

Culture and Ethnicity in psychological practice: A Thematic analysis

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May 2017

A thesis submitted in partial fulfilment of the requirements of the University of
East London for the Professional Doctorate in Clinical Psychology

ACKNOWLEDGEMENTS

I would like to thank Dr. David Harper for his support and guidance throughout the development and write-up of this study. I am grateful to my father for proof reading my work, for being so generous with his time and taking my little man off my hands enabling me to complete this thesis. I would also like to extend my thanks to my family and friends for their encouragement and support during the three years of this doctorate. I would particularly like to thank Jay and Aryan for bearing with it all! Finally, and perhaps most importantly, I would like to thank all the individuals who took time out of their busy working lives to participate in my study and for sharing their valuable experiences.

ABSTRACT

The literature on providing an evidence base for clinicians to deliver culturally appropriate services appears to be responding to the changing demographics in the United Kingdom (UK) but appears slow to respond to the gradually changing demographic of the profession. The research on ethnic minority status is largely focused on clients with the assumption that the therapist is White (Iwamasa, 1996). Literature exploring the experiences and issues of ethnic minority therapists emerged in the United States of America (US) before being explored in the UK. Even today, a large chunk of the literature is produced in the US and more so from the counselling and psychotherapy disciplines.

This qualitative study explores the practice of clinical psychologists who identify as British Asian, when working with ethnically similar and different clients. Ten clinical psychologists were interviewed about therapeutic interactions where they encountered ethnicity and culture. Thematic analysis was used to analyse the interviews of the participants who self-identified as British Asian. Three dominant themes emerged from the analysis: Addressing culture and ethnicity in therapy, challenges in the room and dilemmas in the profession.

Findings revealed that culture and ethnicity were not central to all therapeutic interactions. However, when ethnic and cultural differences were present, participants responded in various ways to the issues they faced in the therapy room and dilemmas they encountered in the profession. There were varying levels of comfort in having conversations about culture and ethnic differences in therapy as well as with colleagues, indicating a need for appropriate training of all clinical psychologists in working with culture and ethnicity. The role of supervision was also highlighted in helping clinical psychologists to enable reflecting on the impact of their own culture and ethnicity on practice.

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1. INTRODUCTION

1.1 Introduction

Race, culture and ethnicity play a pivotal role in how we see ourselves and the world. Strong racial or ethnic identities may be a source of resilience for some, however, they may be accompanied by adverse social implications of disparities in healthcare, employment, financial and judicial systems. Research has looked at the impact of race, ethnicity and culture on mental health and on the therapeutic interactions between clients and therapists to serve the client's mental health needs appropriately.

The aim of this chapter is to give an overview of the literature on the experiences of ethnic minority therapists impacted by their race, culture and ethnicity. It begins by considering the conceptualisation of race, ethnicity and culture and the impact on the experiences of individuals from ethnic minorities. An overview of the relationship between ethnicity and mental health is provided, followed by literature on the need for cultural competence. It finally discusses the experiences of the ethnic minority therapists and concludes with a section on the rationale for the present study.

1.2 Literature search strategy

The research literature was searched using selected electronic databases (PsycINFO, EBSCO and Google Scholar) using variations of key words such as 'clinical psychology', 'clinical practice', 'South Asian therapist', 'South Asian psychologist', 'ethnic minority therapist', 'race', 'culture', 'ethnicity', 'mental health' 'cross-cultural therapy', 'culturally adapted therapy' 'cultural competence'.

Relevant papers were identified by title and abstracts and were included if there was a focus on the practice of ethnic minority therapists. Snowball searches were then manually conducted through the references of relevant papers to identify other literature. The Health and Care Professions Council (HCPC) and British Psychological Society (BPS) websites and their publications were also searched. To complement the database search, additional search strategies included searching reference lists of relevant articles/books, using Google Scholar.

Due to a paucity of literature on South Asian/ethnic minority therapists in the United Kingdom (UK), literature from the United States (US) was also considered.

1.3 Constructions of race/ethnicity/culture

It is important to define and distinguish the terms race, culture and ethnicity as they are often used interchangeably. It is also imperative to understand these constructs to understand the work psychologists may do on an individual level with clients and also at an organisational level in their place of work. People's identities are based on these concepts which influence their worldview.

1.3.1 Race

The term race is based on the idea that humans can be divided into distinct categories based on biological characteristics like skin colour, blood group and hair texture (d'Ardenne and Mahatani, 1999). However, race is not a scientific concept and has no biological or anthropological validity. In a real sense, it simply does not exist. Its meaning and reality are socially and politically constructed and have been used historically to justify domination and to create ideas of racial inferiority and superiority (Durrheim, Hook & Riggs, 2009).

1.3.2 Culture

Definitions of culture emphasise the intergenerational transmission of traditions, ways of living, values, norms and beliefs (Betancourt and Lopez, 1993). It is important to understand culture as evolving, linking past to the present and that it may be shaped in part by our socio-political histories and contexts. Fernando (2012) describes a postmodern view of culture as 'something that is difficult to define or pin down, something living, dynamic and changing- a flexible system of values and world views that people live by' (p. 113).

Culture refers to patterned ways of thinking, feeling and behaving, and their attached values, that develop among a group of people from shared experiences over time; culture tends to be stable and may be passed on to later generations (Hofstede, 2001). Cultural patterns influence an individual's reaction to experiences and may serve as vulnerability factors or protective factors when encountering the stresses of discrimination and this produces differences in mental health.

1.3.3 Ethnicity

While culture is about group practice, values and beliefs, ethnicity is characterised by a group identity, a shared cultural heritage and a sense of belonging (Fernando, 2010; Fernando, 2002). Since ethnicity may be viewed as

self-ascribed and therefore socially constructed, it may affect how we view ourselves and how we interact with others within the therapeutic process. This concept of ethnicity seeks to acknowledge a myriad of cultural identities based on many factors like country of origin, languages and customs amongst others. Fernando (1988) has observed how ethnicity can be a value-laden term and is seen as accounting for mental health problems amongst people from ethnic minority groups. Ware and Back (2002) suggest that it constructs White people as non-ethnic versus non-white as ethnic, thereby hiding the multiple ethnicities of the white population. Venkatesh (1995) describes ethnicity as an ideologically fashioned term to describe a group that is culturally and/or physically outside the dominant cultures of the day. This implies ethnicity only becomes apparent or experienced when one is in a minority and he concludes that ethnicity should instead be defined by self-identification of the group concerned. Fernando (2002) offers a simplified definition of each term: race is largely about physical features, culture is of sociological origin and ethnicity is psychological because that is how people define themselves. These terms have something to do with people's proclivity to mark others as different. Failing to recognise the constructs of race, ethnicity and culture in our social and political contexts may cause us to pathologise functional and adaptive cultural practices, thus reifying negative cultural stereotypes. It has been hypothesised that social adjustment, discrimination and racism experienced as a result of migration has an impact on psychological well-being (Bhugra and Becker, 2005). For these purposes, it is important to consider the history of migration.

1.4 Historical context– Mapping the development of ethnic diversity in the UK: a changing landscape

Owing to complex historical migration patterns, the UK has developed an ethnically diverse population over hundreds of years but especially in the 20th and 21st centuries. There has been an assumption that prior to recent waves of migration, the UK consisted of a culturally homogenous population. However, the UK has been a culturally diverse country since the Roman invasion of Britain in AD 43. However, because the different nationalities shared a common skin colour, this diversity may not have been obvious (Abbott, 2011).

1.4.1 Pre-17th century

Following the end of the Roman Empire, the Germanic speakers in Britain developed a common cultural identity and were known as the Anglo Saxons. The Viking raids in Anglo-Saxon England took place in the 8th century (Richards, 1991) and Britain was ruled by them until the 11th century. The Norman French invasion in the 11th century led to a flow of people between England and France. In early 16th century, the Romani people arrived in Britain (Smart and Crofton, 1875). Then followed the arrival of Huguenots, French Protestants, many of whom settled in London and engaged in silk-weaving (British History Online, 1998).

1.4.2 17th-18th century

By the start of the 17th century, there was an established African community in the UK due to its involvement in slave trade (Martin, 2011). People from the Indian subcontinent also settled in England since the establishment of the East India Company (Visram, 2002).

1.4.3 19th- 20th century

In the early 19th century, the Jewish population that came from Russia and Eastern Europe and settled in the UK increased. Another wave of the Jewish population came in the 1930s from Nazi Germany. By mid-19th century, the Indian population arrived in Britain as seamen, diplomats, businessmen, soldiers and students (Fisher, 2007). According to Migration Watch's (2014) summary history of immigration to Britain, the British economy needed a boost and immigration was encouraged post World War II. This saw a large number of people from outside Europe, like the Caribbean and South Asia mainly, arrive in Britain. There was also mass movement of Irish workers during rebuilding after World War II and Jewish resettlement into England from the War. There is evidence that African Caribbean and Chinese sailors established communities in British port cities during the late 19th century and early 20th century. The late 20th and early 21st centuries saw the displacement of people from the Middle Eastern countries due to war.

The colonisation of overseas territories saw the emergence of racist ideas about non-white people who were construed racially and culturally inferior to White

people. These racist ideas continued to be a part of the non-white people's experience in the UK.

1.4.4 Changing identities

With people arriving in the UK through various migration trajectories, and starting their own families, we encounter notions of first, second, third generations.

People arriving in a new country may have differing views about retaining their culture of origin and ethnic identity and becoming part of the new society. First-generation immigrants are seen as individuals who left their countries of birth and settled down in a new country. Their children are known as the second generation. Host community reactions may be difficult to manage, thus making integration for the first-generation harder. The second generation may assimilate better than their parents due to growing up and being schooled in the host culture and may develop a different ethnic identity. Yet they may be heavily influenced by their parents' traditional cultural values and may experience racism. The third generation may feel more absorbed into the host culture and identify as being from the country they were born in. However, such labelling of first, second, third generation can prove to be problematic as it may connect them forever to their ancestral migration, thereby limiting their own identity development.

The relationship between ethnic and national identities and their role in the psychological well-being of individuals may be understood as the interactions of attitudes of the ethnic minority population and of the host society (Phinney, Horenczyk, Liebkind and Vedder, 2001). Individuals who migrate experience multiple stresses depending on their migration trajectories, whether that is due to social, economic or political reasons. This often brings disconnection from familiar cultural and social practices and networks, separation from family and isolation in the new host society, thus causing a grief reaction or 'cultural bereavement' (Eisenbruch, 1990). For non-immigrant ethnic minority groups (e.g.- children of people who have immigrated), acculturation is also challenging as they involuntarily find themselves in the presence of a dominant majority group. If an individual feels isolated from their own culture and not accepted by the culture they have moved into, they may experience a sense of rejection and alienation. It is therefore imperative that mental health practitioners and

healthcare services are attuned to these unique stresses and cultural aspects of an individual's life.

Experiences of migration and the discrimination faced by immigrants due to their visible differences are considered to be key in defining, shaping, and limiting 'one's experiences, opportunities and well-being' (Davidson and Patel, 2004; p.75). In order to understand the experience of BME individuals, it seems appropriate to look at the concept of racism and its impact.

1.5 History of racism

The term 'racism' was first associated with theories in the 18th century about inherent biological differences (Eliav-Feldon, Isaac and Ziegler, 2009). Guthrie (2004, p. 41) defined it as "the subjugation of one group of people over another with the element of power to maintain a hierarchical position". It is argued that racism can be traced back to the attitudes of the Greeks (Isaac, 2009 and Shapiro, 2009). Although it is widely accepted that there is no biological basis for distinguishing race (Banton, 1967) and that it is a socio-political construct, the discriminatory ideas about race continue (Omi and Winant, 1994).

Racism is a set of ideologies and practices, is deeply rooted in society's unequal power structure and is perpetuated by individual and structural practices.

Edward Said's (1978) book *Orientalism* suggested that the term referred to a prejudiced outsider view of the Orient or the East. He proposed that the West believed that the Orient was something to be controlled or feared, which considers the idea of non-indigenous people as the 'other'. In practice, this leads to white/non-white categorisation of individuals.

Immigration often has huge implications for the host as well as migrated populations. It impacts on an individual's national identity, integration into the host society and social cohesion.

Racist ideology was present in Britain from the 16th century when the Roma community, who were victims of racial persecution, arrived in England (Mayall, 1995). Mackenzie (1986) then identified it in the 18th and 19th century as an outcome of the British trade in the African continent and in the Indian subcontinent. The British empire was seen as an employer and had to be constructed as 'superior' in relation to the 'other'. The African and Asian people were portrayed as savages and in need of 'civilisation'.

The political narratives around post-war settlement of the migrant population further instigated negative attitudes towards this people (van der Brug et al., 2015). The term 'Black' then emerged as a broad political concept that could unite all those who faced racism because of the colour of their skin. As a result of discrimination and prejudice, many political struggles began. 'Black' became a political term to bind those who experienced injustices, racial abuse, discrimination. The basic tenet of these movements was to reject all value systems that sought to make people foreigners in their own countries. It implied awareness by people of the power they wield, to build their own value systems and see themselves as self-defined rather than be defined by others.

With the position of power and privilege, racism operates on an individual as well as structural/organisational level (Patel, Bennett, Dennis, Dosanjh, Mahtani, Miller et al., 2000). Acts of overt racism have abated over the years; however, covert racism is still at play. Individual forms of racism may consist of internalised and interpersonal racism whereas systemic racism includes the less visible forms of institutional and structural racism. Littlewood and Lipsedge (1982) suggested that psychiatric assessment is undermined by negative cultural and ethnic stereotypes. This results in culturally accepted behaviours being pathologised which has an impact on service delivery. Non-white people are positioned as the 'Other' in whom difference is located (Kitzinger & Wilkinson, 1996) and are perceived as inferior (Patel et al., 2000).

The ways in which people and communities were segregated, isolated, and marginalized have a considerable health impact. It is helpful to consider how racism impacts individuals from an ethnic minority background in society as well as in the therapy room. Below, I will outline the impact of racism on the psychological well-being of an individual.

1.6 Impact of racism

Racism in the form of discrimination can potentially inflict harmful psychological consequences like the feeling of powerlessness, rejection, loss, low self-esteem and depression on a person (Gray, 1999). The intersectionality of being from an ethnic minority group and with mental health problems makes experiencing stigma and discrimination more likely. Internalised racism (Alleyne, 2004) where

the values and beliefs of the oppressor are absorbed may cause people within the same community to view each other as distrustful and seeking to be 'White'.

There is evidence showing how the distress arising from experiences of racism can bring people into contact with mental health services (Sanders-Thompson, 2002). At a societal level, racism within healthcare settings could affect the physical and mental health status through the way services are organised. Access to mental health services is problematic, with minority ethnic groups less likely to be referred for psychological therapy than their White counterparts, over-medicated and likely to present to services via the Criminal justice system or an emergency pathway and more likely to be detained under the Mental Health Act (Chakraborty and McKenzie, 2002). Healthcare services fail to think about the impact of culture and racism as a social factor (Gee and Ford, 2011).

Institutional racism may be evident in organisations like banks, education institutions and the legal system. This may create and sustain a social status and restrict employment opportunities and further reinforce the socio-economic inequalities. The Sainsbury Centre report (Keating, Robertson, McCulloch and Francis, 2002) talks about the inappropriateness of services that are provided to individuals from minority ethnic groups, suggesting that there are 'circles of fear' between Black communities and mental health services. The institutions are seen as dangerous and untrustworthy by the Black community and the mental health staff view the Black community as dangerous due to a divergence of professional discourses on psychological distress. Fernando (1991) has argued that a focus on individual psychopathology with little or no attention to the socio-economic factors renders psychiatry and mental health services racist institutions.

The Scarman Report (1981) after the Brixton Riots concluded that institutional racism did not exist in the police force. However, the Lawrence enquiry and the MacPherson Report (1999) did highlight institutional racism in the police force. The inquiry into the death of David (Rocky) Bennett in 2004 highlighted institutional racism in the National Health Service (NHS) and it was expected to examine its structures and services to eradicate racism. These reports have framed the changing story of race relations in the UK and led to different national policies like Inside Outside (DH, 2003) and Delivering Race Equality (DRE) (DoH,

2005) being developed. These attempted to specifically address the issues of race and ethnicity in mental health services.

It is important to understand how the impact of race, ethnicity and culture will manifest in the therapy room and amongst colleagues.

1.6.1 Cultural misunderstandings in mental health

Cultural relativity maintains that an understanding of health and illness is relative to each culture and cultural universality indicates that concepts of health and illness are applicable to all cultures in the same way. Some forms of distress constructed as an illness in the West may be seen in religious or philosophical terms in other cultures.

Most Western models of care stem from the idea of mind-body separation or dualism, that was introduced by the French Philosopher Rene Descartes. This idea represents a metaphysical stance that mind and body are two distinct entities, each with a different essential nature (Mehta, 2011). This dualistic stance which formed the basis of the biomedical model of health with a diagnostic focus on psychological distress, fails to consider context and emphasises individualism and universality.

Mills and Fernando (2014) also argue that this method of thinking has been institutionalised and transported to non-Western countries, ignoring the different ways of conceptualising psychology that exist in populations with different cultural traditions. In Asian cultures as well as many other cultures, the mind and body are considered inseparable (Sue & Sue, 2003). The hegemony of biomedicine fails to acknowledge the interpersonal and cultural reactions to disease. It is important to consider that the attempt by one culture to attempt to monopolise the healing traditions and impose its ideas on other cultures may lead to a very narrow conceptualisation of well-being. Discussions around the relationship between culture, ethnicity and mental health can help unpack conflicting clinical perspectives, which is imperative in providing a culturally competent service. Western norms of mental health applied to other cultural settings leads to what Kleinman (1987) calls a category fallacy because this application will find

what is universal and miss what does not fit within the Western parameters, thus missing the influence of culture on health.

Mental health services fail to take the cultural aspects of mental health into account and services are organised around a reductionist approach where mental health difficulties are constructed as illness. One of the main criticisms of any illness-based model is that it locates socio-political problems within the individual (Blackman, 2007). This may impact on people from a Black and Minority Ethnic (BME) background accessing services, resulting in worsening mental health for this group.

Migration and racial discrimination itself provide the basis for ill-health and stress. Racism and cultural misunderstandings may affect access and quality of care for these BME groups. It is therefore helpful to consider the relationship between ethnicity and mental health.

1.7 Understanding the relationship between ethnicity and mental health

Effects of race and ethnicity in everyday life may take different forms and often reflect the socio-political circumstances of the time. Mental health is an area where ethnicity continues to matter, affecting the incidence, prevalence, severity and course of mental health problems, help-seeking behaviour, and care received (Rehman and Owen, 2013). Ethnic differences impact on healthcare in general based on many factors like differences in accessing services, language, cultural beliefs and attitudes, socio-economic factors and disease prevalence (Fitzpatrick et al., 2014).

Psychology is seen as a scientific discipline, traditionally based on the biomedical model and as such assumed to have objective methods of treatment that are free of cultural bias. In adopting this model, psychology may ignore culturally relevant information (culture-blind) and may be ill-equipped to deal with the implications of its own cultural position. However, culture is an integral part of our lives and the therapeutic setting does not produce a culture-free interaction.

Black, Asian and minority ethnic (BAME) communities are generally considered to be at increased risk of psychological distress (Bhui and Mackenzie, 2008). BAME communities and their poor socio-economic contexts have been shown to have worse health outcomes with varying prevalence of mental health

difficulties than the general host populations. The intersectionality here is important to understand how ethnicity affects individuals' experiences. A need to close the health gap has been recognised by the Department of Health by implementation of Race Relations Amendment Act 2000 (April 2011).

Qassem et al.'s (2015) review explored the association between ethnicity, mental health and socioeconomic status and found a higher prevalence of psychosis in people from a black ethnic minority background as compared with the white majority population.

1.7.1 Ethnicity and mental healthcare

The Count Me In census (CQC, 2010) showed an over-representation of minority ethnic populations (young, Black men in particular) in mental health services in the UK and a disproportionate percentage of inpatient admissions to psychiatric units were from BAME communities. Most of the research on the relationship between ethnicity and mental health has focused on the higher rates of psychosis among the African Caribbean population as compared with the White population (McGovern and Cope 1987; Harrison et al. 1988; Cochrane and Bal 1989; Van Os et al. 1996; Bhugra et al. 1997). Evidence shows an over diagnosis of psychosis in Black Caribbean/African men than White British (Keating et al. 2003) and that they are more likely to enter the mental health system via the criminal justice system under Section 136/137 of the Mental Health Act (1983) (CQC, 2005). There is also likely to be over-use of psychotropic medication (Lloyd and Moodley, 1992). Suicide rates are higher for South Asian women aged 25-39 compared with their white British counterparts (Bhui and McKenzie, 2008). Research shows that there is a low uptake of mental health services by women from a South Asian community due to the fear of loss of confidentiality and inappropriate nature of services (Keating et al., 2003). BAME communities on the whole are less likely to be referred for psychological therapy (Bhugra and Bahl, 1999) due to the Western notions of them not being psychologically minded and are also less likely to have mental health problems detected by their GPs (National Institute for Mental Health, 2003). The 2010 All Ireland Traveller Health Study found that in Northern Ireland, the suicide rate among male Irish travellers is 6.6 times more than that of men in the general population.

Research suggests that historical events and experiences, like war trauma, post-migration conditions, host community reactions, separation, loss, unemployment and housing issues increase vulnerability to mental health problems (Tribe, 2002; Porter & Haslam, 2005; Steel et al, 2009).

Fear of institutional racism and lack of information about services may be among the other reasons people fail to access services when they need them the most. This needs to change if people from minority ethnic groups are to have equal and equitable access to health and social care.

1.7.2 Service access and provision

As a whole, White and Black minority ethnic groups experience high levels of disadvantage and inequality. The mental health needs of these groups are often not met and service provision has not always been appropriate (Bhui, 2002). Mental health services in any country are usually set up to cater for the majority cultural group and ethnic minorities may not receive equitable care. In the UK, differences in rates of illness, access to care and outcome and satisfaction with services have been reported (Sashidharan, 2003).

The under-utilisation of mental health services by ethnic minorities may be affected by multiple factors like acculturation, shame and stigma, discrimination (as a result of their mental ill health and also because of their race/ethnicity/culture), ideas about help-seeking, ethnic background of therapist, and Western models of therapy.

A qualitative psychiatry study on experiences of acute mental health care in London showed that ethnicity appeared to mediate unsatisfactory care experiences in in-patient settings predominantly (Weich et al, 2012).

1.7.3 Ethnicity and clinical practice

For clients

With the increased mobilisation of people across geographical borders and the second, third generations of immigrants, therapists are presented with growing cultural diversity in their clinical practice. Cross-cultural interactions occur when there are two or more culturally different individuals present. Although the impact of ethnicity and culture may be highlighted for White therapists when working with ethnic minorities, it is evident that every individual whether minority or majority is influenced by his/her culture. Therapy cannot take place in a cultural vacuum.

The interplay of client culture, clinical setting and clinician culture can pose significant challenges experienced against a backdrop of other factors such as age, gender and others.

The role of ethnicity and culture in the social and psychological functioning of an individual is complex and can affect assessment and treatment in diverse cultural contexts. As ethnicity and culture are subjectively ascribed characteristics, it is important to create space within the therapeutic context for individuals to unpack their ethnic identities (Hickling, 2012).

Fanon (1986) noted that mental health cannot be understood without exploring the relationship of an individual with their oppressive socio-economic and political contexts. The first-person narrative in such diverse cultural contexts is very important to understand the cultural norms, the strengths and resources, ethnic identities and experiences associated with minority status.

For therapists

At the best of times, therapy seems like a daunting undertaking for anyone.

Traditional psychological practice is often based on ethnocentric and Eurocentric assumptions which may not meet the needs of minority ethnic groups. Providing a mental health service and therapy to a racially and ethnically diverse population is increasingly becoming more relevant now. Conversation about ethnicity can feel uncomfortable for some therapists due to anxiety about offending the client or for 'saying the wrong thing' (Cardemil & Battle, 2003). This topic can also be emotionally charged due to the historical narratives around race relations and each individual's experience (Helms & Cook 1999).

For psychological assessments, the cultural variations and ethnic differences of both client and therapist may affect empathy and communication (Bhui and Bhugra, 2004). Working with interpreters, the information is processed through a third person's linguistic-emotional framework and there are potentially many different value and belief systems in the room to contend with. Involving a third person in therapy makes communication subject to distortion along with issues of confidentiality.

The relationship between ethnicity and mental health highlights the need for culturally competent psychology services. Turpin and Coleman (2010) suggest that the diversity of the clinical psychology workforce should reflect the diversity in the population it serves to ensure better access to services for BME groups.

The following section will look at the composition of the clinical psychology profession in the UK, followed by the need for cultural competence in therapy.

1.8 Clinical psychology workforce in the UK

Sue and Sue (1977) identified that culture-specific, class and language differences between the client and therapist may impede cross-cultural therapy.

Figures indicate that 9.6% of qualified Clinical Psychologists (CPs) in England are from BME groups (DoH, 2013). Data gathered by the English Survey of Applied Psychologists (Lavender et al., 2005) identified only 5.8% of qualified CPs coming from Black and minority ethnic (BME) backgrounds. An ethnic monitoring survey of the membership of the Division of Clinical Psychology (47.7% response rate) indicated that 94% described themselves as White, 3% Asian and 1% Black, Chinese and Mixed (BPS, 2004). Caution needs to be exercised when looking at these figures as this data is dated and it was taken at different time-points. More recent figures from the Clearing House (2015) give a breakdown of ethnicity as—6% Asian, 1% Black, 3% Mixed, 2% Other and 87% White.

The present study was conducted in London and comparable data was sought. The 2011 census data indicated that the total percentage of ethnic minority population in London was approximately 30%, making it higher than the national percentage of approximately 12% (ONS, 2011). However, no specific data on the ethnic make-up of the clinical psychology profession within London is available, making it difficult to draw comparisons. The data here indicates that the workforce is not representative of the population of the country and of London.

In order to provide an accessible, ethical and effectively delivered mental health service to the different ethnic groups, it is useful to consider the concept of cultural competence (CC) of the health professional working in these services.

1.9 Cultural competence

The NHS now has to cater to not just the recently arrived immigrant population but also the second and third generation of immigrants. The MacPherson (MacPherson, 1999) and Rocky Bennett Inquiries (INQUEST, 2004) have highlighted the need to address the issue of CC in the UK. Waldegrave et al.

(2003) suggest that therapy risks being racist, oppressive and discriminatory if it does not address cultural meanings and imposes Western norms.

1.9.1 Historical context

The clinical encounter between a psychologist and client is shaped by visible and invisible differences of social position, culture, ethnicity, language, religion, beliefs, gender and other aspects of an individual's context (Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation, Spirituality or GRRRAAACCEEESSS) (Burnham, 1993). The GRACES acronym is a useful concept when thinking about contextual variables in which people feel marginalised by virtue of feeling different. In culturally diverse societies such as the UK, the dominant culture determines what problems to recognise. The origin of the concept of CC has been difficult to trace. Mackenzie (2008) found that it originated in the USA in the early 1970s. However, other literature states that CC emerged as a framework for addressing inequality in the USA in the 1980s. It was first seen in social work literature (Gallegos, 1982; Green, 1982) and was further explored in the counselling literature by (Pedersen and Marsella, 1982).

The concept of CC was developed as a response to inequalities experienced by people from minority ethnic communities in healthcare services. CC operates at the individual professional's level as well as at the organisational level. The key to developing CC at an individual level may involve developing awareness of the self, knowledge and skills. At an organisational level, the organisation needs to sanction CC and include cultural knowledge into policy, infrastructure, and practice through community engagement.

1.9.2 What is Cultural Competence

There is no consensus on the definition of CC. Cross, Bazron, Dennis & Isaacs (1989) define CC as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. iv). Dogra et al. (2007) suggest that delivering appropriate services to all ethnic minority groups is more than a checklist exercise and it needs to be set within an educational and political framework. It involves the capability of

systems, agencies, and practitioners to be responsive to the needs of populations whose cultures may be different from what may be called the majority culture.

The self-awareness of the therapist who recognises when and how cultural values may be relevant to a client's problems, and has the ability to use this information in a nuanced way to avoid stereotyping their clients, is in sharp contrast to 'cultural encapsulation' (Wren, 1962). This term was coined referring to the unintentional ethnocentrism that occurs when therapists are unaware of how their own culture and background frames their interpretation of what the client says and responds to within therapy.

The term cultural competence has been contested. One can argue that this usage of the word may determine individuals as either competent or incompetent (McAllister, 1998; and Watson, 2002). This dichotomy is not necessarily helpful as it may imply that an individual is one or the other. Benner (1984) situates competence along a continuum of novice to competent to expert, thus implying that being competent is better than being a novice but not so good as an expert which can be seen negatively. Dogra et al. (2007) prefer the term 'cultural sensitivity' because they suggest that the term 'culturally competent' may imply that competence is already achieved.

The cultural competence (Sue, 1998) of the therapist is one aspect of delivering services that are culturally sensitive and the following section will discuss the importance of training a culturally competent workforce.

1.9.3 Training a culturally competent workforce

Disparities in the care received by individuals from minority ethnic groups in the UK are well documented (Nazroo and King, 2002; Keating et al., 2002). To provide culturally competent care, a knowledge of cultural beliefs, values and practices is necessary. Organisational and individual CC have been identified as important characteristics of high quality mental health services (Bhui et al., 2007). As a result, CC is a required competency (Patel et al., 2000) and training is provided for all mental health professionals and medical, nursing, and social work students.

As the demographics of the UK continue to change, the Race Relations (Amendment) Act (2000) places a responsibility on public authorities to tackle the disparities in order to provide culturally competent services. The Rocky Bennett Inquiry Report (Inquest, 2004) highlighted the importance of culturally competent

training to tackle overt and covert racism as well as institutional racism. Lago and Thompson (2003) highlight the need for culturally appropriate supervision and training for therapists through exploration of power differentials, historical implications of the client-therapist and therapist-supervisor relationships. Cultural competency is complex and not all of its components can be taught (Sue, 2006) and training courses in the UK do not adequately address working with clients from different cultures (Lago and Thompson, 2003). However, Papadopoulos and Cross (2006) provide guidance regarding this and advise against relying on assumptions when working with ethnically similar and different clients. Reviews have highlighted that although CC training is important, the framework to deliver the training is under-developed (Bhui et al, 2007; Clegg et al., 2016).

A number of conceptual models have attempted to describe elements of CC and there is no consensus regarding the components (see Alizadeh and Chavan, 2015 for a review). Govere and Govere (2016) conducted a systematic review of the literature and found that CC training was significantly associated with patient satisfaction. On the other hand, Bhui et al. (2007) reviewed 9 articles of cultural competency models to improve cultural competency practice and service delivery but found little evidence for the effectiveness of cultural competency training. Falicov (1995) talks about therapists incorporating cultural variables in therapy by taking up one of four positions which will have different implications for practice—universalist, particularist, ethnic-focused and multidimensional. The first three positions disregard the impact of social justice. The fourth position – a Multidimensional, Ecological, Comparative Approach attempts to incorporate sensitivity not only to cultural values of an individual but also the social stressors. She suggests that the multidimensional approach is a good starting point in training as it provides a cultural map for understanding similarities and differences and also developing cultural self-reflexivity.

As such the focus is on training White clinicians to work with ethnicity and diversity (DoH, 2003; DoH, 2004; Fatimilehin & Coleman; 1999; Lago, 2010). The literature largely explores the cultural competency of the White therapist (Iwamasa, 1996), resulting in the experience of the ethnic minority therapist being ignored. By virtue of the psychologists belonging to an ethnic minority group, a

majority of their therapeutic interactions will be with clients from a different ethnic and cultural heritage.

In response to Turpin and Coleman's (2010) suggestion that we need a culturally aware workforce which can work with difference, Patel (2010) challenges the assumption of the need for a diverse workforce. She suggests that psychology needs to question the cultural appropriateness of individual therapy and the Eurocentricity of the clinical psychology profession. Eurocentric models of therapy do not reflect the realities of race and culture that ethnic minority groups may experience because they largely represent the worldviews of their authors (White European men) who never experienced oppression based on their race, culture or ethnicity. In the counselling literature, Laungani (1997) also suggests that client-centred therapy be replaced by culture-centred therapy as the appropriateness of individualised models of therapy for non-western clients is questionable.

1.9.4 Critique

Culture is often presented as static rather than as a dynamic process. Moreover, often cultural competency focuses on identities of people of colour, thus framing Whiteness as a homogenous norm and reinforcing the idea that people of colour are different. These ideas fail to consider that Whiteness also has a set of values and world view. Cultural competency training tends to teach about understanding the Other, rather than examining the Self too. Psychologists do not receive any training on European/ American beliefs during cultural competency training as the therapist is assumed to be White or acultural.

To address health inequalities and practice in a more culturally aware way, it is important to consider that cultural differences are present not just between the client and psychologist but also between client and their systems. By failing to acknowledge this, structural inequalities remain invisible. By emphasising the role of the culture of individuals, cultural competency fails to recognise that healthcare systems are constructs themselves and need to be considered within a historical context.

1.9.5 Understanding aspects of one's own culture and ethnicity in the therapist role

Recognising that all our behaviour is learned and displayed in a particular cultural context is important as it enables a meaningful definition and understanding of

problems by each person in the therapeutic relationship. Cultural similarities and differences are both equally important to understand the complexities of cultural identities as problems are defined and understood in culturally relevant ways. This may include awareness of the therapists' own culture in relation to their clients and colleagues and also an awareness of their own learned assumptions.

Sue et al. (1982, 1992) argue that CC in therapists can be conceptualised by three aspects—awareness of the therapist's own cultural values and beliefs and the impact of these on the therapeutic relationship and process, cultural knowledge about the client's worldview and the ability to intervene in a culturally sensitive manner. Clinical Psychologists cannot adopt their clients' ethnicity or cultural heritage; however, they can become more sensitive to their own and their clients' assumptions and biases. This is in contrast to "cultural encapsulation" (Wrenn, 1962) where the psychologist's reality is based on only one set of assumptions.

The majority of literature located is based on the assumption that the therapist is White, thus obscuring experience of ethnic minority therapists. Moreover, as acknowledged earlier it appears to be slowly responding to the changing demographic of the UK. However, it appears to be slow to respond to the shifting demographics of the profession itself. The next section will specifically look at the experiences of ethnic minority therapists leading on to the present study.

1.10 Experiences of the ethnic minority psychologist

Literature exploring the experiences of ethnic minority therapists/psychologists is limited in the UK. A significant part of the literature is from the US and the applicability of findings may be limited due to the difference in ethnic composition between the two countries. A small body of literature on trainee experiences and some literature from a counselling and psychotherapy perspective were located within the UK. Due to a paucity of literature focusing on the practice of the ethnic minority therapist in particular, the literature outlined in this section has been drawn from all sources mentioned above.

Individuals from an ethnic minority background as providers of services seems to be a neglected area. The literature on working with ethnic and cultural similarities and differences has considered ethnic minority as a client variable. Thorough

searches of literature on the practice of CPs from a South Asian background did not locate any studies.

The literature on the practice of ethnic minority therapists/psychologists has been explored further using variations of the term 'ethnic minority therapist' 'clinical psychologist' 'practice' 'experiences'. Previous trainee theses exploring issues for trainees in the profession of clinical psychology were also explored. Articles were hand sorted for relevance and relevant references from these articles were located further.

1.10.1 Enabling conversations about differences

Ethnic and racial differences between client and therapist may affect the therapeutic relationship and outcomes (Cabral and Smith, 2011). Cardemil and Battle (2003) suggest that therapists feel uncomfortable, uncertain and perhaps anxious when the topic of race and ethnicity surface in therapy, due to the emotions attached to race relations. Other responses by therapists to racism were either frustration, hurt and shame (Rastogi and Wielding, 2005) as this can evoke difficult emotions for the therapist as it may serve as a reminder about their own racial identity (Hardy, 1993).

Thompson and Jenal (1994) suggest that to become a competent counsellor, it is important to discuss race and ethnicity with clients in therapy. They explored the Black therapist-Black client dyad and found that when race was not discussed in therapy, Black clients were less willing to discuss relevant issues. Fuertes et al. (2002) consider working with a culturally different client a skill and that discussing race and ethnicity early on in the therapeutic process is essential.

Maxie et al. (2006) surveyed over 800 psychologists in the US about how they addressed difference with clients and found that a majority of the psychologists only addressed differences if they were relevant to the client's presenting problem and most psychologists reported feeling comfortable addressing these differences.

Knox, Burkard and Suzuki (2003) interviewed 5 African-American and 7 European American licensed psychologists about addressing race in psychotherapy and found that White therapists felt more uncomfortable addressing race with clients than their Black colleagues. The Black psychologists

also said that their previous experiences of racism had shaped their approach to therapy. Therapists' views about race and ethnicity in therapy can be understood from three different perspectives– Universalist, particularist and transcendist (Tyler, Brome and Williams, 1991). Universalists would identify common experiences with clients and believe that identifying differences can impede understanding and reinforce stereotypes (Pinderhughes, 1989). Particularists believe that talking about differences is important (Sue and Sue, 1999). Transcendists believe that commonalities and differences should both be considered, however, therapists may or may not choose to address these issues (Tyler et al., 1991).

1.10.2 Cultural adaptations

Bernal, Jimenez-Chafey and Domenech-Rodriguez (2009) define cultural adaptation as 'the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture and context in such a way that it is compatible with the client's cultural patterns, meanings and values' (p. 362). Sue, Zane, Hall and Berger (2009) conducted a review of cultural competency in psychotherapy and conceptualised cultural adaptations into three categories–(a) the qualities of the therapist, (b) the psychotherapeutic process, and (c) the content of treatment. Griner and Smith (2006) discuss four common methods to culturally adapt mental health services–incorporating the cultural values of the client into therapy, client-therapist matching, locating mental health services that are easily accessible and use of community resources. In their meta-analysis of 76 studies, they found that culturally adapted interventions were more effective than interventions without any cultural adaptations.

Resnicow (1999) discusses cultural adaptations in two categories– superficial/surface adaptations and deeper adaptations. The surface level adaptations can be understood in terms of matching resources to group characteristics (e.g. ethnic matching). The deeper level adaptations incorporate cultural ideas, beliefs and values into treatment. Ito and Maramba's study (2002) explored the perspectives of Asian therapists in the US who were matched with Asian clients by culture or language. They noted that the therapists made adaptations in their work when working with Asian clients. There has been limited research on this, possibly because it is often difficult to understand the

cultural complexities involved and knowing when to stereotype and when not to overgeneralise may not always be easy.

However, it is plausible that cultural adaptations may be less necessary with clients who have a greater level of acculturation. Culturally adapted therapy is nuanced and context specific and the present study has aimed to explore what adaptations clinical psychologists make while working with their ethnically similar and dissimilar clients.

1.10.3 Therapeutic orientation

Family therapy consists of working with families with different ethnicities and cultures. Most of this research is from an Asian American perspective in the US, and therapists have reported that they would usually work with the family for cultural, therapeutic and practical reasons, like the closeness and interdependency of family members (Ito and Maramba, 2002). Norcross (2005) suggests that most therapists work with an eclectic or integrative therapeutic approach and tailor it to suit individual client needs. Therapists using an eclectic approach may be more likely to consider and discuss multicultural issues in therapy, thereby personalising treatment plans to each individual. Berger, Zane and Hwang (2014) found that ethnic minority therapists reported better multicultural awareness and therapeutic relationships with their clients than White therapists, especially if they used an eclectic therapeutic approach.

1.10.4 Amongst colleagues

The wider experience of Othering was also reported in training/profession which impacted the therapists' personal and professional identities (Goodbody, 2009). Othering is described as reinforcing and reproducing the power differentials by positioning Blackness as inferior (Fine, 1994). Rajan and Shaw (2008) discuss being positioned as 'unprofessional' when attempting to challenge the underlying prejudice in the work culture. Adetimole, Afuape and Vara (2005) reflected on the responsibility of supervisors to address issues of racism with their supervisees, suggesting that the supervisors need to develop safe relationships with their supervisees to enable these conversations. Patel and Fatimilehin (2005) also discuss the issue of race and ethnicity seen as add-on during service development and planning, leading to 'ghettoisation' of services for BME clients, locating them in the voluntary sector and reducing their influence on mainstream services.

1.10.5 Working with apparent ethnic similarity and differences

Some people may choose to conceptualise ethnic similarity as belonging to a larger ethnic minority group (e.g. Asian) whereas others may refer to it as belonging to a sub-group within the larger ethnic minority group, for example, Pakistani, Indian, Chinese. Other factors that influence ethnic identity are acculturation levels and other social and political factors. Many individuals live at the interstices of cultures and ethnicities. With the increase in immigration and interethnic relationships, there is a growth of multi-ethnic individuals. With all this comes the feeling of being 'half and half' – not fully belonging to the culture of the home or host country (Danquah, 1998).

Comas-Diaz and Jacobsen (1991) suggest that there is a difference between the reactions of White and Black therapists working with ethnic minority clients. White therapists may feel guilt when they encounter conversations of race and ethnicity. They also suggest that Black therapists may feel resentment or try to be extra cooperative (e.g. extend sessions). One way of explaining the above reactions might be the notion of countertransference, where the therapist transfers his/her own feelings to the client (Gelso, 2001). Tang and Gardener (1999) also described a strong sense of identification by the therapist with the client who were both from ethnic minorities. This may lead to them working harder with these particular clients.

With ethnically different dyads, Wielding and Rastogi (2003) found that ethnic minority therapists struggled with responding to racist comments made by clients in therapy. Different therapists expressed different emotions of hurt, shame, anger and uncertainty about whether to address these comments in therapy. Watson's (2006) review also suggested that Black counsellors experience subtle rather than direct/overt racism from clients. Patel (1998) also found that when clients tried to assert power over the Black therapist in a session, the BME trainee/psychologists managed racism by trying to prove their competence or asserting their power as a professional.

The ethnic minority therapists/psychologists reported positive experiences of working with similar and different clients as well. Wielding and Rastogi (2003) found that ethnic minority therapists reported a positive therapeutic alliance when working with White clients, yet expressed concerns over their competence and credibility. This is inconsistent with literature that suggests that ethnic minority

psychologists feel competent when working with White clients (Bernal et al., 2002). In Jordan's (2001) study with African-American psychologists, the psychologists pointed to the benefits of being an "insider", with knowledge about the community which helped in their work with clients from the same community.

1.10.6 Ethnic matching

Matching is described as matching clients and therapists on a variety of demographic variables to minimise variability and to ease engagement and improve outcomes (Maramba and Hall, 2002). The rationale behind ethnic matching is grounded in social psychological theories that posit an enhanced therapeutic relationship between client and therapist if they are ethnically similar. Baron and Byrne (2002) suggest that human beings tend to seek out and respond to familiar things and are apprehensive of things that are dissimilar. The idea here is that ethnic matching may help reduce the number of differences between therapist and client which may help engagement with services. There is evidence that ethnic and racial minority clients prefer therapists who are similar (Abreu & Gabarain, 2000; Coleman et al., 1995), though some studies find little or no difference in preference (Speight & Vera, 1997; Vera, Speight, Mildner, & Carlson, 1999). This is because there is usually an assumption that shared ethnicity means common cultural ideas and values which may positively influence communication and understanding due to shared non-verbal cues (Sue and Sue, 1977). This assumption of shared values and ideas may exacerbate the perception of similarity between therapist and client, leading to over-identification (focusing too much on shared cultural experiences) (Maki, 1999). This may impede therapeutic work as therapists may not be able to fully explore the client's behaviour and salient issues might be missed. Comas-Diaz and Jacobsen (1991) warn against an extreme version of over-identification- 'us and them', especially amongst ethnic minority groups with a history of oppression.

Research on the impact of ethnic/racial dissimilarity between therapists and clients has shown that it may affect the establishment of a therapeutic relationship and can lead to poor communication which can hinder understanding (Watkins et al., 1989; Sue and Sue, 1977). While working with ethnically different clients, having no knowledge of their culture can be detrimental. However, even if one has the knowledge its application and relevance cannot always be

assumed because of individual differences among members of a particular ethnic group. The danger here is of overgeneralisation of knowledge about ethnically dissimilar groups.

On the other hand, the dissimilarity may have a positive effect on the therapeutic relationship too. The client may feel more comfortable sharing information with an ethnic minority therapist without feeling socially unacceptable (Jackson and Kirschner, 1973).

The literature on racial-ethnic matching of client and therapist in therapy is equivocal. A perception in the mental health field is that ethnic minority therapists possess skills to work mainly with clients from their own or similar cultural background. This places the therapist in a narrow cultural practice and questions their competence to work beyond the 'culture' dynamic (Moodley & Dhirga, 1998). Critics of the ethnic matching hypothesis have argued that even when therapists are ascribed the same ethnicity as a client, they may differ in cultural attitudes and this may be therapeutically inadequate (Bhugra and Bhui, 1997).

1.11 Present study

1.11.1 Rationale

In the UK, the research on ethnic minority status is largely focused on clients and assumes the therapist to be White (Iwamasa, 1996). Literature exploring the experiences and issues of ethnic minority therapists emerged in the US before being explored in the UK. Even today, a large chunk of the literature is produced in the US and more so from the counselling and psychotherapy disciplines. In literature, the practice of the ethnic minority therapist is rarely addressed which sets the tone for research to continue to focus on client issues at the risk of neglecting the experience of working in a Eurocentric profession.

The literature addressing ethnic minority experiences is sparse, particularly for South Asian psychologists (Wielding & Rastogi, 2003). The CC literature is based on the implicit assumption that the therapist is White. Consoli, Kim & Meyer (2008) noted that there is more focus on challenges faced by counsellors who work with ethnic minority clients but less of a focus on the adaptations that a minority ethnic counsellor may make when working with multiple ethnicities.

Literature by therapists from an ethnic minority background has focused on the experiences of racism, and racial and ethnic similarities and differences. The

literature documented has explored the ethnic and cultural differences as a client issue and focused primarily on the role of a White therapist. The review above has also explored the experiences of ethnic minority therapists/psychologists from a predominantly Africa-American/Caribbean and Asian American perspective in the US. There is an obvious paucity of research that involves the voice of CPs from a South Asian background. One of the reasons for this could be the assumption that this particular group of psychologists are less active in voicing their experience of the therapeutic process.

In the UK, individuals are grouped together on the basis of their ethnicity, thus failing to acknowledge the heterogeneity within the same groups. The generic grouping of people as BME may serve to mask the disadvantages experienced by specific ethnic groups. Although all minority ethnic groups may experience racism, differences in each community's religious and cultural beliefs may feed into the experiences they may have in the UK. Often these experiences influence our clinical practice.

I came to this study with my own experiences of having been brought up in India and trained in the UK. I reflected on my own experiences of professional socialisation, experiences of discrimination and negotiating conversations about differences in my clinical practice and in the workplace. There were times when I had to conform to the dominant group values to be accepted into the field of Clinical Psychology. This prompted me to explore the experiences of other clinical psychologists who self-identified as South Asian to understand how they practise.

Specifically, participants were asked to reflect on their own practice, the identities on which they drew in their clinical work, how they enabled conversations about differences and similarities between themselves and the clients and issues they encountered in the therapy room and in the clinical psychology profession.

1.11.2 Aims of study

The present study aims to explore the clinical practice of Clinical Psychologists who self-identify as South Asian, with multi-ethnic/cultural clients. The results should provide insight into the psychologists' experiences, thoughts and ways of working with different dilemmas.

There is a move towards a reflective-practitioner model (Stedmon & Dallos, 2009) which emphasises the integration of theory, research and practice at a more personal level. This study hopes to understand the implications of its findings in clinical work by looking at the role of training programs, supervisors and the importance of self-awareness.

1.11.3 Research question

How do Clinical Psychologists who identify as South Asian work with culture and ethnicity in the therapy room?

2. METHODOLOGY

This chapter will detail the methodology for the present study and is divided into 4 sections- rationale for qualitative methodology, namely, thematic analysis (TA), epistemological and ontological position, followed by a description of the design used and ethical considerations.

2.1 Rationale for Qualitative methodology

The aforementioned research question is exploratory in nature and therefore best suited to a qualitative approach. A qualitative approach enables participants' personal and socio cultural context to be explored rather than measured. Thompson and Harper (2012) emphasise that this allows researchers to generate an understanding of people's experiences. It enables the production of descriptive data that is contextually situated and places emphasis on its the meaning. As stated previously, there is a paucity of literature examining the practice of Clinical Psychologists who identify as South Asian. The aim of this study is to capture a first-hand account of the clinical practice of CPs who self-identify as British Asian or South Asian, using interviews. A qualitative method appeared to offer the necessary tools to do this as it is well suited for exploratory research (Barker, Pistrang and Elliott, 2002). In order to do this, one needs methods that yield descriptive data.

2.1.1 Thematic analysis

Several approaches were considered for the analysis of data. Below, I will briefly outline why thematic analysis was chosen as opposed to other methods.

Interpretative Phenomenological Analysis (IPA) was not considered viable as the research question did not intend to focus on exploring in detail "how participants are making sense of their personal and social world" (Smith & Osborn, 2008, p53). In addition to this, IPA requires a homogenous sample and given that the participants in this study were from different services, working with varied clients and preferred to work with different therapeutic models, this method was not chosen.

Discourse Analysis (DA) was also considered. However, this study did not focus on the use of language in the construction of reality or the quality of discourse

(Willig, 2009). Moreover, given the sensitive topic of culture and ethnicity, I was concerned about adopting DA which may have resulted in participants becoming anxious about terminology, which may have in turn reduced the opportunity for honest and open accounts from participants.

Green and Thorogood (2010) suggest that the primary purpose of Grounded Theory (GT) is to produce new theories that are grounded within empirical data. It can however also be used for exploratory research questions. However, Willig (2009) suggests that this results in a descriptive analysis rather than an exploratory one and for this reason, GT was deemed inappropriate.

An in-depth thematic analysis, embedded in a critical realist paradigm, was used to examine the interviews of 10 clinical psychologists who identify as being from a South Asian background.

Thematic analysis (TA) has been recognised as a qualitative method in its own right (Braun and Clarke, 2006). TA identifies and analyses patterns of meaning within a given data set and aims to organise and describe this in detail. Joffe (2012) suggests that TA is not tied to a particular theoretical outlook and that it can be used within a range of theoretical and epistemological approaches. Considering the dearth of literature on the practice of South Asian psychologists, it was important that the research question be exploratory. Therefore, it felt appropriate to choose thematic analysis as it allowed openness and flexibility to the analysis.

The identification of themes in TA can be done in an 'inductive manner', i.e., "without trying to fit it into a pre-existing coding frame" (Braun and Clarke, 2006, p. 83). Alternatively, a deductive TA involves mapping the data onto pre-established theoretical areas of interest. For the purpose of this study, an inductive approach to TA has been used as this study did not set out to examine a predetermined hypothesis. Moreover, the inductive approach to TA is in keeping with the exploratory nature of the study as it sought to generate themes that would provide a better understanding of the way participants practice therapy with their multi-cultural clients. It allows the researcher to explore how people engage with a particular issue.

2.1.2 Approach to analysis

Thematic analysis appears to be one of the most popular approaches to qualitative data analysis and is frequently cited as the approach of choice in journal papers describing qualitative studies. However, thematic analysis is by no means uniform and is often only partially explained in these papers. The processes of coding undertaken are rarely specifically described. It remains popular and useful because it provides theoretical flexibility and accommodates synthesis of varied data sources (Boyatzis 1998).

TA produces descriptions of individual subjective experiences. Ontologically, TA takes for granted the meanings expressed by individuals. There is no linguistic deconstruction of experiences per se.

2.2 Ontological and epistemological approach

In determining research aims and methods there are two areas of philosophy which are relevant- ontology and epistemology. Ontology relates to the fundamental questions about existence (i.e.- what is there to know?) and epistemology is related to questions of how do we know something exists (Willig, 2013).

Overall the thesis positions itself as ontologically realist and epistemologically as critical realist. Ontological realism implies that there is an external reality which does not depend upon cognitive structures of human investigators. A realist ontological position means that the subject matter – here therapeutic practice of CPs is assumed to be real and independent of the researcher. Participants' views, experiences and understandings of therapeutic practice are seen as concrete subjective realities.

Critical realism is based on the assumption that there is no complete knowledge and though a reality exists, it is only 'imperfectly apprehendable' (Guba & Lincoln, 1994). A critical realist epistemological paradigm seems appropriate here because it focuses on the wider social context that the participants are placed within. For the research question, I take the CPs accounts at face value and accept that their accounts constitute true depictions of how CPs practice when they encounter issues of culture and ethnicity in the therapy room, in the profession or amongst colleagues. The constructs of race, culture and ethnicity

are assumed to be 'real', in as far as they have consequences for those who are positioned within them, for e.g.- for CPs from a South Asian background, the experience of racism and power differentials based on being viewed as inferior owing to their ethnic minority status. These experiences shape people's lives and identities.

Critical realism is one way of interpreting the data as how each individual constructs their experiences will be different.

2.3 Design

2.3.1 Developing semi-structured interviews

Semi structured interviews are conducted with an open framework which allows a focused, conversational style interview. With using 1:1 semi-structured interviews, I am aware of the "necessary problems" (Potter and Hepburn, 2005, p. - 281) that are difficult to entangle in interviews. For example, flooding with an agenda. Here, the interview is indeed flooded with a set of concerns that are central to my research. However, these are essential to carry out this study. Besides, I am aware of potentially biased responses that could be given by interviewees- "what people say in an interview will indeed be shaped, to some degree, by the questions they are asked; the conventions about what can be spoken about;[...]...by what time they think the interviewer wants; by what they believe he/she would approve or disapprove of" Hammersley & Gomm (2008, p. 100). Moreover, interviewees will only give what they are prepared to reveal about their perceptions of events and opinions. These perceptions, however, might be subjective and therefore change over time according to circumstance. However, I chose this type of interview as it would allow me to elicit relevant material from participants. The first draft of the interview schedule was developed after an initial literature review and discussion with my supervisor. This consisted of many open questions. The schedule developed looked at how clinical psychologists identified ethnically and other identities that influenced their work, specific considerations they might make when working with ethnically similar and different clients, how they would work with conflict in the therapy room and their views on cultural competence.

The first draft was then piloted with two trainees, one who self-identified as Asian British and the other as Black. Based on their feedback and further discussions with my supervisor the interview schedule was revised (Appendix A).

Semi structured interviews are difficult to replicate exactly but allow respondents to express their views with more freedom than a structured interview or a questionnaire and have the potential to generate a fair amount of detail. Valid information about how people explain or contextualise certain issues can be obtained.

2.3.2 Selection

I sought to recruit clinical psychologists who self-identified as South Asian. The term South Asian is used to denote individuals who trace their cultural origins to the Indian sub-continent consisting of India, Bangladesh, Pakistan, Sri Lanka, Afghanistan, Nepal, Bhutan and Maldives (The World Bank, 2011). I also actively sought to recruit male clinical psychologists, given the skewed ratio of male-female clinical psychologists (Farndon, 2016). Despite my best efforts, I was able to interview only 2 male clinical psychologists. With interviewing Clinical Psychologists based in London, I worked on the assumption that they would work with a diverse clientele- both ethnically similar and different to them.

Eight to twelve participants have been suggested as an appropriate number for qualitative analysis (Guest, Bunce & Johnson, 2006) and I interviewed 10 participants.

The inclusion criteria were that participants would have been Clinical Psychologists trained and practicing in the UK with at least three years' post qualification experience. It was felt that the psychologists would feel more confident in their therapeutic practice and in the hope that any anxieties about working with different and similar ethnicities would have been assimilated into their therapeutic practice. Diversity was sought in gender, years of practice and therapeutic orientation.

2.3.3 Recruitment

The sample consisted of 10 Clinical Psychologists (8 female, 2 male) who worked in a variety of settings and within different therapeutic modalities (see Table 1). All the participants self-identified as South Asian/ British Asian. The Black and

Asian Therapists Network (BAATN) was contacted for potential participants in the first instance once ethical approval was granted. This did not result in any recruitment of participants. The initial 2 participants were approached through a colleague at university and then more were recruited via a snowballing method. Vogt (1999) defines it as a technique for finding research participants where one participant gives the researcher the name of another participant, who in turn provides the name of a third, and so on.

The possible participants were contacted via email with an attached information sheet (Appendix B). Subsequent conversations were then had about arranging dates and times of the interviews. Participants were given the opportunity to contact me with any questions they had about the study. They were then requested to fill out the consent form and demographics questionnaire (Appendix C and D) before the interview. Semi-structured research interviews were conducted with the participants at their preferred location. The demographic information about participants is presented in the table below.

Participant and gender	Self-identified as	Born and raised in the UK	% of ethnically similar and different clients in work	Therapeutic orientation	Estimated time spent in therapy vs other activities
P1, female	British Indian	Yes, yes	100% different	Integrative/eclectic	35%
P2, female	Preferred not to define self	No, no	Does not count	Integrative and philosophy	50%
P3, female	British Indian	Yes, yes	95% different	Systemic, attachment informed, CBT	30%
P4, female	Indian	Yes, yes	95% different	CBT, eclectic	50%
P5, male	British Indian	Yes, yes	99% different	Integrative – mix of CBT and	90%

				psychodynamic	
P6, female	Indian British	No, Yes	90% different	Systemic, psychodynamic	20%
P7, male	British Indian	No, Yes	50% different	Systemic	20%
P8, female	British Asian/Indian	Yes, yes	95% different	Eclectic but systemically focused	10%
P9, female	British Indian	Yes, yes	95% different	Systemic, narrative, CBT	70%
P10, female	British Indian	Yes, yes	95% different	Systemic	75%

Table 1: Participant demographics

Six of the participants trained at UEL and the other four trained at various other London, Essex and North of England universities between 1989-2011. Nine out of ten participants self-identified as British Indian with the majority of their clinical work with ethnically different clients. One participant reported that they were not comfortable with using constructs of ethnicity to define themselves. All participants worked in ethnically diverse boroughs in London which may explain the fewer clinical examples about working with ethnically similar clients.

2.3.4 Critique

I am aware that the participants recruited were dependent on the subjective choices of the respondents. Like-minded colleagues may have been suggested and there might be a bias towards inter relationships and cohesiveness in professional networks (Griffiths et al, 1993). The danger here is of missing participants who may not be connected to these particular networks either through similar training or professional networks.

However, there were no responses to my information letter sent to the BAATN and a snowball sampling method was considered. Moreover, the common

characteristics between participants may have facilitated their involvement in this study.

2.3.5 Data collection

A total of ten conversational face-to-face interviews were conducted to gather data. The semi-structured interviews were guided by an interview schedule with open questions followed by prompts when required. The interviews ranged in length from 54 minutes to 1 hour 30 minutes with an average of 62 minutes. Each interview was recorded on a Dictaphone and took place either at participants' place of work or at their home at times convenient to them. Confidentiality arrangements were explained and they were given further opportunities to ask questions related to the study.

2.3.6 Transcription

After the interviews were recorded, they were then uploaded to a laptop and were transcribed manually by me. The data was accessible only to my supervisor and me. The participants were all assigned codes like P1, P2, P3 and so on to preserve their anonymity and any identifying details in the study and interviews were edited. I used a simple system for transcription where 'I' stood for the interviewer and 'P1', 'P2' and so on for the participant. I did not use a more complicated transcription system as thematic analysis does not require the same amount of detail as narrative or discourse analyses (Braun and Clarke, 2006).

2.3.7 Data analysis

Within TA, a theme is understood as capturing something important about the data and I recognise that the decision about what counts as a theme is a subjective judgement based on my epistemological position and personal context. Analysis was done at the latent and semantic level.

Below I have outlined the steps taken during the analysis, which is informed by Braun and Clarke's (2006) six-phase guide to TA.

Familiarisation with the data

I began by listening to the interview recordings and made some notes. I then transcribed the interviews, read and re-read the transcripts and noted down any thoughts about the data.

Generating initial codes

Coding was done on a line by line basis and I identified features of interest within the data. As the coding progressed, some codes were collapsed together. The relevant extracts were referenced using participant numbers.

Searching for themes

After I had coded all the data, I sorted the different codes into potential broad themes, first within and then across the transcripts. I paid close attention to the initial codes in order to identify the commonalities and differences.

Reviewing themes

To refine the themes further, the extracts within each theme were re-read and were reviewed for distinctiveness. This led to some themes being merged or split resulting in the final number of themes. The transcripts were then revisited to ensure that the themes represented the data accurately.

Defining and naming themes

Reading through the extracts and writing down what was represented in the theme enabled me to develop a coherent narrative about the data. This involved re-naming some themes with the aim of capturing the essence of the participants' talk. The super-ordinate themes were made up of the sub themes from the initial stages of analysis.

Producing the report

I have produced quotes from the transcripts, referring to participants with their anonymous assigned codes to allow for the evaluation of the relationship between data and analysis.

2.4 Reviewing the quality of qualitative research

Spencer and Ritchie (2012) postulate some principles to guiding principles to evaluate qualitative research- contribution, credibility and rigour. More details about evaluating a qualitative study will be discussed in the Discussion chapter.

2.4.1 Contribution

Contribution refers largely to the value and relevance of the research conducted. This may be to theory, policy or practices. For this purpose, the analysis is summarised and discussed with reflection on the implications it may have on therapeutic practice of psychologists who identify as South Asian.

2.4.2 Credibility

Credibility refers to the plausibility of the findings of the research and depends on the evidence presented. Validation of research findings has also been discussed in terms of triangulation. The main aim of triangulation is to gain good understanding of the data from different perspectives. However, for this study knowledge about the 'real' world (therapy, impact of personal experiences) is always fallible because we need to account for the context-specific variations in meaning.

2.4.3 Rigour

Another conceptualisation of rigour in research is reliability, which is difficult in the context of qualitative research. Although the method could be replicated, it would be difficult for different researchers to identify the same concepts due to the context-dependent interpretation of findings. However, Spencer and Ritchie (2012) propose that reliability be viewed as reflexivity to account for the researcher's subjective bias (see Reflexivity section in the Discussion chapter for more details).

2.5 Ethical considerations

Ethical approval was sought and gained from the University of East London's research committee. (Appendix E)

Informed consent

Participants were given the opportunity to clarify any aspect of the study and ask questions before and after the interview. They were also given my contact details to get in touch if they wanted to discuss any aspect of the study further.

Participants were asked to sign the consent form. The right to withdraw has been an essential tenet of ethical safeguarding in biomedical research (Melham et al., 2014) and when signing the consent form, participants were again reminded of their right to withdraw consent until February 2017 if they wished without being

obliged to provide a reason. This was because once data analysis began in March 2017, it would be difficult to identify and extract data of participants who wished to withdraw consent. This is especially difficult after analysis as the individual's data may be incorporated with a larger data set and individual contributions are difficult to isolate.

Confidentiality

Participants were again reminded of the confidentiality agreements and were assured about how their data would be securely stored. At this point, they were given a chance to satisfy any concerns around their data remaining confidential. No ethical issues were expected and none arose. Following the viva and successful completion of the course, all identifiable recordings and consent forms will be destroyed. The anonymised transcripts will be stored securely for a period of five years.

2.6 Summary

This chapter has described the methodological approach of this present study. The use of thematic analysis and the epistemological and ontological positions have been explained which allows for the experience of the participants to be explored and understood.

3. ANALYSIS

This chapter presents an account of the themes that emerged when clinical psychologists who identify as South Asian talked about engaging with culture and ethnicity in the therapy room and amongst colleagues. Using TA, the initial codes were organised into super ordinate themes with further sub-themes. The emergent themes and sub-themes within each category are described with direct quotes from the participants.

Three major themes with additional sub-themes were identified, presented in a tabular form below.

Culture and ethnicity in the room	Acknowledging and addressing culture and ethnicity in the room
	Adapting practice
	Cultural identities in therapeutic practice
Challenges in therapeutic practice	Negotiating one's own visible differences in the therapy room
	Managing assumptions of similarity and dissimilarity
	Managing cultural boundaries and concept of talking therapy
Dilemmas in the profession	Appropriateness of the Eurocentric culture of the profession
	Being marginal and a model
	On being seen as different and the need to feel accepted

Table 2: Outline of themes and sub-themes from the analysis

3.1 Introduction to themes

Meanings from the data were captured by three major themes as shown in the table above. The first theme captures the influence of culture and ethnicity on practice. It includes the relevance of culture in the room, how South Asian psychologists draw on their own cultural and ethnic identities by bringing aspects of themselves into therapeutic work (making them relevant) and adapting practice with clients.

The second theme voices the challenges faced by participants in their clinical practice. This theme is important as it identifies instances when psychologists faced direct and indirect racism and how they managed these situations. Participants also talked about managing the clients' and their own assumptions in the therapy room and the struggle they sometimes faced with negotiating therapeutic boundaries.

The third theme captures the broader context of the clinical psychology profession and discusses common dilemmas that the participants identified in the profession or amongst their colleagues, like, the Eurocentric culture of the profession, feeling on the margins of the profession. The participants then describe ways in which they negotiated these situations by modelling cross-cultural ways of working and developing themselves through ongoing growth and learning.

(Presentation Key- Appendix F)

Generic elements of therapeutic practice, like establishing a connection with clients, were a common thread in all the interviews. Part of establishing a rapport is expressing a willingness to learn more about the clients' culture by showing genuine interest and curiosity about the clients' realities and culturally relevant worldviews. Participants talk about a connection with clients as a vantage point when working with clients who are ethnically similar or different to them.

Whether they are brown, black I will notice. I will notice the shape of their nose. I will notice the way it evokes a presence, doesn't it? A presence evokes a recognition of culture. So for example, I've got loads of South African [SA] friends. So if I hear a SA twang on someone who is black, I would say (a South African greeting) and if they respond. I say, "You see I

know your language". So I will immediately access the culture, through understanding the twang if you like. (MEGHA)

Below, RINA talks about joining with a White British client when they are expressing frustration at the changing demographic of the area they live in, indicating the influx of immigrants and the impact on local resources and jobs.

You know they really struggle with that and if you can't enter that struggle and you can't join with them on it, you can't, you just can't get anywhere. And you have to enter that world which is a real worry for them. (RINA)

In the interviews, participants refer to forging an authentic connection and meeting clients where they are in their journey to allow the healing process to begin.

3.2 Theme One: Culture and ethnicity in the room

This theme captures how participants view culture and ethnic differences and how they use them in their work. It reflects the way in which the culture and ethnicity of psychologists have an influence on what is addressed in therapy, what aspects of self are drawn on to establish a connection and facilitate the work and how their practice is adapted to meet client needs.

3.2.1 Acknowledging and addressing culture and ethnicity in the room

Most participants acknowledged the fact that issues related to culture and ethnicity are not always a part of the therapeutic interaction. This sub-theme reflects the idea echoed by all the participants that they would willingly address issues of culture and ethnicity if they were germane to the presenting problem.

Some participants talked about using their overly visible differences in therapy to facilitate conversations and establish rapport. As seen below, therapists' ethnicity/culture was made relevant in the room mostly due to their appearance. TASNEEM reflected that she responded with humour if her visible cultural and ethnic differences (e.g. wearing a headscarf) were commented on in her work with children.

Young children will often say what's that on your head? (referring to the headscarf) Why you wearing that? And I often tell them....it's my superhero cape. (TASNEEM)

And I think that was both his experience of society as a whole but also in the room because of my beard, my presentation. I think that was amplified for him. So, we were able to really address the idea that actually you know what, I am religious and my religion does say that it's not the right thing to do, but me as a person I'm going to be in the room with them and say actually, you know what, as I person I know that it's difficult for you. (RAHAD)

However, a sense of vulnerability is conveyed as a result of this visibility, alluding to a part of yourself being disclosed to the client without you saying anything explicitly. The above extracts indicate how the difference or lack of knowledge about the psychologists' background can be appreciated and integrated into the therapeutic exchange. These extracts also highlight the psychologists' dilemmas when faced with the intersectionalities of culture and religion. However, it may appear easier when working with children as it is in their nature to be curious and ask questions whereas with adults, the responsibility to recognise the discomfort of clients falls on the psychologists. It also draws attention to the fact that clients may feel in a position to comment on the visible differences and the psychologist is invited to decide how to respond to that.

Other participants talk about the importance of acknowledging the reality of living in a racialized society and the impact of that on clients and that they would proactively broach the subject of racism in the therapy room

I notice the colour of skin is black, very often I go into the...travel into the blackness and racism, the experience of incarceration [in hospital], I go into that quite immediately. (MEGHA)

...she was really conscious about smelling of Indian food when she came in. And we started to ask, I'm Indian. You don't need to be conscious about that. I've lived in an Indian household all my life...I know they treat you hard once the smells get it in and it's that kind of internalized racism

that can come up. So I speak about racism and experience of racism in that way (RAHAD)

The above extracts demonstrate how participants make the link between the experiences in society and the impact they can have on an individual's psychological well-being. Here, the participants are drawing on their own experience and knowledge of racism and describe how to overcome the power that the problems may have gained over an individual, by naming them and helping clients to clarify emotions that may feel undeveloped yet. This is especially true of situations where race, culture and ethnicity have created personal autonomy issues as well as issues of relating to group identity. Kareem and Littlewood (1992) note that if therapy does not consider the person's whole life experience then it will result in 'fragmenting' the person and causing harm.

All participants said they would be open to having conversations about culture and ethnicity with clients and if they were relevant to the presenting problem. However, all, but one, said that they would only address it if the client brought it up first to deem the significance of them to the client. Other participants when asked about drawing on the ethnic identity of the psychologist said they would hesitate. All participants echoed similar views about not making cultural issues a primary focus as they feared it would be furthering their agenda. What is alluded to here is the uncertainty of broaching the subject of culture and ethnicity with clients and what is an acceptable or expected agenda.

So I wouldn't name it and talk about it because that is enforcing my agenda. (ANIKI)

Well, I don't tend to pull on that lever unless, you know, that lever is being pulled by them. (RINA)

SAMAIIRA below talked about clients recognising her non-English name and her discomfort with engaging in conversations about ethnic and religious differences.

It's tricky with ethnicity and religion I think because I don't like to, I don't like to bring them into...the session, but if people can tell by name then sometimes they bring it up and so then I might... sort of. I don't want to be dismissive. So, I won't ignore it... I'll acknowledge it but then I'll try and

shift things on because I don't want to focus on it too much because then I don't want it to turn into a discussion about that. (SAMAIRA)

I wouldn't necessarily bring it up. If it was important to the client and if they were struggling with aspects of their racial or cultural or gender identity, they bring it and we just unpack together in a therapeutic relationship. (ANIKA)

MEGHA reflected on her power of being a health professional in the room and would use that to initiate conversations about ethnic and cultural issues with clients.

No I always bring it up... You don't wait for them to raise it. In terms of power, you need to utilise your power to acknowledge that there is a possible situation here. (MEGHA)

One participant talked about adopting what is known as a transcendentalist view (Tyler et al., 1991) where they may or may not choose to address ethnic and racial differences explicitly. ARUP indicated that this may also be dependent on his therapeutic modality.

Not really no. I kind of take people as they come really. I don't, you know, it's a part of maybe it's a part of my systemic background. You know, the kind of old days where people would hypothesize to death, you know, before you start seeing someone that has sort of gone now really. (ARUP)

Although participants were aware of the need to raise the issues of culture and ethnicity, they appeared to struggle to decide whether it was an appropriate use of the therapy time, leading to an avoidance or waiting for the client to broach it first. From the above accounts, it is evident that there seems to be an assumption that if the client does not raise it, it may not be an issue. Moreover, participants may not wish to initiate conversations around culture and ethnicity due to the concern of evoking and then managing strong emotions in themselves and clients.

3.2.2 Adapting practice

This sub-theme covers how participants chose to respond when presented with culture and ethnicity in the room. Some participants addressed issues of cultural

difference by talking about it or adapting practice while some others said they would wait for the client to bring these up first.

Participants were aware that they did not consciously adapt their practice in their work with White British/European clients as they felt they were familiar with British culture and did not feel the need to adapt models or ways of working. In the following extracts, participants talk about various ways in which they have adapted practice with some other cultures, to show respect for the client's culture. For instance, RUJUTA felt the need to check if Ramadan would be in the same week she was meeting the family and would check particular protocols with an interpreter.

I thought it [Ramadan] was around then and I checked with it. Would it be okay to bring a glass of water into the session? (RUJUTA)

ANIKA talked about the importance of being respectful to culturally relevant gender roles and adapting modes of communication and appearance according to the community's cultural norms. This participant talked about a psychoeducational video about depression depicted as a 'black dog' when working with an orthodox Jewish community and the changes she had to make to the context of the video.

...it showed a black dog lying between a man and woman in bed...it's a cartoon...it's just a quick scene....and it showed when the black dog can come up and how it can affect your connection with libido and they had to edit it out. They had to edit that scene out because there was a woman and man in bed...So making adjustments according to the cultural norms and values ...you know...it's an ongoing thing. (ANIKA)

Because I was wearing a top that had sleeves to here (elbow) and just showing this part of my arm...it's not appropriate and a skirt and I had boots on...so even though it was covered, this bit of my knee was showing with tights-with tights! And not my bare leg was showing and I got a look up and down...so that wouldn't necessarily be something that would be an issue for me but obviously, that's the culture and you just respect what their rules are. (ANIKA)

Here, perhaps, the psychologists are drawing on their traditional South Asian values of showing respect to others by ensuring considerations were made about clients' religion and gender-based ideas.

MEGHA comments on the constraints of providing therapy in a typical 1:1 hourly format and goes on to explain how she adapted the therapy delivery format for an elderly Bangladeshi lady.

I used to do the hair of this elderly woman who had a manic-depressive side to her. And therapists don't do that. But I think that was really important bit of therapy for her because as an older woman, a young person is coming to talk to her and in the business of doing her hair... she started telling me stories being in Bangladesh, husband dying, what it used to be like and the whole inheritance of loss again. So that could not be accessed in a room 1:1 in 60 minutes therapy. (MEGHA)

In the above situation, MEGHA shows awareness of differences in concepts about mental health in the older generation from a South Asian culture and adapts practice by meeting the client in a space (e.g. home) that feels comfortable for them.

Although participants recognised the need to sometimes adapt practice to avoid clients being jaded by the mental health system that they may not be familiar with, all their accounts described ways to reduce the perception of differences within the therapeutic interaction.

RAHAD alludes to the importance of time needed to talk about ethnic and cultural differences and reflects on the constraints of time-limited work in the NHS. He also refers to the freedom of structuring his own work in private practice and feels there is more space and time available to address these issues.

Whereas, in my private work I flip from telling them openly my understanding and that seems to facilitate something, a better relationship but I feel constrained to do that in the NHS. On the basis, I sometimes feel that I haven't got the time to do that. I should be seeing them for their difficulties. (RAHAD)

In the above sub-theme, clinical psychologists reflected that they would be flexible around religious considerations, cultural values about gender and the delivery format of talking therapy.

3.2.3 Cultural identities in therapeutic practice

Most participants talked about their use of self in their work in order to develop a therapeutic relationship. They drew on various aspects of themselves to acknowledge the difficult experiences of clients in the room.

Participants reflected on the influence of their upbringing, with ideas about differences being the norm, in their work with clients from a different background than themselves. RAHAD shared his personal experience of learning about different religions and festivals and how these were different to his own family's faith. This is how his own ethnic identity was impacted growing up in the UK and made him realise that he was different.

...and as a Muslim, I believe this and this what we practice but that doesn't mean that stuff [other faiths] is wrong. Therefore, I've grown up from a young age knowing I'm different but difference is okay. (RAHAD)

Difference was the norm. We grew up like that. There were Hindu, there were Muslim, there was Sikh. Everybody. (MEGHA)

Participants talked about using their experiences of being different or about their experiences of migration. They drew on their experience or knowledge of 'uprooted-ness' as a result of them moving countries or their parents/family members moving countries.

I do remember growing up what it was like being different and being around people that didn't look like me or didn't sound like me. So, when I work with, say, asylum-seeking people or newly arrived immigrants or even quite established immigrant populations, I do feel quite connected so that my, I guess, it's even in the way that I can look at them. There is a knowing sort of look as opposed to them not needing to give me fuller descriptions of how hard it is for them. Or what, what you know even

quirky things that they might do that I can really relate to that doesn't seem odd to me but that seems like what an immigrant would do.(RINA)

What was it like to move countries? What is your first memory of arriving? I would say something simple like... Yeah or I will tell a story from my own experience of moving countries. The fear you felt. The shame you felt. And I would create dialogue around it. "was it your shame?" So I often relate to my own losses of so many different selves. And I think it gives me a way into the story of loss of these young people who have moved countries at a young age and you know that whole thing about inheritance of loss is a very central thing for me. (MEGHA)

Participants above allude to drawing on certain feelings of loss and difficulties of being the minority in their work with clients who have experienced migration. This was especially useful to explore issues of acculturation and identity of clients. This provided participants with a resource, in addition to their genuine interest and curiosity, on which they could draw on in clinical work with clients.

Below, participants draw on their own experiences of straddling two cultures and the difficulties associated with that. They talked of clients who struggled with balancing traditional South Asian ideas and British ideas of being a teenager. Participants were able to help clients understand and navigate a traditional identity and values at home with a British identity and values outside the home as the clients' experiences mirrored their own experiences.

...for example, with a lot of families that I see, where they weren't born in this country and they were born and parented in a different way closer to their culture of origin and being able to hear their dilemmas of balancing dual or multiple identities and which bits of their culture and values they want to kind of keep going with and which they want to be more flexible with but finding it difficult to. (TASNEEM)

...and I remember thinking whilst, you know, I didn't have necessarily a situation like that being brought up, I could relate to it I guess and draw on my own experiences in terms of different values from a young person's point of view brought up in a culture that's different to the culture that their parents were brought up....you're negotiating lots of things from the start

and trying to kind of negotiate these two identities which are sometimes conflicting, and I feel like I have experienced that and what that might feel like. (NINA)

ARUP discusses drawing on his family's South Asian ideas about parent-child relationships when talking to a mother who expected her son to respect and follow the parents' wishes. Elsewhere in the interview, ARUP also reflected that he would be open to working with family members with the client's consent.

You know her son's relationship choices, and so I was aware of the kind of resonances that had for my own experience of my father and his, you know, his kind of ideas around you know kind of my relationship choices. You know, and I began to make my relationship choices, and you know, he would have liked me to have had kind of an arranged marriage and you know and you know and married a nice Bengali woman and all of those things. (ARUP)

Farver et al. (2002) has suggested that "children of immigrants adapt more quickly to the new culture than do their parents" (p.13). These differences in opinions based on the difference between Western and traditional cultural values could create conflict between parents and children around issues such as choice of relationships, sexuality, education. By drawing on his experience, ARUP suggests that he could help the client explore the pros and cons of these differences.

Similarly, RAHAD talks about working with a client who had a dilemma stemming from two important Asian values– the obligation to roles in the family and academic achievement.

...an Asian male who said he was struggling with balancing how to be a son and how to do his work and be a father to his child and also do some studying that he's doing extra studying, and I was trying to convince him that he needs to make time for himself, and he went against every element of what he had been taught to do by his parents and everything that he needs to study, study, study all the time and he can have a break when he is older....And then it dawned on me, why am I trying to convince this

person to make time for himself in a therapy session because that's going to make his life even harder. (RAHAD)

This demonstrates that RAHAD, by virtue of being born and raised in the UK, became aware of how he was implicitly drawing on cultural ideas of individualism and self-care which might create stress. This helped the realisation of the critical importance of providing a non-judgemental and unimposing therapeutic space.

One participant acknowledges that her interest in working with psychosis stems from the clash of two cultures that she has experienced herself.

My own experiences of living with and alongside interrupted senses of normative selves...woman of colour, not woman of colour, immigrant, non-immigrant, westernised, traditional etc. has influenced the empathic interest I have in the subjectification of the schizophrenic self. (MEGHA)

What MEGHA is trying to convey is that she finds the differences within and between people interesting and wants to learn more and this stems from her own experience in India of living amongst people of varying backgrounds, faiths and cultures. However, she also draws on her experiences of migration, Western ideas and the impact on practice. Here, MEGHA alludes to being familiar with the feeling of being on the margins and opportunities to experience an alternative meaning of self.

The above sub-theme summarises the experiences of South Asian psychologists by highlighting instances where they were faced with similar cultural values as well as cultural dichotomies of values and how they used their own experiences and knowledge about themselves from a South Asian perspective to help resolve clients' internal conflicts.

3.3 Theme Two: Challenges in the room

This theme captures the common challenges encountered by participants in their clinical practice and looks at the times when culture and ethnicity can become salient in a multi-cultural dyad and have an impact on therapeutic practice. The sub-themes cover various aspects like racism and power, client and therapist assumptions and negotiating boundaries.

3.3.1 Negotiating one's own visible differences in the therapy room

Although ethnicity as a construct is different to the construct of race, interactions in therapy often seemed to be influenced by race and the legacy of the Black and White-skinned relationships. This historical legacy reflects the values, attitudes and beliefs of the dominant group which is evident in therapeutic interactions even today.

Participants spoke about the challenge of being faced with direct, indirect and internalised racism in their work. ANIKA discusses an incident when delivering therapy for a group of Black African/Caribbean clients with a Jamaican co-facilitator, where she was perceived as British rather than Black. This account illustrates how psychologists may encounter emotions of hostility or anger when working with someone who identifies very strongly with their racial, ethnic and cultural identities.

...within the first 5 minutes I was verbally attacked by one of the participants. This rage of - what are you doing here? You are not black. Where are all the black psychologists? You know...And just kind of everybody was just really shocked. (ANIK A)

This may indicate a dilemma for psychologists who have been brought up in a different culture than from their culture of origin. ANIKA was perceived to have more power in the room and in society as well due to her being perceived as British. More significant for the client here was the fact that the participant was not African or Caribbean and therefore she was not Black. ANIKA then goes on to explain that one way of understanding this reaction is to be aware of any racial oppression that the client may have experienced. Elsewhere in the interview, ANIKA had talked about the differences in ethnicity and cultural background between this client and herself.

But, I needed to model was just a bit of strength and acknowledging that yes there are these differences [ethnic and cultural] but there are also similarities and there is a shared experience amongst all of us. We have all experienced racism and we have all experienced what that brings up in us because of our minority status and shared racial category....so that's how I dealt with it. (ANIK A)

This also implies that demonstrating an ability to bounce back or retain composure in the face of explicit racist comments are desirable qualities for a clinical psychologist. It highlighted the difficulties in talking about differences as well as similarities between psychologist and the client. However, it also raises the concept of resilience, which is an important quality to have.

However, ANIKA also described feelings of disempowerment at receiving no help from her Black colleague.

Everybody was stunned and it affected everybody because it was very aggressive and the other facilitator who was Black didn't do anything to try to help to balance it and I was literally left to deal with it myself so I brought it back. (ANIKI)

Being aware of the clients' reaction to addressing culture and ethnicity during a therapeutic interaction is important (Day-Vines et al., 2007). This is illustrated when clients who do not identify their ethnic and cultural identity as a significant part of their identity may reject the psychologist's attempts to discuss issues from an ethnic and cultural perspective.

Sometimes it comes like a slap across your face when you mention race and they say to you, "no its got nothing to do with race". So you sort of you back off. "Oh ok." (MEGHA)

Accounts discussed earlier in this sub-theme and below address the different kinds of racism participants encountered in the room. The earlier ones referred to the direct forms of racism where a client may be openly hostile. In the following example of experience of indirect racism, MEGHA talked about her struggle to manage the situation when she felt sexualised by a client due to being perceived as 'Oriental', but felt on familiar ground if she faced racist abuse. This may be because, for ethnic minorities racism is a fact of life. This is also indicative of the impact of colonialism on society in general and representation of the Other.

Yeah recently I have been working with someone. White, male, probably a few years younger, and his interest in me was that of a white man interested in the exotic female. So his ...questions he was asking me ...and then things he was saying to me and I was furious. I was furious,

“How dare you?” So I have in my story, in my head, the story of being exoticised by the White folk. Sometimes I look a bit Oriental ...so people always. So I have that story in my head as well. And as a woman I hate it and I come down heavy... That is a difficulty that I find hardest to work with. When I am racialised I manage. When I am sexualised, I just flounder, I think. (MEGHA)

Another participant also discussed an experience of indirect racism in the room. RAHAD talks about a session with a White British client who was in prison for a racist attack on an ethnic minority man, very similar to the participant.

I didn't know the details but I knew he stopped and beat someone up. I was like yeah, yeah. “Do you know who I did?” No. And then he launched into this excuse and it transpired that he had stabbed and beaten up a Muslim man and he was a part of the EDL, and he didn't like Muslim men, and I was now in a room with him. (RAHAD)

RAHAD explicitly names his difference in his response as below:

I said to him, “well we're going to have to an issue” and I pointed to myself and said, “you're going to have an issue with me. Because we need to talk about this. Because that's what your offence is and you're telling me you're not racist. Right. How're you going to build up a trusting relationship if I represent everything that you hate”, and he laughed and funnily enough by being able to say that he was able to explore a little bit more. (RAHAD)

MANISHA alluded to the internal racism that one can sometimes experience, where other people from a South Asian background may believe that the psychologist is ‘acting white’. MANISHA reflects that she has to be aware of the need to let the client know that although she is in a white profession, she does have some traits or values which are not white.

Is that more about you feeling like you need to let another Indian person know that you're a good cook. Ha..ha.. or that you make Indian food and that you're not as white as they might think you are because you're in a

white profession and that you talk like a white person and that you dress like a white person. (MANISHA)

TASNEEM discussed enabling conversations about differences and often felt perceived as not good enough by the White British clients in the area of London where she works. She talked about how power dynamics play out in the therapy room and acknowledged that she managed the discomfort by proving her competence in terms of divulging her years of experience in the profession.

I would explore with them if they have concerns, what they are. I would then talk about my experience, in terms of how long I have been doing this job. I do feel the need to give them qualifications sometimes particularly in this area of London where parents are very used to.....who are not very used to public sector services and they are more used to being customers and being in quite powerful positions. (TASNEEM)

This demonstration of competence illustrates how participants may address potential assumptions a client might have about the psychologist not being qualified enough.

The challenges of being faced with racism and power in a therapeutic relationship are evident, in that, both the client and psychologist hold different types of power, White privilege and high status of a health professional respectively. One participant talked about acknowledging the power dynamic switching during therapy with a White man who had developed mental health difficulties due to loss of employment as a result of being racist towards another South Asian colleague. This is a situation of how racism can be experienced by the psychologist because of a negative experience the client has had previously, how it may be connected to the presenting problem and stereotypical gender roles may also come into play, for example, a White male client feeling powerless with a South Asian female psychologist.

I kind of had to do a lot of work to let him know that it's really hard to walk through that door. It's really hard to speak to someone like me that looks like me, about something that is so paralyzing to talk about anyway and to then even contemplate letting me help you. He felt furious and the level of anger was always in the room and then he felt even more humiliated

because then he was sent to an Indian therapist and a female one at that because obviously his masculinity was very connected to his work. So actually I probably stood for all the things that he was feeling shit about.
(RINA)

Above is an example which demonstrates that the psychologists were not just responding to the racism but also trying to formulate what the issue was for the client and how it could be resolved while another tried to get alongside the client and their family to understand their worldview. Other participants in the study also echoed this way of working. This is also an example of how difficulties of a White male client may be exacerbated when he finds himself in the powerless position of the client when working with a South Asian female psychologist.

In the above sub-theme participants have discussed their experiences of racism based on their ethnicity and culture and that they drew on the awareness of power that privilege affords them in their status as a health professional.

Psychologists have used hypothesising and formulating to understand these interactions, indicating that they prioritised their professional responsibilities as a psychologist over the emotions reminiscent of contexts outside the therapy room. Here they formulate the conditions and context which constitute the emotions present in these interactions. The role of a psychologist involves noticing, naming and addressing power differentials and participants have been aware of this responsibility during their experience of power differentials in therapy.

3.3.2 Managing assumptions of similarity and dissimilarity

This sub-theme explores the common assumptions about apparent difference and apparent similarity that come up in the therapeutic interaction. All participants acknowledged that assumptions were present on both sides in the therapeutic dyad and could be influenced by their ethnicity. Assumptions capture common experiences that resonate to what it means to be White, Black, Asian. They also provide a basis to relate to someone perceived to be similar or different to oneself. Similarities and differences play an equally influential role in shaping our assumptions and interactions, giving rise to multiple ways of relating, some of which promote understanding and some misunderstanding. The visible appearance of participants can generate assumptions of psychologists holding a

shared cultural worldview as the client, enabling a shared understanding or being very different ethnically and culturally and thereby being unable to understand the client's difficulties.

Most participants talked of assumptions made by clients based on the apparent cultural difference of the therapist and how this visible difference can evoke feelings in the client that the psychologist will not be able to understand their difficulties. This is due to the psychologist being perceived as ethnically or culturally different to them.

I think the comment most often is-- you won't understand. The comment you won't understand or you might not understand this, and the assumption that the client can sometimes have that I won't understand an experience based on the fact that my skin colour is different...the idea that I won't know their cultural landmarks. So, I won't know what T.V. shows they may watch or what music. (RAHAD)

However, some participants talked about the apparent cultural difference being facilitative in therapy. The participant below refers to a strong cultural identity of certain communities which could sometimes be supportive and ostracising at other times. In these situations, a therapist from a different cultural background could help alleviate a client's assumptions about the loss of confidentiality and being judged.

...with ethnically different...It can work better sometimes. Sometimes they feel it's almost more helpful for some people to be seen by somebody who is ethnically different. (MANISHA)

Accounts below refer to participants' views that clients with the assumption of apparent similarity between themselves and the psychologist will have an expectation of understanding. In the extract below, a client refers to the psychologist being 'desi', which is a loose term for the people and cultures of South Asia and its diaspora. By virtue of being 'desi' the client assumes that the psychologist will also hold similar South Asian beliefs, likes and dislikes as the client.

And what comes up in sessions is, you know desi [term used to identify a fellow South Asian], apna [Hindi word for 'our'] style, apna style stuff. And they always talk about things like that. (RAHAD)

I mean I suppose, you know, again there is something sort of implicit really. People might say, oh well you know, as you will understand. As you will understand respect for one's elders is very important and that sort of thing might be said for example. (ARUP)

In the accounts above, it is evident that clients may have a judgement about the psychologist being traditional or not being traditional enough. The advantage of apparent similarity means that clients think the psychologists will not only understand them but also share those values and regard them as not to be questioned.

Some participants discussed situations where clients would make unhelpful assumptions about the psychologist based on the perceived similarity between both of them. Below is an example of how visible similarity can lead to misunderstanding.

So he was an Asian client, and I don't understand Hindi, I don't understand Punjabi. So I'm not, you don't get (language) music in my part. You probably do, but I don't listen to.... and he was just gobsmacked. So, when people talk about Asian cinema and stuff, I can see the look of disbelief but then they think of being oppositional and just being really. To be clear, they think I'm being coconut. Right. They think I'm being brown on the outside and white on the inside. (RAHAD)

All participants recognised the similarity of cultural values when working with clients from similar backgrounds as themselves. However, they were aware of the differences of each individual in relating to these cultural values, which gives rise to within-group differences. Both extracts below recognise the role of reflection to ensure that the therapist's own values and beliefs do not impede therapy. NINA reflects on the awareness of her own assumptions when working with clients from a similar background as hers.

So I think that's one part there being mindful of the fact that actually just because somebody is similar to me in that way it doesn't mean ...it is not the same, and I think it's easy to sometimes get into patterns or get, you know, into a situation where you think, oh no I understand the person because they are from, you know, a similar place to where my family are from or they're from a similar religious background. (NINA)

I think reflexivity is central to this, and an acknowledgement that in recognising that one has a particular view point, that is steeped heavily in one's cultural experiences, however this need not be the 'correct' view point, it is one of many. (RAHAD)

ANIKA discusses working with a Black client who was perceived by his family as defying cultural expectations by marrying a Black woman rather than a white woman to facilitate better social acceptance. This was deemed to be a disappointment as marrying a White woman would have facilitated better acceptance into society. Here, she talks of her own assumptions about the desirability of the client's culture of marrying within the Black community.

He married a Black woman and in his culture, that was another disappointment. Because I thought, my understanding would have been black people are proud to be black and its empowering and you know and just to be with a Black woman is a strong thing and would be favourable and commended but it wasn't. (ANIKA)

Participants' accounts addressed working with the recognition of the assumptions based on apparent similarity and difference by monitoring their own assumptions in their work with clients who were similar to them as well as generally through curiosity, clarifying comments and through supervision.

...if it was kind of problematic I would question her. I would say something like. So okay well you know, I might have my own ideas about that but I'd be really interested for you to tell me what your ideas are about that or what your kind of, you know, or I might even ask, how might you understand, what might you think I would understand about that. (ARUP)

Remaining curious, asking questions, exploring with the family, keeping an ear out for any assumptions they might make, being mindful of the assumptions I might make, and of course supervision. (TASNEEM)

This sub-theme about assumptions highlights that participants and clients both come to therapy with some pre-existing culturally relevant knowledge. These assumptions may prove to be useful or could cloud judgement. It addresses the recognition of cultural values present during therapeutic interactions and how to work with this recognition.

3.3.3 Managing cultural boundaries and the concepts of talking therapy

This sub-theme looks at how participants navigate the ethical landscape in therapeutic practice. Participants expressed a need to be guided by an ethical compass to ensure client safety and well-being. The following participants point out how certain cultural ideas feel incompatible with their Eurocentric training. This was especially evident when the Western notions of boundaries and self-disclosure felt challenged.

MANISHA acknowledges the cultural importance of therapist self-disclosure to South Asian clients and being aware of what might be helpful. It highlights the psychologist's role in assessing the importance of checking out assumptions and balancing the amount of self-disclosure after assessing for the usefulness of it. MANISHA also acknowledges the issues of trust and the client's fear of loss of confidentiality.

...the process of finding out about somebody, somebody Asian is quite important, and even as a kind of way of joining and checking out who you are and you know are we similar or not. At the same time the professional hat coming on, and saying okay yes we are similar but I can't tell you that much about myself and finding the right balance where you're not kind of trusting somebody else and breaking down a therapeutic relationship. (MANISHA)

Some participants reflected on the struggle they face when trying to manage Western therapeutic boundaries as opposed to the clients' culturally relevant notions of boundaries.

So somebody brings you a present. Very commonplace for somebody to bring you a big pumpkin from their garden if you are their local doctor. But you don't do that here. So those boundaries. And then to insult the other if you are aware of their culture, I struggle with that. (MEGHA)

MEGHA talks about transgressing the Western notions of boundaries by being at the labour suite with a client who was in labour, which highlights how other professionals might perceive them.

Now I am not at all worried that I did her any harm or broke any boundaries. But all along you are vigilant for how you will be seen..... So, I don't think I did anything wrong. In fact, I celebrated. I was very proud of that moment. I was a proper/literal midwife. The first time I saw a child being born. The matron comes in "Who are you?" "I'm her therapist." "Therapists do things like this nowadays?" I said, "This one does". (MEGHA)

MEGHA alludes to a discomfort in following her desire to help and connect and show humanity for this client who did not know anyone in this country. This may be due to an underlying disconnect between her ideas of boundaries based on South Asian ideas and the Western concept of boundaries. MEGHA implied that there should be the freedom to innovate whilst staying within the ambit of Western notions of boundaries.

Participants mention how inaccessible mental health services can feel for clients and communities who are not familiar with the concept of talking therapy. That talking therapy is an alien concept for certain cultures and may be viewed with suspicion. For such clients, it will take a lot of time to familiarise them with psychology, which is very difficult to do in time-limited therapy and resource-poor settings. This may have implications in terms of client engagement.

The idea that, you know, you have to work through and process loss or you have to be able to manage anxiety. I mean, you know, that's like a

minefield to them. They want to know what you're going to do about it. Is there a pill? What do I have to do, it's all in the doing. (RINA)

I have to reiterate to Asian and Black clients, and I have seen one Chinese client, that I can't cure them. That will never happen and they really struggled with that. (RAHAD)

It's a very Western concept though I think and this whole idea of like individual therapy and self-actualization. I mean these are all very individualistic Western concepts, and if you're from a communal society it doesn't really fit... I think they probably see it as threatening because you're trying to plant an idea inside the head of this person what they want to be doing. Do you know what I mean? That's a part of their community and you are kind of implanting an idea that's sort of foreign. (SAMAIRA)

Here, participants highlight various cultural concepts of talking therapy, different ideas of distress, notion of cure and Western notions of self-actualisation. It indicates the inappropriateness of the Eurocentric models of therapy.

Participants in the sub-theme above described approaches to negotiating boundaries and found that they sometimes struggled with the decision about staying within Western notions of boundaries by establishing stricter boundaries or allowing themselves to deviate from the conventions of practice.

3.4 Theme Three: Dilemmas in the profession

This theme addresses the broad context in which psychologists work. It explores the dilemmas that participants face in the clinical psychology profession and amongst colleagues and also includes what is required to develop ethical practice that considers issues of culture and ethnicity with individuals as well as at the organisational level. This theme highlights various ways in which ethnicity and culture are constructs of relevance and importance within therapeutic work.

3.4.1 Appropriateness of the Eurocentric culture of the profession

This sub-theme looks at the Eurocentric focus of the clinical psychology profession and training. It also captures how culture is addressed in the workplace, the cultural accessibility of services and cultural competence.

The following extract suggests that psychological therapies have been predominantly developed for Western societies and may not be as relevant to different cultures. This may have implications for therapists working across cultures and hence the need to adapt practice.

The history of psychotherapy is one which has been to work with a particular clientele which has you know been sort of often, you know, white heterosexual middle-class men and women you know. And so if we are to expand psychotherapy from that narrow base then, you know, you need to adapt to practice and you need help to adapt to practice. (ARUP)

A small number of participants reflected on the meaning of cultural accessibility of services. Below are two accounts where participants talk about the disadvantages of specialist services to work with certain populations and the need for all psychologists and entire services to be skilled up in working cross-culturally.

I mean what I have some feelings about is that you know in the world of psychology you could start having ghettos of, you know, certain types of psychologists working with certain people and then you know you'd never get everyone being able to work with everyone, and I'm not quite sure I like that. (RINA)

Because it's almost as if services need to be more culturally competent in understanding what does competence mean- it means accessibility, availability, high quality therapies that are available for people from different communities and that's not the case... Just to get psychologists more confident at dealing with these differences. And that's what competence is. It's not just sending people to a (name) service. (ANIKA)

Participants discussed considerations for practice and ideas to increase cultural competence. There is the recognition that the feasibility of one psychologist to master the ability to understand all the aspects of a particular culture is unattainable. All participants believed that it was important to continue to develop skills in working with a diverse population and learn new information. RUJUTA stresses the importance of exposure to acquire a level of comfort to work with

culture and ethnicity. She also refers to adapting practice to suit a client's cultural needs in order to enable conversations about differences.

I think it's actually really important to have experience working with people from different backgrounds and to have an approach that's kind of somehow flexible or adapting or allowing for that difference to be a positive one. (RUJUTA)

Participants referred to promoting development of cross-cultural skills through membership of a culturally mixed group where a safe space can be created for having conversations about diversity also suggested by Mason and Sawyer (2002). These help in connecting people to think about the impact of being a minority and navigating a very different culture from the one someone else may have and what it is to be visibly different.

Like talking about diversity and people tend to focus on, Brown people and actually we're not just talking about that. We're talking about gender. We're talking about sexuality. We're talking about age. We're talking about all sorts of things. (SAMAIRA)

Some participants discussed using community resources like cultural organisations and consultants to learn from the cultural knowledge, strengths and abilities, possessed by marginalised groups of various ethnicities and cultures, which are often unrecognised.

If they have been advised by a religious leader, I might ask to approach the hospital chaplaincy or talk to a range of religious leaders and ask the family how they understand any differences in opinion. (TASNEEM)

From the accounts above, participants are trying to convey that all knowledge cannot be located in one person and that services need to provide appropriate training for all staff to work with a diverse population.

3.4.2 Being marginal and a model

Often, cultural components are seen as an add-on to serve training or service needs. These may raise vulnerabilities and fears for all present, suggesting the need to integrate cultural components into practice. The efforts to be more

inclusive and diversify the workforce or implement the diversity training have seemed tokenistic.

RUJUTA below talks about the need for cultural components to be a more integral part of services rather than just an add-on.

And giving them you know, putting them at the centre of business if you like. Not kind of as an extra if you like and that would be things about sort of diversity in leadership and diversity in clinical practice and allowing that space and time. (RUJUTA)

You know when I was training I was the only Black person in my year. I was the tokenistic BME and there was a tokenistic man. (ANIKA)

Participants below highlight how funding cuts affect the diversity/cultural competence training and often it is viewed as a meaningless exercise. This may lead to appropriating rather than learning about and engaging with the worldview of others.

You know that is interesting when cuts are made and when there are low resources and that's almost the first thing that drives off. (NINA)

Well it becomes a tick box exercise, doesn't it? I have done the training, I am competent, I know all about this. It is a death of curiosity then.....

Sometimes all this training we do is the absolute.....you know.....masking tape. Shut up. I am trained. I can't be racist.

(MEGHA)

The comment below highlights the signs of organisational commitment.

...steps like the BPS/DCP disbanding the faculty or race and culture does not speak highly of their commitment to encouraging people from the BME communities to engage with the profession or to take it up as a career.

(TASNEEM)

Participants discussed how they respond to being positioned at the margins by their colleagues and the profession. One of the ways was through modelling cross-cultural ways of working to develop one's own cultural knowledge. The resources available within the borough were also deemed to be helpful.

I think having a wide knowledge or the resource of culturally diverse workforce to act as 'cultural consultants', can help offer alternative ideas from within a culture, rather than the clients experiencing psychology as something that is asking them to choose between their culture and a dominant Eurocentric one. (TASNEEM)

So for me the premise is more important, the ability to retain curiosity that is genuine, respectful. So if I come back to [name of borough] I might acquaint myself with Polish culture. I might even go and visit some parts of eastern Europe so I could join with my service user. I want to be able to show genuine interest in who you are. (MEGHA)

RAHAD discusses the ways in which he tried to increase awareness and curiosity in colleagues which enabled conversations around ethnicity and culture in a fun away, thus taking away the tension of having to do that for the very first time in a therapy room.

So, I'll educate them through foods, so I'll bring in Asian foods and stuff, and I tell them what that is and what kind of foods there are. I'll educate them through giving them things to read about or one of the biggest things I'm really keen on is rather than, in the team that I'm in currently, rather than making a big thing about it. I'll get the diversity calendar out where there's things to be aware of coming up and then we'll make specific effort to address that particular month or that particular festival regardless of whether we've got service users or staff do that because I think that also engenders people to be able to come and ask me questions. (RAHAD)

MANISHA indicated that supervision was an effective tool in encouraging people to think about the therapist variables, including cross-cultural issues. It would also then help with preparing to address them in therapy.

And a lot of the trainees I've had, have turned out to be white females. I did have somebody who was Black recently and so in supervision, you know, we have some conversations about how she thought clients would receive her being somebody who is young, who is Black. I mean with all, all my trainees we always talk about the age difference and how they're

going to be perceived, what that will mean, how that might play out in therapy, how they might address those. (MANISHA)

This sub-theme captures how participants feel to be on the margins due to their ethnic and culture differences from the 'White' profession and how they then attempt to model ways of working which encourages interest and curiosity in colleagues and in turn makes them more amenable to working with a diverse population.

3.4.3 On being seen as different and the need for acceptance

This sub-theme captures participants' accounts of their frequent experience of being perceived as different by their White colleagues and also being the fount of all knowledge on all things Asian/Indian.

NINA reflects on the uncertainty that a BME psychologist might experience about not knowing what their colleagues are looking for. She talked about how her White colleagues would position her based on her ethnicity and culture. She goes on to discuss that part of the reason she was 'wheeled in' was the assumption that they will understand what the family's needs were and maybe also that the family might feel more understood. She describes how being 'wheeled in' as part of a reflecting team felt tokenistic and implied that homogenisation of her culture obscured her clinical skills and experience.

I don't know whether it was just kind of the token you know Asian person...let's get her in but I think they were, you know, wanting a bit. Well, I think they were wanting some things from me that weren't necessarily going to be right or appropriate like, you know, knowledge about this family from me. (NINA)

A common misunderstanding that may occur among colleagues of different backgrounds is, when the psychologist belonging to a particular ethnic or cultural group is approached for insight into what it is like for that particular group. The psychologist may feel positioned as the expert in relation to issues of race and culture as suggested by Patel et al. (2000). NINA goes on to say that despite the tokenistic gesture, her input had been helpful and the team's assumptions about her cultural knowledge had also been challenged.

I think that was really helpful actually for the period of time I was in, but also I think it was helpful for the team to know that I don't know all of this. (NINA)

This demonstrates that the similarity between client and therapist had facilitated the development of a rapport. The reductionist approach the team had adopted, with minimal regard for potential within-group differences was also implied. This generalisation still occurs despite many authors emphasising that not all Asians or for that matter all other ethnic groups including white British, are alike (Sue & Sue, 2008; DeLucia-Waack & Donigian, 2004) and within-group differences are often overlooked (Sandhu, 2004).

Participants below discuss how they feel silenced due to their difference. RINA talks about her experience during training referring to the suppression of bringing her true identity into conversations with lecturers who paid attention to cross-cultural issues as an afterthought. Often trainees may play down their experiences and create a silence which may impact on learning and practice. When the theme of difference is present in the therapy room or amongst colleagues, but not talked about, it produces a silence which can have a lasting effect on the therapist or client. RINA perhaps alludes to questioning the effectiveness of further disclosures in training due to experiencing negative reactions from others.

But I think this, I think you can feel silenced when you're different. And I think you are kind of, your sense of self, you know and how you bring yourself to the group can feel quite pressed. (RINA)

MEGHA refers to the colour-blind approach that certain services adopt.

But now in [name of borough], I experience the opposite, you know, I am under attack because I am different. There is very strong colour blindness in what I encounter nowadays. So people will very easily say things to you like, "So what is Black?" "We have to treat everybody equal" is a very common phrase. And it's acted out very strongly. So, and you are not encouraged...you know, you'd think carefully because the operations of racism are different there. So depending on how much the institution permits you to work with difference, that's a very big thing I will always,

you know, very sad isn't it really. I do underplay my ethnicity in (Borough).
(MEGHA)

MEGHA talks about the powerlessness she experienced by being denied her difference. These experiences can be viewed as a subtle form of racism as refusing to acknowledge the complexities of race, culture, ethnicity and other aspects of an individual does not make them disappear. It invalidates an individual's unique perspectives and experiences and rejects their cultural heritage.

Participants spoke of a need to feel accepted and supported in their profession. The following accounts indicate the intersectionalities of class and culture where clinical psychology as a profession is perceived to be 'middle class White' and how participants try to fit in by changing aspects of themselves.

But, I become really aware of [my] accent when, when people have like a more London [working class] accent and so I try, I try not, and I'm just careful about the way I speak. Maybe I'd tone it down a little bit.
(SAMAIRA)

We did live in a poor part of London and everyone did talk like that [working class]. So, I talk like that and so I had to sort of watch how I said things. Placement was often the place where I had to behave it felt like.
(RINA)

RUJUTA alludes to the unacknowledged obstacles and socialisation that aspiring psychologists who identify as ethnic minority must endure and ultimately overcome. The dominant culture of the clinical psychology profession (White and middle class) is alluded to here and the idea that the assimilation of the desirable dominant qualities is needed to be a clinical psychologist.

...think I felt that to begin with because I wanted to fit in. I wanted to, you know, to be like. I don't know. There is so much competition to get into training and then you kind of want to be there... Oh you know am I kind of sophisticated enough. Am I kind of clever enough. Am I British enough even. (RUJUTA)

Participants below talk about the less accommodating nature of professional colleagues and the profession. RAHAD talks about his clients being accommodating of his Friday prayer times and arranging appointments around that. However, on social occasions with colleagues, where they have decided to slip alcohol into a Halaal restaurant, indicates to RAHAD that they are disrespectful of his religious practices.

Say they're less accommodating of my difference in that sense. Whether it be religious or ethnically based. My difference they are less accommodating of. And I find that struggle more with professional colleagues. (RAHAD)

The sense of alienation experienced by MEGHA indicates that she is not seen as 'mainstream'. Here, MEGHA is questioning the institutional practices of therapeutic training courses that privileges White middle class as the norm and alludes to there being a colour dynamic amongst colleagues.

So there is a very acute awareness of the institution of therapy and that I don't fit there. And it doesn't get played out so much with the service user, it gets played out with fellow therapists. (MEGHA)

The following extract captures the impact of changing aspects of ourselves and our practice in order to feel more valued in the profession. It is evident from the account below that there is an imbalance in the way BME psychologists are treated as opposed to their White counterparts, especially males. TASNEEM alludes to a sense of the BME clinician feeling that they are not good enough yet have been given the privilege of working in a White profession. This may result in them taking on more than their share of the work to prove their worth.

I think there are times when coming from a BME background and feeling lucky to be 'allowed' to be in a White world, we sometimes devalue our worth, take on more responsibilities than our paygrade, where perhaps White, particularly White male, colleagues will take on fewer roles or responsibilities, but be more likely to get 'exciting' or financial opportunities. (TASNEEM)

4. DISCUSSION

4.1 Overview

This thesis aims to explore the practice of clinical psychologists who identify as South Asian/British Asian. In this chapter, the main themes of the analysis will be discussed further in relation to my research question. It will begin with discussing the participant demographics, followed by the interpretation of the analysis and finally the critical review and implications of the findings.

4.2 Influence of participant demographics

Participants who could be termed as what is known as first generation drew a lot more on their South Asian values than participants who identified as second and third generation, presumably because of having been born and raised in their culture of origin and therefore possibly having a higher level of familiarity with nuances within the cultural values and philosophies. The other challenges experienced in the therapeutic space and dilemmas in the profession were the same for all participants, regardless of the generation they identified with.

4.3 Discussing findings in the context of research literature

4.3.1 Theme One: Culture and Ethnicity in the room

Many theorists have postulated about the influence of culture on therapy process and outcomes (Carter, 1995; Sue & Sue, 1999). Others have acknowledged that it is important to address the differences between clients and therapists (Zhang and Burkard, 2008). This theme highlights that the therapists' culture and ethnicity is made relevant in the room based on their physical appearance or name and has an impact on the therapeutic process.

The majority of the participant responses about addressing ethnic and cultural differences tended to focus on what the clients may bring to the therapeutic encounter. Participants used their visible differences in their work, which may have led to a sense of vulnerability but demonstrated that ethnic and cultural differences between the psychologist and client can be incorporated into therapeutic practice. This may require not only a level of awareness about their appearance and what that might evoke in the client, but also the confidence to be able to name it in a sensitive way.

Little is known about the dialogue of culture and ethnicity that takes place in the therapy room between the client and therapist (Maxie et al., 2006). Consistent with previous findings (Wielding and Rastogi, 2003), the participants in this study experienced hurt, frustration and uncertainty about the appropriateness in dealing with subtle as well as direct racism. Some participants appeared more comfortable than others when addressing ethnic and cultural differences and reported the benefits of this on the therapeutic relationship and also to facilitate conversations. These are in line with previous research among African American therapists where Black clients were less willing to discuss relevant issues if race was not discussed in therapy (Thompson and Jenal, 1994).

Cardemil and Battle (2003) also encourage increased dialogue about race and ethnicity in therapy. They suggest the reasons for avoiding conversations about ethnicity and culture may include discomfort due to the emotionally charged nature of these conversations, uncertainty about addressing them or the lack of knowledge and skills in initiating these conversations. However, the uncertainty experienced by participants in this study was about whether it was an appropriate use of the time or furthering their own agenda. One participant in particular reflected that he felt he had more freedom to talk about these issues in his private work. This implies that the participants may have felt that ethnic and cultural issues were important to be addressed but felt constrained by the time-limited therapy in a resource-poor setting of the NHS. However, it was also implied that participants may have been concerned about making race or culture an issue when that was not necessarily the case. Although, Cardemil and Battle's (2003) paper is aimed at White therapists, many of their issues are applicable to all therapists regardless of their race/culture/ethnicity and other variables.

Participants who felt able to address these differences were aware of their power as health professionals and felt able to utilise it to facilitate conversations. It may be hypothesised that participants did not disclose discomfort at addressing these issues if this disclosure may have been perceived to suggest incompetence. It is worth considering if the discomfort and uncertainty to address sensitive topics of culture and ethnicity, was influenced by socio-cultural histories (Tyler et al., 1991) and personal experiences of discrimination of the participants.

In the present study, participants said that they would wait for the client to raise ethnic and cultural differences first and would enable conversations about them if they were germane to the presenting problem. Participants perhaps worked on the assumption that cultural differences were only an issue if the client broached the subject. However, this could mean that differences were left in silence, thus perpetuating the operations of oppression in an implicit manner. It is worth considering where the responsibility to have conversations about the differences between client and psychologist lies. Hardy (2008) suggests that the therapist being in a position of power has the opportunity to initiate these conversations. The client may expect the therapist to lead such emotion-laden conversations. Participant experience in working with diverse clients and the number of years of practice may also be other factors affecting discussions around differences.

Participants reported that they would adapt their practice to suit the needs of clients and would consider all variables, not just culture and ethnicity. The idea behind cultural adaptation comes from the fact that three quarters of the world is from a collectivist culture which is very different to the Western models used in therapy (Hwang, 2011). Some examples of surface level adaptations like conducting therapy in the client's language and ethnic matching of client and therapist are often seen in practice. However, all participants in this study were of the view that ethnic matching of the therapist and client should be client-led rather than service-led due to its advantages and disadvantages. Only a small number of participants in this study reported using community resources as an important way to respectfully integrate the client's worldviews. The differences between Western and other cultural communities have important implications regarding the ecological validity of adapting intervention or creating new ones (Trickett and Espino, 2004). This also echoes Maramba's (2002) and Castro et al.'s (2010) views that the deeper level cultural adaptations may present more challenges. This may also be complicated for second/third-generation clients as their acculturation levels may vary.

To listen to another, is, at a deep level, to identify with the other person. One way that participants formed a connection was via empathy, curiosity and using personal experiences in their work. This was characterised by the psychologists being able to move between their identities and experiences without becoming

fragmented. These psychologists may have developed a 'curdled' self (Abbey and Falmagne, 2008), which enables them to work with conflict and different identities of themselves. Participants who talked about recognising the similarities between the client's and their own culture, demonstrated that some basic knowledge about different cultures might be useful and the nuances could be explored in therapy. The similarities between clients and therapists imply an unspoken understanding which may facilitate trust. This draws attention to the importance of detailed examination of one's own ethnic and cultural background (Sue et al., 1992) to prevent 'cultural encapsulation' (Wrenn, 1962) and understand the impact of their culture on the therapeutic process.

4.3.2 Theme Two: Challenges in therapeutic practice

This theme captures the context of cultural templates in operation in the therapy room. It also discusses power issues that are activated due to the relatively powerful position of a South Asian therapist in a therapeutic milieu but being from an ethnic minority, assumptions encountered and struggle with negotiating boundaries.

Participants in this study responded in various ways to the different forms of racism encountered by them and the clients. Hill, Kellems, Kolchakian, Wonnell, Davis & Nakayama (2003) have found that therapists often have difficulties managing client hostility. On the contrary, in the present study, participants responded to direct racism from non-South Asian clients by explicitly naming the similarities and differences while others chose to join with the client and conceptualised client anger as contextual rather than locating it within them with the ultimate goal of connecting with clients. They also used the power of being a therapist and sometimes sought support from colleagues/supervisors. Similar to participant accounts, accounts in literature show that naming the impact of racism and power can have positive outcomes for therapy (Lee, 2005). The inadequacy of the major Eurocentric theories in addressing impacts of racism, ethnic identities, boundaries and other cultural concepts of mental health was evident in the findings of this theme which is consistent with Bernal et al.'s (2002) claim.

Subtle racist inferences from client interactions included doubts about the participants' competence, implying that South Asian psychologists' abilities were

undermined by clients based on their ethnicity. Thériault and Gazzola (2005) found that feelings of incompetence were common in all therapists despite their years of experience and therapists sometimes felt inadequate and questioned their own skills. As a psychologist, some level of this is to be expected but the feelings of participants in this study stemmed not just from within but felt imposed by others. The feeling of incompetence may relate to deeper doubts about their own identity and abilities based on their perceived ethnicity. This may influence the way they appraise difficult situations, with the potential of them being too self-critical or appearing competent in situations when they may not feel so. This was not explicitly stated in the interviews; however, it is of note that the participants were being interviewed by a trainee CP, which may have influenced the material they may have shared. Although this did not emerge in the study, previous research has reported feelings of shame and insecure feelings induced by these interactions (Comas-Diaz and Jacobsen, 1991). Similar to accounts in Rastogi and Wielding's (2005) book, findings in this study indicate that participants struggled to respond appropriately to racist comments made by clients towards other minority groups. Participants appeared to prioritise their professional responsibilities of working with these racist comments, implying they were not clear on their position with regards to dealing with racist comments from clients towards other minority groups. Moreover, professional guidance on responding to racism in therapy was also difficult to locate.

Another angle of looking at the difficulty of conversations about racism and differences is that the feelings evoked may have been too personal to discuss with a stranger and a trainee who held significantly less power and they may have wanted to appear competent. Dealing with issues of racism and power in the therapy room, raises an ethical question of whether psychologists should be expected to continue working with clients who express racist comments and there are no discussions strongly evident in literature yet.

The evidence of two-way assumptions in a therapeutic dyad was evident from participants' accounts. Assumptions of understanding from similar clients and assumptions of being unable to understand from ethnically different clients was a common occurrence. Similar to the literature on the facilitative role of assumptions (Comas-Diaz and Jacobsen, 1991), findings in this study suggest

that the ethnically similar client's assumption that the therapist will understand what it is to feel disenfranchised could be used to foster a sense of shared meaning to enhance the therapeutic relationship. The therapist has the opportunity to make the client feel authentically understood. A downside of this is that, by virtue of the participants' education, training, social status and other factors, they may be perceived as distant from their own culture and therefore 'White' or 'coconut', a term used to denote people who are perceived to have assimilated too much into the White culture, resulting in a disconnect from their culture of origin. Participants felt the need to be guarded about overidentifying with the client (Davis and Gelsomino, 1994) as it could prevent the psychologist from fully exploring issues in therapy.

Common assumptions about the participants' inability to understand the client's background and issues were evoked in culturally different therapeutic dyads where the participant was visibly different. Very few participants felt able to address these in therapy. Maphosa (2003) found that Black clients held these assumptions when working with White female therapists. In the present study, it seemed that White clients also held similar assumptions when working with a South Asian psychologist.

Participants reflected on monitoring their own assumptions about clients, which links with Littlewood and Lipsedge's (1989) idea of not making assumptions in therapy. Fernando (2002) also warns against the dangers of stereotyping as it prevents clinicians from seeing the individual in their context. Psychologists embraced the assumption-laden work of therapy and formulated that client hostility may not always be about the psychologist but what they represent to the client at that time based on their past experience.

Participants reflected that they sometimes struggled to negotiate the Western notions of boundaries versus the cultural boundaries in an ethical and effective way. They juggled between their professional Eurocentric 'hat' and the cultural one before deciding to cross boundaries. Although, none of the participants discussed receiving gifts from clients themselves, one participant alluded to the meaning attached to gift-giving in some cultures and the implication of insulting the client by refusing the gift (for an example, see Neki, 1973). Different

therapeutic modalities have different notions of boundaries. For example, humanistic approaches promote the use of self-disclosure in response to the client's situation whereas any deviation from interpretation is seen as a boundary violation in psychoanalysis (Lazarus and Zur, 2002). However, the issue of boundaries is not just a cultural one. Boundary crossings may occur when therapists work with small communities in rural areas or interdependent communities e.g. church, ethnic, LGBT. The Code of Ethics and Conduct (BPS, 2009) addresses only boundary violations and boundary crossings are perhaps assumed to be based on clinical judgement. However, the main message across the board when boundary dilemmas occur is that protection of client is paramount. Feminist and pink therapy literature also echoes similar sentiments of protecting the client (Guthrie, 2006) and that the definition of boundaries is variable (Brown, 1994).

Participants talked of being aware of their own cultural values when working with clients and the disconnect with Western concepts of health. Western ideas about individual autonomy (Chadda and Deb, 2013) and the relational autonomy perspective of Eastern cultures (MacKenzie and Stoljar, 2000) may play a part in considering the different cultural understandings.

4.3.3 Theme Three: Dilemmas in the profession

This theme captured the wider context of the clinical psychology profession identified by the participants. Participants critiqued the use of Eurocentric psychological theories and models in training and practice as they did not represent the realities of other cultures. This was consistent with previous literature which has stated that the Eurocentric theories do not discuss aspects like racism, cultural values or ethnic identity (Bernal et al., 2002). Participants also talked about swapping their 'South Asian', 'British' and 'gender' hats amongst others. This was not evident in their Eurocentric training where they were trained to be what Hardy (2008) describes as 'a pretty good white therapist'. Participants discussed the need to decolonise psychological models, theories, research and practice to reflect the values of human diversity and that this needs to start with the training programmes.

Participants understood the meaning of cultural competence as increased accessibility to services and providing high quality therapies. Many participants also stressed the importance for all psychologists to develop the skills to work across all cultures rather than have a specialist service for BME clients. The idea of ethnic matching, in the guise of client choice or recognising limitations of own competence, may actually to some extent discourage psychologists from working with culturally different clients (Noelte, 2007).

Participants believed that working with differences is an essential part of cultural competence, also influenced by ongoing learning. They learnt new things by gaining more exposure to a variety of clients in their work, through travel and reading about different cultures and by having open conversations with colleagues if they had the opportunity. The role of supervision, reflection and peer group discussions mediated the meaning making of experiences in practice. Similarly, authors in the literature have advocated caucus groups (Waldegrave, Tamasese, Tuhaka & Campbell, 2003) like the gender and ethnic caucuses in the New Zealand Just Therapy team to address the imbalances of power held by men and Pakeha (White) groups in their organisations.

As a result of being perceived as different and therefore feeling on the margins of the profession, participants talked about the need to feel accepted and were also faced with the responsibility of modelling working with differences. Using community resources, increasing awareness amongst colleagues and taking on the role of a cultural consultant or 'cultural broker' (Kim, 1999) were some of the strategies participants used to help with this. Many spoke about their difference and heterogeneity within their ethnic and cultural groups being devalued within the profession, alluding to the oversight of their strengths and resources as a result, echoing experiences of other ethnic minority psychologists/trainees (Adetimole et al., 2005; Goodbody, 2009). Participants also referred to the paucity of commitment of the BPS and the NHS, underpinned by this narrative. Psychologists, students (and other professionals) from ethnically diverse backgrounds have commented that training does not complement their experiences or speak to their identities as individuals (Ellis and Cooper, 2013). The present study adds to the literature by describing the feeling of being marginalised and different from a White, middle-class norm that characterises the

profession (Fatimilehin and Coleman, 1998). It also sheds light on the effort that the South Asian psychologists make to manage being different and feel accepted by their colleagues.

4.4 Critical Review

4.4.1 Evaluating qualitative research

The notions of reliability, validity and replicability that are widely used to evaluate quantitative research are not appropriate for a qualitative research paradigm (Smith et al., 2009). The critical realist stance means that the findings do not offer a general truth about the practice of psychologists who identify as South/British Asian.

I chose to analyse the data at semantic and interpretative levels simultaneously. I acknowledge that the interpretations and conclusions I made are one possible perspective amongst others influenced by my own background and I have referred to my role in the study through the process of reflexivity (see 'Rigour' in this chapter).

The qualitative research was evaluated using a combination of Spencer and Ritchie's (2012) three guiding principles and some of Yardley's (2008) evaluating principles, which can be applied to all qualitative research, including the critical realist thematic analysis that the present study adopted.

Contribution

Contribution refers broadly to the value and relevance of research. To enable the reader to reflect on and understand the contribution of this study, the findings have been summarised and the relation of these to the previous literature has been discussed. In addition to summarising the findings of the study and reflections, I have also considered limitations and implications of the findings.

Credibility/ Coherence and transparency

Credibility relates to the plausibility of claims made and is dependent on the evidence presented (Seale, 2007). Due to the critical realist stance of the present study, other raters were not drawn upon to provide inter-rater reliability. However,

the themes and extracts were discussed with my supervisor as a credibility check.

Transparency can be seen in describing the methods used and detailing each stage of the research process and clarity of the final report and the provision of verbatim quotes from the interviews.

Commitment and Rigour

I have attempted to demonstrate the commitment to the research process through my introduction chapter by engaging extensively with the research in the area. This was to ensure a good understanding of relevant ideas and themes. Supervision was also used to reflect on any potential biases. Spencer and Ritchie's (2012) third principle of rigour proposed the consideration of reflexivity as reliability for qualitative research. With the present study, I have attempted to present a snapshot of a transcript with the coding and themes of the raw data (Appendix G). Appendices also include the interview schedule and extracts from the interview are included in the analysis chapter.

Sensitivity to context

Sensitivity to context requires utilising all relevant literature as part of being sensitive to the socio-cultural context of the research. This was adhered to in the steps leading to the formation of the idea for the study and the introduction chapter by consulting literature that has already been conducted into the practice of trainees and clinical psychologists which highlighted the absence of literature to understand the practice of qualified clinical psychologists especially from a South Asian background. Other ways of demonstrating sensitivity included offering participants the opportunity to choose the location for the interviews to enable comfort and feelings of security. This was important for them to be able to express themselves freely.

Impact and importance

Yardley (2008) suggests that true validity concerns the extent to which research is useful and is also determined by its ability to communicate to the reader something of importance. As stated earlier, the rationale for this study was to give voice to an understudied group- clinical psychologists from a South Asian

background. I believe this study was relevant in giving this group a voice and I hope that the analysis and discussion chapters have resonated with readers.

Reflexivity

My personal position as a researcher stems from the fact that I am from a 'visibly' different ethnic background and self-identify as an ethnically Indian woman, belonging to a South Asian culture. As an immigrant to the UK for higher education, I consider myself first generation and more aware of the differences in the South Asian and British cultures. The perspective I bring to this study is that the therapist's culture and ethnicity is salient for therapeutic practice. It is inevitable that my own worldview will have had an influence during the analysis.

By virtue of this, a majority of therapy I provide will have a significant cross-cultural aspect. Therefore, it was important to understand how this aspect of therapy manifested in clinical practice as well as in interactions amongst colleagues. I anticipated that participants might feel more at ease discussing issues of culture and ethnicity in their practice with a trainee who identified as South Asian. The assumption here was that I, as a South Asian researcher, might be more familiar with the references they made to their own South Asian background.

I realised that I had started my research looking for and expecting similarities between my perspectives and those of the participants. My view was that, as clinicians, who identified as South Asian, participants would be drawing on more nuanced knowledge of their South Asian cultures. However, I noticed that I was surprised by the difference, when participants reflected that they did not draw on their South Asian values very much. I recognised that there may have been many other factors which could have influenced participants' way of working, like, how they defined their South Asian identity, whether they were first, second, third generation and whether they used their own cultural ideas in their work. Nine participants identified as British Indian/Asian and second and third generation and it made me think about the impact of the British part of their identity on their work, which seemed to be more prominent. One participant who identified as first generation seemed to draw a lot more on her cultural and ethnic background as compared to the other nine participants.

Due to similarities in ethnicity and culture between participants and myself, I wondered if at times there were implicit assumptions at play during the interview process. I was aware of the need to adopt a research rather than a therapeutic focus. Another consideration as a trainee was the possibility that participants may have downplayed the full extent of difficulties encountered and managed during therapeutic practice as they were qualified CPs practising for a number of years.

Additionally, my role as a Trainee Clinical Psychologist interviewing experienced Clinical Psychologists about sensitive topics like culture and ethnicity, may have influenced the accounts of participants, as divulging details about practice may have felt exposing. I was aware that I held significantly less power than all the participants and wondered if at times I did not probe areas which perhaps felt challenging. I also wondered if participants perhaps held implicit assumptions about my values as a UEL trainee, with a few participants referring to the critical approach of the course. The implication of this is that participants may have responded with ideas that may fit with mine. Of note were the comments by some participants at the end of the interview that the interview had been a good opportunity to reflect on and discuss culture and ethnicity in practice.

The critical realist epistemology I adopted meant that I interpreted the factors that may have influenced participants' accounts. This made me question the ethics of interpreting accounts about sensitive and personal conversations, not just about culture and ethnicity but also about clinical practice (Willig, 2013). I wondered if participants expected me to adopt a naïve realist position when analysing their data rather than use a deductive approach.

In attempting to minimise my own influence, I endeavoured to gather accounts by asking open questions, clarifying and using prompts to encourage participants to elaborate.

4.4.2 Limitations

This research initially sought to recruit participants who self-identified as first-generation South Asian. However, these participants were difficult to identify. As a result, participants who self-identified as second/third-generation British Indian/Asian were recruited. An oversight on my part was failing to consider the meaning of ethnicity and the level of familiarity with their own cultures for each

participant and how much they identified with their British and Asian cultures. This may have affected the content of interviews in terms of how much the participants drew on their South Asian culture in their practice. Using a snowballing method to recruit participants, it is possible that participants may have identified other like-minded individuals whose accounts might have echoed similar themes. Moreover, although every effort was made to get a higher number of male participants, the sample was representative of the clinical psychology profession in terms of gender (8 female and 2 male) (Daiches, 2010). This led me to endeavour more to incorporate the two male accounts, for fear of marginalising them.

However, the strength here is the number and range of participants who trained at five different universities in the UK and had varying years of experience. This ensured I could get a broad perspective.

I recognise that by recruiting psychologists who identify as South Asian and not considering other ethnicities in the study, I have inevitably positioned this study as exclusionary and possibly discriminatory. However, it was important to hear the voice of psychologists who identified as South Asian due to a dearth of literature. Time permitting, the feasibility of exploring the practice of psychologists from various ethnic groups or perhaps a comparative study with multiple ethnicities could be considered.

4.5 Implications and recommendations

Within this section, the implications and recommendations for clinical practice and training in the profession of clinical psychology will be addressed along with ideas for future research.

4.5.1 Training

Curriculum: Training programmes could consult existing guides (Patel et al., 2000) to increase commitment to incorporating material from a diverse range of professionals about their practice that are not seen as 'add-on' but equally valuable as 'mainstream'.

Teaching: One way of accessing different narratives about theories and practices would be to invite visiting faculty from other countries and cultures and

developing a library or a resource to read up or talk to people from various cultures. Moreover, it is imperative that all trainers and lecturers have critical consciousness of the self and the other when training professionals from diverse cultures to work with clients from diverse cultures.

4.5.2 Practice

Given what we know about the Eurocentric theories and models in the clinical psychology profession and the lack of reflective space in supervision and with peers on aspects of culture/ethnicity and other differences, training programmes should integrate these aspects to help trainees/psychologists feel able to practise ethically and effectively. Failure to do this will result in ill-equipped mental health professionals who are unable to work with the dynamics of difference and unable to reflect on the impact of their own identity and privilege. This can be offered in the form of training for supervisors to consider how they might engage with aspects of a supervisees' cultural/diverse worlds in practice/training.

The findings suggest that culture and ethnicity are made relevant in therapeutic practice and conversations around these issues are difficult to have due to a lack of supportive spaces for clinical psychologists who might experience difficulties. The role of supervision was highlighted to support these conversations. This suggests a need to develop avenues to discuss issues of race and culture with culturally mixed peer groups in training and colleagues in the workplace. When working across cultures there is a greater need to be aware of one's own ethnocentric bias. Therapies are more likely to be effective and cross the cultural divide if they are based on curiosity and respect for the different beliefs of that culture (Benson and Thistlethwaite, 2008). Supervision structures are critical to ensure that health professionals develop good insight into their own ethnocentrism, receive good support, and are flexible in their approach to adapting their practice to meet client needs.

With regard to clinical practice, inadvertent matching of the psychologist and client appears to hold both advantages and disadvantages and it may be difficult to develop practice guidelines to account for all these complexities. Clients should be offered a choice with regards to their therapist where possible.

The assumption that clients will raise cultural differences in therapy only if it is significant to them needs to be questioned. It is imperative that the psychologist recognises the cultural importance of a client's issues and translates cultural knowledge into meaningful practice. In addition Patel et al. (2000) suggest that based on the powerful position of the therapist, it is the therapist's responsibility to initiate explorations of the effects of racism and differences, in therapy.

Participants alluded to professional work cultures which adopted a colour-blind approach and were not supportive of acknowledging differences in a constructive way. The disbanding of special interest groups about race and culture made participants question organisational commitments. This will continue to foster the perception that our professional bodies are not representative of the communities we serve. This in turn risks clients disengaging from services due to the service's lack of knowledge to explore underlying difficulties pertinent to therapeutic change. This warrants devoting more time to helping organisations and services change their philosophy and way of thinking about culture and ethnicity. This will clearly impact on psychologists being able to have open conversations about aspects of their culture and ethnicity with clients and help develop resources within their boroughs which all psychologists can draw on. The idea of caucuses as a part of the organisational structure can use the space to develop a clear collective voice and build knowledge and resources. This may be one way of keeping the power and biases in check on a day-to-day basis. However, I feel that such a space should be formed of like-minded individuals regardless of their ethnicity/culture to enable multiple perspectives. Boundaries should be set to ensure everyone's voice is heard in a safe way.

Much of the responsibility for managing boundaries lies with the therapist and boundary transgressions may often be viewed as inappropriate by other colleagues. Issues identified here like the assumptions, over-identification and negotiating therapeutic boundaries may help or hinder ethical decision-making and have an impact on the clients (Gutheil and Gabbard, 1998; Eleftheriadou et al., 2006). Flexible boundaries within the boundaries of the therapeutic process is a consideration. However, this raises the question of how and who should decide whether a boundary crossing is a transgression or violation as this is context dependent.

Whilst the challenges and dilemmas in highlighting culture issues may apply more specifically to BME psychologists, one should not assume that these experiences are not shared by White trainees/psychologists. Psychologists from other marginalized groups may, in all likelihood, find it challenging to highlight other areas of diversity, for example sexuality, religion or physical disability.

4.5.3 Wider implications

Different cultures engage with teachers and the educational system in different ways, some being more involved than others. Culture may impact the way students engage in learning. To engage them effectively in the learning process, educators must consider individual capabilities in order to maximise each student's potential. The curriculum in a particular country may decide what topics to cover and from what perspective. Educational institutions also tend to prefer uniform practices over diversity, most likely because sameness is easier to accommodate than difference. Curriculum could include different voices and ways of knowing and understanding in order to prevent a clash between an individual's culture and the dominant culture.

Community psychology has been interested in culture, diversity and marginalisation. However, it is shaped by Western academic traditions, discourses and structures that reproduce historical power hierarchies intertwined with the legacy of colonialism (Martín-Baró, 1994). Culture may often be seen as a static marker to understand group differences. Culture as we know, is shaped by socio-political and power discourses and integrating a decolonising standpoint can promote deeper critical thinking. It is important to consider and understand the different discourses about culture and ethnicity that position individuals as the 'Other', in order to understand how geopolitical and historical factors shape everyday lives. If clinical psychologists are unaware of the power differentials in a therapeutic relationship or unable to talk about differences, it could result in disempowering interactions.

4.6 Future research

As acknowledged earlier, the literature on experiences of psychologists from an ethnic minority is limited in peer-reviewed journals. If the voice of BME therapists

is to be heard, more research based on their experiences needs to be carried out and published.

Given the experiences of the participants in this study, it would be interesting to explore how psychologists who work explicitly with the client's cultural beliefs practice, how they make sense of differences and similarities with the client and navigate conflictual material between the client's culture and client's wishes.

Future research could also explore the difference in practice between psychologists from the first and following generations to determine the level of familiarity with their own cultures and the impact on therapeutic practice.

It would be interesting to explore the converging and diverging experiences of psychologists from other marginalised groups. A quick scan of the literature revealed that Daiches (1998) described her sexual identity as 'cloaked' from colleagues, referring to the dilemma of bringing that identity into the workplace. Martinez and Baker (2010) describe how psychologists tended to keep their faith separate from their work, echoing the feelings of participants in the present study, of living and working in different cultures.

4.7 Summary

This study aimed to explore how clinical psychologists from a South Asian background work with culture and ethnicity in therapy. Findings revealed that culture and ethnicity were not central to all therapeutic interactions. However, when ethnic and cultural differences were present, participants responded in various ways to the issues they faced in the therapy room and dilemmas they encountered in the profession. There were varying levels of comfort in having conversations about culture and ethnic differences in therapy as well as with colleagues, indicating a need for appropriate training of all clinical psychologists in working with diversity. However, some participants felt able to hold conversations about racism and acknowledge power differentials in the room, while others felt a need to prove their competence to clients if their abilities were questioned based on their visible differences.

Participants responded in various ways to challenges they faced in the therapy room. Some participants highlighted the importance of educating themselves

about the clients' socio-political history. Reflexivity, attempting to tailor the delivery of therapy and orientations according to their clients' cultural values, beliefs and needs were some of the ways of integrating cultural differences between clients and themselves in their work. In addition, participants emphasised hypothesising and formulating when faced with challenges in order to help themselves and others make sense of what was happening in the therapy room. The role of supervision was also highlighted in helping clinical psychologists to enable reflecting on the impact of their own culture and ethnicity on their therapeutic practice.

Participants commented on the Eurocentric nature of the clinical psychology profession and discussed navigating professional lives by modelling culturally competent ways of working like attempting to increase curiosity and awareness amongst colleagues. There was recognition that all the elements of a particular culture cannot be learned and that ongoing self-growth and learning was key to ethical practice. There was an acknowledgement of lack of diverse, safe spaces to hold conversations about dilemmas in clinical practice, using community resources or challenges faced in the profession.

More of an active approach to talk about racism and power differentials in therapy, amongst colleagues and a critical psychology approach may well improve the alliance between client-therapist, therapist-therapist and therapist-psychology discipline.

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6. APPENDICES

6.1 Appendix A - Interview Schedule

Opening/orientation questions

- How define their own ethnicity?
- Other identities drawn on?
- Generation and influence on practice?
- Other influences?
- In what way is knowledge about the self from a South Asian perspective needed/relevant in your practice?

In the therapy room ...

- How do you support clients to talk about cultural similarity/difference in therapy? Times you do and don't? Examples?
- How would you say your practice with ethnically similar clients differs from ethnically different clients?

IF NOT COVERED:

- How does therapeutic orientation influence this kind of work?
OR
- Specific considerations/adaptations you make when working with ethnically similar/different clients? Any reading? Use a different therapeutic orientation? Find out more about client's community and practices/beliefs? Incorporate client's culturally related resources into therapy?
- How do you work with the contradictory positionings of you and client based on cultural background- that may arise in therapy?

Specific issues

- Common difficulties faced? Examples.
- How resolved?
- Needed external support? Examples.
- Views on ethnic matching of therapist and client?

Cultural competence (CC) when working with ethnically similar/different clients

- How do you understand CC?
- How can a therapist best develop this? What training is needed to learn about this/become critical thinkers?
- What barriers?

Closing questions

- Working with multiple cultures at structural/organisational level? Example?
- Any closing thoughts?

6.2 Appendix B - PARTICIPANT INVITATION LETTER

Researcher:

Aishwarya Pethe-Kulkarni, Trainee Clinical Psychologist, University of East London.

Contact Details: u1438318@uel.ac.uk

Supervised by Dr. David Harper, Reader in Clinical Psychology, School of Psychology, University of East London

Tel: 020 8223 4021; Email: d.harper@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in my research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

Project Title

Culture and Ethnicity in the Therapy Room: A Thematic Analysis

Project Description

This research study aims to explore how Clinical Psychologists who identify as members of an ethnic minority (South Asian) adapt individual practice when working with ethnically similar or different clients. I am interested in how culture and ethnicity is made relevant in the room and how psychologists respond to it, the challenges faced and what training needs are identified.

Who can take part?

I would like to hear from Clinical Psychologists who identify as being from an ethnic minority (South Asian) who work with ethnically diverse service users.

What will you be required to do?

If you decide to volunteer, after signing the consent form and completing a short demographics questionnaire, you will be asked to take part in a one hour face-to-face interview with me. This interview can be arranged at UEL, your place of work

or another mutually agreed place if you prefer. The interview is expected to last for approximately one hour. The interview will be audio recorded and transcribed by me and all interview data will be kept anonymous and confidential. You will be asked to talk about your individual practice and any adaptations you make to it.

You will also be asked your opinion on training needs to achieve cultural competence and identify any barriers to implementing this training in practice.

Benefits

Your participation will help enrich the literature from a cross-cultural perspective and help understand how to enable conversations with clients from different cultural backgrounds. It is hoped that your participation will help in identifying training needs and barriers to achieve cultural competence.

Risks

As you will be interviewed about your routine practice, there is little risk associated with participating.

Confidentiality of the Data

Pseudonyms will be used in place of real names in the interview transcripts.

Electronic files (audio-recordings, transcripts) will be stored in a password-protected files on password-protected computers. Audio recordings will be erased 5 years after the completion of the study. Should you choose to withdraw consent after participation, you will be able to do so before the data analysis begins (February, 2017).

What happens next?

If you agree to take part, I will send you the consent form, information sheet and a short demographics questionnaire. I will collect the completed demographics questionnaire and signed consent form in person before commencing the interview.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study

you may do so without disadvantage to yourself and without any obligation to give a reason.

Thank you for taking the time to consider your participation in my study.

6.3 Appendix C - Consent to participate in a research study

Culture and Ethnicity in the Therapy Room: A Thematic Analysis

I have read the information letter relating to the research study and have been given a copy to keep. I have understood what it involves and what is expected of me. The nature and purposes of the research have been explained to me and I have had the opportunity to discuss it further. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

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

I understand that any interview extracts used in the thesis or future publication will be fully anonymised. I understand that audio recordings will be erased 5 years after the completion of the study and I can withdraw consent after participation, until the time when the data analysis begins (February 2017) and will not have an opportunity to withdraw consent for data to be used after this date.

I understand that my participation in the study is entirely voluntary and I can choose to withdraw at any point without any consequences and without being obliged to give a reason.

By signing below, I agree to take part in this study and understand that I have the right to withdraw at any stage.

Participant name:

.....

Researcher name:

.....

Participant signature:

.....

Researcher signature

.....

6.4 Appendix D - Demographics questionnaire

1. What gender are you?

☐ Male

☐ Female

2. What country did you train in?

3. Which programme did you train on? What year did you finish training?

4. What client group do you work with?

☐ Adults

☐ Children

☐ Older adults

☐ Learning disabilities

☐ Neuropsychology

☐ Other

Please specify

5. How would you describe your ethnicity?

6. Can you give an approximation of the percentage of ethnically similar and different clients you have seen or see in your work?

7. What gender do you see frequently in your work?

☐ Male

☐ Female

☐ Other

8. How would you describe your therapeutic orientation?
9. What percentage of your time do you spend in therapy vs. other activities?

6.5 Appendix E

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

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

REVIEWER: Mark Finn

SUPERVISOR: David Harper

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Aishwarya Pethe-Kulkarni

TITLE OF PROPOSED STUDY: Mind the Gap: Enabling conversations through adapting clinical psychology practice for ethnically similar or different clients

DECISION OPTIONS:

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

3. NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION

REQUIRED (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

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

MINOR AMENDMENT

Minor amendments required *(for reviewer):*

Good comprehensive application but in the Participant Invitation letter (and added to the consent form) participants could be told that transcripts will be destroyed after study (as stated in the application) and what will happen to their data if they want to withdraw – more is said about this in the application form than the participant invitation letter. You may want to consider allowing participants who withdraw to have their data destroyed but only up until the time of analysis

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

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

☐ HIGH

☐ MEDIUM

☐ LOW

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

Reviewer *(Typed name to act as signature):* Mark Finn

Date: 10/05/16

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

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

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

Student's name (*Typed name to act as signature*): Aishwarya Pethe-Kulkarni

Student number: u1438318

Date: 10/05/2016

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

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here:

<http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

6.6 Appendix F

Presentation Key

For the presentation of interview extracts, minor changes have been made to improve readability. Where words have been omitted to shorten quotes, 3 ellipses (...) have been added.

Where additions to text have been made to offer explanation to the reader, square brackets [text] are indicated. Identifying information has been removed or changed and pseudonyms given to participants to protect their anonymity. The main themes drawn out in the analysis were discussed by all participants to varying degrees.

Repetitive words or filler words have been removed for reader clarity (such as, 'sort of', 'kind of').

6.7 Appendix G

Example of coded transcript

	CODES	THEMES
<p>I: Do you have an example in mind about using...umm....supporting people to talk about these things in therapy.</p> <p>P3: I just name it. I would say something like, "were you bullied at school?"</p> <p>I: Ok</p> <p>P3: What was it like to move countries? What is your first memory of arriving? i would say something simple like..... Yeah or I will tell a story from my own experience of moving countries. The fear you felt. The shame you felt. And I would create dialogue around it. "was it your shame?" "what was it? What was it?" And they talk. And they talk</p> <p>Did you go to a school that was all Black and you were the only White person there? In (Borough) where you know (inaudible) this Black guy was going to get her. So I would the tension that I am aware of that exists in the community.</p> <p>So this woman that you are reading that chapter, there was a lot about being female and about not knowing language. There was a time I would walk up to the ward and people would say. "Look she is a psychologist" I used to do the hair of this elderly woman who had a manic depressive side to her. And therapists don't do that. But I think that was really important bit of therapy for her because as an older woman, a young person is coming to talk to her and in the business of doing her hair, um..."kejuribeni", that means the plait with 6 strands, I was doing her hair and she started telling me stories being in Bangladesh, husband dying, what it used to be like and the whole inheritance of loss again. So that could not be accessed in a room 1:1 in 60 minutes therapy. I had to.....If therapy is about connecting then I have to move where I can connect. You know.....</p> <p>Yeah that's the way to put it actually. If therapy is about connecting I have to move. That piece of work was very very interesting. (Psychologist) and I because he was the man. Her suffering was the woman's suffering. I was a woman but I was not Islamic. So all the differences were there. He was Islamic. And we used to just turn up and we didn't have the western paraphernalia of therapy. She would give us a drink, she would cook us something, I would....you know the whole way of talking was socialised for her if you like.</p>	<p>naming</p> <p>drawing on own experiences</p> <p>self-disclosure</p> <p>name socio-political tension</p> <p>therapist role?</p> <p>respect for elders</p> <p>Eurocentric model inappropriate</p> <p>connection</p> <p>western ideas of talking therapy</p>	<p>Bring self / cultural identities</p> <p>addressing racialised society (C+E)</p> <p>knowledge of S. Asian values</p> <p>cultural concepts of talking therapy</p> <p>adapting practices / boundaries</p>

CODES

THEMES

I: Yeah. And are there times you would choose not to discuss these topics of ethnicity or race or culture?

P3: Are there times?

I: Are there times you wouldn't?

P3: No.

I: No. Ok. And you would.... regardless of who it is or what setting it is, you would mention that?

P3: (Borough) is very different where I am now. You feel much more aware. You see there are 2 things. One you have your.....right at the beginning you talked about professional socialisation. One of the way to professionally socialise nowadays is to master CBT, unfortunately, I.....or evidence base or hobnobbing with NICE. I don't have those edifices to fall back on. So sometimes you can really suffer feeling.....its not about not feeling good enough.....its not about doubting yourself. Its about being very very lonely.....being extremely lonely.

I: Yeah

P3: You are alienated actually and you have to do it...what they say.... "Ekla Cholo Re". you know "Ekla Cholo re"?

I: In Bengali? Yeah.

P3: in Bengali. Its Rabindranth's famous song. So if nobody listens to your "daak". "Daak" is call then you have to travel alone, on your own.

Yeah it doesn't humiliate me anymore, it doesn't scare me anymore. It can get tiresome. You feel very alone...yeah you feel exhausted, even tired but this is the way it is. I'm philosophical about it. I am very philosophical about and I must get on with it. Are there times when I don't discuss my ethnicity?

I: Or the clients?

P3: Or the clients.

I: So are there times you wouldn't bring it up?

P3: I don't consciously go in saying I am not going to but there are times when I make a decision not to attend to ethnicity because mainly because you don't want people to assume....ah...leanings on your part. So if its an Asian client in front of me, for a little while I keep things neutral so that people don't think you lean one way or the other, you see? And then you find the right place, so yeah there are times when, so attending to it, although I said earlier on I do it all the time, the default position is I talk about it.

But equally there are many situations where I have to be...I have to check things out a bit. But I can always sense when it is ok. And when I need to wait for a little bit. Because people

ethnically less diverse workplace
Eurocentric culture of professional socialisation the profession

sense of isolation
tired

feeling Marginal & different

fear of being misunderstood

Always address C+E but time appropriately

always talk about C+E

clinical judgement

timing

similar clients + colleagues' internalised racism

assess relevance

<p>sometimes, especially Asian folk, are not ready to talk about it. If they are educated Asian folk, they are even more not ready to talk about it. So a typical situation where I would be very careful not to talk about ethnicity straight away would be, if the person is say a medical student, about 28. You can sense that.....its happened recently actually, he said to me quite clearly, "I won't even ask where you are from". What I presume.....So what you are trying to avoid is "I'm one of you". You don't want to give people the impression that you'd want to be doing that. He very quickly said to me, "Oh really you are from India?" So he volunteered. He said, "yeah but we are Anglo-Indians". So with him, if he ever came to me for therapy, I wouldn't do Indianess very quickly. So I would assess the defence. I would assess defence.</p> <p>I: Yeah. Ok. And do you find yourself or your practice differing when you work with ethnically, and I use the word ethnically, if someone is similar to you or different</p> <p>P3: Differing. How do you mean?</p> <p>I: So does your practice differ in any way between clients if they are ethnically similar or ethnically different to you</p> <p>P3: I think it's bound to differ. But I think the thing is, for me the main, what would I call it? The main.....the highest context is connection, it's not ethnicity. So the highest point is connection. So as you enter the room, and you sit with someone, your body will tell you, their body will tell you how the receiving is happening and you proceed from that. So.....</p>	<p>formulate before discussing C+E</p> <p>differ based on context connection most imp. clinical judgement</p>	<p>Formulate reasons for reaction</p> <p>C+E - not central to all therapeutic interactions. Consider context</p>
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