, once all interviews were completed, all the participants received a debrief letter (Appendix Six). The letter explained the reasons why the interview was conducted and my aim in generating a theory on how South Asian therapists work with South Asian clients in a therapist-client matching service. During this process, as advocated by Willig (2008), all participants were invited to reflect on the process and any insightful information was recorded in writing by me.

Post interview, I took time to complete a set of memos which allowed me to reflect on my process during the interview and any significant thoughts and ideas that had emerged during the interview (Appendix Seven).

Reflexivity: Recruitment and interview process

I was really worried about the recruitment process to begin with. Knowing that there are few organisations that offered matching, and with the climate of organisations facing cuts, I knew that many would turn the down the chance to take part.

However, I found the recruitment process really enjoyable! I do feel that by them acknowledging me as a South Asian therapist, this helped with recruitment, as many were interested to meet me and to see from what perspective I was conducting this research. I feel that I managed to use the idea of offering space to reflect on practice and voice their thoughts as a way of enhancing the recruitment process overall.

Out of the 20 organisations I contacted, 7 responded and were keen to share and take part. Recruitment did get easier as, firstly, therapists would speak to one another and then ask if they could take part: this made me feel really good! I felt happy knowing that interviewees were getting something from the process too.

Equally enjoyable was the interview process. I think I did fall for approaching interviews as therapeutic encounters to begin with, but with practice and reflection, I was able to critique my style and the position I took.

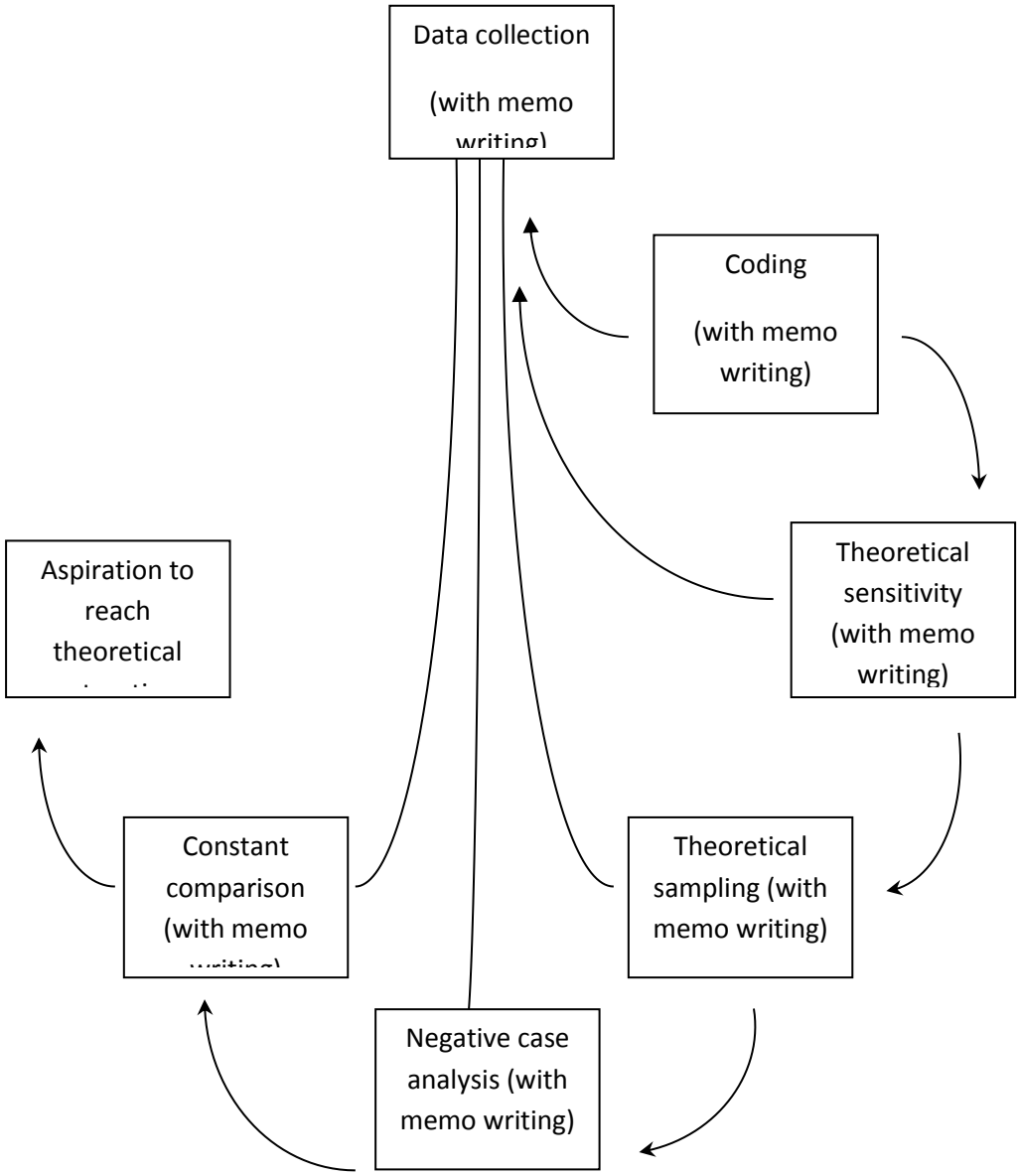
I was constantly aware of remaining curious and investigatory in the process. Once again, reflection and memo writing really helped to facilitate this process. There were times when interviewees wanted me to participate and indulge in hearing my own experiences. It was hard to refrain from doing this and to collude with them on their experiences!

2.10 Analysis of data

Once interviews were conducted and transcribed, I proceeded to analyse the narratives collected. This was done by following the process of coding, memo writing and producing themes. Coding was carried out to 'generate the bones' of the analysis (Charmaz, 2006, p. 45) and entailed two main phases: initial coding and focused coding, carried out line by line (Appendix Eight). Both allowed the synthesis, integration and organisation of the large amounts of data collected. Once this was done, memo writing processes revisited codes and further analysed the data to note groups and categories. This process of coding to memo

writing was carried back and forward, hence following a flip-flop process known as the cyclic process (Fig.1). The traditional process of analysis in Grounded Theory is shown below, and this was followed as closely as possible within the constraints of the abbreviated version of Grounded Theory (Willig, 2008).

Figure 1: Pandit (1996): the cyclic process of analysis in Grounded Theory



Coding

Analysis of the data collected began with the initial process of coding. As Willig (2008) described, this process is largely descriptive to begin with and entails attaching evocative labels to emerging instances of phenomena; this phase was the initial line-by-line coding. The process then moved to identifying subsequent categories that emerged, starting from low-

level categories moving to high-level systematic categories. This encompassed the focused coding phase.

Initial line-by-line coding

The main principles of initial coding were to allow me to remain open to explore any theoretical possibilities that emerged from the data. This step is critical in informing later stages of analysis as initial coding helped in the decision-making process of identifying core conceptual categories (Charmaz, 2006). As advocated by Charmaz (2006), I remained very close to the data and labelled each line/segment of the transcripts from the interviews. Each label reflected meaning or action that was conveyed in that part of the narrative, thus allowing labels to crystallise participants' experiences. I worked hard to ensure that codes were able to identify meaning *from* the data, rather than applying meaning *to* the data. This was highly important, as both Willig (2008) and Charmaz (2006) noted that being able to stay rooted in the narratives and data from the interview allows pure labels to emerge. This would then also allow me to fully immerse myself in the social constructions of the participants' reality and their world without bringing in my own assumptions, preconceived ideas, experiences and thoughts.

Overall, the process sparked interest and discovery, which then progressed to in-depth exploration of all the data collected. Working quickly yet effectively, as suggested by Charmaz (2006), meant that I could view the data fresh, capturing instant feelings and ideas.

Focused coding

Focused coding facilitates the process of condensing analytic codes. The process involved going through the initial labels and drawing out the most significant and frequent codes that would enable me to establish analytic direction and categories. As Charmaz (2005) proposed, this phase required me to make decisions that followed analytic sense and, also, as stated by Hesse-Biber et al. (2010), allowed me to shift from the research field to a more directive and analytic area that corresponded with the research question at hand. The process was also useful in scrutinising the data to then outline strong focused categories that best explained or interpreted the phenomenon (Appendix Eight).

Theoretical coding

The final stage of coding required sophistication and thoroughness; it entailed the process of exploring relationships between themes developed from the focused coding stages. During this stage, I was able to outline codes that could connect with each other and could convey an analytic story according to the phenomenon being explored. As suggested by Charmaz (2006), the theoretical codes were able to 'fit' coherently, allowing me to convey embedded relationships between the codes found during focused coding. Glaser (1992) stated that theoretical codes should be able to 'weave the fractured story back together' (Glaser, 1978, p. 72) and so I found that whilst exploring the relationships between codes, I could formulate analytic schemas that explained the reality that South Asian therapists experienced.

Memo writing

Throughout the analysis stages, I was committed to the process of memo writing where I was able to note and outline emerging thoughts, ideas and information about codes and the development I followed through at each stage. This was a crucial and very informative process as it provided rationales and also underlying thoughts of why, how and what I was progressing through whilst analysing the data I had collected.

Willig (2008) stated that memo writing is one of the most important stages of analysis and can be an important step in tracing ideas and relationships of codes that emerge as analysis is carried out. Glaser (1998) also stated that committing to this process allows one to be fully immersed in the research process itself, thus allowing the researcher to stay grounded in the ideas and concepts that interviewees developed about their phenomenon.

Memos were written throughout the research process (Appendix Nine) and were noted with dates so that they could be identified by their relation to each stage of the research. They were free-flowing and allowed me to capture comparisons and connections and, as Charmaz (2006) proposed, the notes allowed me to keep in mind directions and avenues within the research that I wanted to pursue. As Kelle (2010) and Charmaz (2006) anticipated, the memos also served as analytic references and, on reflection, provided knowledge of how an emerging theory was produced. Alongside analytical memos, I also kept a reflective diary, allowing me to reflect on personal challenges, thoughts and achievements within the research.

Theoretical sampling

The theoretical sampling process was carried out with great care and I was conscious of ensuring that this step was carried out as a cyclic process suggested by Pandit (1996). Willig (2008) stated that this process allows the researcher to continuously compare the emerging theory with reality, thus helping the theory to stay grounded. Accordingly, this process required me to concern myself with refining the categories, labels and data. The process allowed me, as Hesse-Biber et al. (2010) had suggested, to extend and push the boundaries of where I was collecting data and recruiting from. Therefore, I was inclined to sample incidents that elaborated upon or appeared in contrast to incidents already examined. This motivated me to test the robustness of the emerging theory and, also, as Charmaz (2006) directed, allowed me to gain an overall insight into the phenomenon being investigated. I was able to do this by making sure that I reviewed narratives and sought to interview therapists whose narratives could bring something different to the data already collected. Hence, I followed Negative Case Analysis (Willig, 2008). The sampling was monitored and carefully selected from those that responded, and reviewed to ensure that narratives brought different incidents and examples to the fore, and expressed different views. This ensured that the theory emerging from these narratives would provide a whole understanding of the complexity and variations in realities that were being experienced within this phenomenon of working within a therapist-client matching service.

Theoretical sampling was also used to guide further data collection, where needed, to ensure that attempts were always made to attend to gaps in the emerging theory. As advocated by Pandit (1996), I transcribed all interviews and ensured that whilst carrying out line-by-line coding I made every attempt to stay close to the transcripts to ensure any meaning identified was fully grounded in the participants' narratives. Thus, constant comparisons and reviews of categories to codes to labels and back were made.

Theoretical saturation

In Grounded Theory, saturation signifies the ending of the data collection process. Glaser and Strauss (1967) described this process as being when no additional data can be found and all important gaps in the theory are now filled. Saturation is also achieved when no new emerging labels, concept and categories/themes are found and so the researcher is in a

position to stop interviewing. Reaching theoretical saturation was achieved under different circumstances during this research. I was under the pressure of a deadline and also had limited access to resources. Therefore, from the commencement of the research, I was aware that theoretical saturation, as outlined by Glaser and Strauss (1967) above, was an ideal concept but would not be the desired outcome under the circumstances I found myself in. Hence, as discussed earlier in this chapter, I followed an abbreviated method of Grounded Theory by which saturation was achieved artificially after eight interviews were completed. As Willig (2008) argued, artificial saturation should only be used when the researcher is under time and resource constraints.

2.11 Data analysis and process

In total, eight interviews were carried out: the first six were carried out consecutively and the last two followed after transcribing the first six. This was done as I wanted to fully immerse myself in the data collection process. Being new to Grounded Theory, I was eager to investigate the chosen field and was enthusiastic about exploring the narratives with a desire to build and facilitate a new theory within the phenomenon.

As advised by Mills and Birks (2014) and Charmaz (2006), after completing each interview I would write down a series of memos to capture immediate insight into themes, thoughts and concepts. The memos also served as a reflective space for me to note down post-interview observations of self and the interview process as a whole. I also found it helpful to reflect on each interview as it provided me with space to comment on the interview style and skills used. The reflection for each interview also helped me to either alter the style of the interview or the interview schedule, thus allowing the evolution of the interview schedule to help guide analytic direction in data collection. Memo writing also informed the process of theoretical sampling, as I became more robust and direct in reaching out to different participants in order to grasp a wide variety of narratives.

Each interview was transcribed verbatim and all identifiable information was omitted. The process of initial and line-by-line coding was performed following Charmaz's (2006) suggestion. This was carried out quickly yet effectively in order to grasp immediate insight and knowledge, as well as to ensure that interest was built and curiosity with the theory emerging was kept alive (Rennie, 2000). I then continued to use Grounded Theory method

principles to develop the analysis. Constant comparisons of old codes to new codes were made to allow categories to be formed from low level to high level. The process of refining and attaching relationships between categories was also advocated and carried out (Willig, 2008).

Data collection took place between March 2011 and November 2011. Throughout the process, as discussed above, I observed close scrutiny with data to ensure that all analysis carried out was grounded within the narratives. Theoretical sampling and sensitivity was advocated throughout.

Reflexivity: Analysis

As advocated by Charmaz (2009), I made great use of reflexivity to constantly review the data analysis and collection process. I mention that by reflecting on the process, biases and assumptions made can be catered for. The process of doing this will allow true discovery to emerge. However, I was not so naïve as to assume that my own subjections and interpretations would have no impact on the themes and overall presentation of the model.

The process of analysis was a hard one! I constantly went back from the original narratives to codes, to themes and then back to codes. I struggled with judging at which point I had enough codes and feared that I was not truly representing each account truthfully. I had to trust that the themes that were emerging were sufficiently enriching and were true representations of the data collected.

Once I was able to establish codes and themes, the process of bringing these together for the theory and model was a real challenge. I think I had a lot of anxieties about it not looking neat or comprehensive, and I worried immensely that the model did not cover enough or did not have substantial depth. I also held worries that I had simply scratched the surface of South Asian therapists' experiences and that with more time and following traditional Grounded Theory, I could have found more.

Having faith in my process, what I believed and the way I had conducted analyses allowed me to reach a point where I had enough courage to go on to write the results section. Having this faith and the comfort of knowing I was being truly reflective was empowering! I believe that this led to a shift in my analysis process, too, and I suddenly became liberated with regard to my own stance and position. I then became fully taken by the process of creativity and the interaction of results and analysis and became excited by the process of producing this theory that I had taken so much care over.

2.12 Limitations and transferability of results

I am fully aware that the Grounded Theory produced here was a result of the narratives participants explored and also the contribution of their own subjective thoughts, feelings and pre-conceived beliefs and identity. Hence, I acknowledge that the transferability of the theory produced here is purely limited to the narratives involved. This is further supported by Madill et al. (2000) and Drisko (1997), who stated that generalising results to a wider sample other than those involved would be a mistake, as qualitative research is based upon one's subjective knowledge and, thus, the theory upholds only those experiences of the narratives shared in the data collection process (Charmaz, 2009). Thus, the theory produced holds and conveys the experiences of those involved, and attempting to portray this theory as a way of understanding all those who are a part of the phenomenon (e.g. all those that are South Asian therapists) would be a critical error. Whilst I am fully aware of this position, I also believe and understand that the Grounded Theory produced here would still be useful in understanding the experiences of other South Asian therapists working with South Asian clients to some degree. There is a possibility that, for some readers, certain aspects of the results may resonate with their own experiences, whilst there may be some who experience their work in a polar opposite way.

Overall, in relation to transferability of results, I hope that in conveying this model and theory, ideas for the reader will be generated, and their own curiosity in their own experiences will be instigated, hence allowing discussion to occur with their colleagues and peers, enabling the whole therapeutic society to review, discuss and explore their services.

Another limitation ties in with the subjectivity aspect of qualitative research. As Morgan (1998) suggested, with any qualitative research, the researcher's position within the data can impose a threat to the 'objectivity' of their research. I highlighted earlier in the chapter that I do hold the position of being part of the researched sample and this gives rise to many concerns and possible limitations on the research. There is a risk of holding assumptions, bias and possible blind spots when it comes to data collection and analysis. In order to best manage this concern and limit the bias, I ensured that all aspects of my work were overseen by my supervisor who also had invested time and thought in the study. This allowed blind spots to be uncovered and challenged in discussion between us, thus allowing me to obtain some objectivity.

2.13 Reliability, validity and trustworthiness of applying Grounded Theory

Validity, reliability and trustworthiness are all seen as important in measuring the scientific rigour of qualitative research. However, as suggested by Henwood and Pidgeon (1992) and Willig (2008), there is a risk that in striving to simply apply the above concepts to research, and in particular to that research which takes a social constructivist stance, without understanding the process of doing so risks failing to explore the natural subjective process which all those who are active and present within their research would bring.

Furthermore, arguing against Pandit (1996), who stated that measuring the validity of Grounded Theory research is vitally important, Mandill et al. (2000) argued that whilst carrying out social constructivist research one is not able to accurately follow the process of measuring validity. Having a second reader verify and review analysis would simply bring a second set of subjective thoughts, ideas and beliefs held about the research, and there would be the slight possibility of both the first and second reader sharing the same two experiences. Thus, assessing validity using Grounded Theory is easily dismissed by Madill et al. (2000).

I held similar concerns when assessing the reliability of the research. As Henwood and Pidgeon (1992) explained, to ensure research is reliable, we must endeavour to show that our methodological process is one that can be replicated by another with the hope that if they had similar participants, methodological concepts, contexts and sample characteristics, they too would produce similar findings. Nevertheless, in trying to achieve this, do we risk eliminating subjectivity, and if we were to somehow achieve it, how would that actually come about? Is it even possible?

I found both validity and reliability hard concepts to understand and follow, but I made attempts to ensure that I was able, to some degree, to ensure a level of reliability and validity with results produced. As suggested by Wilson et al. (2002), a trail outlining decisions, procedures and audit was carried out and memos were written and shared in supervisory discussions after interviews and throughout analysis to ensure that a level of credibility and trustworthiness could be attributed to the overall process. Furthermore, I invited my supervisor to oversee the data analysis stages to ensure that concepts and the theory emerging best represented what the original data conveyed. I also made attempts to follow the criteria laid out by Henwood and Pidgeon (1992) in *Qualitative Research and Psychological Theorizing* as an alternative protocol in ensuring the trustworthiness of the overall research.

2.14 Ethical considerations throughout the project

To maintain ethical standards for the research, the project has been supervised by an experienced City University London lecturer. Before the research project commenced, I submitted a research proposal to City University London Ethics board. The board reviewed the proposal and approved the project with no amendments (Appendix One). Throughout the project, ethical considerations have been considered that are in line with the BPS Code of Ethics and Conduct (2006) and the BPS guidelines for Minimum Standards of Ethical approval in psychological research (2004). Throughout the data collection process and write-up of this research, the following areas have been considered and constantly reviewed.

Consent/information about the study:

All participants were given information and consent forms (Appendices Two to Four) prior to the interview. This provided them with details about the purpose of the research and why their participation was required. All participants were asked to review the information letter, and once they had sufficient understanding of the research, they were asked to sign a consent form (Appendix Four). There was an opportunity for all participants to ask questions and clear any concerns prior to the commencement of the interviews. Also, the right to withdraw at any point during the research was openly discussed and outlined in the information letter. There was an opportunity to ask any questions or seek clarity throughout any stages of this process.

Support and monitoring:

A debrief (Appendix Six) of the interview was given after interviews took place and there was a chance for participants to reflect on the experience and ask any further questions or raise concerns about their interviews. I was as transparent as possible about the potential risks involved prior to the interview and reiterated the importance for participants to seek support from their personal therapists (a list of independent therapists was provided to those who did not have one in place) to discuss any emotional difficulties following the interviews. None of the participants that were interviewed requested this.

I was constantly sensitive to the questions being asked and the movement of exploration within the interviews. I only explored as far as the participant was willing and I gave full right to participants to refuse to answer any questions.

Confidentiality and note-keeping:

All participants were advised and reassured that all information shared was to be kept confidential. Audio recording and any transcripts were stored and kept under a password file on a password-restricted laptop. Any consent forms and other hard copies were stored in a lockable cabinet. Any data used for the write-up of my doctoral thesis has also respected anonymity, and when sharing data with my appointed supervisor, anonymity has also been respected. Once the write-up of this research was completed, all data files, transcripts and any other materials that were not being submitted as research were destroyed.

Safety:

All interviews took place at the participant's place of work. Full contact details of the organisation, point of contact, contact numbers and full address of each participant's work place was logged and passed to my supervisor. Once interviews were scheduled, I informed the interviewees' supervisors of dates and times and where the interviews were to take place. This was to ensure safety for myself and allowed access for the supervisor should they need to intervene in an emergency. Throughout data collection and interviews, no emergency occurred and I was safe and in reachable contact at all times. All interviews took place during working hours and in a building where additional staff were present.

Chapter 3: Results

Overview of Grounded Theory Analysis and Model

3.1 Outline and presentation of the Grounded Theory model

The Grounded Theory model presented in this chapter is developed from data I have collected using the principles of Grounded Theory. The theory has evolved by drawing on vocabulary and expressions the therapists used during their narratives produced through interviews conducted by me.

The model is presented in Figure 2. It will continuously be referred to throughout this chapter. I aim to take the reader through all relevant parts of the model and will signpost the reader to each theme being discussed in the model by highlighting relevant sections as they appear.

There are three emerging lower level themes that operate in the background when South Asian therapists are working with South Asian clients in a matching service. These three themes are: (1) reasons and justification for working in a matching service; (2) constructing experiences through clients' experiences; and (3) support needed whilst working with South Asian clients**.**

1. Reasoning and justifying why therapists interviewed work for a South Asian matching service comprised of South Asian therapists gaining insight into their personal experiences and passion for the South Asian community as a way to convey why they chose to work with the community and in a service where matching occurred.

2. Constructing the value of their experience through understanding their clients' experiences involved therapists outlining satisfaction of their job role with regard to being able to meet the needs of their South Asian clients.

3. Support needed whilst working with South Asian clients incorporated therapists describing their own therapeutic needs in allowing them to work successfully in a matching service. Needs outlined were: gaining specialist cultural training in addition to qualification training and specialist supervision support, which consisted of choosing 'similar' supervisors and personal therapists.

I experienced each therapist's narrative as a story-telling process and, through this, the lower level themes were presented as a prelude to then allowing therapists to discuss higher level core themes (presented later). Therefore, these themes subsequently emerged as ***background or introductory themes*** that created a foundation level in understanding the therapists' experiences. I refer to these themes as inter-related since they collectively form the foundation to the experiences of the therapists interviewed. The arrows between these themes represent the relationship between each theme. It emerged that, collectively, the three themes gave rise to the construction of the higher level core themes. The introductory/background nature of these themes is represented in the Figure 2. (The three grey sections).

The higher level core themes convey the more abstract interpretations of South Asian therapists' experiences of working with South Asian clients in a matching service. Three higher level core themes emerged; these were: (1) acknowledging self-processes when working with similarities; (2) identifying internal conflicts; and (3) highlighting their level of experience.

1. Acknowledging self-processes involved therapists describing the process of assumption-making, working with attachment and the frustration experienced in identifying their role and the impact of particular levels of matching.

2. Identifying internal conflicts drew on the therapists' struggle between using two therapeutic hats: South Asian and non-South Asian, their struggle between achieving self-satisfaction through job role versus wanting to grow professionally, and the process of defining their professional role to other professionals.

3. Highlighting their level of experience incorporated therapists' understanding of their level of comfort as a South Asian therapist working in a matching service and also their ability to work with differences and bringing it into the therapeutic room with clients.

All three higher level core themes are presented in the red triangle in the model. This conveys how each high level theme connects with the other two and, collectively, how they produce the core understanding of the South Asian therapists' experience when working with South Asian clients in therapist-client matching services.

Within the write-up of the results, I will attend to each theme in turn, providing quotations from across all interviews and the data obtained. The themes will be presented in two sections: **Section 3.2.1, lower level themes** and **Section 3.2.2, higher level core themes**. Each theme will contain a number of sub-headings to convey how the theme as a whole emerged from the data set.

Memos completed from interviews and analysis stages from which this Grounded Theory has been constructed are included in the appendices.

Use of vocabulary and use of quotations

The term 'therapists' is used collectively to describe all interviewees who participated in the data collection process. The term is also used irrespective of job title, level of experience and/or theoretical background.

To provide a representation of the narratives collected from the therapists, I used quotations taken directly from the narratives. Quotations are presented numerous times and may overbalance my voice. This is to ensure that the Grounded Theory model presented here is truly based on the therapists' voices and experiences alone.

However, I would still like to share my personal position throughout this chapter and to voice personal thoughts and reflections on emergent themes and the process of establishing the Grounded Theory model. This is shown through reflection boxes and they will be presented periodically after section one, then after section two, and then at the end to convey overall reflections on results and the model.

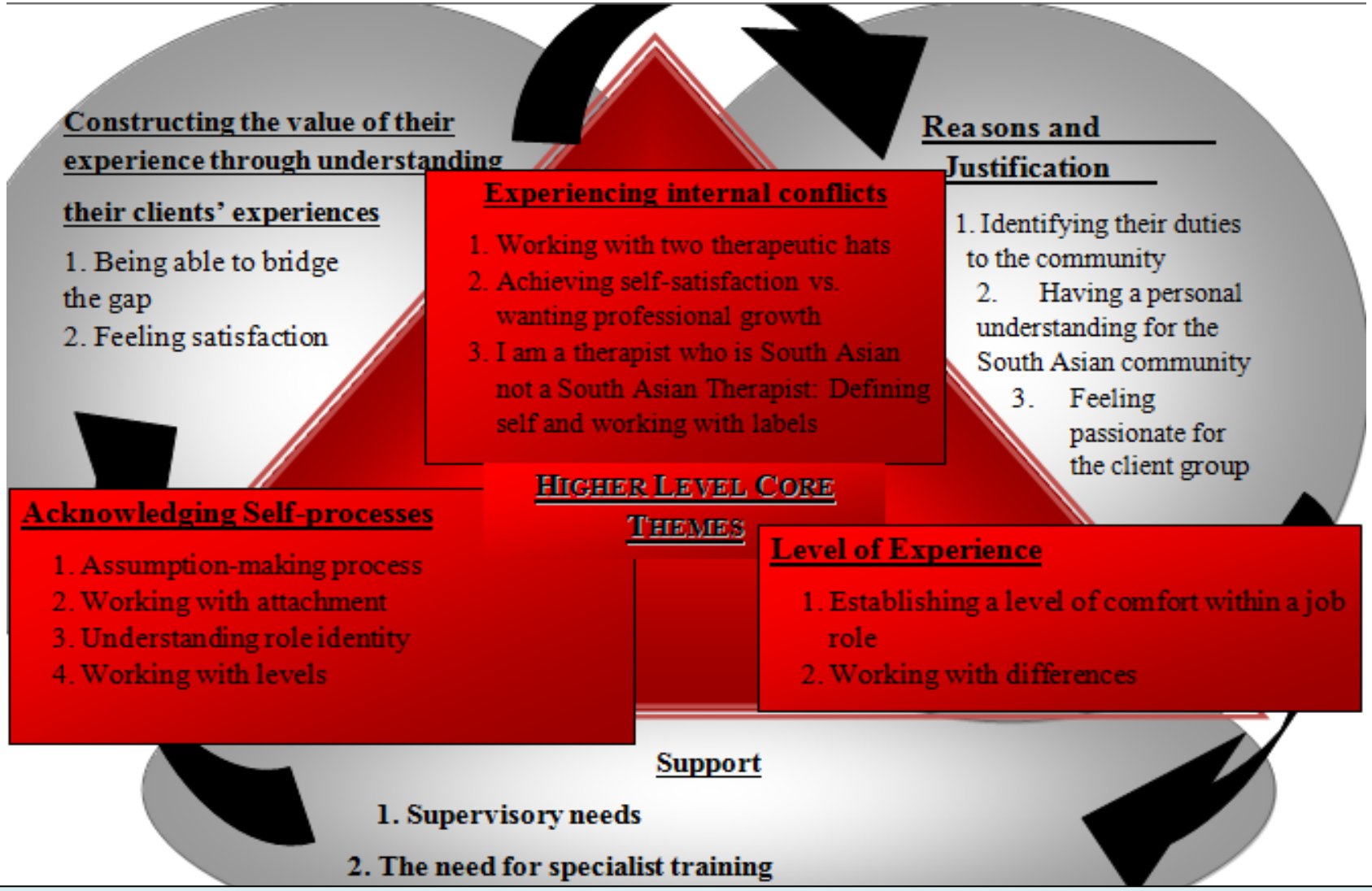
All quotations used from the narrative are provided throughout this chapter in *italics*. To convey a flow whilst still hoping to retain clear meaning, utterances such as ‘umm’, ‘er’ and ‘erm’, repetitions and non-starting sentences, have all been omitted.

Each quote will be presented with a code, for example, 01:10. This code allows me to sustain the interviewee’s anonymity, but also allows the reader to know which interview the quotation has been taken from; for example, the code 01:10 indicates the quote was taken from interview 01 and from page 10 of the transcript.

Where quotations have been used from more than one part of an interview, all page numbers from the transcript for those quotations will be shown, for example, 01:3,7,8.

Figure 2: the Grounded Theory model:

How South Asian therapists experience working with South Asian clients in a therapist matching service



KEY: the grey sections indicate the lower level themes, known as the background/introductory themes, and leading into the emergence of the higher levels themes. Higher level themes are represented in the red boxes attached to the triangle, indicating that they are the core themes which allow one to understand the experiences of South Asian therapists.

3.2 Lower level themes

1. Reasons and Justification

When starting to explore participants' experiences of working with South Asian clients, all therapists began by exploring the reasons for why they had chosen, decided upon or sought out a matching service in which to work. This was a profound emerging theme as all therapists explored this and made this a central foundation of their experience. Their experiences of this were captured in three distinctive ways. These are set out as follows.

Identifying their duties to the community

Therapists felt that due to their background and identity of belonging to the South Asian community, they could understand the needs the community had with regard to receiving counselling. Being able to meet the needs of the community and having this insight and awareness was seen as a key aspect to feeling it was their responsibility to work in a therapist-client matching service with them.

"I'm aware of the need for this community and if I can do something about it, it is my duty to do it."

(02:3)

"I was passionate about being involved and knowing I could do something because I am from their community, I can understand their needs, and it was my responsibility to act."

(07:2)

"It is a privileged place to be in from my perspective and I can offer a service that is not offered anywhere else and I love that. I am able to do it so why shouldn't I?"

(03:3)

Therapists could also see the struggle that individuals from the South Asian community experienced in accessing mainstream services. They believed that sharing 'similarities' and being able to present a service to which people could gain access also contributed to the feeling of 'duty' in working for a matching service for South Asian clients.

"And actually a lot of women I see they would normally not go to a normal service and I feel that there are so few services for women that are South Asian that can be seen by another South Asian woman who is of the same religion, speaks the same language and the rest of it. So, the fact that there is one here for them, I think that is a fantastic thing. If I fit this and can help this to happen, I felt like I should and so I did."

(08:1)

"I will do whatever I can to my community to help them in distress when no one else can help or dismiss them."

(06:4)

Having a personal understanding of the South Asian community

Therapists felt their decision to work with clients from their community also came from their own experiences and direct understanding of what it must be like for South Asian clients who were experiencing problems.

"Having that understanding and what that must be like for them [South Asian clients], and how isolating and frightening and lonely these things can be when you can't go to mainstream services because they don't understand, I have been there, I get that."

(01:6)

Therapists also spoke of their own personal experience of counselling and held this as another reason for wanting to work for the community. Many felt that their own experiences had been negative, where seeing a non-South Asian therapist led to difficulties in being understood and having a productive counselling experience.

"I found that when I had to find my own personal therapist, I found it really hard to find someone who was South Asian. So I guess for me it is my own interest to sort this out!"

(05:1)

"I remember from my training when I had to go to therapy I had a non-Asian therapist and I deliberately chose that because I did not want her to make any assumptions about me but the opposite happened because the non-Asian therapist was asking me too many questions and I was thinking how is that relevant to what we are talking about? I didn't understand that, I remember thinking that I'm not coming back because this isn't working for me and so I like the fact that we have similarities because that is the very thing that helps and I learnt that from my own experience."

(08:5)

Feeling passionate for the client group

As well as being able to understand South Asian clients due to shared similarities, therapists also spoke at length about their passion for wanting to work for this community. They explored their fascination for working with individuals who were of the same background as themselves and discussed how previous job roles were experienced as limiting in terms of

being able to fully meet the needs of this client group. Therefore, passion was seen as a continuous factor in allowing them to work with South Asian clients and choosing counselling as an area in which to utilise their passion and care for the client group.

"Each time I hear a story, no matter how similar it might be, it still fascinates me each and every time and it's that fascination that keeps me there and makes me want to work more with these clients."

(01:1)

"As a housing officer I could only offer limited support and when I went into counselling I felt this is my passion and what I completely believe in and stand for helping South Asian women and I want to set up a service that offers them a space just for them where we understood them in every way and I knew from the beginning I wanted to do this."

(07:6)

"I have always wanted to work with South Asian women. It is my own interest and passion. You know I want to go out there and work with the South Asian community that I belong to, I want to help them. It is my passion. Most of my clients are South Asian and female just like me."

(05:1)

2. Constructing the value of their experiences through understanding their clients' experiences

Whilst exploring their understanding of working with South Asian clients in a matching service, therapists tended to construct their own experiences based on the encounters they shared with their clients and the observations, thoughts and feedback they made based on this work. A lot of what they felt about their role in the service stemmed from what they could see they were offering their clients.

Being able to bridge the gap

Therapists spoke clearly about the position they were able to hold by working in a matching service for the South Asian community. They believed that taking this position allowed them to bring South Asian clients closer to accessing psychological services. They also saw themselves as playing a key role in bringing together the community and mental health facilities. These beliefs contributed largely to how they were evaluating their own experience; for many, holding this belief led to positive experiences of working with South Asian clients.

"The positive is that when they see a female figure sitting in front of them doing something positive, it has been a really good experience. And the whole counselling experience in the Asian culture, there isn't such a thing as a counsellor and for them it's what is this talking business? So I can bring that to them."

(08:1)

"Obviously working with a South Asian community, there is a stigma attached to counselling in general so people might think he or she is going to counselling, there must be something wrong with them and why are they going to counselling etc… so you can come across those kinds of things but in general I would say any kind of barrier like that is overcome by the

services that do matching and offer them this space, that is what I feel and have learnt from my experience."

(03:2)

Therapists also spoke about using the similarities shared though the levels they were matched on, to use different lens to perceive the clients where they were no longer just seen simply as clients. Being able to do this was an imperative part of their experience of working with South Asian clients.

"Having the shared understanding through the levels we are 'matched' on allows us to work with a different lens and you realise that when you put on a different lens how pathological everyone [other professionals] else is. And you need to learn how to understand South Asian client groups and meet them and counselling in the middle and make sense of their illness within their culture, language, ethnicity and so on. This is so important for them and such a big part of my experience of being with them. Doing this leads to me feeling happy about my role."

(06:2)

Feeling satisfaction

Feeling satisfied with their job role as a counselling therapist whilst working in a therapist-client matching service for South Asian clients was found to be vital in making sense of how they felt about their work. Therapists spoke about feeling proud, rewarded and useful in a matching service. It is thought that being able to work with the similarities such as language, ethnicity, culture, and religion gives rise to feeling fulfilled and satisfied, conveying a preference for working in a therapist-client matching service.

"Personally I prefer it because it is just better for me and what I believe. If someone can't speak a language and they can't access the service any other way and I can provide that, I

can give them that, it makes me feel good. And I know there are not many organisations that can give it and so it makes me feel good and so that is why I was drawn to this organisation, it is for my community and I'm doing something for them."

(02:3)

"It feels more useful and a better use of my time and I feel more useful as a therapist. I feel like I am using more parts of myself my religion, my culture, my language and so many parts of myself in the levels of matching. So, my time is better used and I feel more valued as a therapist and I might be the reason that they access a service that can help them."

(02:4)

"You need to have a better understanding of culture and yourself, and once you can do this and you do because you use so much of yourself, it is very rewarding."

(06:2)

"Because I had a language I thought it would be a good idea to use my language as well and so initially I really found it really positive to begin working here."

(08:1)

This sub-theme, satisfaction, relates heavily to the first sub-theme of being able to bridge the gap between the South Asian communities and counselling services. Therapists were able to feel satisfied realising that they were using themselves in a role where they could provide a service that possibly other therapists with their qualifications could not. In addition, highlighting their role in providing counselling to a community that finds it hard to access counselling through mainstream services led to self-satisfaction, self-value and positive experiences.

"I enjoy that I can fill in a gap that others can't. You can relate more to their stuff and backgrounds."

(03:3)

"I have had a lot of clients saying they wish they had counselling before. It really makes me feel they are using it and that they are benefitting from it because of the way we work and the matching and what I can give them. They would say that this is what I have done and if I hadn't come for counselling I would never had done this. It makes my job worthwhile and hearing the changes they have made for the better because of the unique service I can give."

(07:4)

3. Support

Therapists identified the importance of receiving support throughout their clinical work. What was interesting is that they acknowledged the importance of receiving 'specialist' support from a South Asian supervisor or receiving specialist training in addition to their core training received upon obtaining their qualification.

Supervisory needs

Therapists felt that in order to work successfully with South Asian clients in a matching service, they needed to experience this level of shared understanding or similarities with their clinical supervisor. Therefore, South Asian therapists looked for clinical support from South Asian supervisors as many felt this supported the therapeutic process they accomplished with their clients.

"I would recommend that you should have a supervisor who is from the same community, because supervision is much more effective. I don't have to say everything about it in detail about what I am talking about, but sometimes I know there is a danger of making assumptions but this can be addressed, but then again you don't have to explain all the details and/or explain the relationship."

(07:7)

When exploring why they thought it was important, therapists felt that certain presenting problems that came from working with South Asian clients needed to be understood by the clinical supervisor, otherwise, it was difficult for the therapist to explore effective interventions and understand the process when working with that client.

"If you are talking or presenting a client from a culture where there may be forced marriage issues, supervisors with very little awareness of that culture may make assumptions about the impact and so may not be able to guide the practitioner appropriately. I'm definitely not saying all, as some are very equipped, but I think it is very useful to think of it from that point of view."

(08:7)

In addition, language also played an important role in the need for a clinically matched supervisor. Therapists felt that being able to use the same language used by clients in the supervision sessions was vital in being able to work effectively and productively with their clients. Many felt that not being able to do this through supervision resulted in a loss of process and understanding of the client's frame of reference.

"*When they [clients] say 'cha cha' and I use this with my supervisor, they [supervisor] know what that means, and when they [clients] say 'masi' they [supervisors] know what that means. When you are with your clients and you have that level of understanding and acceptance of phrases and language, it is the same thing at a different level in supervision and if you are working with matched levels you need to experience this in supervision."*

(05:6)

Furthermore, those that received clinical supervision from non-South Asian supervisors experienced negative experiences where, often, they felt misunderstood, annoyed about having to explain themselves and felt that they would be better supported in their clinical work if they were to have a South Asian supervisor.

"I have so many that say 'oh I am sick of having to educate my supervisor' and supervision should not be that, you know. It should be held in a different manner, not to educate them."

(07:7)

"I tried to find an Asian supervisor, but I couldn't find one. I had to settle and she is very good and very understanding and listening. I do, however, believe that in this process and working with matching which is so unique you need someone who is part of it, someone who lives the process with you. I do believe that sometimes important things, phrases, understanding or a special relational moment is lost in my supervision now."

(02:4)

The need for specialist training

Besides highlighting the need for specialist clinical supervision support, therapists also explored their need and want for continuous specialist training. They explored their struggle in working with the South Asian group through a matching service, having not received full 'cultural training'. It was explained that training received was westernised, thus not acknowledging the training that is needed to work with non-Western clients, for example, South Asian clients. Through this exploration in their narratives, it was identified that South Asian therapists very much see their work with South Asian clients as something separate to that of working therapeutically with other client groups.

"We can't apply Eurocentric understanding to people, because healing is different to different communities. Working with a South Asian community, your assessments are different and clinical work will be different with this community. I think my training was on intercultural psychotherapy. We had to learn about what is therapy and how it is different, and I think this is lacking in the Western training and it is a very Eurocentric way of training and it suffers the South Asian client group."

"I think people need to learn regardless of their background to offer service provision to people of different backgrounds and there was lack of training all the time."

(06:1, 3)

"I do feel like I have been thrown in to the deep-end and I was training when I first started and special intercultural training is missed out, which is a shame and I think it is really needed."

(03:3)

Reflexivity: the process of discovering lower level themes

The idea of calling the three themes just discussed lower level themes came from a discussion I had with my supervisor. Taking the time to discuss the process of interviews and revising the interview memos I had written, I spoke about how I had encountered all the interviews as a storytelling process. I struggled at the time to articulate how to explain that these three themes appeared as almost 'setting the scene' for the interview, for which I knew something more concrete and insightful would later come; now, of course, I call these 'later insights' 'the higher level core themes'.

With this revelation, I began to question how important the themes were and how valuable the themes were in relation to a South Asian therapist. As I began to analyse each theme and read through narratives, I questioned whether these insights/experiences were true of any counselling therapist rather than particularly limited to those who are South Asian.

I struggled to see what new knowledge I had gained from the discovery of these three themes as I accepted their perceptions as experiences which I too could relate to. I wondered at this point whether my thoughts were being influenced by my own background and personal insight as a counselling psychologist in training who had worked for both a matching service and mainstream service.

Realising that bracketing my own experience and self-influence in this process was vital, I decided to get another perspective through supervision. It was here that I came to understand and accept, from a researcher's point of view, that whilst the themes may be extendable to all therapists, they were still of value in understanding how a South Asian therapist made sense of his or her experiences and how they 'set the scene' for exploration of themselves in understanding their experiences of working with South Asian clients.

Therefore, documenting and acknowledging these themes is important and they now seem vital in opening up the space to discuss the higher level core themes. Reflecting upon the narratives and presentation of lower level themes in the model, I consider these themes to be operating continuously in a South Asian therapist's day-to-day experience of working with South Asian clients in a therapist-client matching service.

3.3 Higher level core themes

1. Level of experience

Level of experience emerged as a primary level in how South Asian therapists valued their role in a therapist-client matching service. Through the therapists' narratives, it transpired that level of experience was related to how comfortable therapists felt in their role. In addition, it also conveyed their ability to work with differences when working with clients who shared the same religion, culture, ethnicity, gender, sexual orientation and language.

Establishing a level of comfort within job role

- **Newly qualified**

Level of experience was defined by the number of years a therapist had been working specifically for a matching service for South Asian clients. There were widely varying views on this experience for newly qualified therapists.

For some, it created a safety net for starting out and was seen as a way to utilise and develop their skills in a setting that was highly comfortable and useful for them.

"To start my career, I knew I wanted to work with a client group I was familiar with. It was easier than to start with a client group I didn't even understand, so it was easier progression and felt safe enough to do, which made me feel more relaxed to then move to diversity if I wanted to."

(04:4)

For other therapists who were still eager to develop their skills and experience with a range of client groups, working for a matching service seemed limiting. Many commented that they felt

the skills they had qualified with were forgotten or put to one side. Therefore, some therapists felt a real desire to branch out and experience other client groups.

"I am working for Asian women and I remember at times thinking 'Oh, I stopped using that skill because I am now using a new set of skills on top of that I was trained to use.' The skills I used to use when I was being trained stopped and I use the skills that were helping the client, which was great, but I was thinking 'Oh am I limiting myself' because some of things I was taught I have forgotten and I still want to learn and push myself, I'm not ready to feel settled or to just use one set of skills, I'm still early in my career."

(08:6)

Therapists also spoke about feeling frustrated as a result of working with one client group and this gave rise to feelings of regret for not learning more and pushing oneself professionally by working with others.

"It would limit therapists if they continuously worked with only South Asian clients and especially if you are starting out your career because you learn so much from your clients and you wouldn't learn that much if you didn't branch out. You don't feel limited and such when working with more than one type. So it is good to be broad and not only work with clinically matched organisations. We are learning all the time and to keep going and you feel frustrated when you don't learn, you start resisting your role. So, I do think you don't learn or push yourself when in matching service. I felt this in the first few years of qualifying."

(02:5)

- **Qualified for a number of years**

On the other hand, therapists who had been qualified for a number of years and had chosen to work in a matching service with the South Asian community spoke about feeling extremely

comfortable and well settled. In contrast, they did not feel limited as therapists but spoke about incorporating core training skills, in addition to others within their role, comfortably. Furthermore, they tied in their experiences with feeling passionate about the community and being more able to deal with and appreciate the complexities of working with matching with South Asian clients.

"As experience builds it is not that you don't care anymore, but you become more aware of boundaries and don't let it get to you and as in any other work, you use supervision and time to reflect on myself, who I am and the differences and how much I involve myself in it, and you feel that this is what you want to do and you are comfortable."

(03:3)

"I think over the years you become equipped to handle the challenges and more able to deal with it than giving up and you learn to be more ok with the similarities and the levels of it and the depth and you learn to work and appreciate it and find it the basis of everything."

(07:3)

"Core principles are the same, time given is the same, the counselling is the same; the only difference is we have been matched. But apart from that I work with all and it doesn't make any difference for me and that at the end of it, the empathy needs for their issues and emotions are the same. I feel very comfortable with this and as time has gone by this is what I have been doing all my life and I don't feel matching is what it is, it is just therapy. Experience and maturity makes you understand this and you don't feel limited or held back."

(01:7)

Working with Differences

- **Newly qualified**

In addition to discussing their level of comfort within their role and being able to work with matching, therapists also explored the difficulty in working with differences in relation to level of experience.

Therapists who were newly qualified discussed the struggle in identifying differences with their clients and feeling overwhelmed by the levels on which they were matched. They discussed feeling empowered by the process but also spoke of the difficulties in over-identifying and expecting life experiences between them and their clients to be the same.

"I have been there and so I start with what is similar and disregard differences. I don't know if it's because this is still new to me and I wonder if it gets easier in looking at what we don't share."

(01:7)

"When I first started in this area, finding differences was hard, all I could think of what, omg we share so much!"

(04:6)

- **Qualified for a number of years**

In contrast, therapists who were more experienced spoke about how easy it felt to separate the 'levels matched' from their work and put this down to years of practice and supervision. They explained that they were able to position themselves in the service of the client; therefore, if it

was raised by their clients, they worked with it. They realised the importance of bracketing themselves and felt more at ease to follow their clients' lead. Therapists also acknowledged the importance of this for South Asian clients, stating that for some clients, matching might just bring them to the service but not necessarily the thing they want to talk about. More senior and experienced therapists were able to respect this, so similarities were encountered as secondary to their work

"What I might assume is common might not be common for them [clients]. Over the years and through experience, I now respect clients don't want to talk about this, you know. So for them, I strive to find differences and use this as the basis. I don't struggle with doing this anymore."

(04:8)

"I was happy that we shared the same thing. I acknowledged it. I don't think that was anything positive or negative. It was important for me to acknowledge our shared stuff, and I didn't want to not address it, because it was important for her but I did it for her. I have spoken about this in supervision so many times and through learning and growing; you learn to bring it up only if they want to, if they need it. I learnt that it's not important for me. It might sound weird, but I have done this a long time now and it's something I have learned to just do."

(07:6)

- **Highlighting clients as individuals**

In addition to the above, most therapists, regardless of level of experience, were able to acknowledge the importance of being able to diffuse the 'shared understanding' to some degree, to provide individualistic therapy.

Therapists felt that whilst understanding similarities and paying respect to the matching process in which they were established was important, it was also essential to the therapeutic process to define clients as individuals. This was a shared belief held by all therapists regardless of being

able to work with differences or wanting to work with similarities. They believed it was vital to encourage clients to explore their own experiences, instead of conforming to what they thought they 'should say' to their therapists. Therapists also felt that being able to do this prevented clients from fearing rejection and non-acceptance.

"As far as I am concerned I just think that everyone has different names and everyone is different and everyone is an individual; if someone has the same name it doesn't mean they are part of my family, does it? Yes, I might want to work with it [similarities], but at the end of the day they are another and someone I don't know. Sometimes you have to draw yourself away and look at it like that; you have to allow the client to feel their own within all the 'similarities' that are being presented in our space."

(07:6)

"It wasn't different to working with non-South Asians, it is just working with the client alone and seeing what separates you, that's how I deal with it. That's how I let the client know there are no expectations to act, speak or believe in a certain way, it helps with trust and fear of rejection from me."

(01:11)

2. Acknowledging Self-processes

Throughout the process of making sense of their experiences, therapists spoke largely about internal self-processes. This was an insightful development into understanding how they made sense of the way they feel, think and practice when working with South Asian clients in a matching service. A number of processes were identified and these will be discussed in greater detail below.

Assumption-making processes

Therapists discovered that many of them found the process of assuming, either from the client or from themselves, to be a heavy price to pay for working with clinically matched clients. They identified that when committing to this process from their side, it gave rise to over-identification, misjudgement, bad practice and even rejection from the client. Therapists explained that, for them, working with clients who shared the same language, ethnicity and/or gender sometimes opened up the space to feel vulnerable, leading to 'slip-ups' where they assumed clients had experienced certain things the way they had. Some also spoke about the challenges in having to keep this 'in check' and the need to constantly remind themselves of the differences they shared.

"*I think over the years and because I'm a first-generation Indian, working with first generation and the same language, same sex and race, there was a lot of transference for me because of my own experience. I can understand immigration coming from another country and starting again, and so I have to be very careful of my own boundaries and transference when with clients who have experienced this too. I would want to assume, because all I could think of was my stuff. They [clients] do turn around and go 'No, you have got it wrong' and that's when you think this is so dangerous."*

(04:1)

"Because of similarities, I make assumptions on what I might know, but South Asia is a big sub-continent and I have only lived in one part and, even then, my matched clients are different. So I have to keep a check of things that am I really assuming things or is this really real? I fall for it [making assumptions] sometimes."

(04:6)

Therapists also spoke about the challenges when clients made assumptions about them. Many felt that clients almost had expectations that their therapists would act, behave or even over-step boundaries because of the similarities. Furthermore, therapists feared rejection, clients not returning to their sessions or a breakdown in therapeutic alliance if they were to not conform to the assumptions made by their clients.

In order to work with this, therapists worked hard to define boundaries from the beginning with their clients. Therapists explained that enforcing this was imperative and they worked harder to achieve this with clinically matched clients than with non-matched clients.

"When I see South Asian clients they use phrases like 'Oh you know what it's like, you know what it's like in my family, you know what it's like in our community,' and so they have already made that assumption that you know what it is like. Whereas a non-Asian would not say to me that 'Oh you know what it is like to live in a non-Asian family' and so because of that lots of assumptions are present and they are looking at me that you are a woman, you are Asian and you speak the language so you must know how it feels and that's the biggest difference of working with South Asians and being matched to them and knowing them on that level, compared to non-South Asians."

(08:2)

"It was really hard to fulfil their expectations and it did feel like I was letting them down and I was worried that that is it; she won't come back."

(06:3)

"Clients will over identify or think we will share the same views on things as them, so boundaries have to be defined and be clear from the beginning, and I have had to say can you explain that to me instead of them thinking that I know it. They sometimes get angry because they want you to just know and it puts an expectation or pressure on you."

(05:2)

"I had to manage the boundaries by saying that we are from the same culture and speak the same language and we share so much, but I don't go the same places you go. I do feel or I have felt under pressure to incline things like this and to explain a bit more and set firm boundaries, more than non-Asian clients. By doing this, I have thought oh shoot, will they go away because I'm not giving them the very thing they want."

(07:5)

Working with Attachment

Therapists expressed the feeling of being predisposed to feeling compassion for their clients and the process of feeling emotionally involved with them on a deeper level then a client-therapist relationship would normally entail. Many attributed this to working with clients clinically matched to them on numerous levels.

Included in this process was the practice of over-identification and transference. Therapists often experienced and saw clients as members of their family, leading them to indulge in other processes such as making assumptions.

Therapists also spoke about this process as the underlying factor in experiencing relational depth with their clients. Incorporating relational depth and transference into their work often led

therapists to finding it hard to say no, putting in boundaries or stepping outside of the box and taking a different perspective. Being able to ensure that they did attempt to place some distance was imperative to the feeling of working ethically.

"It is hard to not become emotionally involved because of the slight connection you have and to not become attached because so much is similar in the room."

(03:3)

"Yeah, well she looked up to me as an older sister. The reason why I think she kept mentioning it was because she needed that figure in her life, an older sister figure, you know what I mean. So her mentioning it ensured her that I was around for her. So yes, I had to think about who I was and who she was for me, at times I felt like she was my sister and transference was so present. I did find it so hard to put in boundaries because of this and to say no when she asked for me like, reading a letter or replying to something."

(07:6)

"I think if I'm working there are lots of circles of relational depth. When I am working with a South Asian client and we have the levels of matching, I feel that I am nearer to that client, but when I am working with a non-Asian, I am slightly away from that circle. So what I think happens is that there isn't this baggage that I am bringing with me, you know. That baggage is left by the door. I do that with all my clients, but when I am working with my South Asian clients, that baggage is sometimes there with me, which seems to get left behind with a non- Asian."

"[What is the baggage?]"

"Things that I feel about my relationship as an Asian woman and as a Muslim and as a Muslim woman that speaks the same language, is the same gender, is of the same ethnicity. A woman of colour in general, it's that baggage that goes everywhere with me. When it is a non-Asian that

gets left behind and it is not that when I am working with a non-Asian that it is not relevant. But it just comes in [when working with South Asian clients] and I can't stop that. When an Asian client is talking about stuff that I can understand or things that I have seen, then I can't help but think oh I know what you mean. Not to say that I make that assumption because I have seen it and I know what you are feeling but, yes, in that circle I know how that feels for you because I have felt it too. It is powerful and I worry that because I feel this, am I doing too much, am I overstepping that line, you know, the boundary."

(08:4)

"I would never say no to my own mother if she asked me to do anything more and so here I am where this client, she thinks I'm the daughter and I see her as the mother how did I feel about saying no, I can't do this? That was really hard and it was a challenge for myself and for her, by making her understand that this is not what we do here. First time in our relationship I am saying no and that is really hard. Because I have had to say no, because as a counsellor this is not what we do but it was going against myself, what I have been brought up with and what I do outside. I was really worried that she might not come back because I did not collude with her and say ok. But I had to say no, it was ethical for me to do so, I would have been doing so much wrong if I colluded."

(08:2)

"I think the experience is different and you take something else on. I can't really name it, but it is an additional pressure or something that you add on to yourself because you feel so close to them and how much you share. And you struggle back and forth between what you want to give and what you can give through your professional role."

(03:3)

Understanding role identity

Therapists held the belief that working in a clinical matching service meant that explaining their role and the purpose of counselling would be easier. They believed that for South Asian clients, not understanding counselling or the role of therapists made it hard for them to access mainstream services; however, therapists believed that in matching services for their own community, this barrier would be taken down.

Yet in reality therapists experienced a very different process to what they believed or expected. They experienced frustration in not being accepted in their role by South Asian clients and found it hard to explain what counselling was, the purpose of their role and sessions, and the limitations on what they could do. On many occasions, South Asian clients expected therapists to undertake responsibilities outside of their job specification. This amounted to pressure and frustration for many therapists and challenges in coping with this were experienced continuously by therapists.

"The thing that I found difficult was that the Asian women that did come to see me, they thought I was a doctor and wanted me to solve their problems and I would say that you need to see a GP for that. Or they saw me as a daughter figure and they would want me to do as they asked or because I was younger than them or looked younger than them, I would do what they wanted and expect me to follow, but I would have to say that I can't and that is not want counselling is about. So that has been a really difficult and very frustrating process."

(08:1)

"They expect that you will be here and you will always tell them what to do and go out with them. So you have to explain counselling, which can be difficult and hard because they misunderstand who you are and because of the similarities they hold on this. It is hard to move away from the levels shared here; here it is a negative thing."

(02:1)

"I think because of the cultural issues and the amount we shared together you felt you were with someone who was more than a client. Like, you have to respect them because they are older and you can't say their first name, it was very difficult and for them to see me as their therapist, and as a result there were a lot of boundaries issues. It was very hard to stay in boundaries. They would constantly want more and want to know about me and talk to me as their daughter."

(04:1)

"I think disclosure is quite hard and they disclose quite easily and with some of them you have this whole problem of child protection which has come up a few times and you have to report it. And even though you have talked about confidentially and explained it to them they still don't understand; this I find hard and I wish they just got it!"

(04:5)

Working with levels

Therapists all acknowledged that working for the South Asian community in a matching service meant that allocation of clients was dependent on what aspects of identity were feasible to clinically match on. When exploring the levels, therapists all held the belief that language played the biggest part in matching and that being clinically matched on this level accounted for more than ethnicity, gender and sexual orientation. They all believed that for the South Asian community, language played the biggest part in being able to access psychological services and that South Asian clients were most drawn to accessing matching services because of language in particular.

"Language is very powerful and they can express themselves better. Because I am not from their community, they feel better and it is highly likely that all they really wanted to share with me was their language; this is the primary reason they have come to a service like this. Ethnicity and gender and other levels as you call them, are secondary."

(07:5)

"I then said that given that you speak Bengali, I also speak Bengali, we can speak in your language it is up to you. Her next sentence was in Bengali. I don't know whether it was to do with feeling more connected, I don't know but that is what she wanted. And even though it was just an assessment meeting, I got so much material out from that one session. The other facets of shared identity, I felt just went into the background, she didn't care if I was Muslim or Hindu, she just cared I spoke Bengali."

(08:4)

Therapists also find that when working in their mother tongue, the experience of therapy is not only different for their clients but for them too. They acknowledged that this level of matching can be seen as the most effective in the therapeutic process, and possibly the hardest to work with when operating with boundaries and overall therapeutic processes.

"There are so many similarities that are present, but in the South Asian community, they don't really have a language for therapy, so language is really everything. In English it is very tough to talk to them. You can feel it, we [South Asian community] have such a strong vocabulary and we reflect and say different things and so on. But in English I struggle to find the words. Also, at home I speak my language so it is very easy for me to go in the cultural mode and slip out of therapy mode and enter chit chat mode. So language is the hardest to work with and that is when the matching really plays a part and I experience it right there in that moment. I guess it is a balance and I have to stop myself and I ask myself what is going on."

(01:6)

3. Experiencing Internal Conflicts

When making sense of their experience as 'matching' therapists working for the South Asian community, therapists cite various internal struggles. These are (1) how they encompassed their therapeutic knowledge-training skills versus cultural skills to work in a matching service; (2) understanding where they want to go professionally in comparison to where they enjoy working; and (3) role identification for themselves, other colleagues and professionals. These three sub-themes gave rise to a powerful insight into the core experience of what South Asian therapists held as beliefs about themselves in this area of therapeutic work.

Working with two therapeutic 'hats'

Therapists identified a process of swapping between their core therapeutic skills obtained through their generic training, and the skills set obtained from working with the South Asian community – cultural therapeutic skills. They expressed that having the ability to work for this client group meant needing to be able to swap between the two skills sets or two sides of their identity. Many held the belief that this swap between their 'cultural' and 'non-cultural' sides was a constant struggle. Furthermore, it caused tension in understanding how they could collaborate Eastern psychological thinking with Western training. All therapists explored the idea that working for a matching service with clients from their community represented a fusion of their upbringing (predominantly Eastern) and their view of the world now, obtained through training and education (Western).

"I think that in my head I have got an Asian head in my head, but always have a non-Asian head ready. When I have an Asian client I think with an Asian head, I do that, so I think I have my own issues and I know what is going for me in my life and family and I know that things they will bring up will have impact on me too. For example, recently I had client who was talking about their daughter-in-law and she was saying that, essentially, her life was perfect till the daughter-

in-law came into the household and was now disruptive. I know how I felt being a daughter-in-law from an Asian background and thinking omg she has hooked me and I was thinking ok I need to unhook myself and right now this is not the time for me to think about this, I need to take this to supervision and right now I need to think about her and what she is thinking and what she is feeling. So, yeah, I put on my non-Asian head at that moment and thought don't think like an Asian, think like a non-Asian. I had to change myself and use something else."

(07:3)

"It brings out the east meets west side of me and I have to stop and change constantly between what I share with them; this includes being a woman who is Asian and just being a woman. It is so different and hard to keep up with it. So I work using two sides and bring in the moment what is needed. I don't think other therapists working for mainstream go through this weird stopping and changing self thing!"

(8:8)

"I keep swapping my therapeutic thinking between 'matching thinking' and then 'core condition Eurocentric thinking'."

(05:4)

"When you share the same culture and religion and gender and the rest, then it becomes a social mode and then it becomes hard and not natural. You try and hold on to the core skills, the Western thinking of not looking at culture or whatever, it is such a struggle and I'm thinking about it now and thinking, I can't believe I put myself through that."

(04:5)

Achieving self-satisfaction vs. wanting professional growth

Another personal conflict faced by therapists was an inconsistency between feeling proud of being able to help their community, and so feeling personal satisfaction, versus paying the price of limiting themselves professionally and not being able to move into other areas of work. Therapists held the conviction that working for a matching service prevented them from moving out towards mainstream services. They compared themselves to those they trained with and felt frustrated that their peers had gone on to experience a lot more professionally. This struggle between wanting to feel happy versus wanting more experience was a key exploration for therapists when considering where they wanted to go with their careers. Many cited not feeling valued, coping with cuts in the voluntary sector, and lack of government support and funding as reasons for wanting to possibly move to the NHS mainstream services, where they would feel more valued and safe.

"I feel bittersweet, because it means I work in that way only and you miss out on other things, but I struggle with this because I hold so much pride with what I do and love it and I chose to work in this way, so I don't know. I want more, I want to be valued not only by myself but by others and I don't think I am valued in that way working here."

(08:6)

"I think for me, I was thinking that I am doing therapy and so it was fine, but going back to the course and some of my training has been eye-opening for me. I question things and myself, is it really therapy, what I do? Is this all I am going to do? I enjoy it and it is my passion, but professionally I want to know that I will have a job for the next two years instead of waiting to see if our organisation survives another phase of cuts. I also want to be able to use my core training skills. I feel here, it's just culture or language or South Asian-related stuff. I love it, I do, but I do stop and think, did I do all that training just for this?"

"You are moving towards burn out. I think working with domestic violence and forced marriages and things like that are common in this field, especially in a matching service. The whole process

is so much more intense when it is with matched clients because they speak of your culture, your beliefs, your background and it all has an effect. I think after some years it is important to have that change and to work with something different."

(04:4,7)

"I look at my friends who were training with me and where they are and what they are doing. I'm fascinated by it all and in conversations I feel like I'm always trying to catch up. Maybe it's an insecurity, I don't know, because I do feel happy, so maybe I just want to look good? I don't know, I guess being able to say you work in the NHS sounds good and people value it better and it is hard to understand why I can't have both."

(07:9)

"I do wonder what if, what if I didn't work here and I wonder in a primary care setting or something, would I be as happy with what I am doing, contributing, would I know more?"

(03:8)

I am a therapist who is South Asian, not a South Asian therapist: defining self and working with labels

In concluding interviews, therapists drew on all themes discussed to convey thoughts on their overall identity as South Asian therapists working in a matching service for South Asian clients. Various beliefs were held by the therapists, and there was a strong desire to ensure that I was able to hear them.

Therapists spoke about the importance of first being able to identify who they were to themselves before attempting to convey who they were to others. Constructing a sense of understanding about their role stemmed from the pride and satisfaction they felt with their choice

to work in a matching service. It also appeared that acknowledging that their identity encompassed values and beliefs from a South Asian ethnic background alongside their Western experiences of living in London was important in making sense of who they were as therapists.

"I am proud to be a South Asian woman and proud to offer counselling to South Asian women who are needing to speak to me as a South Asian woman. I am very proud of my identity and that is really important to me. I value both Eastern and Western culture. Having being brought up in two cultures, I like to believe that I have taken both and embedded it in my way of being as a therapist. I am sure there are lots of things I shouldn't do, but who I am and who I want to be is down to the way I was brought up in India. But at the end of the day I'm not just South Asian, there is so much more to me and I struggle with having to identify all of this to myself with my work, because I have an 'English' side to me as well and just because I chose to work in a service like this does not mean I can't live in another way, in a English way, does it? I don't know."

(07:8)

"In Asian organisations I feel valued and understood and encouraged to understand and discuss everything openly. In my other jobs, I was not allowed to challenge some things and approaches and I was not allowed to think in that way. I like that here I understand myself and who I am as a person, kind of matches the way I work, I think."

(06:4)

Therapists also recognised the difficulty they faced daily in having to explain their professional identity to other professionals. They felt that whilst they enjoyed working with South Asian clients, it was also not only their duty to explain why they chose to work in this area. Furthermore, due to the constraints on mainstream services, it was left for matching services to ensure that clients from the South Asian community had some level of access to counselling

support. This created a sense of anger, annoyance and resentment, as many therapists believed that it was the duty of all those in the profession to ensure that a psychological service was provided to everyone regardless of ethnic background and that matching services should not alone be left with the responsibility. This meant a struggle for therapists between feeling it was their duty to act versus feeling that everyone in the profession should act.

"I think the whole psychology world needs to pay attention to this, it is not as simple as that. It needs to be filtered through to all mainstream services and not just left to us. I mean, I do feel I should do it and I do. I guess it is just a battle that needs to keep going and they [other services] need to stop 'boxing us' then we might not feel so alone in working with this community and maybe then duty and 'Oh I'm the only one who can help' won't be the primary reason for working for this service."

(05:7)

"A part of me feels, why should I take the responsibility to deal with this? Other therapists should take responsibility to work with these clients because they are abandoning their clients and so their own ethical duty."

(06:4)

In addition to beliefs portraying the struggle of making other services understand the importance of doing more to reach out to the South Asian community, therapists also identified the struggle of working with labels. South Asian therapists felt that choosing to work for a service within their own community meant that they were segregated from other professionals in the same field of Counselling Psychology. Many said they were stereotyped or labelled as a 'South Asian therapist ***only***'. This gave rise to feelings of anger, distress and being undervalued, as many believed that they were regarded professionally for their ethnicity and chosen area of work, rather than their core competency as an all-round therapist. Furthermore, therapists felt that

differences were drawn out between them and other therapists who did not work for the South Asian community. These differences led to feeling unappreciated and, in some cases where multi-agency work was carried out, as if they could only have a say or be allocated a case when it related to race and ethnicity.

"You are, like, stereotyped. I think within the South Asian community, there are so many differences and maybe we don't realise this and think we are the same. Therefore, one can make the mistake of making assumptions or thinking they understand. It is important to not stereotype with our own understanding."

(06:1)

"I have a label that I am an Asian therapist. I don't call myself an Asian therapist, I call myself a therapist, but when I talk about my clients, that I only counsel Asian clients, that is what I get called; it feels restricting to me and I don't know why. When I talk to other people about it it's almost like it is not valued being a therapist that I only counsel Asian clients. But if I was to say that it is a general practice and I counsel anyone who comes, then that would probably be more valued as to being just an Asian therapist. See I'm saying it myself right now ***'just'*** *an Asian therapist."*

(08:7)

"People can assume that being from the same culture it can be easy. But now with training in the borough people know that it does not always mean that it is easy and sometimes South Asian people actually don't want to see Asian therapists anyway, so they [non-South Asian therapists] have to see them. But when you are working with a multi-agency and you are the 'South Asian' therapist, they just limit you to that and only ask for your thoughts when a case regarding language or race comes up. They ignore that I am a therapist who has gone through the same

training as them and might not even know the culture properly, they just see you as the South Asian one and that's what she does and who she is. It's stigma and it's horrible."

(04:11)

Reflexivity: the higher level core themes

The discovery of the higher level core themes has been wonderful for me. I feel that discovering this has given me an accurate in-depth insight into the working lives of South Asian therapists.

To be honest, I was surprised by some of the things I found, especially with the two themes internal conflicts and working with labels. It really drew me into my research and I started to think about how expansive this research could actually be. I set out thinking after the discovery of the lower themes that a lot of what I might find would come from what the therapists see and think about their clients, but here I was, getting first-hand insight into their inner deep thoughts and struggles! I think, for me, at this stage in the analysis, I really sat and thought about myself and reflexivity really kicked in.

Being a trainee, and considering working for matching services, I really took to what these therapists were saying and I found myself thinking about my identity and the role I was playing as a researcher but also as a practitioner who is learning and evolving.

When considering the model and theory, I had to stop and ask myself was I forcing the discovery of the higher level themes for my own selfish learning and possibly coming from a point of view whereby I wanted the struggles and hardships faced by the South Asian therapist to be heard? Was I creating my very own pressure by making sure this voice was heard? Did I feel like I owed them something?

Realising that these were some of the questions I was asking, I took the issues to supervision to reflect and achieve some distance in bracketing my own experience. Having my supervisor run through codes and themes and the model itself I was able to achieve another perspective and was left feeling assured and comfortable that these themes were, in fact, present. In discussion with my supervisor, I realised that by asking these questions and using my own understanding and personal experiences, I was facilitating curiosity and this was actually allowing me to have access to deeper insights into the experiences of South Asian therapists.

Overall, having the space to stop and think and being constantly conscious of what position I take up has been imperative in this process. Looking back, I feel immensely grateful that I have discovered the higher level core themes and I do believe that these themes provide a profound, undiscovered insight into the experiences of South Asian therapists.

3.4 Therapists' reflections on the interview process

In addition to presenting the Grounded Theory model and overall reflective process from my point of view, therapists also felt it was vital to voice how they reflected on the process of being interviewed and taking part, and a number of important comments and thoughts were identified.

Reflection on taking part

All therapists commented on the experience of taking part as fun, relaxing and enjoyable. They were keen to acknowledge that the process provided them with a space to stop and think about how they felt and experienced their work and themselves. Therapists were able to identify and reflect that through exploring their experience, they understood the complexities of their work, and that taking part gave them an opportunity to learn and understand this in great depth.

"It has been very useful and refreshing and the opportunity to think about who I am and how I feel."

(07:9)

"It was really insightful for me to think about the complex way we work in and having you here to acknowledge it, I feel I have learnt so much or spoken about things that I am sure I rarely think about [laughter] because we are so busy!"

(05:8)

"Wow, it went so quickly and I did so much talking. But I really do think I'm gonna sit and think about this even after you leave."

(02:5)

"I've really enjoyed that, thank you. [Laughter] I was worried I wouldn't know what to say, but I could keep going."

(01:11)

"It has been good, I love talking about it and it's great. It's my views and my experiences and I really enjoyed it, actually."

(08:9)

Opportunity to network and meet likeminded people

Therapists also spoke about having the chance to meet and discover that other therapists were exploring issues they were experiencing too. Many explained that realising this research was taking place made them feel empowered by their work and proud that it was being acknowledged. They also commented that having this space was a great attempt at filling in gaps in the support network for South Asian therapists.

"It was nice to meet you and hear about your training and research, it makes me think maybe we are moving forward [laughter], maybe someone will take notice!"

(05:8)

"It has been so good to speak to someone who might understand! [Laughter] Do you know how hard it is to find this?!"

(03:4)

"I wish we could all get together, make tea and talk like this [laughter]We should set up a network like this, it would be so insightful and fun [laughter]."

(07:8)

Reflexivity on the model, write-up and supervision

I look back at this chapter and feel quite amazed by how the theory and model have come together and I can easily reflect on how much I enjoyed writing this chapter.

I feel the data used truly reflected the emerging themes and feel immensely grateful to the participants for their willingness to be open and honest in their interviews.

The model at first felt hard to visualise and I had many discussions with my supervisor about the nature of what a theory looks like, and came to the conclusion there is no right or wrong answer. Especially with Grounded Theory, the nature of the model and theory itself is what it appears to emerge as. In this case, the visualisation representation of the model truly does reflect on how the themes emerged through my analysis stages.

Supervision has been vital during this stage and I am lucky to have had the space truly reflect on how to comment and use data to best convey themes. My supervisor became my second eye in challenging me and providing opposing thoughts to help me see the nature of themes and the theory itself. This has allowed me to step back and see the theory not as individual segments but as a whole.

Chapter 4: Discussion

4.1 Introduction

In this section, I hope to draw conclusions on the Grounded Theory model which has emerged from the analysis of this research. I hope to do this by providing some in-depth conclusions on each segment of the model and draw comparisons between them and the existing literature that has been considered. I will also critically evaluate the model by highlighting its strengths and weaknesses and the overall utility of the model in Counselling Psychology today. Consideration for future research and areas to develop will also be discussed at the end of this chapter.

As an overall conclusion, I believe that the study fulfilled the aims set out, and a detailed model assigning the complexities underpinning the experiences of therapists working with South Asian clients was discovered. Furthermore, comprehensive illustrations drawn from the narratives convey well the model on the whole and the reflective spaces highlight my journey through this process.

Reflexivity: the use of 'South Asian therapist'

On reflection of the theory and data collected, I have decided to stop using the phrase South Asian therapist. This decision comes from the emerging theme: 'I am not a South Asian therapist, but a therapist who is South Asian.' As I begin to write this final chapter, I feel this theme and the words spoken by the therapists in interviews shouting out at me (!) and so staying with what they would like to convey, how they see themselves and the theory itself, I feel it is only right to collectively use the term 'therapists' or 'therapists who are South Asian' wherever appropriate.

4.2 Overall conclusions

The experiences of therapists who are South Asian working with South Asian clients are very unique and many inter-related and complex themes have emerged from the data.

Justifying and identifying reasons for why they chose to work in a matching service was seen as a vital factor in understanding therapists' processes and decision-making. Many therapists felt it was their duty to provide services for those in the same community who were unable to access

mainstream services. Some also felt that having the personal advantage of understanding some of the complex issues that occur in the South Asian community and the passion for the client group allowed them to be in a good position to offer the service.

Therapists also described the satisfaction of seeing clients being able to access a service that would not be so widely accessible or offered within a mainstream service as a reason for a high enjoyment rating for their job role. They also validated the process of evaluating their experience of working for a matching service by measuring it against how their clients felt. Most therapists felt high levels of satisfaction when clients gave positive feedback and were able to receive a service of which they were in need. Therapists also related feeling satisfied with their role to being a figure in bridging the gap between counselling and the South Asian community.

Support from clinical supervisors who were also South Asian was similarly deemed important in being able to perform and work well with clients in a therapist-client matching relationship. Furthermore, therapists spoke about their frustrations when clinical supervisors who were not of the same ethnic background or did not speak similar languages were not able to provide appropriate clinical supervision, and frustration grew further when therapists found themselves having to explain aspects of the South Asian community to their supervisors.

Following on from this, therapists felt that the training they had received in gaining their qualification failed to give specific attention to skills needed to be able to work with culture and religion. There was a call for specialist training where skills needed for matching could be developed or discussed, as many therapists felt alone in this.

Level of experience played a big part in how therapists explored how they were able to work with similarities faced in a matching relationship and how to bring differences into the room. Therapists who were newly qualified discussed their desire to ensure they worked with other client groups as they feared not developing ongoing skills gained in training and becoming too comfortable if they were to stay with this client group. On the other hand, therapists who had worked for matching services for a number of years spoke about their comfort in being able to face similarities and to also work with differences and how their years of experience had matured

them in their job role, allowing them to separate the 'matching' nature of the work and to simply focus on the clinical issues at hand.

Acknowledging that a number of unique internal processes were activated when working in a matching service was also important when it came to therapists making sense of how they worked and experienced their work. These internal processes involved the role of making assumptions in identifying, attachment and working with various different levels. Assumption-making was identified as the biggest challenge faced by therapists, as many feared that as they became comfortable in their role and with their client group due to the similarities shared, they made assumptions about their clients' experiences that were really a reflection of the therapists' own understanding and or upbringing. Furthermore, therapists spoke about clients over-identifying with them and the challenge of keeping boundaries in place. Therapists were able to highlight that these internal processes were not experienced when working with clients in a non-matching relationship and were specific to working in a matching service with South Asian clients.

Experiencing internal conflicts where therapists felt the push-and-pull factors of working in a matching service was also highlighted. Therapists felt that, professionally, they were undermined, seen as being less than other professionals in the same field. They attributed this to their desire to work within their community, rather than working for a mainstream service, and to the lack of education around trans-cultural counselling. This was in direct contrast to the pull factors of feeling passionate, active and useful in their job role.

Following on from this, identity was highlighted as a key aspect of their experience. Many disliked the idea of being called a 'South Asian therapist' and so felt they were on a journey professionally and personally to achieve the title of 'therapist who is South Asian'.

4.3 Comparing results and the overall Theory to existing literature and theories

The findings of this research help us to add dimensions and further contribute to the existing literature found on therapist-client matching. Whilst a vast amount of literature is found looking

at clients' experiences, the minimal literature that does attempt to convey therapists' experiences has been studied. Two thoughts on existing literature can be supported and confirmed by results found in this study.

Matching enables therapists to create safe, honest and effective therapeutic relationships.

Results from this study acknowledge that therapists feel that being able to work with similarities shared with their clients allows them to create a unique space that is honest and open for clients. This strongly supports research carried out by Iwamasa (1996), who also found this when interviewing therapists. Furthermore, in this research, therapists' attributes, such as having passion for the client group due to the cultural similarities, having a personal understanding of the community and some of complex issues arising, allowed them to work effectively in this way.

Challenges therapists faced due to matching

The model developed in this research conveys that, for therapists, internal processes such as making assumptions are triggered. Therapists spoke about their difficulty in segregating themselves completely from their clients and the desire to do more for their clients as they held on to the shared aspects of their identity. This confirms earlier work by Rogers (1951), who also spoke about the desires therapists could have for holding on to shared structures, experiences and thoughts to facilitate positive therapeutic processes. However, in this research, therapists acknowledged that whilst they had this desire to do more, they were aware of the huge challenges that accompanied this feeling. They highlighted these challenges as the following internal processes: over-identifying, relying only on similarities and the danger of crossing boundaries. These findings support and confirm earlier work carried out by Maki (1990), who also found matching could lead to disruption in the therapeutic process due to assumptions made about the client and their presenting problems, leading to a misunderstanding and the failure to question and understand.

Therapists spoke about the need to pay attention to these internal processes to ensure they did not occur, and to pay attention to their own experience when working in a matching dyad. This was raised by Ho (1995) and Alladin (2002), who suggested that those who work with clients in a

matching dyad should all take special care in attending to their internalised feelings and structures as confusion could arise leading to stereotyping, difficulties in making and believing assumptions, and over-stepping clinical boundaries.

Furthermore, supplementing the above finding, it was found in this research that due to the nature of the work and the 'danger' of processes discussed above, therapists sought specialist training and supervision to ensure they were able to look after themselves and receive the right level of support, enabling them to work with matching. This confirms work carried out by Iwamasa (1996), who suggested that where matching does occur, therapists should take care in deconstructing what similarities they share through the use of reflection, learning and supervision. Findings also support Reid (2010), who found that therapists working with similarities seek support from colleagues working with matching, supervision where similarities can be explored, and often need training to explore appropriate coping strategies for working with the processes discussed above.

In addition to the above comparisons between findings of this research and those of existing literature, I also found that the lower level themes discovered in this research have already been documented or made known to those in the field of Counselling Psychology. Whilst the lower level themes (reasons and justifications, constructing experiences in relation to clients' experiences, and support) have not been documented explicitly in literature related to matching, I do believe that the themes are known to be important in any aspect of clinical work. Having passion, and the beliefs and knowledge about a chosen client group that one decides to work with, are things that are experienced by many therapists, regardless of whether or not matching is present. The need for support is also a theme that is well documented and known, as it is recommended that if a therapist chooses to work in a specialist field (i.e. eating disorders), they would then also need specialist supervision where the clinical supervisor would have extensive knowledge of that area. Finally, all therapists hold some evaluation of their own experience of clinical work by comparing it to that of their clients and would feel satisfied if clients fed back positive outcomes, and this is the case regardless of whether or not matching is present. Therefore, bearing this in mind, the findings found in respect of lower level themes were not unexpected or new, and I also feel they are not explicit or solely experienced by therapists who

work in a therapist-client matching service but relevant to all therapists working in Counselling Psychology.

4.4 New findings

I was surprised by the complexity of the higher level core themes and the amount of knowledge discovered with regard to how therapists themselves felt about matching. The movement away from the clinical aspects of matching discovered and explored through the lower level themes to the deep insightful exploration into self-identification, labels and conflicts both professionally and personally, as well as the understanding of a personal journey working for the South Asian community and in a matching service, was an interesting and deep process.

Therapists spoke passionately about the satisfaction of working with matching; however, I was surprised to find therapists who were newly qualified or had fewer clinical experiences convey their frustration and desire for more. This push and pull between feeling passionate about their role and not wanting to 'just have this' was a fascinating finding.

In addition, therapists also spoke about the use of two therapeutic hats and the constant need to move between the 'Asian hat' and the 'non-Asian hat'. This finding was intriguing and I was surprised to get this insight into the struggles and push-pull nature of their work. It was surprising to learn the complexities and the deep-rooted feelings and conflicts many therapists experienced when working with matching and South Asian clients. I appreciated having the chance to explore this side to their experience, having already gained some insight into the clinical processes and aspects of matching via the discovery of the lower levels.

Furthermore, I appreciated the honesty and the openness of therapists when talking about the labels and internal conflicts they faced within their job role. I was also intrigued that therapists shared their feelings about being a 'therapist who is South Asian' versus a 'South Asian therapist'. This finding demonstrates some of the challenges faced by therapists who are South Asian and their fears of being pigeon-holed or undermined. I found this interesting as many of the therapists who spoke about the challenges also attributed high importance to how much they enjoyed and valued their work, thus conveying the split and two extremes of their work. Moreover, these findings demonstrated the inner deep-rooted complexities of working in a

matching service and demonstrated the need for self-care, reflection, training and support. This was supported and confirmed when therapists reflected on the interview process, where many spoke about positive feelings of discussing these difficulties and having the chance to share and explore them, which provided them with some time to deconstruct what they experience on a day-to-day basis.

4.5 Additional observations and thoughts

The role of semi-structured interviews

Reflecting on the use of semi-structured interviews, I found the process rich, natural and inviting. This is evident in the results found and the feedback on how therapists found the interview process. As Flick (2009) and Litosseliti (2003) suggested, the use of recordings and focus groups could have hindered the process of natural exploration. Therefore, I am glad I did not use any of these methods as the semi-structured interviews were not only enjoyable but also explorative and invited therapists to bring enthusiasm and trust to the process. I also enjoyed the aspect of using my own counselling skills to create a safe, open space to allow therapists who participated to feel comfortable. I also found it useful to then reflect on this when writing memos and notes of observations.

Furthermore, in line with Charmaz (2006), the semi-structured interviews provided a space for therapists to construct and reconstruct thoughts, feelings and experiences grounded in their reality of matching and working with South Asian clients. The method also facilitated the production of rich narratives, allowing room for flexibility and a degree of focus (Willig, 2008).

Role of self

Upon reflection of the analysis write-up and the process of conducting the semi-structured interviews, I see an interesting parallel process between what the therapists were acknowledging about their work with South Asian clients and the very same experience being experienced by me when interviewing the therapists.

Being a trainee Counselling Psychologist who is South Asian, I found myself bracketing my own clinical role, thoughts and experiences of working with matching when interviewing the

therapists and, furthermore, experiencing the idea of wearing 'two hats', one that of being a South Asian therapist who has experience of working in a matching organisation, and the other that of being a curious researcher who is coming from an perspective of not knowing to learn and understand. I found it very interesting that the experiences I encountered were on a par with the experiences of the therapists interviewed for the study. Documenting this process feels important as it acknowledges my own role and position in this study and the underpinning processes that have taken place in the journey and discovery of the overall model through this research.

I was aware that my position in this research would have some effect on the research itself due to the shared identity I had with the participants. Working with this directly, I always encouraged participants to explore their own experiences and realities and used my curiosity to explore further rather than to assume shared understandings. In addition, I followed Charmaz (2006) and used prior knowledge to help guide the process as any assumptions identified by me were used to attend to certain possibilities and question-marked with curiosity within the data collection process. Also, parallel processes and the effect of one's identity and experiences are well documented in Grounded Theory, and many accept that one's personal perspectives will inevitably impact the process; however, instead of neglecting this, it should be accepted and pushed as an empathetic tool in discovery, exploration and as an analytic resource.

Breaking down the significance of matching and 'in-group differences'

As I reflect on my findings and the research process, I find myself with some important thoughts about the process of matching based on my research and my own clinical experiences.

Prior to conducting this research, I had a good understanding of the process of matching on different levels. Literature reviewed conveyed that matching could exist when common variables and characteristics were identified between the client and therapist. Furthermore, matching was successful for some levels – ethnicity and religion (Sue, 1998). However, now that I am in a position to conclude my findings and reflect on the theory that has emerged, along with my own personal experiences of matching, I cannot help but propose the thought: can matching be appropriately achieved in a therapeutic dyad?

When reflecting on two of the core themes that emerged: (1) acknowledging self-processes; and (2) level of experience, I reflected on therapists' narratives that were collected on whether

matching can be appropriately achieved in a therapeutic relationship. Through these two themes, it was observed by therapists that individual differences can occur and are very much present in a dyad where characteristics may have been selected to be the same (such as gender, religion and language) to create a shared and similar foundation.

Within the theme 'Acknowledging self-processes', therapists spoke about assumption-making processes as a heavy price to pay for working clinically with matching, as many of them expected to share similar life experiences. However, they spoke of understanding that differences existed within the matching and the importance of constantly needing to remind themselves of this. Furthermore, under the theme 'Level of experience', therapists spoke about the difficulty in realising that matching did not rule out differences within the levels that are matched. Some spoke about this positively, stating that it then allowed room for individualist therapy. However, some believed that the process of matching did not hold up once therapy began, as differences over-rode this. Therefore, it is acknowledged that in-group differences occur and are found within the levels that are matched, which creates significant doubts about whether matching is or can be appropriately achieved.

In supplementing evidence for the above reflections, literature exists which presents similar views, some of which were shared in the earlier section of the literature review. I have spoken about some of the current tensions with multicultural counselling and applicability of matching. Referring back to this, I share some of the arguments and discussions that support my current reflections.

Supporting the thought that matching is not easily applied, Sue (1998) argued that matching can be a step forward in providing specific services for hard-to-reach communities. However, the degree to which matching takes places is vital, as it cannot be assumed that simply sharing the same ethnicity can lead to a successful matching relationship. Furthermore, the importance of the matching lies within what ethnicity means to the therapist and client. In addition, Sue (1998) talked about the possibility of cognitive matching as an additional process, so that matching of beliefs, understanding of goals, and perceptions is achieved to ensure the strength of the match overall. Ibrahim (1991, 1985) put forward the view that cultural/ethnic matching cannot be

obtained as easily as one may think. He discussed the complexities involved in the amount of differences found within ethnic and cultural groups. Therefore, the expectation to gain equal shared understanding when matched on ethnicity/religion is a hopeful one, taking into account such varied experiences and beliefs within one group. Further supporting this, Speight et al. (1991) also discussed the 'matching model' as something which reduces individuals and that the process is not as simple as others have stated. Placing an individual into a characteristic category is not beneficial, as you risk neglecting true individual characteristics and identity that will come into play later in the counselling process.

As I combine the literature read on this topic with my own personal experiences, I too can relate to this argument. I am aware that as my position is of a therapist in the dyad, my understanding of my language, religion, and ethnicity, and so on, whilst matched to that of my clients, could still hold a very different meaning for me. My social construction of my experiences and personal understanding of being a female, Hindu and British-born were undoubtedly different to that of clients who were matched to me, to some degree, on these levels. Of course, no two people can have the same experiences of these levels and our own thoughts, opinions, perceptions contribute to this makeup. Therefore, differences occurred within a matching pair. This feeds into the question of how far we can go to 'match' a therapist to a client. Are we hoping for and expecting more from this process than we actually witness? Through my reflections on the theory that emerged, the literature and my own clinical experiences, I argue that there needs to be further consideration of the 'matching model', in which the above reflections are taken into account.

4.6 The process of discovering theory

I began with the unknown of where and how theory would emerge and where the narratives collected would take me. I feel that I committed fully to the process of staying with the unknown to remain embedded in the narratives and discovery of themes as they emerged. I was unsure of the complexities of the model and struggled at times to understand how the theory and model itself was meant to look or take shape. However, by letting go of this anxiety and attending to the flow of emerging themes and their understanding using memos and other observations, I felt

more comfortable and had a better position from which to see the theory and model for what it is now.

4.7 Reflexivity

I feel that the reflexivity aspect of using Grounded Theory has been imperative to the findings and overall process. Due to the nature of sensitive theoretical sampling and its constant to and fro between the theory emerging and the narratives, reflexivity played a vital part in documenting the thought processes and development of self through this analytical journey. I was able to acknowledge times of doubt, frustration and/or anxiety about the journey, thus allowing me to accept and use the process to learn, mature and develop as an academic researcher. In addition, having willing, honest and open participants undoubtedly encouraged this process and contributed to the end satisfaction with the model.

I also am glad I took the decision to document reflexivity throughout the write-up instead of documenting it at the end. This helps readers understand the research in all its various aspects and stages. Finally, I wanted to invite readers to experience and accompany me on this personal journey through the research, not only from a researcher's stance but from that of a trainee embarking on a piece of doctoral research carried out on an important topic which raises strong passions.

4.8 Strengths

This research provides a comprehensive theory and model to convey the experiences of therapists who are South Asian and who work with South Asian clients in a therapist-client matching service.

A major overall strength of the study is that it offers coherent and original insight into the experiences of these therapists. The theory and model that have emerged allow one to modify, broaden and build upon the current literature on matching and the experiences of therapists from an ethnic minority background. The results also push one to ask many more questions about this topic in general, and can therefore be seen as a facilitator to expand to further research on the topic of matching and its application in clinical work.

Application of the Social Constructivist Grounded Theory

One of the strengths of this research was its application of Grounded Theory methodology. This methodology enabled me to explore narratives with curiosity and allowed this to then spark further exploration and discovery whilst staying with the moment-by-moment experience (Glaser & Strauss, 1967). Furthermore, social constructivist Grounded Theory methodology facilitated the development of a model and theory that is truly embedded in the narratives of human experiences that are socially constructed (Charmaz, 1990, 2006).

In addition, using Grounded Theory allowed an active space to exist for me within the research. My interest not only intensified the interest in the topic, but my knowledge helped me to pursue different ideas and concepts within the interviews whilst remaining open and 'grounded' in the narratives (Willig, 2008; Charmaz, 2006).

Following this, and according to the guidance set by Charmaz (2006, 2009), reflexivity has been vital in documenting my thoughts and feelings. The usefulness of this for me has been well documented throughout this write-up and, thus, further confirms Charmaz's (2006, 2009) beliefs about the nature of Grounded Theory, in that Grounded Theory allows the researcher to fully immerse themselves from a researcher's/academic's perspective. Furthermore, Yardley (2000) suggested that sensitivity to the topic at hand and the transparencies of the research process are some of the vital principles needed in psychological qualitative research for it to be regarded as of some quality. I believe that following the suggestions made by Yardley (2000), these guided principles were obtained through my reflexive approach and my commitment to sustain rigour throughout my research.

Finally, applying the social constructivist Grounded Theory methodology to this study has allowed me to move freely back and forth between data collection and analysis, thus allowing me to retrieve rich and natural data from the interviews (Strauss, 1967; Charmaz, 2006). This also provided a sound framework to work with which was innovative and systematic. Furthermore, the methodology satisfied my thoughts on the process of construction of experiences when people are invited to talk and explore them. As suggested, I was able to commit to participants

epistemological stance using this method and was able to confirm and understand that there is no one absolute knowledge; instead, through constructions of experiences and realities, a number of *knowledges* can emerge and be discovered (Goodman, 1978).

Transferability of results and filling in gaps in the current literature

A second strength of this study is the possible transferability of theory to others in the same field: therapists working within matching services/clients. I take on board the suggestions of Madill et al. (2000) and Charmaz (2006, 2009) that whilst the results cannot be fully be generalised beyond the group of therapists that participated and the frame of context in which the research was conducted, the theory can be useful and serve a valuable purpose in informing us of what others in the same profession may experience, and the processes highlighted by this model could possibly resonate with those who work in a therapist-client matching service. Therefore, this model and theory could be highly valuable for services and therapists hoping to understand the process of matching and what complex processes underpin effective matching or self-care in that role.

Furthermore, the findings from this research do well to fill in gaps in the literature highlighted earlier on in this write-up. The model discovered provides some insight into an area that is highly under-researched.

Theoretical sampling and diversity

Another strength of this research is that I endeavoured to include a diverse range of therapists in the study to ensure that theoretical sampling could take place and that the model and theory would be a sound representation of therapists who are South Asian. Therefore, all the therapists who participated had varied years of experience, came from different theoretical backgrounds and also worked in different parts of London. A final consideration was to use a number of therapists with varied South Asian ethnic backgrounds, including Indian, Pakistani, Bengali and Sri Lankan.

4.9 Limitations and consideration for future research

Abbreviated Grounded Theory

I accepted that due to time constraints of the research and reasons underpinning the nature of this study taking place, I had to commit to an abbreviated version of Grounded Theory, as advocated by Willig (2008). Whilst this still incorporated all of the techniques and analysis of Grounded Theory and allowed me to apply all methods to data collection, analysis and write-up of the research, it did undoubtedly create some disadvantages. Appropriate time was given to coding, exploration of themes and the discovery of the theory and model; however, following the traditional concepts of Grounded Theory and subsequent process of natural saturation and saturation (Glaser & Strauss, 1967 ; Charmaz, 2006, 2009; Willig, 2008) would have enabled me to (1) collect more data and interview a greater number of therapists, thereby increasing the trustworthiness, credibility and transferability of results; and (2) incorporate the use of additional methods, focus groups, quantitative methods and additional information that could have been supplemented by organisations the therapists worked within. This would have provided a far greater foundation upon which to code and analyse, consequently pushing the boundaries of the model and theory itself.

Furthermore, I did not verify the model or theory that emerged with therapists that participated in this research, and I now regret this decision. If this had been done, it would have further confirmed and validated the accuracy of the theory and model discovered and shown that they were truly embedded within the narratives and experiences shared by the participants through the semi-structured interviews. This is an key limitation and should be carefully addressed if this study is to be replicated or taken further.

Extend on the number of interviews

I carried out one interview with each participant and this provided a rich collection of data; however, I believe that going back to the interviewees following coding and the emergence of themes and the model itself might may have been useful to allow therapists to further explore or discuss thoughts shared and views on other data collected. Having this feedback would have increased the trustworthiness of the emerging themes and given me the chance to verify the

model itself. This is a useful consideration for any future research which uses Grounded Theory methods.

Additional methods and resources

As briefly mentioned above, due to time constraints, semi-structured interviews were chosen as the method of data collection. I acknowledge, through final observations of this study as a whole, that using a qualitative method was extremely efficient as it allowed deep and meaningful narratives to be heard and used for data collection. However, using quantitative methods would have added another dimension to this research and so is put forward as a consideration for future research in this under-researched area.. In addition to this, I am aware that many of the therapists who took part in this study came from various theoretical backgrounds. Employing quantitative methods such as questionnaires to explore experience or preferences with regard to outcomes of their clients when working in a matching service would have also been very interesting and useful. As I found the qualitative method thoroughly beneficial, implementing mixed methods is suggested as a future step for this topic.

I am also aware from the results of this study that there is a need for other services (mainstream) and other professionals to gain a better insight in to trans-cultural counselling and how services that provide matching are facilitated and provided to users. Therapists that took part discussed reports produced by their services that explained outcomes and the benefits of matching. Using these reports and combining information in this way would have complemented and further pushed the boundaries of this research and provided scope upon which to further explore and confirm themes produced in this study and existing literature.

Exploring other professional relationships and ethnic backgrounds

I thoroughly enjoyed exploring the experiences of therapists from a South Asian background and believe that the aim set out was achieved with regard to the population that had been under-researched. However, through reflecting on results and comments made by those who participated, it seems appropriate to acknowledge that matching of this level occurs in other professional relationships, such as GP-patient and within social care or the work carried out by interpreters. I can appreciate that the nature of such experience, of course, would be different, but

it would be an interesting extension to this study if those relationships were explored to see how much their experiences differed from the experiences of those who took part in this research and in what ways. This research would enable us to have further insight into matching, what is entailed in different job roles and what are the needs of different professions. Insights like this could allow services in various parts of health care, not just mental health, review how they meet the needs of their employees and other South Asian people who need services other than counselling.

Another consideration would be to explore other ethnic minority backgrounds. The results of this study have conveyed themes such as stigma, labelling and specialist needs and training, and it would be important to see if this was true of all ethnic minority therapists. Research like this would once again heighten the knowledge in matching as a whole and provide useful insight in to training and supervision for those working in trans-cultural services and/or matching.

Male therapists who are South Asian, and Age

I was fortunate to be able to include two male therapists in my study but, at the same time, I acknowledge the difficulty in recruiting male therapists who are South Asian. I recall on recruiting that many spoke about not wanting to discuss their role or simply not wanting to acknowledge what they did. This itself provides some insight into another dimension of being a therapist who is south Asian and a MALE. I wish I had taken the opportunity to explore this explicitly with the two male therapists I interviewed, but I only came to acknowledge the above insight towards the end, where I had already interviewed the two male therapists. I think it would be of great interest to explore the experiences of male therapists who are South Asian. I understand that nothing explicit with regard to this was discovered through my study; hence, I cannot assume that anything more or new would be found. However, I am intrigued by the slight insight I did receive, and it would be of great interest to see whether findings from such a study would differ from mine, where participants were predominantly female.

Furthermore, age is also a factor that could be taken into account. Many therapists spoke about age being a fundamental issue when being matched because of the transference of feeling like daughter or a mother. I understand also from my own background that age and life experience

related to this is significant to the South Asian culture with regard to social relationships and how people act with another. Therefore, it would be interesting to research this further to see if age is a preferred matching variable, or if it contributes to effective positive experiences for either therapists or clients.

4.10 Implications for Counselling Psychology

Counselling Training

Particular findings indicate a need for more acknowledgement of trans-cultural counselling in training. Many therapists spoke about the frustration of having a good grasp of core counselling skills but struggling to know how to apply them when working with culture, religion and/or language matching. Some discussion took place around realising that clinical practice and implementing interventions were indeed different, and more consideration is needed to be given to client needs and boundaries within which therapists are able to work. As such, providing counselling in a matching relationship involves complex care, considerations, decision-making and knowledge. Whilst training approved by the BPS (2009), BACP and UKCP suggests that all training programmes incorporate cultural diversity learning and that this be a core competency requirement for qualification, further teaching with greater focus on working and carrying out assessments with BME clients is required. Training and workshops can be developed through group discussions around existing literature or exploring models such as the one found through this research. Time can be spent looking at how lectures and training on culture and diversity can be extended to include practices and counselling techniques. Space could also be provided for reflective learning using the model found in this research, to explore aspects of self that therapists use in training. This model and thinking is not only proposed for those who are South Asian, but for all practising therapists. Furthermore, training could be given by therapists working in a matching service to provide knowledge to those interested in the area; this could also offer opportunities to break down stigma and challenge labels that may have been created through lack of teaching and learning on training programmes.

Development of clinical needs for therapists

Results from this study also suggest a strong need for therapists working in a matching service to have space where their own needs can be met. A vital insight into South Asian therapists'

experiences involved the inner conflict and struggles in defining their identity and purpose of their work. Furthermore, many therapists, on providing feedback on the experience of taking part in an interview, spoke about their enjoyment in reflecting on their work, speaking to other people who were interested in their experience, thus validating them and their role, and wanting to have more opportunities to talk to others in the same area.

Supervision and personal therapy

Following on from the above, we can see that services providing matching should think about how they meet the needs of their therapists, ensuring that personal therapy is recommended or adequate supervision time is given. This research suggests that there is a need for more specific supervision that meets the needs of the practices the therapists may be working with. This includes identifying self within client and assumption-making as examples. Therefore, thought needs to be given by services as to how they provide supervision, what supervision entails, and how therapists may need and want to use this space. A reflective space whereby peer supervision opportunities to explore process of therapeutic work should also be invited for discussion within such services. The unique practices of matching have been described and highlighted in the model. Therapists should be given time and space to think about such processes and how aspects of self are being used in personal therapy or within the service. Encouragement for open discourse around this should also be welcomed, allowing services to acknowledge the practice of their therapists and how this impacts upon them.

Support forum/groups

Encouragement should be given to attend support groups where networking with other therapists could be established. This would hugely benefit individuals working in this area. Self-care and space to discuss emotional aspects and difficulties should be an essential service provided to the therapists in order to break down some of the negative experiences and conflicts they encounter in their work.

Techniques and strategies used in Counselling

The model implicates some of the tensions in internal processes experienced by South Asian therapists. This model could be used as a discussion point for therapists to think about the

techniques and strategies they use as a part of therapy where matching occurs. Concerns of assumption-making, over-identifying and the use of self were highlighted. Therefore, further input as to how this can be developed within counselling is a vital consideration going forward, especially for those wishing to be, or who are currently, working in such services.

Overall development of Counselling Psychology and services

The findings of this research shed light on a unique branch of therapy and on the extensions services are taking to be able to meet the needs of their clients in matching services. Implications of findings here show that such processes can at times be fruitful and rewarding. Hence, there is a real space for further exploration. Looking at both how therapists develop themselves to work in this way and the motivation to do so creates the foundation for this to be further encouraged and supplemented in the community. This would help to reach the areas where services accessible to such populations are limited.

Final reflection: final thoughts

Writing the discussion has been a rewarding and satisfying experience, as bringing together the aims, results and concluding thoughts of my research has allowed me to truly reflect and appreciate matching, an area that is under-researched. I leave this research with many after-thoughts and a deeper curiosity commences, bringing with it further questions that I would like to explore.

Writing my thoughts on considerations for further research and the impact of this research on counselling practice has opened my eyes to the potential of this research if pushed further. Coming from a position where I am on the final leg of my training and ready to make decisions about job roles and experiences, and also a therapist who is from an ethnic South Asian background, I really value the findings of this research and take on board fully the impact this has for Counselling Psychology as a whole. I valued being able to talk to other therapists who have had clinical experiences similar to mine, and I enjoyed hearing what they go through and how they feel about their work. Therefore, I fully stand behind the need for supporting therapists both professionally and personally working with BME clients and the need for further training, workshops or courses that discuss the issues that arise in trans-cultural counselling. Furthermore, I believe this would be useful not only for therapists from ethnic backgrounds but for all therapists that work with clients who share certain 'similarities'.

Finally, I look back on this journey as a whole and feel that I have taken a vital step forward in an area of Counselling Psychology – an area that I feel is important yet under researched. During the course of the development of the model, I feel that I have grown in confidence and maturity. Using Grounded Theory has allowed me to fully immerse myself in this study and I have enjoyed the challenges, times of confusion, the unknown and the satisfaction with the discoveries I have made.

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Appendices

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Appendix One: City University Signed Ethics Form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

D.Psych

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

A qualitative study exploring how South Asian therapists experience, working in a therapist-client matching service for South Asian users.

2. Name of student researcher (please include contact address and telephone number)

Hatel Bhatt

Add: [redacted]

3. Name of research supervisor

Dr Malcolm Cross

4. Is a research proposal appended to this ethics release form? **Yes**

5. Does the research involve the use of human subjects/participants? **Yes**

If yes,

a. Approximately how many are planned to be involved? Eight

b. How will you recruit them?

Participants will be recruited through the services that they work for. These services will be specialist South Asian counselling services, where the therapists are matched to their clients based on their similarities they share. Services will be contacted through letter and emails inviting them to take part.

c. What are your recruitment criteria?

(*Please append your recruitment material/advertisement/flyer)*

The inclusion criteria are as follows:

Participants will be:

- over 18 years of age
- able to give personal consent
- able to read and write in English
- Qualified therapists (counsellors, therapists, psychologists, psychotherapists etc) working within a specialist South Asian counselling service where they provide counselling for South Asian users.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? No

d1. If yes, will signed parental/carer consent be obtained? N/A

d2. If yes, has a CRB check been obtained? N/A

(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Participants will be asked to take part in a semi structured interview for about an hour. These will be done in confidential space and at the therapist's place of work. Interviews will be recorded and the participant will be invited to debrief at the end.

Times and dates will be arranged before hand and when most convenient for the participant. Participants will also have the researchers contact number, should there be a problem.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes

If yes,

a. Please detail the possible harm?

- Participants may become emotional when talking about the nature of their work as it may seem personal and sensitive for them.

b. How can this be justified?

Support will be available for the participants. The will be asked to advise their personal therapist and or given a list of therapist they can contact, should they need to. The researcher will also make it clear to the participants, they do not have share anything they do not wish to and do not have to answer any questions they don't want to.

c. What precautions are you taking to address the risks posed?

All participants will made aware of this possibility and the researcher will be as transparent as they can be about this. The information and consent form both convey their right to withdraw from the research at any time, should they wish to. The research will also provide space to reflect back on interviews and will be open to provide support and discuss any problems or concerns.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

If no, please justify

n/a

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

- Audio files/tape recordings will be kept of each interview conducted.
- Excel database of organisation/therapist contact details and notes regarding each interaction
- Paper copies of therapist consent forms

- All tape recordings and audio files will be stored on a password restricted laptop and will be encrypted to preserve anonymity. The laptop will belong to the researcher only and will be kept locked when not in use.
- Excel database with contact details will be encrypted and stored in a password protected folder on the password protected laptop.
- All hard copied will be stored in a locked filing cabinet.
- All data collected will be dealt with by the researcher only and if shared by their appointed supervisor, they will be bound by confidentiality too. All transcriptions shared with the supervisor will also be encrypted.

13. What will happen to the records at the end of the project?

As soon as the research has come to an end and the researcher has finished her doctorate all data collected will be destroyed.

14. How will you protect the anonymity of the subjects/participants?

Names and contact details will be stored in a password protected excel database on a password secured laptop. No named or identifiable data will be taken from this laptop and no data will be transported or transferred electronically or manually. The researcher will only have access to this information.

All audio file names will be encrypted and no real names or personal identities be revealed at any point in the write up of the research.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

.

After each interview, a standardised debrief information sheet will be given to each participant. All participants will be invited to ask any questions and if they want to; reflect on the interview conducted. They will have the contact details of the researcher should they need to get into contact to discuss any worries or concerns.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Date: 28/1/11

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal yes

Recruitment Material yes

Information Sheet yes

Consent Form yes

De-brief Information yes

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? YES

If yes,

a. Please detail possible harm?

The researcher will be travelling to the participant's places of work, where interviews may be conducted.

b. How can this be justified?

To be able to conduct the interviews where it is most convenient for the participants, the researcher will have to travel to their place of work. This ensures they are most comfortable and it is most convenient for them.

c. What precautions are to be taken to address the risks posed?

All interviews will be pre arranged and dates, times and locations will be recorded and sent to the supervisor to keep record. A point of contact at each place will be stated and all emergency details will be provided should a problem occur. The supervisor with the details in hand should be able to intervene appropriately and without trouble.

Section C: To be completed by the research supervisor

(*Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.*)

Please mark the appropriate box below:

Ethical approval granted ✓ [redacted] mc

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

[redacted]

Signature ---------- Date---------- 15/05/11

M. Cross

Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where* ***underlined bold*** *items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature --- [redacted] ---------- Date 8/2/17

Appendix Two: Research information letter sent out for recruitment

Counselling Doctorate Research Project
Researcher: Hatel Bhatt **Address:**
School of Social Sciences City
University Northampton Square
London EC1V 0HB **Tel:**
[redacted] **Email:**
[redacted] **City**
University London Research
Supervisor: Dr Jacqui Farrants

[Date]

Subject: A qualitative study exploring how South Asian therapists experience working in a therapist-client matching service for South Asian users.

Dear Therapist,

I am writing to invite you to take part in a research project exploring how South Asian therapists work with South Asian clients in a counselling relationship. The aim of this research is to be able to gain an understanding of how South Asian therapists work in organisations where they are clinically matched to their clients on the basis of language, religion, gender and ethnic background. The researcher aims to capture your experience to gain a better understanding of the experience of working in such a therapeutic relationship.

Your involvement would require you to participate in interviews sharing your experience of working in such a setting. Interviews would take between 45 and 60 minutes and they can take place at your organisation or at City University during work hours.

Along with this letter I have attached an (1) **information sheet** that will provide you with more information on the research being conducted. If you are happy after reading this to take part in the research, you will need to sign a (2) **consent form** before interviews can go ahead. These will be signed before our first interview, but a copy is attached for you to look through.

Thank you very much for your time and consideration in taking part. I look forward to hearing from you soon.

Kind Regards,

Hatel Bhatt

Researcher: Hatel Bhatt (City University London)

Appendix Three: Research Information letter for participants

Counselling Doctorate Research Project
Researcher: Hatel Bhatt **Address:**
School of Social Sciences City
University Northampton Square
London EC1V 0HB **Tel:**
Email:
City
University London Research
Supervisor: Dr Jacqui Farrants

Information sheet

I would like to invite you to be interviewed about your experiences of working in a South Asian organisation where therapists and clients are matched on the basis of their language, gender, religion and ethnic background. This information sheet explores the research further. Please take your time to read the information below.

What is the study?

- I am interviewing South Asian therapists who work in South Asian organisations providing counselling for South Asian clients.
- I hope that this research will generate findings on how South Asian therapists make sense of their unique relationship and what organisations can do better in helping to care for them and their clients.

Do I have to take part and what will I have to do?

- If you are happy with taking part, you will be asked to sign a consent form, but you are not obliged to take part if you do not feel comfortable to do so.
- Once giving your consent, you still have the right to withdraw at any point in the research, and you will not have to provide any reason for doing so.

- If you are happy to participate you will be interviewed to explore your experiences of working with South Asian clients.

- You will be asked to read and sign a consent form to show that you understand what is involved in the research and that you accept to take part. The whole interview should last approximately one hour and can take place wherever is most convenient for you. The interview will be tape recorded so that I can compare your experiences to those of others who work in these settings.
- The consent form will ask you to consent to the interview being recorded.

Confidentiality?

Only I, the researcher, will have access to any data collected, which will be kept on a password-restricted laptop. I may have to share some of the data with my research supervisor, who will also be bound by confidentiality. In the write-up of this research, quotations may be included, but your identity will not be exposed. I will make every attempt to anonymise wherever possible. Your information will not be passed on and will not be used irresponsibly. Once the research is completed, any information that is no longer needed will be destroyed.

Advantages and Disadvantages?

Advantages: I hope that by with your participation and by and sharing your experiences, I will be able to share results with organisations that carry out such services so that that they can improve the way in which their services meet the needs of South Asian therapists as well as the needs of their clients.

Disadvantages: Discussing your experiences, you may feel emotional. Should you feel any discomfort at any time during the interview, you are free to withdraw from the research. You also have the right to only answer questions during the interview that you feel comfortable answering.

What happens after the research is completed?

I will be happy to share the results of the research with you and your organisation. Research will be then submitted to conferences and journals so that the results can be shared with those interested in how South Asian therapists work with South Asian clients.

Review and Ethics Approval

This research has been reviewed by Dr Malcolm Cross, who can be contacted at City University, School of Social Sciences, Northampton Square, London, EC1V 0HB. The research has also passed the City University London Ethics Review Process.

If I want to take part, what do I do next?

If you are happy to take part after reading the above information, please contact me on [redacted] or at [redacted] and I will get in contact with you to arrange a mutually convenient time for us to meet.

If there is anything else you would like to discuss or any problems or worries, please do not hesitate to contact me or my supervisor: Dr Jacqui Farrants. (Email: [redacted])

Appendix Four: Research Consent form

Interview Consent Form

Date of interview:

Please tick each box if you are happy to take part in this research

1. I confirm that I have read and understood the information sheet for the above study.

☐

2. I understand that my participation is voluntary and I can withdraw at any time I feel the need to without having to give a reason to the researcher.

☐

3. I am happy for the researcher to interview me to explore my experiences of working with South Asian clients.

☐

4. I am happy for the interview to be audio-recorded and I am aware that the recording will be retained for the write-up and transcribed by the researcher. I understand the data will be destroyed once the research is completed.

☐

5. I understand and am happy with the confidentiality aspects of the study

☐

_____	_____	__/_____/_____
Your Name	***Your Signature***	***Date***
_____	_____	__/____/___
Name of Researcher	***Signature***	***Date***

Appendix Five: Interview schedule

1. What do you think about therapist-client matching?
2. What attracted you to working for this particularly service?
3. What made you want to work with South Asian clients?
4. What do you find positive about your therapeutic work and/or challenging?
5. How do you work with the issues that you mention?
6. Do you work for another organisation that doesn't have South Asian users? Does it differ?
7. How are you able to take care of yourself in your work; what role does supervision play for you?
8. How have you felt about the interview today?

Prompts to use during interview

- Can you tell me more about that?
- How do you manage/understand that?
- What happened next?
- What led you to do that?
- Could you provide examples of this?

Later questions added:

- How would you describe some of the processes or decision-making that takes place when working with matched clients?
- How do value your job role?
- Do you feel different sides are identified when working with non-South-Asian clients compared to South Asian clients?
- What does transference mean to you; is it something that is experienced in your work?

- How do you view your personal self compared to your professional self with regard to the type of work you do?
- How would you relate training and support needs with therapist-client matching?

Appendix Six: Debrief letter for participants

Dear Participant,

This interview was conducted to explore your experiences of working as a South Asian therapist.

Research has shown that therapist-client matching is seen to be beneficial for the South Asian client. However, little research exists looking into the South Asian therapist's experience of being matched to the client, especially on a number of levels. With this in mind, I was particularly interested in hearing about how you work with South Asian clients.

To gather some knowledge in this area, I am interviewing a number of South Asian therapists who are working in specialist counselling services to provide counselling for South Asian users. By exploring your experiences, I am hoping to gain an insight into what it is like for you to work in this way.

Finally, I would like to take this opportunity to say thank you for taking time to be a part of this research.

Appendix Seven: Interview memos

Below are samples of interview memos taken straight after the interview was conducted. Memos represented my thoughts and understanding of not only the interview and the knowledge gained but the process and experience of gathering information and my position throughout the interview.

Interview 03:

- Not of the same quality as the others, connection was off, was I different in this interview compared to others?
- Participant was male – could this be the reason for 'off' connection. Talking about matching – did our difference in gender create moments of apparent differences in our interview? – wonder if this ties in with what participant was saying when talking about women and not connecting in the same way.
- Newly qualified – keen to impress? Offering more good than bad as a result? – was commented on when he concluded how he felt about his work.
- KEY POINTS: Passion for group as main reason to start working, thought about good points more but mentioned that job role still felt unfulfilled – new to career, is there more?
- Observations: distant (gender?), silences – conscious of not filling in the gap with my own stuff.

Interview 05:

- Really good, I really enjoyed listening to her – open and vocal about her thoughts – almost as if she felt this was her chance to 'tell her story'.
- Anger towards NHS, why can't 'they' see the needs. Strong differentiation between NHS and voluntary.
- Bitter about status and how she is viewed – wants more acknowledgment and wanted me to realise this.
- I felt I needed to let her voice her thoughts, struggled with wanting to find out more about NHS experience – my own curiosity away from topic at hand.
- She really enjoyed interview – wanted to go on.
- KEY POINTS: 'us' and 'them' – conflict, stereotype, anger, frustration. LABEL

- Observations – felt alert! Wanted to hear more, she spoke fast!! Interview process was energetic, passionate; feel excited about topic – my own stuff? Wanting to unpack and let voices be heard?

Interview06:

- Good moments after tape finished!!!! Conclusions on her experience of the interview – chance to speak, never really heard...frustration I couldn't explore this within interview itself.
- Passionate about her work (talked excitedly when discussing reasons for why she joined organisation), strong conflict when having to talk about the bad – wanted to justify a lot.
- Attracted to helping because of personal frustrations in finding SA therapist.
- Two heads – feelings of push and pull felt in the process of the interview.
- KEY POINTS: labels, needing a space to talk, other professionals don't get it. Loves client group – the need to be there – who else is?
- Observations: relaxed a lot after interview, seemed tense when talking about labels and not being recognised. Discussed a lot of facts and figures.

Interview 08:

- Difficult interview – I held thoughts of possible codes in my head and participant struggled to engage fully. Short answers given and hesitated to explore with me.
- Lots of examples given to convey feelings: boundaries with older clients felt – experience of acting like a daughter, wanting to give more and feeling bad.
- Felt comfortable in own language more than English –'English brings in differences'. Language strongest factor in therapist-client matching. (Aware this has been mentioned a lot, but explicitly explored here.)
- Connection felt at the end when talking about training – really opened up about difficulty in finding support – looked sad and angry? Who at? – uni, organisations, self??
- KEY POINTS: power of language, acceptance by clients and clients accepted by them, Passion, older clients = more problems in therapeutic boundaries broken.

- Observations: slow paced, trying to ask questions against present knowledge I had to explore, but struggled – got lost on examples – worried if information knowledge is gained from them.

Appendix Eight: Example of transcript with worked stages of analysis

Track changes: LINE BY LINE CODES

Left hand side: FOCUSED CODES

Reasons for working therapeutically through mattering

Preference for South Asian client group

Interviewer: So maybe we can start of, with you telling me about yourself and the organisation and how you came to the organisation

Erm, the organisation is [omitted]and we work with south Asian women. It's a [identifiable information- omitted].

I came in 6 years ago I think, I first started off as one of the housing support workers here and did that for a while and moved out in to outreach and did that for a good couple of years and left and then back in to housing support and then finally got into counselling. Which is my favourite place to be.

Comment [HB1]: Prefers counselling compared to housing and outreach support

Interviewer: Ok, so how was the shift from working in housing, then coming into counselling, how was that, what made you come into counselling and especially working with south Asian women?

I think I've also known that I've always wanted to so do something more therapeutic. Erm, but it was just doing the course. Do you know what I mean? It took a while and took stages and financially the help. So I knew that's what I wanted to do. And I noticed that with each role, with the housing support and the outreach, that I was kind of drawn more into the emotional and well-being of the client as well as the practical. So that was my preference role and I spent a lot more time working therapeutically with my client which worked for me and my clients at the time. And when I realised finally this is definitely where I want to be and there is only one way I can do this, I went and studied for it. And that's what I did and I have no regrets about what I want to do and I realised that I have had a fabulous time in housing and fabulous time in outreach but this is you know, and I have had a wonderful couple of years doing this and particularly with this client group as well, so yeah.

Comment [HB2]: Incentive to work therapeutically all along.

Comment [HB3]: Drawn to counselling work

Comment [BH4]: Preference for counselling

Comment [BH5]: Enjoying counselling particularly with South Asian women clients

Interviewer: You mention wonderful years because of working with this particular client group, can you tell me more.

preference for client group.

I think, that's a good question, the fascination. Erm. Although I've been around for a few years and was at another Asian project before here as a housing support. Each time I hear a story no matter how similar it might be it still fascinates me each and every time and it's that fascination that's keeps me there and makes me want to work more with these clients and help them work through these issues if that makes any sense. Its its....

Comment [HB6]: Fascinated for South Asian women

Comment [HB7]: Being fascinated leads to anting to work with south Asian clients

Interviewer: Mmm, so you feel fascinated by working with South Asian clients?

enjoyment of role/work.

Yes, Absolutely, it has to do with looking at patterns and similarities across the whole kind of Asian board when working with south Asian clients is what I enjoy. If that makes any sense, umm, there could many communities, but in general when working with south Asian community, there is such strong similarity in terms so of pressure and stereotype and discrimination and oppression and it's just so powerful it just keeps me alive and I just I don't know it's just...

Comment [HB8]: Observing patterns and similarities within Asian community, enjoyment in role

Comment [BH9]: Working with problems community faces keeps her feeling alive, finding this work powerful

Interviewer: mmm

Understanding for self

I think for me, in general, I think working with South Asian women, it has definitely given me a good foundation and err, a huge awareness; huge insight in to my personal life, being in this you know how it works and so I think my empathy skills are probably, I would say are quite high in that sense, because of my own identity, I get it

Comment [HB10]: Providing a foundation for self

Comment [HB11]: Working with South Asian provides insight in to own life

Comment [BH12]: Empathising with clients because of shared cultural identity.

Interviewer: And do you think that's because you share some of the things that they obviously bring because of the matching?

Understanding experience through clients outcomes/ consuming experience

Yeah, having that understanding and what that must be like for them, And how isolating and frightening and lonely these things can be.

Comment [HB13]: understanding

Interviewer: Hm…Hmmm, it sounds like you really enjoy it, and enjoy the fact that you can understand and have the empathy

I do. The advantages of doing this job, is when you see good results when you see clients at the beginning and what it is like for them at the end, when they come through this period when they, when they sort of are able to trust themselves more and just somehow happier more happier in their own skin of that makes any sense..

Comment [BH14]: gaining good outcomes

Comment [BH15]: clients are found to be happier

Interviewer: Mmm

That's a really huge thing. Coz I find that most of the clients I have worked with probably have never had the experience of being able to tell anybody what they have gone through. Or been going through It's a very scary thing of even opening their mouths particularly to a stranger. Because it's just a no no thing it's just you don't share your problems, whatever happens in the house stays in the house kind of mentality so than to cross that barriers it's such a huge thing and an achievement for my clients and for myself, that they can overcome that. When they kind of discover, start to discover who they are and what they can do in life and what they allow themselves to do, you know when they learn about themselves, that's a real a gift I think there.

Comment [BH16]: important to see good outcomes

Comment [BH17]: clients unable to seek help elsewhere

Comment [HB18]: Asian clients don't share their problems

Comment [HB19]: helping clients to cross barriers

personal achievements

Comment [BH20]: clients finding themselves in counselling, seen as a gift.

Interviewer: So being there and watching their journey?

Yes definitely, definitely, from there to there to there. Definitely, and I think if it wasn't this bit here, the discovering... it wouldn't be as fulfilling...because of the things we share, the matching, we can discover lots of things.

Comment [BH21]: matching permits discovery, finding this process fulfilling

Interviewer: Hmm

It is hard at the end, when you have gone through that journey. I'm happy for them you know and I'm happy that they are off in to the world and do their own thing and you know and that they are in a much better place and def more happier for them. But there is a part of me you know, when especially you connect with clients , I do miss them but glad that they are out doing what they want to do kind of thing, but yes there is part of me that misses them. I guess, because I have shared some intimate times and erm being a counsellor we have our boundaries so it not like I can just see them. They find this hard to deal with that the boundaries. It's the hardest bit with this type of work (matching), because you have to detach yourself and so do they, they find it hard because we haven't only shared the journey we have shared all the levels, language, religion, culture and all that. That's what get you the connection most of the time, so you are leaving that. But then what I usually say to clients, also is that, they also might return back to counselling and it's like there isn't one dose and that's the end of it, you kind of use it as a resource isn't it? When you need to kind of thing. and so some of my clients dip in and out if they feel they need to.

Comment [HB22]: happy to see outcomes of clients work

Comment [BH23]: having a connection

Comment [HB24]: sharing intimacy

Comment [BH25]: Boundaries are challenging.

Comment [BH26]: Sticking, acknowledging Boundaries are challenging in matching

Comment [BH27]: Process of detachment.

Comment [BH28]: sharing

Comment [BH29]: sharing permits a connection

Appendix Nine: Research memos for the process of discovering emerging themes.

1. **Memo: My reflective analysis process of line by line – shared in supervision**

- Struggle between being objective and interpretative...reminding myself of the process of coding – need to discuss in supervision.
- Too many line-by-line codes? How am I defining a line code? Being too 'picky'?

2. **Memo**: **My reflective analysis process of focused codes – shared in supervision**

- Picking frequent line by line to discover focused codes – struggle and having to review a lot of codes. Worried if they are focused codes or 'am I' making it fit? – Review in supervision**.**
- Discovery of focused codes – clearer knowledge in my head – feel better! Lots of focused codes – did that derive from too many line-by-line codes? Have I picked it apart too much??

3. **Memo**: **Samples of emerging focused codes for interviews:**

Interview 01

- Acting as a link between community and mental health
- Experiencing job stratification
- Placing demands on self
- Making assumptions
- Breaking boundaries
- Being pushed to break boundaries
- Feeling misunderstood
- Having to explain
- Using personal experience in work
- Feeling accepted when similarities shared
- Comfort experienced when knowing similarities exist
- Wanting to meet the needs – feeling a sense of duty
- Acknowledging the guilt of working in another profession
- Lacked support in training

Interview 02

- Job meeting the needs of personal life and passion

- Having to deal with being misunderstood, therefore preference for matching
- Experiencing relational depth
- Feeling and experiencing reward/passion
- Identification in clients – boundaries and assumptions
- Feeling comfortable due to experience
- Still having core values – how am I different from others? – working with 'sameness'
- Measuring self-value
- Understanding what matching is and how useful
- Similarities being pushed to one side – core values of approaches used
- Gaining support through supervision

Interview 03:

- Highlighting gender importance for matching to work
- Matching key to feeling accepted
- Passion led to finding this client group
- Very fulfilling, feeling useful
- Still has gaps – wanting to learn more
- Acknowledging the start of career
- Fearful of feeling limited as a therapist

Interview 04:

- Unpacking personal experience – bad when not with a SA therapist
- Wanting to correct, make a change
- Feeling passion about job role and client group
- Being accepted
- People stereotyping
- Being understood
- Fighting other professionals
- Boundaries blurred
- Experiencing transference both ways
- Questioning identity and role

- Wanting support through supervision

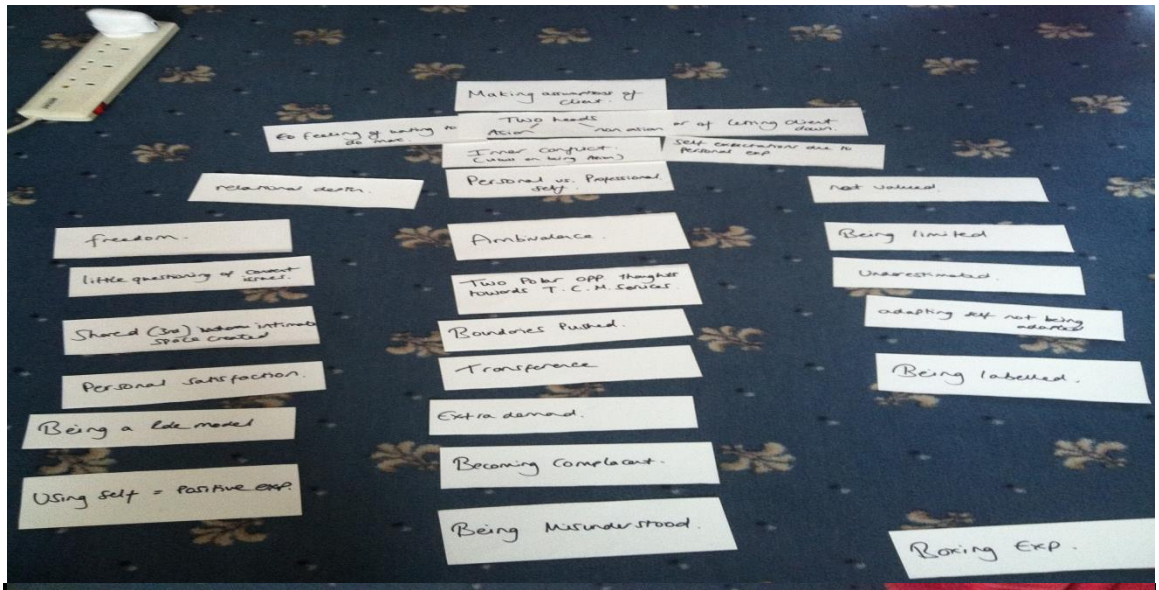
Interview 05:

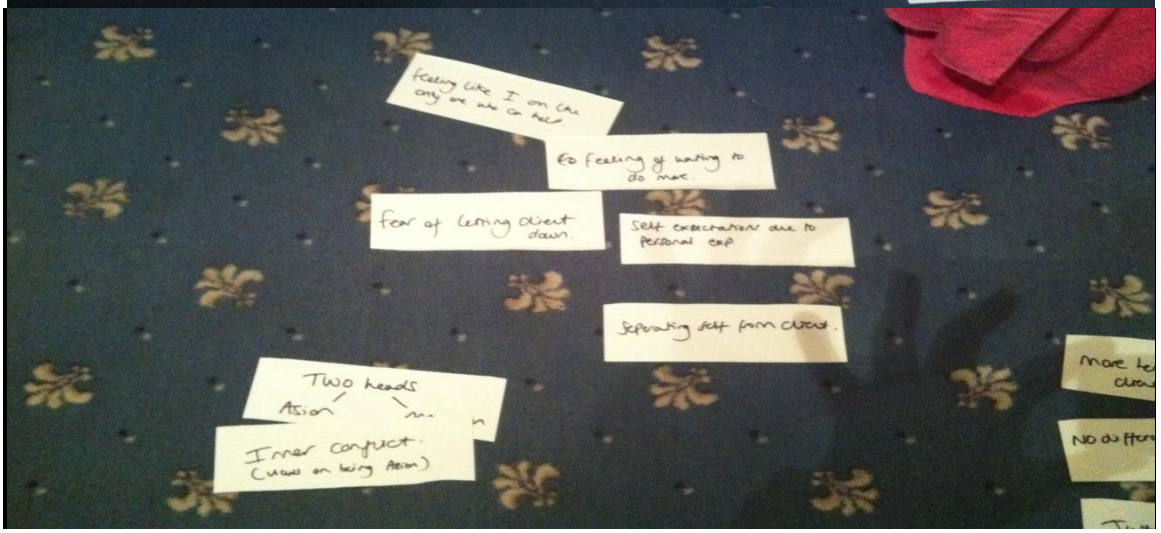
- Labelling
- Differentiating between other therapist and SA therapist
- Organisation being discriminated
- Matching is ‘normal’
- Comparing with NHS – they don’t meet the needs
- Feeling passionate for community
- Using personal experiences
- Feeling comfort with working with sameness

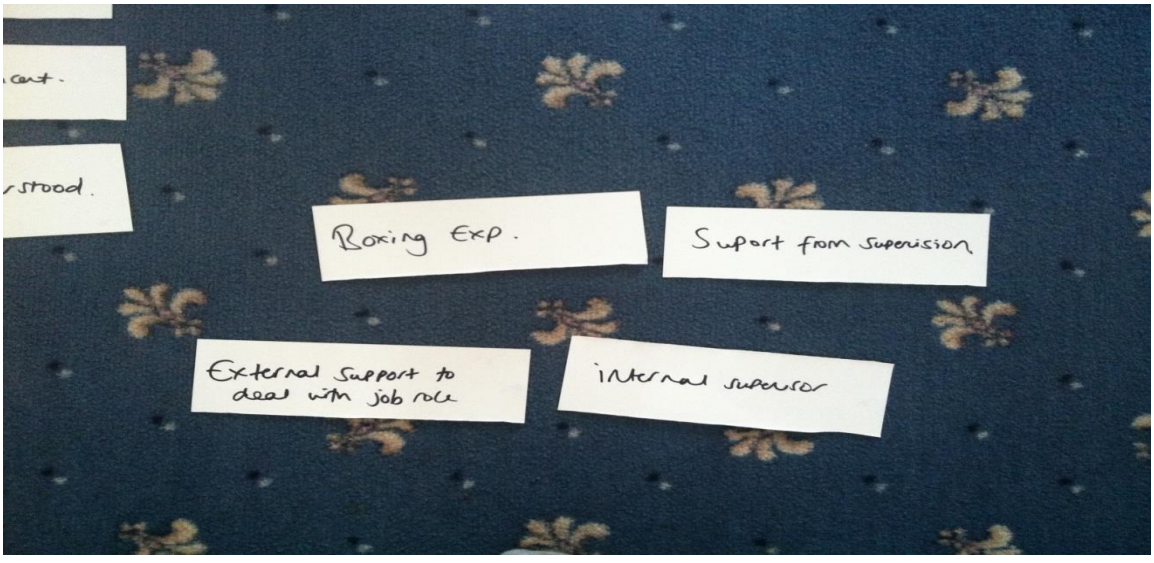
Interview 08

- Experiencing two heads
- Separating personal and professional self
- Wanting to do more than job role

4. The process of discovering categories – creatively.



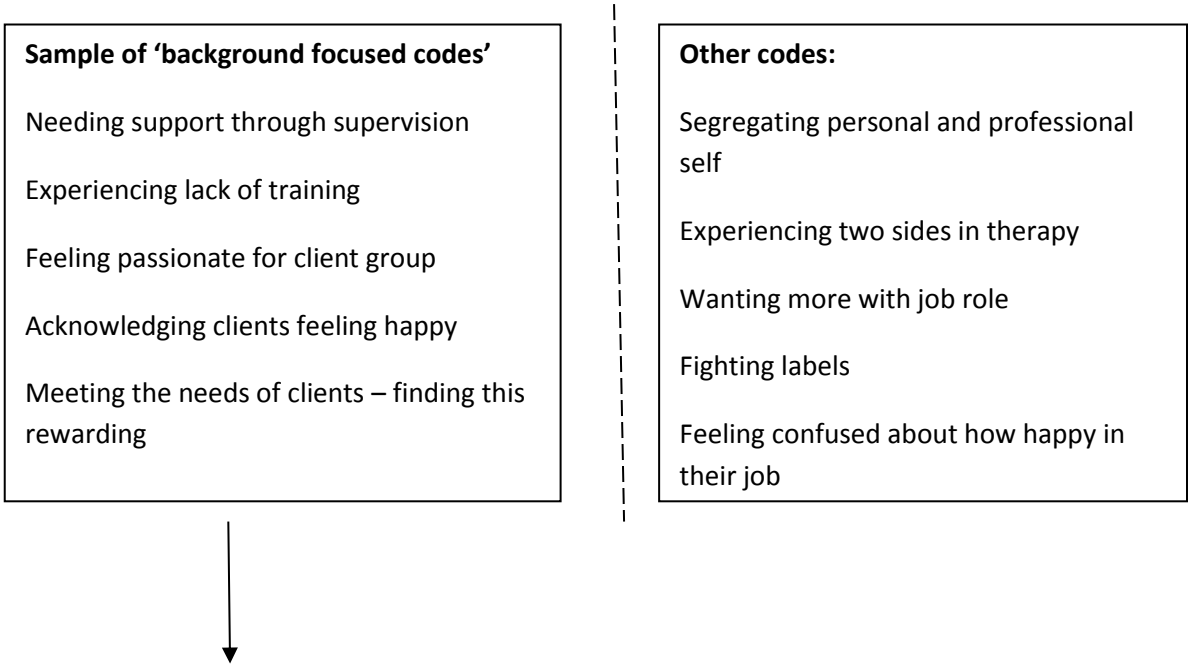




5. Memos for lower level themes

Focused codes segregation in how specific they were to this research focus group.

- When focused codes were analysed, I felt there was a clear divide in those that 'faded' into the background and those that seemed very specific to the questions at hand.
- Further thought went into understanding the role of the 'background' codes.



Why do these feel familiar – not as important?

- Experienced by only South Asians or by all?
- What part do these play in understanding the experience?
- How were they presented in narratives?

Identifying codes as important but at the lower level

- Codes were important and they were very present and embedded in all narratives. All therapists spoke about the 'basic' needs of their role, what their reasons were for joining a matching organisation and experiences of their work in examples of what clients' experiences were.

- All codes attached to this were found at the beginning of the interview – experiences were a storytelling process. All of these focused codes came when therapists were 'easing' themselves into the interview – hence the foundation to their experience? Therefore, they give rise to higher, more core level themes.

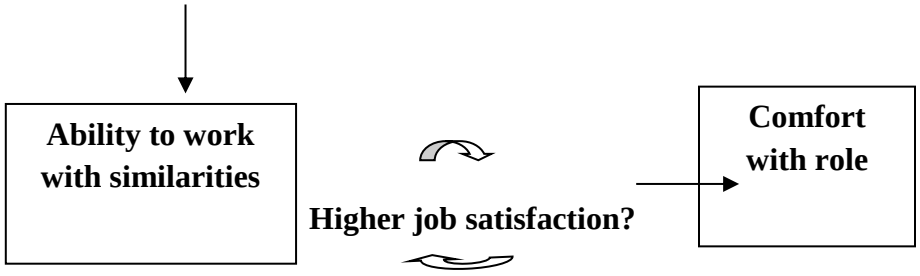
6. Memos for higher core themes

Acknowledging self-processes

- Examples of focused codes: making assumptions in clinical work, being pushed to break boundaries, finding it hard to separate from work.
- Strong voice heard with regard to this theme. Very apparent in all narratives. Sensed as the moving, flowing and driving forces of experiences.
- Acknowledged that some of these processes were encountered in interviews themselves – bringing processes in to the interview?
- Struggling to determine if this theme is lower level – are processes identified, experienced by all? – NO!
- **Explanations given are specific to the experience of therapist-client matching**
- Understanding role identity – a part of experiencing internal conflicts? – review codes – NO – codes very much convey the process of understanding the limits of their role and what they should be doing when helping clients. Therapists did not describe 'conflict' or 'struggle' when discussing this aspect of their experience. Therefore, highlighted as internal processes rather than conflict.

Level of experience

More experience, more supervision, more training



In addition: Newly qualified, wanting more from job, conveyed less comfort with working with similarities – less job satisfaction? (Interrelated themes?)

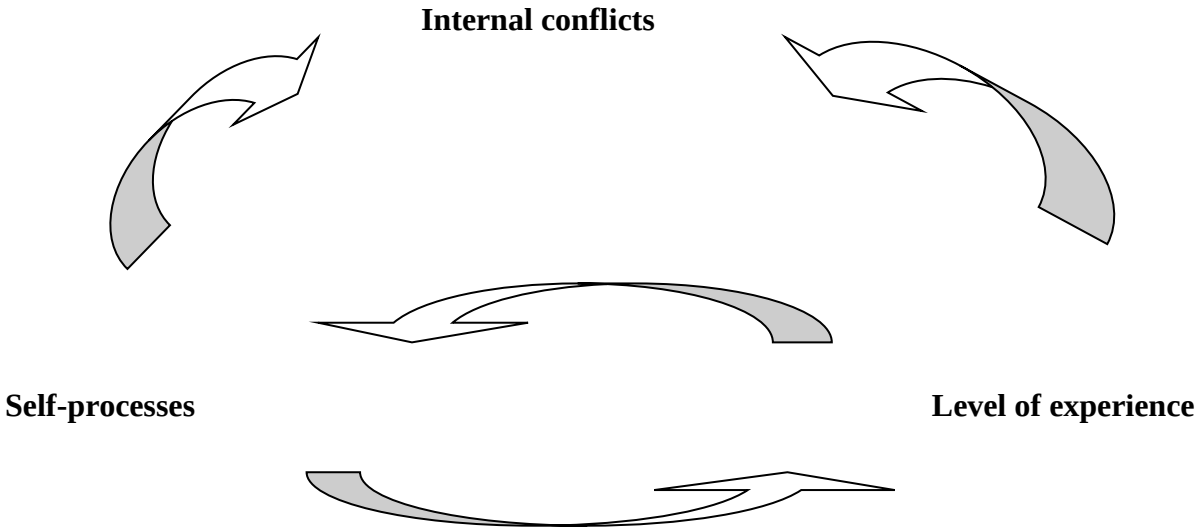
Experiencing internal conflicts

- Therapists speak of and make every effort to voice and highlight the struggle faced within their role. The everyday struggle between 'switching' between South Asian self and 'normal' non-South-Asian self in therapeutic interventions. Many spoke about the decision-making in realising when to use which one.
- Observations from interviews also give strong input into the discovery of this theme; a lot of anger, frustration and wanting to voice and use this study as a platform to raise awareness over labels created. Strong theme encountered from the very beginning.
- I felt this was the 'loudest' theme I heard when given insight into their experiences... Head of the core higher themes? Most central to their experience?

7. Memos for overall theory

Higher level core codes - the formation of the triangle

- Internal conflicts seem to be the most complex and deep-rooted aspects of the experiences shared by South Asian therapists. Also presented at the end of most narratives – seen as final statement – a lot of impact and unpacking.
- Internal processes and level of experience seen as underpinning internal conflict.
    - Therefore...



- But are the ‘related’ concepts my own thoughts? Not explicitly said!

Part Two

Clinical Case Study

Social Anxiety Disorder – Meeting the client's needs:

An advanced clinical case study looking at ways to evolve therapeutic practice in Cognitive Behavioural approaches

Abstract

I present my work with [1]Mary, who came to therapy to understand and find ways to cope better with her social anxiety. The study will convey the therapeutic work that was carried out between Mary and me in conjunction with working with Clark and Wells' (1995) Social Anxiety Disorder (SAD) model and later using Acceptance and Commitment Therapy (ACT) interventions. The process of therapy will be described, including elements of difficulties, use of supervision and our overall treatment plan. Finally, an evaluation and reflection of my work and experiential process of being a Cognitive Behaviour Therapy (CBT) practitioner will also be discussed.

Chapter One: Introduction and Start of Therapy

1.1 Introduction and Rationale

There are a number of reasons why I chose to present this case study about my clinical work with Mary. Firstly, I am able to demonstrate how I was able to use Clark and Wells' model of Social Anxiety Disorder (1995) with Mary to gain an understanding and formulate her reality of living with SAD.

Secondly, our therapeutic relationship throughout our sessions was at times challenging as well as unique, and so this was certainly a development point for me at this stage in my training. Therefore, being able to discuss and evaluate this throughout this case study allows me to reflect on how much growth I was able to obtain from working with Mary and her presenting problems.

[1] Please note that in the interest of confidentiality the client's identity has been protected through use of the pseudonym 'Mary' and all other identifiers have been changed.

Finally, whilst working with Mary, we experienced a fundamental change in our process and treatment plan. This change allowed me to broaden my understanding of CBT. For this reason, I would like to present this to showcase how I have personally and professionally matured in understanding the breadth of CBT and the development of the approach from its core traditional principles when first established.

1.2 Theoretical Orientations

CBT combines both cognitive therapy (Beck, 1970, 1976) and behavioural therapy (Bandura, 1977). The approach helps individuals in therapy to recognise and highlight their negative patterns of thinking and dysfunctional behaviours. The model informs that negative thoughts arise from the way one individual interprets situations and past events they have experienced, (Beck et al., 1979). The behavioural element is recognised as the individual's reaction to the emotions attached to their distorted thoughts. The behavioural elements of the approach are also identified as the processes that help to maintain the emotional disturbance one experiences.

Clark and Wells' Model for Social Anxiety Disorder (1995)

In working with this client, I have specifically worked with the Clark and Wells' (1995) model for Social Anxiety. This is a widely known and used model to effectively work with individuals who suffer from SAD within a CBT framework. The model (Appendix One) takes into account the following: (1) triggers; (2) belief systems and assumptions activated as a result; and (3) the perceived level of danger. The model also has a strong emphasis on combining both cognitive restructuring and attending to safety behaviours. NICE guidelines recommend that this model, as a form of CBT, is used to inform treatment for an individual suffering from SAD (NICE guidelines, 2009), and research has shown that working in this way is most effective in treating SAD (Mattick & Peters, 1998).

The model was appropriate to use when working with Mary as it encompassed and established a treatment plan that identified effective interventions for Mary's presenting problems. She had stated that her social anxiety was generalised to many social interactions and situations. Within these experiences, Mary discussed feelings of being exposed and therefore feeling as if she was

in danger. As a result of this, she further felt a risk of being subjected to loss of self-worth and scrutiny by others. Because of this perceived danger, she experienced a high level of distress in the form of anxiety and therefore experienced physical and psychological symptoms.

Mary also disclosed that she feared that by talking to me, her anxiety would be triggered and prevent her from making the most of our sessions; as such, she expressed a strong concern about starting therapy and making a commitment to it. I recognised that effective CBT stemmed from collaborative empiricism (Padesky et al., 2008); therefore, working in this framework would allow me to support Mary through her sessions and for us to join together to manage her fears and work with both the behaviours and cognitive elements of her disorder. Furthermore, the collaborative nature of CBT would enable us to reach the goals outlined in her assessment.

1.3 Referral and context of work

Mary was referred to our service by the Older Adult Team within the community's Mental Health Service. She had requested therapeutic support to help manage her feelings of anxiety and her inability to leave the house. Therefore, our service was suggested as a resource for individual therapeutic work.

I worked with Mary in an NHS counselling service which provides secondary care. Mary had already been seen by another member of our team, a qualified counselling psychologist who had carried out an initial assessment. As a result of the assessment, Mary was referred to the CBT list for individual therapeutic work. The service provided 12 sessions with a review to be carried out in the sixth session. Supervision was provided to me on a fortnightly basis by a qualified consultant psychologist with a clinical background in CBT approaches.

1.4 Client Profile

Mary is 72 years old and currently lives with her daughter. Mary was married for 44 years, but, sadly, her husband died three years ago from cancer. She reported that whilst she found this difficult and heart-breaking at the time, she did not cry but instead became very 'inward', not

talking much about her feelings or letting family members know how she was coping. She reported that she still missed him as she had spent her life doing "everything with him" and they had been very independent. Mary also reported that she did not think there was any clear link between her presenting problems and the death of her husband as she had become anxious before he died or he became very ill. Overall, Mary appeared in good physical health and was always well presented and arrived on time, often early, for her sessions.

Mary describes her relationship with her two children as loving and supportive and "would not know what she would do without them". Mary was always accompanied to and from her appointments by her children as she found it too anxiety-provoking to attend any appointments, including our sessions, alone.

Mary also had a close relationship with her younger sister despite there being a big age difference. She reported that she often felt like her second mother and wished she was as carefree as her sister. She attributed the differences in their personalities to the different types of upbringing they had. Mary grew up during the war and had a stricter upbringing than her sister due to the stresses and quality of life during that time. Mary remembered being a good, obedient child who was surrounded by adults for most of her childhood until her sister was born.

Mary found it difficult to remember if her social anxiety had persisted when she was younger and reported no history of mental health or similar symptoms to those with which she presented at the time of beginning therapy. She stated that she thought her anxiety became problematic after she came back from a holiday with friends four years ago, as prior to this, she was out and about and reported being called a 'social butterfly'. She explained that the holiday did not go to plan as the hotel and trips Mary had booked for her friends were not up to the standard she wanted them to be and she felt her friends, as a result, did not have a good time. She reported feeling guilty for this and therefore had subjected herself to a process of post-event rumination since returning home. She also described evaluating herself negatively as a result of the holiday, despite her friends telling her they had had a good time. Since this holiday, Mary had reduced considerably her social excursions and engaging in social activities with others. She mentioned suffering from chronic worry about things going wrong as a result of this experience.

1.5 First session

Our first session was used as an initial meeting where we were able to introduce ourselves. We agreed that our first session would be used to gain an insight into and explore what Mary wanted from therapy, and the goals and expectations she might have at the beginning of individual therapy. I also ensured I carried out a CORE evaluation and explained the terms of therapy, confidentiality and our general contract. Opportunity was also given for Mary to ask any questions or to address any concerns she had about beginning therapy.

Mary had arrived early to our session and so had to wait in reception. She appeared very anxious and admitted that she had found it difficult to attend the first session. She found it hard to articulate what she was specifically feeling and mentioned the worry about not "coming across right" when talking. When discussing her presenting problems, Mary became quite anxious and began to stutter and described feeling heavy. It was apparent to see that the conversation and initial meeting itself was a social interaction that Mary perceived as dangerous and anxiety-provoking.

I described the CBT (Beck et al., 1979) model to convey the relationship between our thoughts, feelings and behaviours. I empathised with how she was feeling and conveyed that I could understand how difficult it must be for her to attend our session but also acknowledged that attendance was sign of motivation for change.

1.6 Assessment and presenting problems

It is important to note that because Mary had disclosed in her assessment feelings of low mood and depression, a risk assessment was carried as part of her overall assessment. Mary had showed no intentions of taking her life and was reported saying that her "family and motivation to feel better" kept her going. Along with this measure, a detailed assessment was carried out where Mary's background and family history, any presenting problems in relation to precipitating factors and other significant maintenance factors, were identified.

Mary explained how over the past three years she had struggled to manage her anxiety. She explained that although she never suffered from any panic attacks, she frequently experienced

somatic sensations, which included breathlessness, heart palpitations, sweating and feeling heavy. She also explained that she felt extremely nervous, anxious and apprehensive about engaging in social interactions due to the fear that she would look "stupid" and be "judged". Mary also expressed that these thoughts and feelings were now disrupting her daily cognitive functioning. She reported having chronic worries about everyday situations and events, including talking over the phone, going shopping and communication with neighbours. Mary reported that feeling this way had made her lose interest in enjoyable activities. She felt withdrawn and unmotivated and so found herself staying at home.

Revising the information gathered from the assessment and the first session, Mary's presenting problems can be understood using Beck's (1976) cognitive model (Appendix Two).

1.7 Case Formulation

Reviewing Mary's presenting problems and the therapeutic work we had carried out so far, it appeared that Mary suffered from generalised Social Anxiety Disorder (SAD). The symptoms she conveyed fully satisfied the DSM-IV criteria for social anxiety disorder/social phobia (Appendix Three).

The core of what Mary was experiencing was a real desire to convey a favourable impression of herself, but she constantly battled against her own insecurities. Heimberg (1995) argued that the process and aspiration of portraying a favourable version of oneself is driven by an underlying belief system that has been produced from early experiences and social encounters. In Mary's case, the expectations her parents had of her when living through the war and the premise of having to be the "perfect child" who "did no wrong" and who brought little attention to herself as her parents were too busy to be attentive were now the foundation upon which Mary formed her beliefs around who she must be and how she must behave. In the present day, Mary echoed the very same expectations: "I must know what to say/do", "I can't get it wrong" and "if I don't act in a certain way [the way she believes is correct], then people will think less of me and I can't have that". In the previous two years, her core beliefs had been further activated due to the negative experience she encountered whilst she was on holiday, where she was not able to provide her friends with an experience she expected herself to be able to provide. In not being

able to live up to the 'ideal' person Mary believed she had to be, she became the object of her own scrutiny.

Based on the beliefs Mary had about herself, she developed rigid Negative Automatic Thoughts (NATs) and assumptions. These thoughts and assumptions (thoughts: "People must think I am useless", "I can't do anything right", "I am silly, I am stupid"; assumptions: "I will be the subject of rejection", "loss of self-worth", "mockery" and "scrutiny") were then triggered when she entered a feared situation (Clark & Wells, 1995). For Mary, this transformed into an event or social situation where she felt she was primarily evaluated by her "performance" in her social surroundings. Holding these assumptions and NATs when in a "feared" situation made her prone to shifting the attention on herself and so was exposed to believe that she was in danger, with the consequence that (1) there was an enhanced awareness of herself, thus information was constructed in the form of her NATs and assumptions; and (2) the construction of these NATs and assumptions were further supported by the activation of her core beliefs (Hofmann, 2004). The cognitive process of experiencing this caused a psychological breakdown, and so she subjected herself to an induced period of anxiety where symptoms were translated both physically (sweating, palpitations, feeling heavy and tight) and mentally (chronic worrying, ruminations of NATS). Clark and Wells (1995) would describe the breakdown that Mary experienced as an automatic 'anxiety programme', built on cognitive, somatic and behavioural defences to protect her from the danger she perceived to exist in her social surroundings.

The precipitating and maintaining factors that allowed Mary's presenting problems to persist were conveyed in two forms. Firstly, to cope and defend herself from experiencing the 'anxiety programme', Mary prevented herself from being exposed to social events, situations and surroundings. For the last two years, she had stopped attending her social clubs and, if possible, avoided attending to daily tasks that involved leaving the house (shopping and running general errands). She held the belief that this allowed herself to be "protected" from the overwhelming anxiety she felt when she faced these situations. Secondly, Mary spent time at home ruminating on social situations of the past, giving herself permission to further catastrophise perceived negative outcomes should she engage in a social situation. Leahy (2003) explained that this behaviour only then reaffirms negative self-images and predictive self-rejection, thus allowing the underlying core beliefs to stay firmly in place.

1.8 Negotiating contract and therapeutic plan

NICE guidance (2009) for secondary-care treatment of Social Anxiety Disorder advocates the use of CBT. Clark and Wells' (1995) SAD model recommends 16 sessions; however, due to the limitations and constraints of the service I was working in, 12 sessions were offered to Mary with a midway review in session six.

I was keen to establish a strong therapeutic relationship that would then allow trust and faith in our therapeutic work to help ease Mary's anxiety about being in therapy. Therefore, I emphasised the use of CBT and its approach to SAD and collaboratively shared my understanding of the model with her to convey how well it complemented Mary's therapeutic goals. These goals were (1) to reduce the symptoms of anxiety she experienced both physically and psychologically; (2) to understand the role of her core beliefs, NATs and assumptions in anxiety, thus understanding the processes using the model; and (3) to challenge her NATs and underlying core beliefs so that she was able to engage in some level of social activity.

Mary and I agreed to combine in-session and behavioural homework tasks to help build exposure to coping with social situations and to complement the cognitive work we would do in our sessions. Furthermore, our agreed therapeutic plan included activity monitoring, cognitive restructuring and behavioural tasks to test currently placed assumptions and beliefs. The therapeutic plan was in line with treatment implications for SAD outlined by Hofmann (2004).

Chapter Two: Development of Therapy

2.1 Pattern of therapy and main techniques used

- ***Sessions two and three: 'anxious about being anxious'***

Mary experienced a high level of anxiety about beginning therapy, and so I felt it was important to attend to the safe and supportive nature of our therapeutic relationship to begin with. As suggested by Clark (2001), many individuals who suffer from SAD often view therapy itself as a dangerous social interaction. For Mary, her coping and safety behaviours were activated and, consequently, she resisted and avoided engaging fully in the process. Mary's resistance was

manifested in a number of observational behaviours. Mary would infer that she had to leave early, as attending a full hour was difficult. Mary also took time entering our clinic building and reported that she felt nervous when talking to reception staff and waiting for me when other clients were present. This resulted in her entering our session already very nervous and appearing defiant against exploring or engaging in sessions.

Making therapeutic attempts to work with Mary's initial anxiety, I introduced muscle relaxation techniques and breathing exercises that we did together in our sessions. I drew upon Berstein, Borkovec and Hazlett-Stevens's (2000) understanding of muscle relaxation training for individuals who suffer from overwhelming physiological arousal in anxiety- provoking situations. They explain that carrying out such techniques helps to diffuse the dangerous element from social situations. I also believed that carrying out simple breathing exercises helped Mary attend to the physical changes in her body. We carried out 10 minutes of deep breathing where I modelled for Mary the correct way of breathing. It helped her to become aware of the positive changes she felt when she became more relaxed and also the heightened arousal she felt when she panicked. Becoming aware of her physical changes during this exercise was particularly useful when introducing behavioural techniques later in our sessions. Mary was able to note when her body became tense, stressed or aroused when working with social exposure tasks. She was able to note these changes as triggers to turn to relaxation and mindful exercises to cope and reduce any heightened aroused/panicked feelings. Acknowledging the benefits of this exercise, we used relaxation techniques in all 12 sessions. Mary reported that this was particularly helpful when starting our sessions; she was able to feel more present in her surroundings, and she allowed herself to feel safe and to challenge any physical sensations that triggered the feeling of "danger".

By the end of session three, Mary and I had been able to share and discuss a formulation of her presenting issues. We used Beck et al.'s cognitive model (1979) to first illustrate the relationship thoughts, emotions and behaviour in sessions one and two. In session three, I introduced the Clark and Wells (1995) model to highlight Mary's presenting problems in a SAD model specifically (Appendix Three). This model also helped us to collaboratively understand Mary's safety and maintaining factors and the processes she engaged in as a result. Using this technique

also allowed us to reconfirm the therapeutic goals Mary had established in her assessment session.

- ***Sessions four to six: Cognitive restructuring and behavioural exposure strategies***

Once we established our formulations, we began to use elements of cognitive restructuring (Beck et al., 1979) to address Mary's NATs and assumptions; this was facilitated by challenging and exploring Mary's perceived standards and expectations of herself in social situations. Hofmann (2004) also promoted collaborative identification of negative appraisals by re-evaluating past events and using knowledge gained to develop more positive, realistic and flexible thinking patterns. Socratic questioning was used to explore Mary's NATs and her underlying core beliefs in relation to past social situations. Understanding what Mary experienced in our initial two sessions helped us to identify possible NATs, assumptions and the relationship these had with the onset of heightened arousal and physical anxiety. Some of the NATs we were able to identify were: "I am stupid", "people must think that I am weird or inadequate", "I will say the wrong things and look bad". Having these thoughts led to the assumptions: "I am incapable of doing this and so it is best to stay away" and "I will be rejected by others and so I will not go".

Behavioural social exposure tasks were also introduced to encourage Mary to practise the relaxation techniques we had established in session two. This allowed Mary to become more aware of when she felt the physical and emotional changes that she went through when she became anxious. Examples of tasks were Mary going out for dinner with a selected friend or using the phone to make a phone call regarding utility bills. Tasks were set initially on a small scale to allow Mary to gain comfort in carrying them out.

A strong emphasis was made on asking Mary to consciously become aware of external cues rather than the internal ones, hence making a shift in her attention pathway. As Clark (2001) suggested, individuals like Mary have easy access to internal cues rather than external as they constantly evaluate themselves rather than their external surroundings. Mary would feedback on possible anxiety-provoking situations and we would explore what her cognitive processes were. This provided further detailed insight into Mary's NATs and assumption-forming process. Mary appeared to do well with these tasks and was able to do at least one outing each week. She reported using our relaxation exercises before after going out and the technique of focusing on

where she was and what was going on around her rather than how she appeared and what others thought of her.

In session five, we attempted to complete a thought record that was used to encourage Mary to cognitively restructure some of her NATs. Mary found this extremely difficult. Discussion was held around the difficulty Mary faced and the anxiety she had from directly challenging her core beliefs. Mary here conveyed the pressure and anxiety she felt in challenging her negative thoughts using this technique, as it required her to fill in a form and specify exact emotions and feelings. Mary believed she lacked the ability to do this and therefore became anxious. She started to report feeling panicked and worried about what I thought of her and blamed herself for not being to fill in the sheet "correctly". By using direct traditional cognitive interventions, there appeared to be a strong emphasis and pressure on having to restructure her cognitions to reduce/eliminate her anxiety, but having this pressure in turn just made her feel more anxious.

- ***Sessions six and seven***

In session six, we decided to hold a review of how Mary was finding therapy on the whole and her evaluations of the interventions we had used so far. The review session was also conducted to facilitate discussion on our therapeutic process and relationship, as advocated by Clark (2001). During this session, Mary reported that she was struggling with some of the interventions and explained that when she reported on her homework tasks, she experienced some of her NATs and therefore feared that I would reject her if she did not complete them. We further explored what particular interventions she could relate these feelings to and spoke about completing the thought record in our last session. I was able to acknowledge with her the difficulty she had had with this and empathised with how hard it was for her when she was unable to work through the sheet. Mary here disclosed that she was worried about having this review and sharing her thoughts, with the fear that I would judge her as a result. Advocating Beck's (1976) thoughts on providing clients with an open and honest space to create a shared understanding, I fed back that I was glad Mary was able to disclose this to me and that, by doing this, she had challenged her very own NATs. She had, in fact, been able to share her worries even whilst she was scared that I would judge her or regard her in a less respectful way. I appreciated Mary's honesty and was able to establish that our therapeutic alliance here was strong and trusting enough for her to discuss her thoughts with me.

In feeding back my own comments, I also shared my own worries of feeling stuck and not being able to help her feel fully comfortable in some of the interventions we were using. Leading on from this, we both acknowledged that traditional CBT interventions were not helpful for Mary's therapeutic needs. It is here that I then introduced some thoughts on possibly expanding our interventions to third-wave therapies and being more creative with the way we challenged or understood her presenting problems. Mary agreed to try new interventions whilst still working with elements of Clark and Wells' model of SAD. Her motivation to keep going and to try was remarkable and, looking back, a true testament to the progress she made in the end.

In session seven, I introduced Acceptance and Commitment Therapy (ACT) to Mary. Using the Hayes and Strosahl (2004) approach, I described how this differed from CBT, as we were no longer going to work at challenging the thoughts directly as this created substantial pressure for Mary. Rather, ACT would allow her to accept thoughts as thoughts and to then diffuse their impact using a number of varying techniques. Mary reported that she found this easier to understand and realised that ACT looked at attachments one made with one's thoughts rather than attempting to reconstruct the whole thought. Using this understanding, we explored her attachment with her thoughts and how tightly she held on to them, not allowing herself thinking space for other thoughts. I provided Mary with some reading on ACT so that she could understand it further and asked her question me on this in our next session. Whilst we were changing our therapeutic plan, I still encouraged Mary to continue with interventions that had worked; these included breathing exercises and to continue to make a social trip once a week.

In addition to introducing ACT, we also decided on new therapeutic goals. Mary expressed that challenging her thoughts, which had developed over a number of years and possibly from experiences in her childhood, was difficult for her to do. She expressed a strong desire to want to reintegrate back into the social community and felt that if this were to occur, she would then be in a better place to construct alternative helpful thoughts about herself in social interactions. Therefore, helping Mary to engage in social interactions, and gaining confidence to go back out, was our primary goal.

- ***Sessions eight to ten: values and acceptance of anxiety***

Over the next three sessions, we worked hard to use ACT interventions appropriately, encouraging Mary to understand her attachments with her thoughts and the value she gave them. Mary and I discussed the six core principles of ACT (Acceptance, Cognitive Fusion, being present, self as context, values and committed action), as advocated by Hayes, Strosahl and Wilson (1999). Being aware of the limited sessions we had left, Mary and I collaboratively chose to look at certain elements of the hexagonal ACT model. We began by looking firstly at Acceptance. Mary had shown high levels of resistance towards feeling self- compassion and was quick to judge or resist feeling positive about herself. When using traditional CBT techniques, we had looked at challenging her thoughts and asked her to remove anxiety. When using ACT, I instead invited Mary to accept her difficulty and to accept the thoughts she was experiencing and the anxiety she felt when in social situations, therefore asking her to turn towards the anxiety and not away. Holding this position, ACT allows individuals to find immediate ways to cope and find tolerance with thoughts they have constantly battled to remove (Hayes et al., 1999). For Mary, this was insightful and she discussed feeling a sense of liberation and freedom, mentioning that some of her anxiety came from always feeling "silly" for having these thoughts and working to keep them away, but she now found permission to feel and understand this part of herself.

Continuing the process of acceptance, Mary and I worked through various techniques suggested by Hayes and Strosahl (2004), such as unhooking, identifying the problem and using metaphors to detach from certain thoughts. Unhooking allowed Mary to break down the idea that thoughts and feelings always lead to certain actions. In her case, it meant breaking down – "because I have these thoughts I cannot cope, it means that I should not go out and engage". Instead, we tried accepting the thoughts but working towards managing these thoughts whilst advocating a different action – still going out to meet friends. Supplementing this, we worked on defining the problem, and so Mary worked on breaking down what a social interaction experience was for her. We explored how she felt from her thoughts to her feelings to her mood and resulting actions. Realising that Mary could hold the thoughts she had and had permission to feel anxious, we looked at her actions and how these could alter. Mary's normal actions would be to run away and keep away from social interactions; instead, using suggestions made by Hayes and Strosahl (2004), we carried on using traditional behavioural interventions related to exposure. Hayes and

Strosahl (2004) argued that many elements of ACT still have traditional behavioural elements of CBT and this should be encouraged wherever possible due to evidence-based effectiveness. Behavioural interventions consisted of Mary attending her club day once a week, which she had already been doing since session three. We used goal-setting (goals: who she might talk to, what she might discuss, role-playing these conversations) and breathing exercises to help her cope whilst at the club and to make her feel more comfortable and engaged.

Interventions using metaphors was the creative part of our therapeutic plan which Mary thoroughly enjoyed and in which she had strong input. Trying to find ways for Mary to "let go" or "de-diffuse" with thoughts, we carried out a clipboard exercise suggested by my supervisor. This involved Mary holding up the clipboard in front of her face and naming what she could or could not see. Once Mary could acknowledge that with the clipboard in her face, she struggled to think or see anything else, I asked her to place the clipboard on her lap and asked her once again to name what she could see. Mary was able to realise that with the clipboard still in her hands but out of her face, she could now attend to what was in the room, what she could see, hear, feel, smell and taste. Using this metaphorical exercise where the clipboard stood for her negative thoughts, I highlighted that, for Mary, she could hold her thoughts at a more manageable level, thus allowing her to see other things going on around her, but when occupied by them, it was hard to see past the thoughts. Hayes et al. (1999) discussed that finding the balance between holding one's thoughts and attending to external cues is imperative in creating change; and I felt the clipboard exercise was able to facilitate some learning regarding this for Mary.

By the end of session 10, Mary continued to attend clubs once or twice a week. She did report that she still had minimal conversation, but she was at least able to stay and be in the presence of others for the duration of the club session. She also spoke about feeling less heavy and that it had become easier each time, allowing her to build confidence to try and initiate some conversation. She reported that she did not worry or act upon her negative thoughts as much as she used to and was beginning to develop positive thinking and hold thoughts such as "I am a friendly person and people want me to go out with them". This was a big progress step for Mary. When discussing what she thought helped or had changed, Mary spoke about not having to feel occupied with worrying about worrying. She mentioned feeling less heavy and used her thinking

space to think about conversations or what else was going on around her so that she could develop her social skills again.

- ***Sessions eleven to twelve: acknowledging progress, summarising and end***

As we came towards the end of our therapy, we worked to summarise the process we had gone through and what, consequently, Mary had learned about herself. Mary attributed one of her biggest strengths and learning points as being honest and stating that she found traditional CBT interventions as anxiety-provoking. She mentioned that the review session had been a turning point, and because together we decided to change our plan, she felt more motivated and confident in herself to try ACT. She also mentioned feeling "free" and trusting me and our process together to become more comfortable with herself, allowing herself permission to acknowledge and work with her feelings, as opposed to challenging and removing them.

In reviewing Mary's progress, I also noted our review session and our therapeutic relationship as being the essential part of our sessions. I commented that her honesty was helpful for me in changing our therapeutic plans to meet her needs instead of defying her. Her honesty also gave me permission to express my concern with her too. I also commented that Mary was more accepting of herself and that whilst the steps she had made were very recent and still developing, her strength and motivation to change would be useful in continuing with progress once we had finished. I also spoke about values and committed action, two other core principles of ACT. We discussed the process of outlining value on directions she wanted to move in (wanting to go out, attend dinners with her friends, and hold conversations confidently) and her goals, rather than placing value on her anxious thoughts and diffusing them. Finally, we discussed committed action and the development of effective behaviours allowing her to move in the direction of change she wanted. This involved continuing to attend clubs each week, making plans for an additional social interaction and using her breathing exercises effectively.

In our last session, Mary acknowledged how at ease she felt and commented on the times when she would worry about attending our sessions. I too spoke about how talkative and explorative she had become and how she now easily confronted her feelings with me and spoke about her challenges or worries without the fear of being judged. I also spoke about the relationship and

the parallel process we experienced, with both of us feeling more comfortable and relaxed towards the end of our work. We ended our session by drawing up a summary intervention sheet for Mary to take away and spoke about liaising with her care co- worker (older adult team nurse) about continuing her social activities. Mary and I both acknowledged that work was still needed to be done, and whilst Mary had made progress, she still needed to build her confidence and self-compassionate thoughts.

2.2 Key content issues and the therapeutic processes around them

- ***'Stuck' – the foundation of our relationship***

Although during her initial assessment Mary voiced that she was motivated to make change and was eager to seek help to address her presenting problems, she faced a real fear about attending sessions and so appeared 'stuck' in her anxiety. Karp and Dugas (2003) suggested that, for many individuals who suffer from SAD, committing to therapy will be thoroughly difficult as they immediately have to face their biggest fear and will instinctively begin to worry about how they will be evaluated by the therapist. This was explicitly addressed in our very first session so that Mary could gather some therapeutic understanding within the model for her behaviour and reaction to attending her first session.

Mary's anxiety about attending our therapy sessions made it difficult for her to come to our first meeting and to stay for the full session. I was aware, as Clark (2001) also discussed, that Mary was avoiding or resisting the process. She wanted to leave and seek her safety behaviour of avoidance. Having this in place would only then confirm for her core beliefs and maintain her anxiety about subsequent sessions we would have. Therefore, it was vital that I empathised with Mary about what she was feeling and the difficulty she had about coming to our session. I used our first session to provide a safe space to explore how she felt about being in the room with me, and the process she was feeling when discussing her anxiety. Time was also taken to acknowledge that Mary wanted to leave the session and that this was her coping strategy/safety behaviour to protect herself in a fearful situation. We acknowledged that carrying this out would then preserve Mary's anxiety about subsequent sessions. Hence, Mary voiced her dilemma as feeling stuck. She wanted to break the cycle but was faced by a wall of fear and danger.

Beck (1976) advocated that providing space for shared understanding allows both the therapist and client to develop their therapeutic alliance, and Clark (2001) further agreed that forming a layer of therapeutic understanding initially will evolve into trust and a non-judgemental relationship and that this is vital when working with individuals suffering from social anxiety.

At this stage, the process was interesting. I started to feel Mary's anxiety and I became anxious about finding therapeutic ways for her to feel safe, secure and contained in our sessions. Bond (1995) reported that this parallel process could be an experience of a strong therapeutic alliance and that I was able to successfully understand what Mary was experiencing. I shared what I was feeling and the concern I had about her fear of being in therapy. We described this anxiety as a wall of fear that she and I were both up against. I modelled 'sitting with it' by naming it between us and listening to what transpired physically through the relaxation techniques. I believe this then opened up the space to explore her inner world, thus gaining a better understanding of her NATs and underlying beliefs.

- ***Interpreting external experiences as internal negative evaluations***

Working with Mary to challenge her negative thoughts and assumptions was a difficult process. I believe that exploring Mary's NATs caused her more internal anxiety. Although we started each session with a muscle relaxation technique, I found that as we progressed within each session, her anxiety would build. Using techniques such as Socratic questioning and then a thought record proved difficult, and Mary became frustrated when she was unable to work with these. Clark (2001) hypothesised that individuals like Mary would instinctively process external cues as excessive negative experiences or evaluations of self. I believe that this was evident with Mary not only outside of sessions but in our therapeutic work too. The frustration she felt at not being able to discuss and hold conversation with me made her feel inadequate and led to her developing NATs such as "I can't even explain what I feel", "I don't understand" and "I can't do this". Here, Mary was interpreting the frustration of not being able to challenge her thoughts and ability to work with the techniques as being catastrophic internal evaluations of herself, thus supporting the core beliefs she held (Beck, Emery & Greenberg, 1985; Clark & Beck, 1988; Clark & Wells, 1995).

The therapeutic process surrounding this also felt difficult and stressful. Our therapeutic space became contaminated with frustration, self-doubt and anxiety. I explained to Mary that for anyone coming to therapy and attending to their core beliefs that they have had in place for a long time would prove to be difficult and that this was not a measure of her ability, but rather conveyed how difficult things were for her and her thinking patterns. I allowed us to wrestle with how difficult this process was and made her aware of the interpretations she was making about herself and the anxiety she conveyed in our sessions when she was unable to work with a technique. Leahy (2003) suggested that being able to achieve this in the therapeutic process can be key to identifying faulty thinking patterns associated with emotional difficulties. This was helpful for Mary as, indirectly, she was now gaining an understanding and awareness of her thinking patterns and coming to realise how her physical symptoms were connected to her cognitive processes (Beck, 1967; Lazarus, 1966). Allowing Mary a safe space to experience her anxiety and the method of naming out loud her connected cognitive processes within our session allowed us to fully picture her in line with the Clark and Wells (1995) model. I also believe that providing this space for Mary was vital in allowing her to be heard, letting her know that, contrary to what she thought, I did understand what she was feeling. Trower et al. (1988) explained that, by advocating this, the therapist is not only able to refine what the client is actually experiencing but also aids the collaborative nature of the work; both client and therapist follow the same route of discovering and it prevents the client entering a cycle of self-depreciation without the therapist containing the process.

- ***Cognitive attention and behavioural exposure: working with BOTH simultaneously in ACT***

Whilst we worked and attended to Mary's cognitive processes, some of our therapeutic work was also continued outside of our sessions through behavioural social exposure. Mary's progress with exposure to social situations was remarkable. By session six and before introducing ACT approaches, Mary had started going to her social club once a week. In contrast to the difficulty and frustration Mary had felt with challenging her cognitive thoughts directly, she felt more at ease with the behavioural social exposure tasks. This was due to the fact that Mary was gradually observing her social world through a different lens. No longer was the attention so internally focused. Mary voiced that being aware of the formulation we had developed and simply recognising her cognitive processes had given her another level of understanding of her social

interactions. Clark (2001) spoke of the importance of integrating cognitive processes and behavioural exposure tasks when working with SAD, as it cognitively allows an individual to shift their attention from internal self to external world. I also believe the relaxation techniques drew her attention to recognising the changes in her somatic and emotional experiences of anxiety. Furthermore, continuing to bring in behavioural aspects with ACT approaches allowed Mary to cope better with her anxiety and to then begin testing assumptions and predictions she had in outside social interactions. As Mary engaged in exposure, she became more comfortable with her social world and began to experience external cues rather than internal, therefore allowing her to accept her thoughts but challenge her safety behaviours. Therefore, for Mary, the behavioural work supported and led to the development in her awareness of her cognitive processes and the diffusion and attachments she had with her NATs. Previous studies have also conveyed that exposure strategies can indirectly help individuals to challenge their cognitions or become aware of cognitive thoughts without implementing any cognitive interventions (Hope et al., 1995; Mattia, Heimberg & Hope, 1993; Newman, Hofmann, Trabert, Roth & Taylor, 2004).

2.3 Difficulties in work and how these were addressed

- ***"I'm stuck" – activation of my underlying core beliefs***

Mary experienced a high level of anxiety both psychically and emotionally. Often, she became sweaty, stopped talking and was upset with the frustration she felt. Being in the company of this activated my personal core beliefs and I too began experiencing anxiety in our sessions and in my own supervision. Initially, I was worried and anxious about reaching an understanding of how to engage Mary in our work and then containing her anxiety in our subsequent sessions. My underlying beliefs relating to being a trainee and the fear of being incompetent were activated and I experienced having NATs: "I might not be able to contain her", "This might be too complex a case for me to work with" and "I am not helping her but making her feel worse". Sharing my concerns with my supervisor allowed me to recognise the parallel process between Mary and myself and between myself and my supervisor. In supervision, I conveyed a strong desire to portray myself as an "expert" and a therapist that could effectively "fix" Mary, and, therefore, I experienced high arousal states and worry about how to work with Mary.

Recognising this and giving it a name in supervision was informative. I was amazed by the feeling of being "stuck" in sessions with Mary and exploring this effectively gave me exceptional insight into what Mary was feeling and experiencing too. I understood that I was trying to find techniques and an understanding of theory related to SAD to reduce symptoms that Mary presented with in order to indirectly reduce and manage mine. Supervision intercepted this process by exploring the root of my worry and anxiety, and it allowed me to effectively "sit" with the anxiety. By understanding the benefit of this process in supervision, I was then able to apply this to my work with Mary. I named the feeling of being "stuck", giving us both permission to just "be" with the anxiety we felt, which was further supported and facilitated when working with ACT interventions. Often, the expectations to remove and reduce symptoms of anxiety were the core causes of the anxiety we both felt in the first place. Thus, permission to experience it and use techniques such as relaxation and acceptance to listen to both the physical and emotional aspects of the anxiety was valuable and rewarding.

- ***Changes in therapeutic treatment plan: welcoming ACT approaches***

Whilst working with Mary, I have developed a greater understanding of the theories, research and implications of treatment available to those who suffer from SAD. In learning about this and reflecting on my work with Mary, I recognise the struggle I have faced with applying core elements of the theories available.

Using Clark and Wells' (1995) cognitive model for SAD was effective in developing a shared understanding of the cognitive and behavioural processes Mary was experiencing on a daily basis and gaining an insight into Mary's maintaining factors and safety behaviours. Using this model also allowed us to reach a collaborative understanding of what she wanted from therapy and also allowed us to develop a strong working, helping therapeutic relationship, which has been beneficial for the progress Mary has made so far in therapy.

I highlighted in "key content issues" and in "development of treatment plan" the difficulty I experienced in applying cognitive interventions to effectively help Mary challenge her NATs, assumptions and core underlying beliefs. I realised that in adhering so closely to the Clark and Wells (1995) model, I ran the risk of making Mary fit the model, rather than observing and reflecting on how the model could be adapted to suit both Mary's personality and the

characteristics of Mary's presenting problems. This was highlighted in the review session I had with Mary and I recognised that traditional cognitive challenging (Beck et al., 1979; Clark, 2001; Clark & Wells, 1995), suggested as being a strong aspect of therapeutic progress in SAD, was ineffective for Mary and did more harm than good. I also recognised that behavioural strategies/interventions were effective and that the behavioural tasks we encompassed in our work did indirectly help Mary to challenge/accept her cognitions.

Struggling to unpack what I was fast realising and wanting to find an effective way to change our treatment plan in order to meet Mary's needs, I used supervision to investigate research and theories which explored other treatment implications for SAD. It is here that I began to entertain the idea of incorporating Acceptance and Commitment Therapy (ACT) into our work. From discussion in supervision and my reading, I learnt that the ACT model integrates mindfulness, acceptance interventions and exposure-based strategies (ACT; Hayes, Strosahl & Wilson, 1999). ACT also embraces the idea that the psychopathology experienced in SAD is due to the "fusion" individuals produce with their negative thoughts and the pressure instigated upon themselves to eliminate and reduce the struggle of experiencing anxiety (Hayes et al., 1999). Therefore, the principle of ACT is not to focus on eliminating the struggle and frequency of the anxiety but, instead, to experience the symptoms in a non-defensive and manageable way (Herbert et al., 2006). The primary goal of ACT is not symptom reduction through challenging one's NATs directly but, instead, striving to understand *how* the individual has become attached or "fused" to a specific NAT, hence indirectly challenging what they are.

Using ACT interventions has been a wonderful therapeutic process and, on reflection, I feel that this not only provided me with a platform from which to learn and develop but a space for Mary to explore, feel safe and learn with me. I felt that using the notion of "fusion" and attachments to negative thoughts was more helpful for Mary than the traditional CBT approaches, and our interventions took the pressure away from direct traditional cognitive challenging. There also appeared to be a slower, deeper process and pace in applying ACT interventions compared to the direct, overwhelming and anxiety-provoking process I experienced with Mary when using traditional cognitive interventions.

I hesitated in taking this step as I worried that I was embarking on a separation from traditional CBT and felt unconfident in doing so. I had many discussions in supervision about this concern

and came to understand that ACT's foundations and principles were still heavily embedded in CBT approaches and borrowed a lot of its understanding of attachments to thoughts, feelings and avoidance behaviours from the traditional Beck et al. (1979) cognitive model (Herbert & Dalrymple, 2006). Therefore, I learnt that ACT was not to be misunderstood as being a complete departure from the CBT approaches, but rather welcomed as an evolving therapeutic approach under the CBT umbrella, encompassing ideas, theories and techniques from a number of cognitive, behavioural and experiential theories (Herbert & Dalrymple, 2006).

2.4 Changes in therapeutic plan and therapeutic process

I have talked at length about the changes in the therapeutic plan throughout this case study and, therefore, I take this opportunity to emphasise, in summary, how making the changes to the therapeutic plan allowed me to wholly meet with Mary's needs. I felt our review session in session six allowed us both to reach a level where honesty and allowing oneself to *be* took over elements of anxiety, misunderstanding and pressure. Mary appeared different after this, and the process of our session became slower but more in-depth and I experienced this by observations I made of Mary, who appeared more open and willing to share her struggles and concerns, taking time to ensure that I was understanding her and her reality.

I was also able to observe that once we changed our therapeutic plan, our process became less dangerous and threatening and I found it remarkable how I perceived us as being free-moving as opposed to stuck and embedded in chronic worry.

Chapter Three: Conclusion of Therapy and Review of my Work

3.1 Ending of therapy and follow-up

Mary completed twelve sessions in total and showed a vast amount of progress. By the end, Mary was attending her club twice a week, engaging in more conversation with family members and they were now also commenting on her progress. Mary also attended a full day trip with her friends and fed back that this was enjoyable rather than anxiety-provoking. In summarising our

work, Mary and I both acknowledged the steps she needed to continue to take. To focus on relapse prevention, we held a care discharge review with her care co-ordinator and spoke collaboratively about what was needed next with regard to ongoing support for Mary. This liaison and committed holistic support further brought together the work we had done and gave Mary the confidence to outline what support she needed following discharge from our service. It also gave me a chance to report and case-present our work with her care co-ordinator, thus facilitating a learning point for myself.

3.2 Evaluation of work

The initial session was a difficult start for both me and Mary; but, now, on reflection, I can see that it was a poignant part in the development of our relationship and trust with each other. Mary conveyed strong resistance to begin therapy and avoided engaging fully. I feel it appropriate here to criticise myself for not realising the activation of my own core beliefs at the time. Gaining an insight into the activation of the beliefs of both Mary and myself may have helped in containing Mary earlier and, thus, would have had further positive implications for the depth of our relationship.

Using the shared formulation we had achieved by session four was helpful in allowing Mary to understand what she was experiencing. She was so often preoccupied in trying to reduce what she felt, she had not been able gain insight into why. Using the Clark and Wells model (1995) here gave her the space to achieve this. Following this, the anxiety I felt about containing Mary's anxiety prevented the process of realising other treatment plans for her. Trying to contain my own anxiety, I believe I ran the risk of making Mary "fit" the model and therefore I ignored the specific needs Mary had in therapy. Having supervision and our review in session six allowed reflection of our work and changes were subsequently made. I do feel, however, that realising the implications of treatment from the Clark and Wells (1995) model and being aware of Mary's needs from the outset could have resulted in starting to work with Mary using ACT from the beginning.

Reflecting on our subsequent sessions after the review, in session six, I appreciate that ACT was a welcome intercept in our therapeutic plan, and seeing Mary's progress and how she was able to

further explore her symptoms using ACT interventions was a credit to the theory and its intervention in working with rigid presentations.

3.3 Reflection of my work with Mary with regard to the practice of matching

The therapeutic work I have facilitated with Mary has enhanced my understanding of the practices of matching in a therapeutic dynamic. It has further allowed me to push the boundaries and understanding of what can define a 'matching' relationship. As noted in my introduction to portfolio, this case study conveyed how 'matching' of the less obvious aspects of the therapeutic relationship between myself and Mary was used to facilitate a helpful therapeutic relationship between us.

Mary and I were faced with many challenges with the therapeutic plan and process of therapy. We both acknowledged that there were, in fact, many similarities between us in facing these challenges. It was Mary's first time in therapy and my first time working with an older adult client, and working with ACT approaches in therapy. We both acknowledged that this process was new to us and, hence, we both explored together our experiences of a parallel process of anxiety and feeling 'stuck'. Labelling this and investing in this shared (matched) feeling allowed us to support each other in making choices for our therapeutic plan and allowed each other the freedom to speak about the worries during this process. It has been argued that a therapeutic alliance based on 'understanding' and 'empathy', of accepting your client's position in therapy, and being able to 'align' yourself with this, is a strong component and a much-needed ingredient for positive outcomes (Duff & Bedi, 2010; King & Bambling, 2001; Okpaku 2008; Horvath & Luborsky, 1993). This was an interesting insight into our relationship as from the outset, Mary and I presented as two very different individuals in this dynamic. Furthermore, there were many differences with regard to our demographics, such as ethnicity, age and religion. Therefore, this allows me to question whether matching simply of demographics is or can be sufficient. Can there be 'matching' of other components or aspects between the client and therapist? Through this case study, I argue that there can.

Another aspect to present is the argument that differences between a therapist and client are just as validating for the process and relationship as matching could be. I have spoken about the 'matching' of less obvious aspects between Mary and I, but this was driven by the fact that we both presented with many differences between us. This allowed us to strive to create a foundation and the differences helped spark the curiosity and 'curious enquiry' into what presented between us that could be useful for our work. Furthermore, it is noted that matching between a client and therapist can be unhelpful in a therapeutic dynamic, as it can lead to assumptions and over-identifying (Sue, 1998; Knipscheer & Kleber, 2004). It has been argued that therapists are encouraged to use their expertise in empathy, warmth and overall competency in working with differences with their clients, to gain insight in to their clients' world (Sue et al., 1992). This then creates a joint working role to understand each other and to develop the relationship. On reflection, this was the basis of my work and the approach I took with Mary.

In conclusion, I am able to see that whilst we were not 'matched' to each other on obvious levels, it was our shared 'matching' experience of the activation of our core beliefs that proved fruitful for our relationship. This was initiated by working with and accepting our differences. This case study allowed me to see deeper and beyond the levels explored in other parts of this portfolio (age, gender, religion, ethnicity and language). I found that our differences drove us to access a shared understanding of the goals of our work together. Furthermore, this then laid the foundation for a more collaborative piece of work.

3.4 Overall theory, practice and self-development

This case study provided me with so much scope to research, better inform and practise the theoretical implications of CBT. Being able to use the Clark and Wells model (1995) for SAD gave me structure and focus in understanding what Mary was experiencing and I appreciated the advantage of working model-specifically to begin with. I feel that by containing my anxiety and what Mary was experiencing, we were able to then use the theory and shared formulation to give us a foundation from which to then develop and work.

As our therapy has evolved, I have further immersed myself in the research available for SAD. I have taken a critical standpoint with regard to some of the treatment implications available. I do

believe that cognitive therapy and restructuring interventions (Clark, 2001; Beck et al., 1979; Hofmann, 2004) alone added little efficiency to therapeutic progress I have seen with Mary. I also have a strong belief that a greater emphasis should be made on exposure, rather than cognitive interventions, as I have seen that behavioural strategies alone can evidently have indirect implications for challenging cognitive thoughts. This has been supported by Rodebaugh et al. (2004).

Finally, I believe that taking into account the client's individual needs should be the forefront of all treatment plans and implications. In realising Mary's specific needs and personality, I was able to explore other treatment suggestions, such as ACT. Using third-wave therapies has been encouraged, and a variety of research has shown the positive implications of doing so (Eifert & Heffner, 2003).

Using ACT was a new learning curve for me but one that I felt enthusiastic about. I believed the theory and practice encompassed Mary's personality and ability to therapeutically support herself. The theory encompassed values, goals and elements of traditional CBT. Embarking on this journey allowed me to understand the breadth of CBT and its evolving research, ideas and practices for Counselling Psychology.

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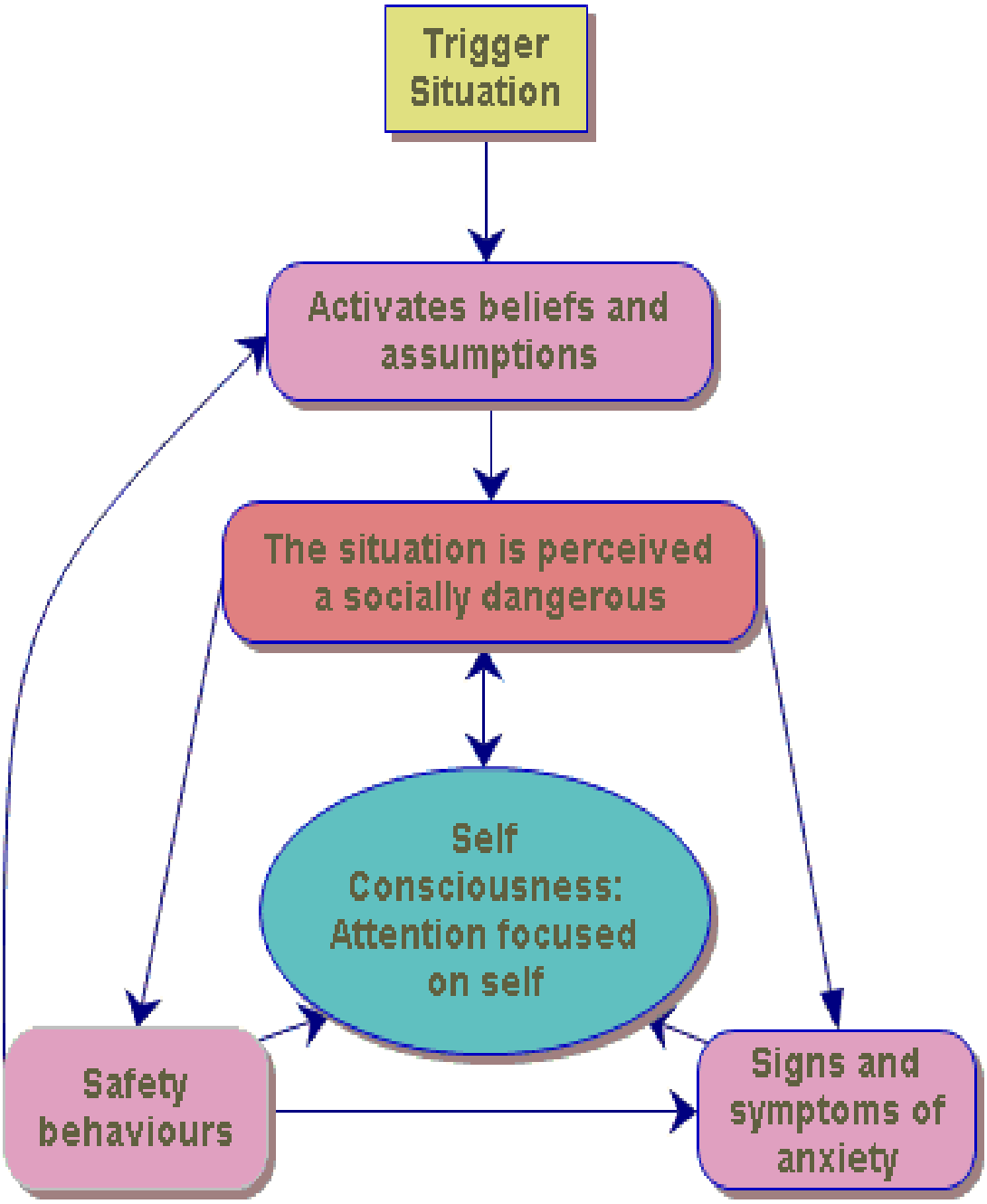
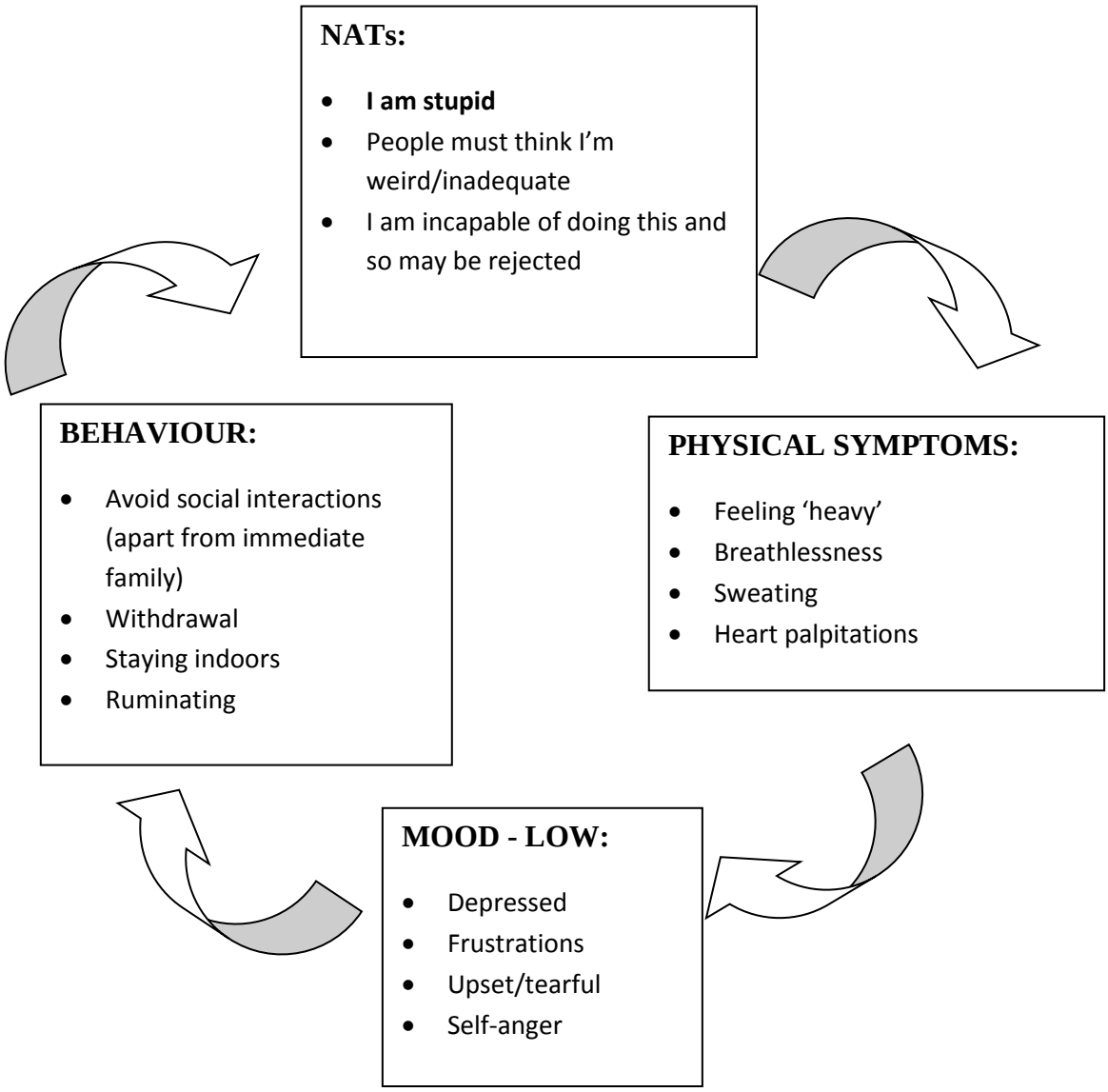
Appendices

Appendix One: The Clark and Wells (1995) Social Anxiety Disorder model



Appendix Two: Mary's presenting problems shown in Beck's (1967) CBT model



Appendix Three: Case formulation within the Clark and Wells (1995) model