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Navigating cultural contexts: exploring the experience of cultural difference for South Asian women in psychological therapy

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Navigating Cultural Contexts: Exploring the Experience of Cultural Difference for South Asian Women in Psychological Therapy

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And finally, I cannot show enough appreciation to my family for their patience and encouragement to help keep me going and keep me grounded throughout this journey…

Abstract

This study aimed to explore the experience of cultural difference for South Asian women in psychological therapy. Specifically, it was to explore the contextual experience of having therapy derived from a western, individualistic discipline and navigating this with the interplay of South Asian women's everyday collectivist lives. Previous research in this area and on South Asian women in the field of psychological therapy has been significantly lacking.

Interpretative Phenomenological Analysis (IPA) was the chosen methodology for this research. Semi-structured interviews were conducted with seven UK-based South Asian women who had had at least 12 sessions of exploratory, psychological therapy with a qualified, non-South Asian therapist. The analysis reaped five superordinate themes each with their own set of subthemes: (1) *'Negotiating Self and Other'* looks at participants negotiating South Asian cultural expectation and responsibility with focusing on their developed individual sense of selves; (2) *'The Challenge of Power Dynamics'* describes how the experience of power and powerlessness both within therapy and in participants' everyday lives influenced degree of change; (3) *'Finding a Sense of Belonging'* describes participants experiencing a reassessment of their identity and cultural belonging; (4) *'Breaking Barriers'* demonstrates participants challenging stigmatised views to create a greater degree of integration between therapy and South Asian culture; and (5) *'To Share or Not to Share'* portrays how stigma and judgement contributed to participants negotiating openness both in therapy and in their everyday lives.

The findings are discussed mainly in terms of the way South Asian women negotiate both the therapeutic and collective contexts with consideration of both themselves and their culture. This research invites therapists to be aware of and tailor their work to support these negotiations that clients from more collectivist cultures may face in order to facilitate creating suitably desired, meaningful change in their everyday lives.

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1. Introduction

1.1. The Topic

Imagine the following case: Jaspreet, a 30-year-old, UK-born, South Asian woman is the eldest daughter-in-law in a family home. She feels great responsibility to maintain the family and household, whilst trying her best to care for her 2-year-old son. Almost daily, Jaspreet battles between wanting to raise her son in a more modern way than her in-laws desire, which has started to cause her anxiety and stress. She begins to feel trapped and makes the difficult decision to seek psychological therapy knowing her family would not approve, but she also feels uncomfortable seeking mental health support as it is against her cultural norms. A question for the reader: what might Jaspreet's experience of therapy be and what might it be like for her to navigate this with her everyday life in an attempt to create meaningful shifts?

Little is known about the experience of psychological therapy for South Asian women. This cohort is currently underrepresented in both mental health literature and the field itself. Research shows time and time again that there is greater psychological distress and higher suicidal rates among South Asians, particularly women, compared to males or their white counterparts (e.g., Anand & Cochrane, 2005; Bhugra, 2002; 2020; Gater et al., 2009; Pilkington et al., 2012; Williams et al., 2015). Yet, South Asian women still underutilise mental health services.

Of the knowledge that does exist within literature, it focuses mainly on their experiences of considering or accessing therapy. This opens up the need for the mental health field to know more about the experiences of South Asian women like Jaspreet. Understanding what it is like for them to navigate therapy with their everyday lives is crucial considering the more collectivist culture they come from, which is seen at odds with the more westernised, eurocentric nature of psychological therapy. South Asian women may tend to experience cultural difficulties due to their responsibilities to family life and their community. This may implore them to tread carefully to ensure that these institutions are not impacted by issues such as honour, stigma and shame (Gask et al., 2011; Goel et al., 2022; Marrow & Luhrmann, 2012). Seeking psychological therapy therefore may be difficult for them, also due to the stigma that collectivist cultures attach to mental health.

However, the experience whilst having therapy in conjunction with a South Asian woman's everyday life is not known. Outside of the cultural realm, this experience of navigating therapy with one's everyday life is generally very sparsely researched. By focusing on the first-hand experiences of South Asian women, we can begin to acknowledge and understand their process throughout their therapeutic journey. This would encourage and urge Counselling Psychologists to appreciate this journey in order for them to provide psychological therapy in a way that is sensitive, ethical and optimal for this underrepresented cohort.

I therefore introduce the current research which uses a phenomenological approach to study the experience of cultural difference for UK-based South Asian women in psychological therapy. The focus pertains to what it is like for a South Asian woman, from a more collectivist culture, to have therapy that is based on a more western, individualistic discipline, and what her experience is of navigating this with her everyday life.

1.2. Structure of the Thesis

In the remainder of this introduction chapter, I will present the various definitions of terms that will be used throughout the thesis to allow the reader familiarity with the meanings inherent within the study. *Chapter Two* sets out the wider background context and rationale for the study, including the reasons I undertook this research both from a personal and professional stance. The chapter ends with a description of the way that this research intends to make a contribution to the field of Counselling Psychology. *Chapter Three* provides the literature review, comprising a discussion and critical analysis of the key studies in the field. This gives a further rationale and argument for the current study, which concludes with the research aim and research questions. *Chapter Four* presents the methodology section, giving a clear rationale for the methodology used for the study. This chapter also provides a description of the study design, the analytic stages and the ethical considerations, finishing with a reflexive account of undertaking this part of the research. *Chapter Five* details the

findings of the research study following the analysis, which reaped five master themes with their individual subthemes. The themes are supported by verbatim quotes from the seven research participants to show both convergence and divergence of their experiences. *Chapter Six* provides a discussion about the findings of the research, linking them to the literature in the field, which both support and challenge other findings. This chapter further describes the important implications of the study to the field of Counselling Psychology and beyond, alongside the strengths and limitations of the research. *Chapter Seven* comprises another reflexive account of my personal experience of undertaking this research, and the way it has altered both my personal and professional life. *Chapter Eight* concludes the research, summarising ways that this research can create change to the profession. *Chapter Nine*, as the final chapter, presents the references and appendices to the full study.

1.3. Terms and Definitions

For clarification purposes, below are some important terms and their definitions that are present throughout this research.

Psychological Therapy

I will be using ‘psychological therapy’ as an umbrella term that captures counselling, counselling psychology and psychotherapy. I acknowledge that

there are distinctions between each of these terms, although lay people generally tend to refer to them interchangeably as will be apparent from the data in this research.

The thesis focuses on exploratory therapy, which includes unstructured approaches such as psychodynamic, relational and humanistic therapies. Although I refer to these approaches when using modality-specific language, there is a tendency for me to use more psychodynamically oriented terms such as ‘splitting’ and ‘internalisation’ as this is the modality that I predominantly use in my clinical work.

Culture

Culture is an amorphous term for which there are varying definitions that point to it being a rather complex and dynamic term to define. The definition of culture that I used for this research is that it is the way of life that includes customs, values and behaviours that are shared and passed on within a particular society or group of people (Baum, 2017). ‘Cultural difference’ therefore pertains to differences in these aspects between societies or groups of people. Whilst acknowledging that there are a multitude of cultures within culture, and that these can intersect with factors such as age, gender and class, I will be discussing ‘cultural difference’ with a specific focus on individualist and collectivist cultures for reasons mentioned further below.

Individualism and Collectivism

In understanding individualism and collectivism, I have adopted definitions from both Hofstede (2011) and Triandis (2001). Attributed more to those from a western, eurocentric background, 'individualism' places importance on the individual person. It emphasises independence, freedom and liberalism alongside a focus on personal goals, thereby holding an "I" consciousness. 'Collectivism' emphasises interdependence where the goals of the in-group are prioritised over an individual and behaviour is shaped by in-group norms. Collectivism therefore prioritises maintaining relationships, essentially holding a "we" consciousness.

In recent years, the individualism-collectivism construct has been criticised for being too broad and attempts have been made at trying to look at narrower aspects of the constructs (e.g., Brewer & Chen, 2007; Wong et al., 2018). Yet, these have also been criticised due to methodological issues alongside there being a lack of significant evidence to warrant the use of the narrower elements (Hofstede, 2011; Taras et al., 2014). Accordingly, I have used 'individualism' and 'collectivism' in its broad sense, which psychologists have largely reacted positively to since its conception and has been the most widely used way to show significant difference among cultures (Hofstede, 2011; Triandis, 2001). Nonetheless, rather than as a dichotomy, I have used the terms to reflect a continuum. This is to highlight the variation and complexity that cultures may not be purely individualistic or collectivist, thereby acknowledging the fluid and

dynamic nature of these constructs (Kuchel, 2000). Accordingly, reference to 'individualistic culture' or 'collectivist culture' in this thesis pertains to these cultures being considered as more individualistically-oriented and more collectively-oriented, respectively, compared to a binary notion.

Black and Minority Ethnic (BAME)

Although I rarely use this term or the term 'ethnic minority', I take the Institute of Race Relations (2020) definition which is that 'BAME' is *"normally used in the UK to describe people of non-white descent"*. Although some geographical areas may have BAME groups that outnumber those with white descent, Perry (2001) states that 'minority' would still be accurate as the concept refers to political and economic power still residing with those who come from a solely eurocentric background. He further adds that the core norms/values of the country would also resemble eurocentric views, and is therefore not dependent upon a quantitative comparison.

South Asian and Immigrant Status

'South Asian' reflects the definitions of Dasgupta (1998) and Handa (2003) who describe this as being individuals with both historical/ancestral and cultural connections to the South Asian subcontinent. This includes India, Pakistan, Sri Lanka, Bangladesh and Nepal. I have referred to South Asian immigrants of

various generations, though particularly those from both first and second generations: first-generation immigrants are those who have immigrated from a South Asian country to a western country; and second-generation immigrants are those who were born in a western country though whose parents are first-generation South Asian immigrants.

I will now provide the background context of the current research, which will provide its rationale. I will then present my personal relationship to the research topic, and will close the chapter by highlighting the contributions that I hope the research will make to the field of counselling psychology and psychotherapy.

2. Background

2.1. The Context and Rationale for the Study

Since around 1975, immigration to western countries such as the United Kingdom (UK) has been increasing (Office for National Statistics - ONS, 2016). According to the 2011 Census, the Black and Minority Ethnic (BAME) community made up 14% of the population in England and Wales, of which 5.2% comprised those who identified as 'South Asian' (ONS, 2012). Although the latter population makes up the largest UK ethnic minority group, research has consistently shown that they underutilise mental health services compared to the general population (e.g., Bhui et al., 2003; Fazil & Cochrane, 2003; Mind, 2013). Yet, research and COVID-19 mental health statistics indicate that British South Asians, especially women, experience greater levels of psychological distress than Caucasians (e.g., Anand & Cochrane, 2005; COVID-19 study, 2021; Gater et al., 2009; Pilkington et al., 2012; Williams et al., 2015). This implies that greater focus on their mental health needs is required to ensure a healthier society.

The Department of Health (2003) released the "Delivering Race Equality: A Framework for Action" report in an attempt to address these discrepancies and understand the needs of these underrepresented ethnic minority groups. Despite this, mental health service uptake and retention still remain relatively low from South Asian communities compared to their White British counterparts

(Baker, 2018; Mind, 2013). One important factor for this appears to be due to mental health services, and therefore the discipline of psychology, being rooted in western cultural practices and traditions (Marsella, 2009; Marsella & Yamada, 2010). As these eurocentric traditions are grounded more in individualism, which promotes autonomy and self-sufficiency, they seem to clash with more non-western, collectivist cultures, such as South Asian culture, which tend to focus on group harmony and catering to others' needs. Accordingly, western psychology has received criticism for not adequately meeting, nor understanding, the needs of those who do not belong to the majority white, western population, often resulting in marginalisation, stereotyping and labelling these groups as 'hard to reach' (Burr, 2002; Lamb et al., 2012).

Research has shown that this has further led to General Practitioners (GPs) being less likely to both recognise mental health difficulties among the South Asian population and refer onto specialist support even once recognised (Bhui et al., 2001; Bhui et al., 2003). This has raised concerns around institutional racism and inequalities among ethnic minority groups, which are experiences that South Asian communities have commonly endured since immigrating to western countries such as the UK (Bhui et al., 2018). A somewhat vicious cycle therefore appears present where mental health difficulties go undetected among South Asians, compounded with experiences of discrimination which then lead to further negative impacts upon mental health as it creates social exclusion (Bhui et al., 2018).

Furthermore, structural socioeconomic and sociopolitical factors have also been found to contribute to mental health distress and disadvantages for South Asians: they seem more likely to experience poorer housing, educational opportunities and struggles with employment than those from white backgrounds (Toleikyte & Salway, 2018). These intersecting factors suggest that societal power dynamics are also inherent within the mental health system as its embedded individualistic, eurocentric traditions means that the needs of those from the latter background seem to be better catered for than for the South Asian population.

The above indicates an interplay of factors that impact South Asians receiving psychological treatment. Yet, psychological therapy itself appears to be weighted in individualistic traditions that point heavily towards cultural exclusion for South Asian groups in mental health services (Bowl, 2007). This indicates a strong need for the psychological field to cultivate a more wholesome practice that is sensitive to the cultural norms and values of those from more collectivist backgrounds in order to improve therapeutic engagement and health outcomes. There have been attempts at doing this such as through ethnic matching between therapist and client, yet research on its effectiveness has largely been inconclusive (e.g., Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002; Shin et al., 2005). Psychological approaches have also integrated techniques from collectivist cultures, a main one being the spiritual practice of mindfulness meditation (Nita, 2019): This was given key priority status by the National Institute for Health and Care Excellence (NICE) in 2009 for its proven effectiveness to manage mental health difficulties, particularly depression.

Despite this however, it has not seemed enough to address the mental health needs of collectivist groups such as South Asians. This is especially given the greater prevalence of psychological difficulties among South Asian women as mentioned above, including higher suicidal rates among them compared to males or white women (e.g., Bhugra, 2002; 2020; Ineichen, 2008).

Research shows that South Asian women face cultural struggles due to their collectivist responsibilities: these appear in the form of family, marital and community conflicts alongside issues around honour, stigma and shame that impacts their ability to both seek psychological support and improve mental health even when having therapy, implying potential conflict in navigating therapy with their everyday lives (Gask et al., 2011; Goel et al., 2022; Marrow & Luhrmann, 2012; Time to Change, 2010). For South Asian women, maintaining family relationships appears to play a more significant role in their lives compared with their western counterparts (Lavender et al., 2006). A study by Kalathil et al. (2011) found that the negative family attitudes that South Asian women face alongside difficulty for mental health professionals to tend to their needs impacts psychological recovery. Literature shows that South Asian women instead often resort to pluralistic treatments including seeking spiritual and religious support, often favouring this over therapy as it provides strength and healing during difficult times, especially if mental illness is believed to be attributed to these causes as is often the case in collectivist cultures (Hordern, 2016; Hussain & Cochrane, 2003). Yet, another presented argument is that such practices are adopted due to South Asian women feeling dissatisfied with the lack of cultural competence from mental health professionals, again

highlighting cultural exclusion in mental health services (Incayawar et al., 2009). The above implies that the more individualistic nature of therapy may be at odds with the wider collectivist issues that South Asian women face in their everyday lives. This indicates a potential struggle to navigate and integrate both contexts to reap healthier psychological outcomes.

The majority of research seems to focus largely on barriers to help-seeking experienced by South Asian women. Given the research base that South Asian women experience cultural conflict, not much is known about this experience in relation to receiving psychological therapy: precisely how UK-based South Asian women experience the more individualistic nature of therapy and their experience of navigating this with their everyday lives. Greater insight into this may allow for better understanding of how South Asian women manage the spaces between therapy sessions alongside the various experiences they may face. The therapeutic arena may then be able to support them with this process to improve service uptake, retention and health outcomes.

2.2. My Personal Connection

The motivation for this research study comes from a personal place. Apparent from my name, I am a South Asian woman, born as a second-generation immigrant. It feels weird to use the word ‘immigrant’ to describe myself, because I consider myself as fully British having been born and bred in the UK. I have learnt, however, that I cannot hide away from who I am because it is so

palpably obvious. It used to frustrate me every time I slipped into typical South Asian gender stereotypes such as being slightly quieter or pleasing others. My fight against such stereotypes began in 2013 when I started personal therapy as a requirement for studying Counselling Psychology and Psychotherapy. Interestingly, I have always felt the need to justify why I had therapy as this otherwise carries shameful connotations.

However, being a South Asian woman faced with a non-South Asian therapist was a journey that I would not change. In the beginning, I lacked emotional expression, was unfamiliar to myself and repressed. I was warmly welcomed to space just for myself, but had no idea how to use it. Overtime, the space gave birth to my voice, my creativity and simply my sense of who I am. The freedom and openness I experienced was something I wanted to implement into my everyday life. Navigating this came with its challenges however especially as I began to rebel against South Asian cultural norms and values that I saw as outdated. ‘Rebel’ seems like I went off the rails. I never did. I simply questioned. And when no-one could properly answer my questions, I saw it as a reason to break free from such ways of living, gradually letting go of the need to please others. I have been living this way ever since with those around me having gradually become used to and accepting of this ‘new me’. I have reflected on this experience for me as a second-generation immigrant and have pondered over how others of the same or from differing generations experience the collision of two seemingly opposing worlds.

I wish that the changes I was able to make in my life could have been made by particular South Asian women I saw growing up, all mostly first-generation immigrants. I watched them repress their yearnings, desires and creativity, instead spending their time and energy on always caring for everyone else apart from themselves. And yet they never complained. One might say this was where they got their happiness from. But I did wonder whether they had just simply submitted to the collective roles that they had been socialised into occupying since a young age. I doubt that being restricted post-marriage from visiting family/friends, spending money, and decades later still struggling to do things for one's self was done out of happiness. This description is not an exaggeration. It is a life that has been led by certain South Asian women in my life and are the inspiration for this research.

In describing my own and the experience of first-generation immigrant women, it is important to highlight that South Asian women carry with them their experiences of acculturation and the negotiations they had to make owing to their immigrant and generational backgrounds. Espin (1999) suggests that the pressure particularly for South Asian women to follow cultural norms/values may have come from attempting to manage the chaos of transitioning into a mainstream western society, and therefore an attempt to prevent tradition being lost to a more dominant culture (Dasgupta, 1998). I wondered whether the experience of psychological therapy may parallel this.

In being aware of my skewed experience however, which speaks of difficulties and challenges, I would like to highlight another viewpoint. There are many

South Asian women who navigate western and eastern worlds efficiently in this current climate, and are therefore able to spread their wings and experience more of the world than their ancestors ever could. We live in a time where there are positive collaborations between eastern and western cultures such as through music and food. In mentioning this, I am highlighting an ever-developing, fluid and dynamic shift in the domains between individualism and collectivism. Yet, there still appear to be South Asian women, including second-generation immigrants (discussed further in the literature review), that experience cultural conflicts and feel bound by cultural obligations. Bringing the therapeutic arena into the picture and considering my personal experience of therapy, I wondered how South Asian women experience psychological therapy having come from a more collectivist culture, and how they navigate this alongside their everyday lives.

Throughout this research, I have had to be conscious of my 'insider researcher' status in being a South Asian woman, but also one trained in using a western, individualistic approach to therapy. Although this has potential advantages such as understanding South Asian culture, I have had to keep open-minded to the existence of different experiences of South Asian women compared to mine. It has been important for me to be critically reflective in this research and be wary of the potential bias in wanting to unconsciously recreate and confirm my experience of South Asian women. As an interesting parallel, I too have presented how I navigated and managed this within the reflexive elements of this research. Especially in the initial sections of this thesis, I had to step back from making my views louder than the research in the field and coming from a

place of ‘knowing’ based on my experience. This has been challenging as I have had to consciously bracket my experience and emotions, which produced concerns around not presenting a strong enough argument for the research. However, this instead invited me to take a step into the unknown and present a ‘fairer’ representation of the current topic by letting the research speak, allowing me to adopt greater criticality.

Accordingly, I questioned the possibility of a different version being presented by this research compared to the experiences of South Asian women I have been used to hearing. For instance, what if the so-called ‘submission’ that we often hear South Asian women being subjected to or their responsibility to family is in fact an active choice that they make, but we are blind to seeing the decision-making process behind this? I therefore felt it was important that this research focused on the subjective experiences of these women to achieve an ‘experience-near’ understanding of the meanings they attribute to their experiences of having psychological therapy and navigating this with their everyday lives.

2.3. Contribution of this Research

The current research contributes to the field of Counselling Psychology by advocating change in the way professionals work with South Asian women and beyond. There is a general sparsity of research into how clients experience therapy alongside their everyday lives, and how they manage this interplay. The

focus of this research on the cultural difference between the more collectively-inclined and individualistically-inclined contexts experienced by South Asian women undergoing therapy provides a salient way of looking at this phenomenon. This research therefore shows what happens when differing cultural worlds are brought together in the psychotherapeutic field.

Kirmayer and Young (1998) argue that a therapist's tendency to focus on enhancing an individual's self-awareness and development distracts from attending to the social and situational issues that may play a role in producing effective therapeutic change. Being aware of issues that South Asian women may be facing external to therapy sessions would therefore enable therapists to meet South Asian women's needs by gaining insight on how to facilitate this process for them in the therapeutic setting, aiding therapy engagement and retention. This in turn could gradually facilitate reducing the negative stigma that collectivist cultures tend to attach to mental health.

Having a firmer understanding of what the experience is of therapy, the spaces between sessions and what South Asian women have to navigate can allow for a new level of understanding and awareness about clients' personal worlds rather than considering only who they are in the therapy room. This research can therefore invite therapists to consider the complexity and diversity of the cultural interplay that South Asian women face, endure and that are created in their real lives. Accordingly, the everyday reality of these women's lives can be brought into the minds of therapists, facilitating greater cultural competence in psychological therapy. In essence, this could improve services for clients from

other collectivist communities such as the East Asian community and even beyond collectivist cultures. This is because all clients are embedded within wider cultural, social and political contexts which they may have to navigate with therapy, which therapists can be encouraged to hold in mind more when working with clients.

Finally, where training on working with clients from different cultures is lacking in therapy training institutions, the insights provided from this study can prepare trainee therapists to provide more culturally-sensitive therapy to clients, producing more efficient and all-rounded practitioners. This will generally develop greater cultural awareness and competence in the field of counselling psychology and psychotherapy with beneficial effects, not only for therapists, but for tutors, supervisors and clients alike.

3. Literature Review

For this literature review, I searched for relevant studies using EBSCO, Google Scholar and the Journal of Cross-Cultural Psychology. I used keywords such as ‘South Asian’, ‘women OR females’, ‘psychotherapy OR counselling OR therapy’ and ‘individualism OR collectivism’. I initially searched for literature from 2012-2022 although found little within this timeframe. The time period was therefore expanded, and further literature was sought from the reference sections of sourced literature. Although the intention with the literature review was to conduct it systemically, I found that this was not possible due to the lack of research in this area. As I wanted to capture as much of the relevant literature as possible, I physically went through all the possible articles and papers that I came across to assess their relevance. This also included going through all issues of the *Journal of Cross-Cultural Psychology* in the last 12 years. Although this took quite some time to do, I felt this was a robust approach. Due to the overall lack of literature on this topic, the literature review begins broadly by highlighting studies that explore aspects within and outside of the therapeutic setting that contribute to therapeutic change. This funnels down to viewing this from the lens of individualist and collectivist cultures with a particular focus on South Asian culture. I then introduce research into how South Asian women have experienced and navigated cultural difference including pertaining to having psychological therapy, with a concluding section that introduces the aim and research questions of this current study.

3.1. Therapeutic and Extratherapeutic Factors

Psychotherapeutic research has studied therapeutic factors that influence successful outcomes for clients. Whereas this has mostly focused on the influence of therapist techniques, clients have rated the therapeutic relationship as being the driving force, specifically therapist empathy and collaboration (Bohart et al., 2002; Bohart & Tallman, 2010; Wampold, 2015). Client ratings have been considered more valuable than therapist ratings as they correlate more highly with therapeutic outcome (Bohart et al., 2002). Yet, a review by Orlinsky et al. (2004) shows that the quality of a client's therapeutic participation was the greatest determining factor of outcome. They highlight participation as a client's willingness to engage in and implement therapy tasks; their involvement; and their degree of collaboration in therapy. This implies that clients play an active role in determining meaningful therapeutic change.

Client contributions to therapy have however appeared to lack focus in the field (Bohart & Tallman, 2010). Literature shows that extratherapeutic client factors account for a significant proportion of unexplained outcome in therapy (Bohart & Tallman, 2010). For instance, Lambert (1992) found that clients and factors in their life account for 40% of therapy outcome, with only 15% attributed to therapy techniques. He accordingly states that a client's resources and what they do outside of therapy sessions significantly contribute to client therapeutic improvement. However, Lambert's (1992) results have been criticised as being rough estimates. Contrastingly, Manthei's (2007) mixed methods study demonstrates that 71% of change shown by his 20 clients was due to the

counselling they received, whereas only 29% of change was attributed to external events. Nonetheless, Manthei argues that although counselling acts as the catalyst in producing client change, the client's actions outside of and between sessions are also important. This and Lambert's results have been further supported by numerous research studies (e.g., Bowman & Fine, 2000; Scheel et al., 2004; Wampold, 2010).

Yet, much of this research has been specifically tailored towards clients that received Cognitive Behavioural Therapy (CBT), which involved homework tasks being given between sessions, thereby being more directive. The somewhat extensive therapeutic research on CBT comes mainly because it is evidence-based as it measures change more easily compared with non-directive, exploratory forms of therapy such as psychodynamic, humanistic and relational approaches. However, such exploratory therapies also function to create shift/change in clients' lives through developing insight and awareness, and therefore feature in this present study. In line with the above research, a meta-analysis of non-directive supportive counselling by Cuijpers et al. (2012) shows that extratherapeutic factors account for 33.3% of therapy improvement. This raises interest into the extent that external factors may facilitate or impede a client's therapy process, and perhaps their ability to implement therapy into their everyday lives. A study by Paulson et al. (2001) found that clients consider external and structural barriers as being one of three factors that hinders therapy progress.

Therapy in general has received criticism for not sufficiently attending to the relationship between a client's external as well as internal worlds, as only the latter has been given primary focus (Proctor, 2002; Totton, 2000), despite clients being more exposed to the former. Since around the past two decades, however, psychological theorists have paid increasing attention on how one's social context influences their intrapsychic and interpersonal life. They suggest that this is also mirrored in the therapeutic process, particularly in the transference/countertransference relationship between therapist and client as within the psychodynamic approach (Altman, 2010; Comas-Diaz, 2010), further showing the impact that one's everyday life may have on therapy. One's cultural context is deemed further influential, as supported by Wampold (2015) who found significant effect sizes for therapy interventions that were culturally adapted for clients. This implies that influence of cultural factors needs consideration in therapy. For clients from ethnic minority backgrounds, cultural differences along the individualistic-collectivist construct have been put forward as underlying differences in psychotherapy effectiveness (Jaouich, 2007; Sue & Sue, 2016). Therefore, the current research has focused on this particular cultural construct.

3.2. Individualism-Collectivism and Therapy

Hofstede (2011) and Triandis (2001) describe more individualistic cultures as those that place importance on the autonomy, independence and personal goals of individuals; whereas collectively-skewed cultures are those that

prioritise interdependence, and on maintaining relationships and harmony with others such that members focus on the goals of the in-group. Psychological therapy is considered to be embedded with individualistic values as it focuses on the individual client, and on their verbal and emotional expression, where self-development and self-awareness are considered therapeutic goals (Marsella, 2009; Marsella & Yamada, 2010; Sue & Sue, 2016). This invites interest into how clients from collectivist cultures experience the individualistic ethos embedded within therapy.

Literature indicates that collectivist societies view verbal and emotional expression as problematic, particularly as the latter is seen as a sign of weakness and disgrace, which may harm the collective (Khalil, 2018; Zane et al., 2008). The views of the collective and their cultural values may therefore influence a client's therapy journey. Jaouich (2007) even denotes the importance of considering the larger family context in therapy when it comes to decision-making as collectivist cultures do not consider this an individual process. Not acknowledging such cultural factors may impact the development of positive therapeutic relationships and clients' willingness to seek therapy. Research showing collectivist clients' dissatisfaction with therapy due to the lack of cultural competence from mental health professionals supports this (e.g., Bowl, 2007).

Several studies, including meta-analyses and systemic reviews, have shown that therapist cultural competency and culturally-adapted therapies have positively correlated with working alliance, client satisfaction and improvement

post-treatment for collectivist clients (e.g., Draguns, 2013; Tao et al., 2015; van Loon et al., 2013). This indicates the need to appropriately consider cultural difference by accounting for a client's cultural context to improve therapy outcomes as a client's progress may otherwise be hindered. However, as much of the above research has been conducted in the United States (US) with less research on clients from the UK, the latter has featured in the current research. A qualitative study conducted in the UK, however, also found that culturally-adapted therapy reaped more positive effects on ethnic minority clients including South Asians, than non-adapted therapy (Naeem et al., 2015).

In terms of South Asians, there has also been a lack of focus on this collectivist population generally in cultural research. The psychological field appears to have had studied mainly the East Asian population comprising Chinese, Japanese and Korean communities where findings from such research have been generalised towards the BAME population (Arora et al., 2016). This can become problematic as it can ignore the difference in needs of those from the South Asian culture. Accordingly, the current study has researched the latter collectivist group, especially as research shows that British South Asians consistently underutilise mental health services compared with Caucasians, despite the former experiencing greater psychological distress (e.g., Anand & Cochrane, 2005, Gater et al., 2009; Mind, 2013; Pilkington et al., 2012; Williams et al., 2015).

3.3. South Asian Culture and Mental Health

The South Asian population comprises individuals with an Indian, Pakistani, Bangladeshi, Sri Lankan and Nepalese origin (Dasgupta, 1998; Handa, 2003). South Asian culture tends to operate on a power hierarchy based on gender and age (Tummala-Narra, 2013): traditionally, the top authoritative position is held by the oldest male within a family and the bottom, least powerful position is held by the youngest female. The decision-making role therefore often resides with the elders and men in a family. This may also explain low uptake and high termination rates of therapy as South Asians may equate therapists to authoritative family members, from whom more direction and guidance is expected (Khalil, 2018). They may thereby lack understanding of the process of more non-directive therapy by expecting similar power dynamics as in the family, perhaps therefore creating psychodynamic transferential enactments (or 'replays') between therapist and client.

As a collectivist culture, research shows that family pride and honour are considered most important among South Asians, which can cost individuals their freedom, thereby influencing willingness to seeking therapy and discussing issues outside the home (e.g., Goel et al., 2022; Husain, 2020; Pilkington et al., 2012). The idea of seeking psychological support tends to risk bringing shame upon the family. Like other collectivist communities, South Asians attach a negative stigma to mental health and psychological support as it becomes associated with mental instability, which can lead to community rejection, and therefore reduces help-seeking behaviour (Conrad & Pacquiao, 2005; Goyal et al., 2015; Guzder & Krishna, 2005). South Asians also consider therapy as a

sign of weakness as they believe it focuses on expressing emotions, which creates deeper depression whereas constraining emotions is viewed as a strength (Inman et al., 2007). Laungani (2002) states that exhibiting inappropriate emotions such as anger and disclosing psychological problems can lead to potential ostracism from the family as it indicates an inability to handle emotions efficiently alongside indicates inadequate upbringing.

Qualitative exploratory research by Goyal et al. (2015) showed that Indian mothers only sought mental health support for post-partum depression if it was severe enough and caused harm to self/others. Otherwise, they asked their husbands to decide whether to seek support as they knew elders in the family would consider them a weak mother. This was supported by Khalil's (2018) research which found, using thematic analysis, that South Asians tended to access services when in crisis. She states this is perhaps because it is more 'acceptable' to receive help at this point, whereas otherwise there is pressure to maintain an image of 'perfection' of one's self and therefore of the family. Accessing help mainly at crisis point may therefore explain the higher psychiatric hospitalisation rates found among South Asians compared to Caucasians (Bansal et al., 2014; Weich et al., 2014). This implies that it can be difficult for a South Asian individual to professionally address mental and emotional suffering as they may be conflicted in choosing between their own needs and family expectations (Inman et al., 2001). This provides an insight into the potential conflicts these individuals may face when actually having psychological therapy. Accordingly, the South Asian family can appear a source

of distress, but contradictorily also as a supportive strength as South Asian families often choose to resolve matters in-house (Goyal et al., 2015).

Interestingly, research reports lower social support and increased negative social interactions among South Asians compared to white Europeans (e.g., Williams et al., 2009; Williams et al., 2010). This suggests that perhaps the idea of support and social harmony among South Asian families applies to situations which best suit the entire family unit as part of a wider community. This may however occasionally be at the expense of an individual's wellbeing, often resulting in repression. In the instance that these individuals seek psychological support, it is more likely to be done without the family's knowledge to save face. The question arises as to how South Asian clients experience a therapy journey as therapy traditionally encourages self-focus whereas South Asian culture emphasises the collective along with a negative stigma to mental health. The above suggests that it may be difficult for them to transfer progress outside of the therapy setting, implying that attempts at creating personally beneficial shifts/change may be challenging. The gender hierarchy and Goyal et al.'s (2015) research mentioned above suggests that this experience is likely to be more pronounced among South Asian women than men. This cohort has therefore been studied in this current research, especially as research on experiences of therapy has lacked focus on South Asian women (Ashiq, 2017; Rasheed, 2011).

3.4. South Asian Women and Psychological Therapy

Research shows that South Asian women are taught that family reputation and honour is their responsibility (Gilbert et al., 2004; Zaidi et al., 2016). This deters them from engaging in behaviours seen as culturally inappropriate and stigmatised such as having pre-marital relationships or disclosing family matters outside of the home. Several research studies have shown this to be a barrier to accessing psychological support (e.g., Gask et al., 2011; Goel et al., 2022; Husain, 2020; Moller et al., 2016). South Asian women may potentially therefore be unable to disclose any family distress or otherwise they may be experiencing, which may further exacerbate mental health problems as supported by qualitative research (e.g., Chew-Graham et al., 2002; Shankar et al., 2013). A quantitative study by Masood et al. (2009) further supports this as their South Asian female participants attributed their distress to family factors whereas it was more diffuse for males.

This seems to provide an understanding of somatisation rates found among South Asian women as it appears they repress their distress to reduce any potential negative societal consequences for the family, although this renders such women as poor candidates for psychological therapy (Burr & Chapman, 2004). Physical problems are also often more accepted than mental health problems due to the stigma on the latter (Burr & Chapman, 2004). Nonetheless, repression alongside having a different cultural vocabulary for psychological distress seems to contribute to an inaccurate understanding of South Asian depression rates especially as GPs tend to misdiagnose this cohort (Bondi & Burman, 2001; Burr & Chapman, 2004; Khalil, 2018; Netto et al., 2001). Yet, it

has been argued that South Asian women can recognise psychological distress although the eurocentric model of mental health is unable to factor in language and cultural labels for distress (Nazroo et al., 2002). For instance, findings show that South Asian women are able to express their difficulties using psychological terms when talking in their mother tongue (Anand & Cochrane, 2005), and that physical problems reduce for Asians when a strong therapeutic relationship is established as they feel safe to disclose emotions, which they may feel unable to do in their collectivist contexts (Bhugra & Mastrogianni, 2004; Hwang et al., 2008). Therefore, this suggests that South Asian women may not always experience difficulty with expressing their emotions, but that there may be other barriers in place for them.

Accordingly, South Asians become dissatisfied with ineffective treatment given, and lack faith in GPs and service providers if cultural understanding is lacking, thereby even impacting having psychological therapy (Chew-Graham et al., 2002; Husain, 2020). They have instead been found to seek support from complementary/alternative healing such as homeopathy, their social networks and their religion (Amin et al., 2015; Goyal et al., 2015; Hwang et al., 2008; Incayawar et al., 2009; Minhas et al., 2015). Interestingly though, Ashiq's (2017) study shows that as well as her British South Asian female participants being able to clearly articulate and distinguish psychological from physical symptoms, they considered their GP as their first port of call if experiencing mental health difficulties. However, both Ashiq (2017) and Khalil (2018) found that there is a tendency for GPs to offer only medication for such issues rather than referring

to therapeutic services, adding further to experiencing dissatisfaction in services.

Contrary to Ashiq (2017), qualitative interviews with Kallivayalil's (2004) second-generation South Asian women in the US, found that they struggled expressing their distress. They reported it being customary to minimise feelings and accept their family role. South Asian women in Inman's (2006) mixed-methods study also felt an expectation to behave selflessly in order to maintain family peace and harmony, and viewed women as selfish or self-centred if they tried to disrupt this. This raises interest into how South Asian women may therefore navigate having therapy if met with such views from their culture.

Such roles have contributed to South Asian women being stereotyped as submissive, passive, subservient and weak (Patel, 2007; Tummala-Narra, 2013). These labels were further exacerbated from the 9/11 attacks as South Asian men were viewed as "terrorists", reflecting gendered racism (Patel, 2007) where such stereotypes were interpreted as traits and values inherent within South Asian culture. Qualitative research from Chew-Graham et al. (2002) using framework analysis shows that fearing racism within help services influences help-seeking among South Asian women, where such discrimination also contributes to mental health problems (Currer, 1984; Tummala-Narra et al., 2012). This was further supported by Ashiq's (2017) research as her participants feared their therapists potentially holding stereotypical/judgemental views of South Asian woman and therefore were concerned about not being taken seriously.

Yet, Patel (2007) argues that such stereotypes may exist because the concept of ‘strength’ is being viewed from the lens of western culture in defining a ‘strong woman’ and therefore also becomes infiltrated into therapy. For instance, ‘strength’ within humanistic therapy may be seen as achieving self-actualisation (the complete realisation of one’s potential and full development of one’s abilities), and in psychodynamic therapy as developing ego strength or a stronger sense of one’s self, both therefore focusing on individualistic strength. Instead, Patel (2007) states that from the viewpoint of South Asian culture, ‘strength’ can be considered from a more collectivist frame, where maintaining strong emotional family bonds and willingly making sacrifices is considered to require greater strength than an individual only doing what is best for themselves. This somewhat challenges the view of South Asian women as ‘weak’ and implies the importance of viewing South Asian culture without a comparison with western culture. Moreover, it implies the potential difficulty that South Asian women may face when having therapy as they may consider it more important to have to sacrifice therapy or certain elements of it to maintain family harmony.

One may argue however that the sense of self for a collectivist individual is therefore enmeshed with that of the collective. The individual may struggle to establish a sense of their own individuality as encouraged in psychological therapy as they consider their role to be mainly caring for others. However, earlier-thinking scholars (e.g., Lamb, 1997; McHugh, 1989; Mines, 1994) argue against this:

> a view of persons or selves as interconnected with others does not mean that people have no sense of an inner, private self (with distinct thoughts and feelings, not directly known by others), or a sense of themselves as agents who are at least partially responsible for the origins of their own actions. (Lamb, 1997, p. 297)

Ewing (1991) further proposes that interpersonal engagement does not take away from an individual's autonomy and that individuals are aware of their own perspectives and needs whilst negotiating this with the needs of others. This is somewhat supported by Raval's (2009) mixed methods, qualitative research on Gujrati women as her participants actively negotiated conflict between their personal desires and others' expectations. This was done within the parameters of the family structure to take care not to appear disrespectful. Raval (2009) therefore also cautions against rendering the collectivist value of interdependence as signifying intrapsychic enmeshment, and thwarting one's individual sense of self and development/ambition. This implies that South Asian women have the capability to apply the more individualistic characteristics of therapy into their everyday lives, though this may have to be negotiated with aspects of their everyday cultural life.

Yet, Raval (2009) having only researched Gujrati, Hindu women means that the experience is still unknown of how women from other South Asian backgrounds such as Pakistani, navigate their personal desires with others' desires. The women in Raval's (2009) research were also all from an upper caste, alongside

all being married and educated. It is therefore questionable whether the experience of this niche cohort is representative of other women who may not share these same characteristics. Furthermore, upon a closer look at the experience of the women in Raval's (2009) study, their personal desires actually involved attending to the needs and wellbeing of their children and grandchildren rather than their own needs. It seems that South Asian women may struggle to still recognise and encompass their sense of self, instead seeing themselves in the context of a particular gendered role. Markus and Kitayama (1991), although speaking from some time back, present a reason for this: that the needs of others become such a central focus in a woman's consciousness that it is considered as coming from their own personhood, therefore blurring the boundary between personal and others' needs. It may hence be necessary to consider that the meaning systems embedded within one's culture may heavily influence how one develops their personal desires and motivations (D'Andrade, 1984; Strauss & Quinn, 1997).

Accordingly, there appears to be an expectation for South Asian women to fulfil dutiful roles of wife, mother and daughter-in-law. Interestingly though, Indian female participants in Srinivasan's (2001) cross-cultural qualitative study report being expected to adopt the western cultural attitude by having successful and accomplished careers like their male counterparts. Yet, they were still expected to fulfil their traditional household gender roles. This appears to fit with the 'model minority' stereotype largely attributed to South Asians who are considered more likely to succeed academically, economically and socially than other racial groups due to their strong sense of work ethic and obedience

(Gupta et al., 2011; Tummala-Narra, 2013). Although this challenges the stereotype of South Asian women as being ‘weak’, it can create further pressure to conform to this other stereotype. This could deter them from seeking mental health support as this would be considered an admittance of failure in success (Yip et al., 2021).

Yet, the above research introduces the view that such women may continuously navigate varying and contradictory roles where they have more freedom, autonomy and power outside than inside the home, potentially also creating contradictory sense of selves (Tummala-Narra, 2013). Therefore, conflict can arise for such women who are trying to live within both cultures, which Srinivasan (2001) reports can lead to women experiencing pressure and resentment. The above literature’s depiction of South Asian women further indicates that they may find it challenging to accommodate individualism into their lives as their collective role is expected to be given precedence. With regards to actually having psychological therapy therefore, navigating differing cultural contexts may be challenging for South Asian women.

3.5. Experience of Having Psychological Therapy

Research on therapy for the South Asian population has more heavily focused on their experience of barriers in accessing psychological therapy as shown by above research, where only a few studies have sought experiences of actually receiving therapy (Naeem et al., 2015). This current research therefore focused

on the latter to see how this was navigated with everyday life. Tummala-Narra (2013) states that exploratory therapies such as psychoanalytic therapy can facilitate ethnic minority clients to explore aspects and meanings of their culture such as identity more deeply. Supporting this, Guzder and Krishna (2005) state that therapy can create more open dialogue and encourage clients to explore their inner worlds. However, they also argue that it may create upheaval in the lives of South Asian women who tend to be socialised to abide by their traditional gender roles. This is particularly due to the earlier-mentioned criticism that the eurocentric nature of mental health services tends not to acknowledge intercultural differences from which difficulties can arise for collectivist clients (Khalil, 2018; Memon et al., 2016).

Of the little research on experiences of therapy for South Asian women, interesting results are however portrayed: Khalil's (2018) recent UK study found that most of her British South Asian participants had a positive experience of talking therapy, which comprised CBT as well as non-directive, exploratory therapy. All of Khalil's (2018) service users were female, making this research relevant, yet the representativeness of participants is questionable as they were all Pakistani rather than from a mix of South Asian backgrounds. Specifically, participants' initial anxiety/apprehension in accessing therapy dissipated when they understood the role of the therapist and felt genuine care from them. Their initial feelings were influenced by cultural attitudes towards help-seeking alongside unfamiliarity with the therapy process and therefore fearing judgement from their therapist. This implies that bridging the gap in understanding between therapy and clients' cultural perceptions of counselling,

facilitates the therapy experience. Yet, participants were still uncomfortable disclosing family matters in therapy. This indicates the strength of the presence of cultural stigma inherent in discussing family matters outside of the home, which participants carried. Problems were therefore often dismissed or blamed on external factors, presenting a need to keep the therapy setting and everyday life separate.

Looking at the positive experience of participants in more detail though, this appeared to arise from participants experiencing their therapists as being actively interested in their culture or already possessing knowledge about it, which enhanced the therapeutic alliance. Therapy was felt to be hindered when such cultural understanding was not present, as also found by Kalathil et al. (2011). Participants, which included South Asian women, in the latter London-based study further desired family involvement in order to feel better understood and supported, but felt that the eurocentric nature of their therapy did not allow for this as it only focused on themselves. This confirms earlier-presented research and qualitative research by Rathod et al. (2010) who found cultural understanding and awareness to be beneficial in rendering successful therapy outcomes for BAME clients. This supports research which suggests that current mental health services are unsuitable for individuals from collectivist backgrounds (Bowl, 2007).

Nonetheless, there have been further studies noting positive experiences of therapy, including non-directive, exploratory therapy, for South Asians including women (Ashiq, 2017; Kalathil et al., 2011; Netto et al., 2001). In these studies

which have included using thematic and narrative analysis, participants experienced therapy as a safe, confidential space. This enabled them to experience relief and self-empathy by disclosing their emotions; develop greater confidence and self-esteem through recognising their value, self-worth and qualities; and establish more acceptance and control over their lives alongside having better ways to manage their mental wellbeing. Therapy further helped Ashiq's (2017) participants adopt an altered perspective on shame and self-blame, which helped them to further accept having therapy.

The majority of the above research, however, appears to focus mainly on the therapy experience itself rather than the way a South Asian woman's everyday cultural life may have been implicated within this. An aspect of Masood et al.'s (2015) qualitative study provides loose insight into this: they found that engagement with family members made accessing therapy for British South Asian women with post-natal depression easier. These women, who were randomly allocated to the intervention, experienced positive changes to their behaviour and attitude alongside increased self-confidence. However, no feedback was sought from the women who dropped out and who chose not to opt-in to the intervention at all. In conjunction with Goyal et al.'s (2015) study mentioned above, lack of family cooperation may have played a factor in this. This is further supported by participants in Khalil's (2018) study who stated that family and community pressure to uphold family reputation and avoid shame impacted seeking external help. Accordingly, establishing a therapeutic relationship and therapy progress may depend on families' views (Khalil, 2018). Yet, the experience of the drop-out participants in Masood et al.'s (2015) study

would have facilitated confirmation of this, therefore providing insight about potential difficulties South Asian women may face in navigating therapy with everyday life.

Yet, Masood et al.'s (2015) study researched into the experience of a culturally-adapted CBT group intervention, which was not the focus of the present study, and could have therefore produced biased results towards participants' positive experiences as their cultural needs were catered for. Moreover, the definition of having completed the 12-session intervention was given as those participants who attended at least four of the sessions. Only 27 out of the 42 participants qualified for this, of which 17 were interviewed about their experiences. No information was provided on exactly how many completed a significant portion of the programme, and therefore the validity of the results is questionable. Furthermore, all of their in-depth interviews were conducted in Urdu before being translated into English as 15 of their 17 participants were Pakistani/Bangladeshi. This means their sample was not representative of all South Asian backgrounds, alongside not being from a wide geographical area as they were recruited from only two areas in Northwest England.

More definitively, two of Tummala-Narra's (2013) South Asian female psychotherapy clients detailed their experience of negotiating personal autonomy with the greater collectivist value of interdependence, indicating experience of cultural conflict. Psychotherapy appeared to enable them to explore more deeply how to navigate this conflict. Yet, greater challenges in negotiating across western and South Asian cultural contexts were present for

the first-generation compared with the second-generation immigrant client. Neither client nevertheless had to segregate from their collectivist contexts in order to exercise autonomy as was suggested by Bhopal's (1997) research which received criticism for implying that all South Asian family structures are oppressive. Therefore, Tummala-Narra's (2013) cases show that psychotherapy can provide a space where South Asian clients can explore their attributed meanings to differing cultural contexts and any concerns in identifying with these (Guzder & Krishna, 2005).

Nonetheless, Tummala-Narra (2013) herself is South Asian, therefore cultural understanding may have benefitted her clients, and only presenting two cases limits the generalisability of their experience. Furthermore, the details of her case vignettes were only specific to the cultural conflict difficulties that her clients brought from their everyday life that they explored in therapy, rather than looking at this from the lens of cultural difference inherent in the interplay between therapy itself and everyday life. Yet, it does indicate that one may potentially struggle to establish an authentic sense of self when navigating seemingly incompatible/contradictory cultural contexts, which may cause stress. Furthermore, Tummala-Narra's (2013) cases present clients' immigrant status as potentially influencing one's experience of navigating therapy with everyday life as such status alongside acculturation may influence the degree of cultural value conflict experienced.

3.6. Immigration, Acculturation and Cultural Navigation

The below definition of cultural value conflict is provided by Inman et al. (1999):

> an experience of negative affect (e.g., guilt, anxiety) and cognitive contradictions that results from contending simultaneously with the values and behavioural expectations that are internalized from the culture of origin (South Asian culture) and the values and behavioural expectations that are imposed on the person from the new culture. (p. 18)

Individuals who immigrate into a new country undergo a process of acculturation, which is seen as “the extent to which individuals have maintained their culture of origin or adapted to the larger society” (Phinney, 1996, p. 921). Berry et al. (1989) present four ways that ethnic minorities who enter into a host country respond to the new culture: assimilation (culture of origin is dropped and only the new host culture is adopted); marginalisation (associating less with people by breaking ties to both original and new host cultures); separation (continuously identifying only with the culture of origin, so the new host culture is rejected); and integration (both cultures are maintained).

Research on immigrant status and acculturation has provided insight into the experience of managing two differing cultures for South Asian women, which may offer further insight in relation to navigating psychological therapy. Some research shows the presence of cultural conflict when first-generation immigrant, South Asian women attempt to integrate and manage both the

values of their ingrained ethnic culture and those of the new host dominant, individualistic culture (Grewal et al., 2005; Inman, 2006). Other research has more specifically shown that intimate relations and sex-role expectations were affected when South Asian women attempted to negotiate incongruent cultural expectations (Inman et al., 1999; Inman et al., 2001). This was supported by Khan (2002) and Thapan (1997): they highlight that taboo within South Asian culture not just of mental health, but of topics such as sex, creates apprehension for women to express any sexual or autonomous strivings, which are otherwise encouraged within western cultures. This can lead to feelings of isolation when one is unable to discuss such topics within South Asian families (Tummala-Narra, 2013). One may therefore disavow aspects of the self when it becomes too difficult to integrate conflicting cultures, akin to Bromberg's (1996) psychoanalytic theory of dissociative self-states. This thereby supports the notion that South Asian women may find it challenging to manage two differing cultures.

Attempting to navigate two cultures may lead to an individual experiencing conflicting feelings for either or both culture: they may want to engage more deeply with the host culture although not fully immerse into it for fear of losing their original culture (Methikalam et al., 2016). Tummala-Narra (2013) states that first-generation, immigrant women in particular may feel this pressure to ensure cultural connection is maintained within the family. Research supports this by showing that first-generation immigrant South Asian parents tend to believe they are losing control over their children, particularly when the latter become familiar with the culture of the host country. In these circumstances,

parents tend to experience failure in trying to raise their children in a way where they remain close to their cultural heritage (Akhtar, 2011; Tummala-Narra, 2004). They can often compensate by reacting to their child's westernised preferences with anger, monitoring and control in the hope of redirecting their attention to South Asian norms/values (Carolan et al., 2000; Segal, 1991). Specific to South Asian females, Varghese and Jenkins (2009) found that first-generation immigrant mothers were more controlling of their daughters than their own mothers were when in their country of origin.

The above research seems to imply that maintaining one's heritage rather than assimilating leads to better psychological health, especially when seeking an enhanced family life as supported by research (Moghaddam et al., 1987; Ryder et al., 2000). However, interviews with 10 UK-based South Asian women found that they attributed their depression to cultural conflict where they felt distant and ostracised by the host western culture the more that they held onto their original culture (Hussain & Cochrane, 2002). This provides an interesting insight into how South Asian women may experience having psychological therapy alongside their everyday South Asian lives, and whether they also may experience such challenges when navigating both cultural contexts.

Of interest to note however, is how acculturation research often points to immigrants needing to adapt to their new host countries and therefore does not look at the inverse, which sociological research has criticised (Gowricharn & Çankaya, 2017). In the context of the current research, this implies that power lies with western culture. As mentioned above, western values are inherent

within mental health services with slow progress on adapting therapy culturally for clients, indicating existence of power dynamics, which can often marginalise collectivist groups (Burr, 2002; Lamb et al., 2012; Williams et al., 2006).

The above research appears to indicate that first-generation South Asian women may struggle more with navigating differing cultures than other generations as they tend to have a stronger adherence to South Asian norms/values. Platforms such as the media are beginning to show an increasing number of strong, independent, career-driven South Asian women, mostly from the generation beyond first-generation immigrants, who challenge cultural and gender-role stereotypes and therefore may show less adherence to cultural norms/values. Yet, research shows that second-generation South Asian women also experience tension and stress from navigating conflicting cultures (e.g., Bhardwaj, 2001; Bhugra, 2002; Tummala-Narra & Deshpande, 2018). Although conducted on both males and females, Vyas et al.'s (2021) recent qualitative research on second-generation, British South Asians found that they had to move between differing cultural identities depending on the cultural context. This shows that individuals may have to engage in splitting to help navigate differing cultural contexts (Methikalam et al., 2016) as also found by Tummala-Narra et al. (2016). 'Splitting' stems from Object Relations psychodynamic theory (Klein, 1952). The term refers to when aspects of the self are split from one's ego, because they are either feared or considered as bad. This process therefore defends one against experiencing anxiety, which may provide understanding around the splitting of cultural identities when conflicts between the two identities emerge, perhaps making it difficult to integrate both. This

points to individuals potentially having to do the same between therapy and everyday life where they may struggle to integrate both cultural contexts.

Moreover, second-generation South Asians have been found to be at an increased risk of psychosis, which has been attributed to sociocultural factors such as cultural identity, alienation and racism rather than this pertaining to migration itself (Bhugra, 2002; Bourque et al., 2011). Accordingly, this indicates that although first-generation women are more likely to encounter conflicts in relation to communication barriers and loss due to migration, the experiences of stress for second-generation women may differ, particularly due to a potential unwillingness to follow cultural norms/values (Tummala-Narra et al., 2016). Therefore, rather than immigrant status determining one's adherence to cultural values and therefore to degree of cultural conflict experienced, this may be embedded by one's cultural upbringing. This gives insight into the potentially challenging experience of cultural difference for South Asian women across various acculturative and immigrant statuses rather than only for first-generation immigrant women. Therefore, both first- and second-generation immigrant South Asian women were featured in this present research.

3.7. The Gap in the Field

Further research is needed to capture the details of the experience of contextual cultural difference for South Asian women in relation to psychological therapy and how they navigate this as there is scarcity of research in this area.

Since psychological therapy is concerned with self-focus, the interest of this current research was to look into how a South Asian woman experiences therapy and navigates the interplay of this with her everyday life. The importance of this is reflected in Ivey's (1995) statement that there can be an interactional impact of the cultural context and the psychotherapeutic process, which seems necessary to consider. This coincides with Guzder and Krishna's (2005) point that therapists may find themselves caught up in a client's translation of cultural change particularly as, in the case of South Asian women, the family may be urging the latter to maintain their traditional gendered roles. This is supported from research by Kaduvettoor-Davidson and Inman (2012), which shows that the more supportive the family, the less challenging Indian women found it to negotiate their sex roles. This implies the need to account for the system within which a South Asian woman lives, which may not always be as repressive as literature has portrayed it to be, although it proved challenging to find further research that provided a different view. This made it more important for the current research to focus on the voices of South Asian women themselves rather than on the voices of spectators, such as therapists.

Literature providing insight on navigating therapy with everyday life pertains to only a few studies, despite this not having been their main focus. Studies by Ashiq (2017) and Kalathil et al. (2011) found that participants were able to increase open dialogue with their families when having therapy, which helped them to feel better understood and access therapy despite some families taking more time with this. Specifically for Ashiq's (2017) participants, therapy helped them develop understanding of collectivist stigmatised attitudes towards help-

seeking, which enabled them to control how much they allowed it to influence them. One way in which they did this was by only telling people in their lives about therapy on a need-to-know basis, making it easier for them to escape negative judgement and therefore to have therapy. The sense of autonomous selves that participants developed from therapy was furthermore transferred into their everyday lives even though one participant's family did not support this although she realised it would benefit her children more if she cared for herself better. Like Raval's (2009) participants though, this could be seen as Ashiq's (2017) participants still ultimately focusing on others' needs rather than their own, although more so points to this being negotiated.

Furthermore, Ashiq (2017) did not explore the type of therapy her participants received. Therefore, it was unclear how many had had CBT or a more exploratory form of therapy. Participants in Ashiq's (2017) study were also only second-generation immigrants, and therefore lack representation of the experiences of women from other immigrant generations. Similar to other research studies above, only one participant was Indian whereas the others were Pakistani/Bangladeshi, therefore again influencing the representativeness of the sample. Out of Kalathil et al.'s (2011) 27 participants, most identified as members of the black community, thereby also questioning the representativeness of their sample of South Asian women. Subgroup differences among these varying cultures were furthermore not looked into, which would have been beneficial to see the ways that these cultures may differ from one another. Both Ashiq (2017) and Kalathil et al. (2011) furthermore used thematic analysis (TA) to analyse their results. TA can be criticised as not

respecting the individuality of each case as the experiences of all cases are analysed across the whole dataset. Considering South Asian women are underrepresented in psychological research, it feels important for each participant to be analysed individually prior to comparing/contrasting.

Guzder and Krishna's (2005) article may portray a somewhat closer association to the current research. From their few case studies of South Asian women who had exploratory therapy, two cases clearly show the interaction of both therapy and the women's external cultural life, and how they navigated this: one opened up space in her life for a more individualistic way of living, which involved reducing ties with disruptive family members; the other South Asian woman still remained stuck with the latter and negotiated her life accordingly. This provides insight into what it may be like for a South Asian woman to accommodate change in her life from therapy.

However, the four case studies in Guzder and Krishna's (2005) article were based only on Hindu women, three of whom were in Canada. As mentioned above, this current research features women from the UK and from all South Asian communities in order to better represent women from this cohort, where otherwise exclusion could potentially mirror marginalisation from such communities. The current research therefore used a qualitative approach to explore the experience of cultural difference for UK-based, South Asian women in psychological therapy. In particular, it focused on the experience of therapy for South Asian women and navigating the interplay of this with everyday life. This would provide understanding about how South Asian women experience

and navigate the interaction of both cultural contexts, bringing to awareness the experience of the space between therapy sessions, and how this influences their therapy and general lives. The experience both during and post-therapy was investigated. This is as research shows that clients are still impacted by therapy after ending sessions and that recovery is an ongoing process which may involve some setbacks (Ashiq, 2017; Jones, 1978), indicating that navigating and managing this cultural difference is also likely to continue post-therapy.

3.8. Research Aim and Questions

The aim of the current research was to study the experience of cultural difference for UK-based South Asian women in psychological therapy. This research asked the following main questions:

- What is the experience of psychological therapy for South Asian women?

- What is the experience of navigating the interplay between psychological therapy and everyday life for South Asian women?

In addition to the main research questions, the following secondary research question was addressed:

- How does this navigation influence the way that South Asian women lead their lives?

4. Methodology

I will now introduce my chosen methodology: Interpretative Phenomenological Analysis (IPA). The rationale for using a qualitative approach will initially be presented followed by my epistemological and ontological stance, and how this fits the research topic and methodology. I will then detail how the study was conducted. This section will close with a reflexive account of undergoing this part of the research.

4.1. Rationale for Using a Qualitative Approach

Quantitative and qualitative methodologies both reap different types of information/results in research: whereas quantitative methods measure phenomena and analyse cause-and-effect relationships, qualitative methods explore subjective experience (Willig, 2008). The latter appeared more ideal due to the exploratory nature of the present research. Qualitive methodology has also become more popular in multicultural counselling (Ponterotto, 2005) and Counselling Psychology as it uses congruent and empathic skills, which facilitate forming ethically professional relationships between researcher and participants (McLeod, 2003). It therefore appeared important to use such skills to achieve the aim of discovering rich, contextualised and in-depth accounts of participants' experiences, also allowing similarities and differences to emerge between participants (Willig, 2008). Barker et al. (2015) support using a qualitative approach to explore experience in-depth, particularly when the

research phenomenon is novel, as is the case with the current research topic. Willig (2012) further highlights that qualitative research derives meaning and allows understanding of the phenomenon under research, which was the aim for the present study with respect to achieving this from the experience of cultural difference for South Asian women. This emphasises a “bottom-up” characteristic of qualitative methods rather than the reductionist, “top-down” nature of quantitative approaches, indicating that the former methods obtain a description of experience, open for interpretation.

Moreover, the experiences of South Asian women remain rather invisible in psychotherapeutic literature. It therefore felt necessary to adopt a methodology that would allow participants to provide open and extended responses rather than controlled/restricted responses obtained through closed questioning from quantitative methods. The latter otherwise may have paralleled the commonly-viewed controlled/restricted lives that such South Asian women may be socialised into living (Patel, 2007; Tummala-Narra, 2013). For these important reasons, using a qualitative approach appeared a way for these women to breathe into their experiences without any barriers/limitations, allowing greater open expression. Such an approach also highlights the value of one’s lived experience, offering greater understanding into this by hearing personal and deep accounts.

Furthermore, it was important that I chose a methodology that accounted for my reflexive experience particularly due to my ‘insider status’, rather than deny its existence like in quantitative research. Accordingly, I have taken care as far as

possible to be aware of my biases/assumptions throughout this study alongside acknowledge the inherent tensions I experienced during this research, which are explained further below regarding how I managed and mitigated this.

4.2. Epistemological and Ontological Stance

Epistemology and ontology are important philosophical constructs that can guide one's choice of research method (Krauss, 2005). It was therefore important that my perspective on these reflected my chosen approach. Ontology signifies the nature of reality, and lies on a continuum between realism/objectivism and relativism. This compares the existence of one single truth/reality against multiple truths/realities, respectively (Willig, 2008). Epistemology considers the 'grounding' of reality, essentially how it is that we become aware of that reality. This lies on a continuum between positivism (that knowledge can be objectively sought and generalised through testing hypotheses/theories) and constructionism (that reality can be sought through one's perception and specific context). In relation to this present research, it was to look at the relationship between a participant's reality and the researcher's interest in learning about this (Ponterotto, 2005).

Reflecting on my integrative training and role as a Psychotherapist/Trainee Counselling Psychologist, I do not believe that any one therapy suits all. I value individual difference and subjectivity in one's experience of reality, which does not align with a purely realist stance. By listening intently to my clients, entering

into their 'life-world' and attempting to bracket mine as far as possible, it was clear that the beliefs, assumptions and realities of each client never wholeheartedly mirrored that of another. This highlights Willig's (2012) concept that a uniquely different world exists for each individual person that exists. Therefore, although there are underlying experiences and phenomena, different perspectives arise from these, which resonated with personal experiences from my life. My clinical work and personal life have helped me further understand that such varying perspectives are influenced/governed by one's social, historical, cultural and political contexts. I thereby align my stance with critical realism, which highlights that knowledge is contained within its particular context and is influenced by one's perspective (Willig, 2008). As with my clients, I knew that my aim and role as a researcher was to get as close as possible to participants' experiences by entering into, and viewing, their subjective worlds from their lens.

Nonetheless, I was aware that analysing participants' experiences would involve my interpretation. This coincides with interpretative phenomenologists arguing against the possibility of retrieving a purely descriptive experience as some level of interpretation would inevitably occur (Willig, 2012). My therapeutic stance also aligns with this as, through the psychodynamic approach, I attempt to make sense of a client's life-world, involving my interpretation of their experience. Therefore, despite understanding the need to still be acutely aware of how my life-world may impact the research process and interpretation of findings, it reinforced my stance as being that of interpretative phenomenology.

4.3. Interpretative Phenomenological Analysis

The above naturally led me to choose Interpretative Phenomenological Analysis (IPA) as the qualitative methodology for this study. IPA derived from Husserl (1982) who argued against science being the sole originator of knowledge as it can also come from one's personal experience. Yet, Husserl knew of the difficulty in 'bracketing' one's pre-conceptions and life-world to engage purely with the phenomenon in question.

Heidegger (1962) however disagreed that this bracketing was needed to gain knowledge. He instead believed that we exist with respect to our relatedness to-the-world (Smith et al., 2009). Merleau-Ponty (1962) and Sartre (1956) further emphasised that knowledge is contextually-based and therefore interpretative: whereas Merleau-Ponty focused on this being driven by the embodied relationship between individuals and the world, Sartre emphasised the influential context of one's interpersonal relationships. Despite these subtle differences, all three philosophers agreed on the influence of context upon one's worldview. This created the interpretative stance of phenomenology.

IPA obtains understanding of lived experience by engaging with the complexity and context of one's perspectives, sense-making and meanings (Smith et al., 2009). It explores such experience through its three main philosophical underpinnings, which comprise phenomenology, hermeneutics and idiography (Smith et al., 2009). Phenomenology is the study of individual experience and

focuses on the existential perspective of what it is to be human. Rather than seeking an explanation, it emphasises obtaining descriptive knowledge about an experience and its unique meaning. It therefore focuses on retrieving the 'whatness' of an experience in the absence of preconceptions and biases. This occurs through the interaction between researcher and participant (Husserl, 1970), from which knowledge is gained that is 'real' and significant to the individual (Larkin et al., 2006) as it is analysed within their broader historical, social and cultural context (Smith et al., 2009). This sat well with me as I aimed to obtain the immediacy, 'realness' and 'significance' of how South Asian women experienced contextual cultural difference. Accordingly, phenomenological research considers itself to be dynamic, subjective and inductive. It therefore opposes positivist ideology that focuses on an observable, objective and logical reality that can be generalised onto wider society.

Of further importance to me was obtaining South Asian women's interpretation of their experience, essentially how they subjectively understood and made sense of it. This highlights the hermeneutic characteristic of IPA, which acknowledges that making sense of one's experience involves interpreting that experience to construct knowledge. It felt natural to me to agree with Eatough and Smith (2006) that interpreting one's experience is inevitable as we otherwise cannot directly access or understand phenomena. IPA highlights a double hermeneutic quality, which posits that accessing and understanding experience within research happens when the researcher attempts to make sense of the participant's attempt to make sense of their experience. This coincides with both my clinical practice and viewpoint that humans interpret for

themselves what people tell us about how they make sense of an experience so that we can try to understand it. Accordingly, I agree with Finlay (2008) that a researcher inevitably influences the research, yet a reflexive stance and critical awareness of personal bias is needed. I highlight my method on doing this below.

When interpreting experiences, Smith et al. (2009) suggest using Ricoeur's (1970) early ideas to analyse the status of participants' accounts: this is to sit between a 'realistic' and 'suspicious' reading of each account to accept both the details of a participant's experience and search for an interpretation of the structures that may be influencing their account, i.e., to look at what is really happening beneath and in-between participants' words, which I was further drawn to using. Willig (2008) however criticises IPA for its confusion on whether the researcher is "discovering" or "constructing" knowledge. In placing myself as a critical realist, my perspective is that I incorporated both the discovery of knowledge from participants' experiences and constructed it through my interpretation of their experience. As IPA is considered rooted in a critical realist stance, it therefore matches my epistemological position, positing that multiple perceptions about a single reality exist as knowledge is influenced by one's perspective of an experience within a particular context (Willig, 2008). This aligned with the current research study which looked at South Asian's women perspective of a particular phenomenon (i.e., experiencing cultural difference) within a particular context. In effect, this also highlights the need for a homogenous sample in IPA research who have in common the experience of a phenomenon, allowing the possibility of deepening understanding of it.

Finally, the idiographic anchoring of IPA highlights its emphasis on the particular. It focuses on the detailed study of, and gives attention to, an individual prior to comparing and contrasting experiences across individuals. It therefore focuses on the uniqueness of each participant's subjective experience, allowing preservation of distinction in voices rather than producing data that can automatically be generalised. This further drew me towards using IPA for this research considering the way that South Asian women are underrepresented in research. They are also often viewed from an "experience-distant" perspective, which appears to have contributed to literature portraying them stereotypically as subordinate, weak and powerless. By adopting Kohutian "experience-near" descriptions as in phenomenological research (Geertz, 1983; Wikan, 1991), I believe I have invited new narratives to emerge and be given space by closely and directly interviewing South Asian women about their experiences. A strength of IPA then becomes its ability to consider the complexity, novelty and process of accounts (Smith & Osborne, 2008). IPA argues that it studies each particular account to then implement changes and developments to society's laws and structures (Eatough & Smith, 2017). It was therefore my hope that using IPA would both contribute to and critique existing psychological research.

4.4. Consideration of Other Qualitative Methodologies

Prior to choosing IPA, I contemplated using a few other qualitative methodologies. One was Grounded Theory (GT) (Charmaz, 2006), which shares some commonalities with IPA with regards to its inductive approach and systematic method of producing data. It also respects an individual's subjectivity, whilst acknowledging the researcher's actions particularly in the social constructivist GT approach (Charmaz, 2006). However, GT focuses on generating a mid-level analysis and theoretical account of a particular phenomenon whereas IPA focuses on a micro analysis (Smith et al., 2009). IPA therefore appealed to me as I was more interested in obtaining greater detail and nuance into participants' experiences, which was important considering the under-represented cohort of South Asian women in research literature. I considered the construction of a theory using GT as inappropriate for this study as it claims to hold explanatory power. Considering the power processes that South Asian women appear to get caught up in (as mentioned above), I attempted to step away from this and instead look at their experience from a more exploratory level in order to really get to the essence of their experiences, which IPA offers.

Furthermore, creating a theory from data also felt somewhat pathologising of South Asian women's experience of cultural difference. This felt to me as though it might add to assumptions being made about their experiences from a western viewpoint. I wanted to therefore focus on a phenomenon 'as it is' with a smaller number of participants to really highlight subjectivity compared with the larger sample that GT uses. I however somewhat agree with Smith et al. (2009) that IPA research can eventually lead onto a GT research study. Yet, I more so

align with Gjerde (2004) who holds in mind the fluidity of phenomena such as culture which is always undergoing reinvention and is thereby sustained due to the meaning it holds for people. Considering culture was key to this study, I therefore see it as a fluid phenomenon rather than concrete across time, which influenced me to further nullify using GT.

Using Narrative Inquiry (NI) was a more likely option than GT. I considered it powerful to represent South Asian women's experiences as narrative life stories. Its emphasis on the co-created researcher-participant relationship also appeared relational, and respective of power and voicing, adequate for this study's cohort. NI is similar to IPA in the sense that it focuses on the meaning that people attribute to their experiences. Yet, as NI is rooted in social constructionism, it extracts this meaning through, for instance, focusing on the content or structure of stories (Andrews et al., 2000; Crossley, 2000). IPA does this through looking at the experiential features and how these are interpreted by a homogeneous cohort in a particular context. I was thereby less interested in the emphasis being placed on a 'story' and its construction as I felt that my research was asking a different question – one based more on exploring an individual's lived experience. IPA therefore felt like a more flexible method than NI in exploring the range of meaning as it also accounts for the embodied, affective and cognitive aspects of a phenomenon, which I felt would allow me to enter more into participants' worlds.

Finally, Autoethnography (Ellis & Bochner, 2000) and Discourse Analysis (Wetherell et al., 2001) were two other methodologies that I had considered, but

quickly dismissed as inappropriate. However, I still felt it was important to give some space to my reasoning for this. Autoethnography uses the researcher as its main participant to explore and reflexively examine personal experience. Having the lived experience of my research topic due to being a South Asian woman myself and having had exploratory therapy meant that I could have provided a detailed and nuanced account of my experience of navigating therapy with my everyday life. However, using myself as the subject of this research would have meant that I could not anonymise myself nor my family. It therefore felt too exposing and personal a methodology to use as it could not guarantee any privacy. This parallels above literature depicting the importance of privacy within South Asian families/culture. Furthermore, although Discourse Analysis also has a critical realist stance (particularly the discursive psychological approach), it primarily focuses on the specific language that people use to construct and interpret their experience, which was not the sole focus of my research. I was more interested in focusing on the essence of one's lived experience through the meaning/understanding attributed to this, which IPA does by analysing from a linguistic, conceptual and descriptive lens rather than only through language.

4.5. Limitations of Using IPA

Nonetheless, I was aware of IPA's limitations. One is its high level of subjectivity, particularly owing to its double-hermeneutic characteristic. Becker (1996) argues that researchers inevitably provide their own interpretations when

analysing participants' activities whether on an implicit or explicit level and therefore it cannot be avoided. As mentioned above however and detailed below, I have endeavoured to be reflective, open and honest about potential biases/assumptions that may have impacted my interpretations, making reference to these where possible to avoid creating misleading research findings. This required continuous reflection on the research process. I also held great importance to acknowledging and describing *how* I interpreted the data. I documented this in a research diary, alongside have shown my original analysis extracts in this thesis. Yet, I acknowledge that being wholly aware of the impact of all biases/assumptions is not achievable, and that other interpretations of the research data are possible.

Moreover, IPA's idiographic characteristic can mean that findings cannot be largely generalised compared with other methodologies. However, it was not my aim to establish an assumption of what one's experience is, but more so to understand and have greater awareness of individual, personal experience. The same be said for the criticism of using a homogenous sample in IPA research, which also is considered to limit generalisability of findings. The purpose of such a sample is to extract a cohort that closely resembles the phenomenon under study for a niche experience to be understood. IPA therefore does not boast the ability to generalise findings, though it is possible to contemplate what the findings might be for similar cohorts and the potential implications for wider society.

Willig (2008) states that for appropriate accounts of experience to be retrieved, participants need insight into their experience alongside sophisticated understanding and personal strength, which may be challenging in IPA research. The current research may have further fallen short of adequate accounts of experience as I relied on participants' memories, which may have influenced accuracy of recall especially if therapy occurred much earlier in their lives. Despite this, I still took their experiences seriously as I considered that replication of this or similar research may encounter the same problems as well as being applicable to other research methodologies. Similarly, I see Willig's argument as applying to all qualitative research. I also further challenge Willig's limitation as I recently heard a psychotherapist colleague say that "each client is the expert of their own experience". Applying this to research participants, I hold that we rely on understanding phenomena directly from participants and therefore consider them to be a reliable-enough source of knowledge and understanding.

I would further question how one is able to judge what is a 'good enough' level of insight, sophisticated understanding or personal strength from a participant. Accordingly, I am suggesting that a participant who may have said little about their experience perhaps said just as much in their 'not-saying' compared with participants who shared more explicitly. This perhaps comes from my clinical experience of acknowledging the significance and importance of silence, and of non-verbal information in a therapeutic setting. This was particularly important to bear in mind for the current research as IPA assumes a link between what a participant thinks and says. This may not be the case especially in situations

where participants may struggle to verbalise experience due to for instance shame, and may therefore struggle to reflect on their experience (Dallos & Vetere, 2005). Since aspects of shame and stigma are strong in South Asian culture, it was important for me to be aware of this, and therefore interpret also what appeared unsaid or unspoken from participants. It appears therefore that deciphering how much a participant can reflect upon or understand their experience also depends on the researcher's level of interpretation in order to demonstrate this adequately. Yet, this limitation could also be applied to other methodologies and therefore is not unique to IPA. None of these limitations therefore nullified the use of IPA.

4.6. Research Design

The current research study comprised two stages: the first involved me undergoing personal interviews to highlight personal biases/assumptions; the second stage involved using IPA for data collection and analysis.

4.6.1. Personal Interviews

Prior to recruiting participants, I underwent two personal interviews. As I shared participants' collectivist background, these interviews functioned to highlight personal biases/assumptions regarding South Asian culture. This was so I could be aware of and minimise their impact during participant interviews as far as

possible, alongside when devising the interview schedule, analysing the research data and writing up my thesis. However, I acknowledge that complete awareness is not always possible.

The two interviews were conducted separately by a South Asian clinical psychologist and a White British fellow trainee counselling psychologist. I deemed it useful and necessary to have interviewers from both these backgrounds to parallel the two cultures emphasised in the current study. It also enabled me to see how participants may feel being interviewed by me, yet having had a non-South Asian therapist.

Each interview was discussed in depth with my interviewers, which further highlighted my unconscious biases/assumptions (Appendix 10.1.). Intriguingly, our analysis also emphasised my biases/assumptions towards the interviewers. For instance, I assumed that the South Asian interviewer would understand South Asian cultural aspects more than the non-South Asian interviewer. Yet, the non-South Asian interviewer also had a lot of experience and knowledge about South Asian culture, which challenged my assumption that therapists from a different culture would lack understanding of South Asian culture. I also found that I spoke more openly about South Asian culture with the non-South Asian interviewer particularly when discussing family matters, which I felt uncomfortable doing with the South Asian interviewer due to concerns about confidentiality.

I therefore thought deeply about how my presence as an interviewer would impact participants' openness in interviews, and questioned whether someone non-South Asian would be more suitable to conduct the interviews. I settled with interviewing participants myself as I would have otherwise felt distant from the research, which would have impacted my ability to reflect on interviews, instead having to rely on another's reflexivity of the interview process. I also considered myself to hold most familiarity with the research topic and aims, and have greater understanding owing to having a lived experience of the topic, thereby feeling I could more adequately capture what I set out to explore. I therefore agreed with Josselson's (2013) following statement:

> All interviewees are, however, concerned about whether or not you are enough like them to be able to understand them, for this will shape what it will feel like to talk to you. If you and a participant are very different in group membership, then you will have to rely on your shared humanity as a basis for understanding. (p.37)

Yet, I was still mindful about over-identifying with participants due to my insider status, which the outcome of the personal interviews facilitated awareness of. My interviews also helped me understand that although I considered it necessary to encourage participants' narratives, I needed to be mindful and respectful if they did not wish to disclose further information about a certain aspect of their experience.

4.6.2. Sampling and Criteria

IPA recommends using small sample sizes to obtain rich data (Larkin et al., 2006). I interviewed seven participants in total, meeting my intended aim of interviewing six-eight participants, which aligned with IPA's norm lower end of a range of between 1-30 participants (Brocki & Wearden, 2006; Eatough & Smith, 2017).

Inclusion and exclusion criteria were established to meet IPA's requirement of acquiring a homogenous sample by searching for participants who have all shared a particular experiential phenomenon (Smith et al., 2009). Overall, the sample required participants to be a South Asian woman based in the UK of at least 18 years of age, and have completed a minimum of 12 sessions of individual therapy with a qualified, non-South Asian therapist.

The criteria to have had completed a minimum of 12 psychological therapy sessions was for participants to have had the time and space to process therapeutic material, alongside see how it may have impacted/influenced their lives. Participants had to have completed a form of individual, exploratory therapy (e.g., psychodynamic, humanistic and/or integrative therapy as opposed to systemic or marriage therapy) with a qualified therapist. Those who had psychotherapy for psychotic presentations were excluded as their treatment was likely to have focused around symptom management rather than the exploratory aspect of their therapy. I therefore also further excluded participants that had a solely structured form of therapy such as CBT as it often lacks depth

and exploration, and is more researched than exploratory therapies as mentioned above.

The requirement of a non-South Asian therapist was a carefully considered criterion to obtain the research aim. It functioned to increase the chance of participants having had therapy based on more eurocentric values as per the focus of this research. It also avoided making the ethnic difference between therapist and client the focus of this research by having participants who only had non-collective therapists. Having had a criterion of non-collectivist therapists would have further assumed that such therapists are only trained in a western model. During initial phone conversations with participants to check they met the study criteria when they got in touch with me (Appendix 10.2.), details of therapists' ethnicities and the nature of their therapy were sought. From participants' perspectives, it was established that they were offered a form of western, individual exploratory therapy.

I chose not to limit how long ago participants had their final sessions. This was because therapy itself was not the only focus as this research also looked at the lives external to therapy and therefore was not relying solely on participants' memory of their therapy, but the process more broadly. I also considered that having therapy would be a salient life experience as individuals seek it in a time of need and are likely to remember the majority of it. My arguments on this point were supported by previous research (Martin & Stelmaczonek, 1988) which found that clients remembered more than 70% of significant events from their therapy after a period of six months with considerable accuracy, despite only

40% being allocated to a precise session. Whilst accounting for potential reconstruction in memory, I felt that participants would be able to recall their psychological journeys with enough efficiency required for this research.

Due to the qualitative methodology adopted in this research, participants needed to understand and speak a good level of English. This was to prevent the meanings of their narratives being lost through translation (Temple & Young, 2004), allowing me to capture their experiences as accurately as possible. Whilst I acknowledged that one's mother tongue could have added richness to the data, I felt that translation would have involved another level of interpretation that would have added further complexity to this research. This criterion also ensured that participants clearly understood the nature of the research. All the above criteria ensured that a purposive, homogenous sample was recruited, although I acknowledge that achieving complete homogeneity is difficult.

4.6.3. Recruitment

To facilitate participant recruitment and in acknowledging the issue of privacy and confidentiality inherent within South Asian culture, I advertised widely. I produced and emailed a research flyer (Appendix 10.3.) alongside provided further information about myself and the study to inner and greater London counselling/psychotherapy organisations, and to UK-based South Asian social media groups (Instagram and Facebook). Considered effective in IPA research

(Smith et al., 2009), I also used opportunity (personal contacts referring participants) and snowballing (recruited participants referring other participants) methods, which proved largely ineffective. A total of 55 of the 36 counselling/psychotherapy organisations, 39 social media pages, and 28 personal and professional contacts agreed to support me with recruitment, from which I obtained the seven participants who met the study criteria. All participants were from either inner London or just on the outskirts of London. An additional participant decided to withdraw from the research after her interview without providing a reason. All participants spoke good English and also spoke additional languages such as Punjabi, Urdu and Hindi.

Five more potential participants contacted me although did not meet the criteria. I was mindful and sensitive with how I 'turned them down' by highlighting the criteria on the research flyer and further detailing the purpose of the research alongside thanking them for their interest. These five women were understanding and commented on this research being extremely interesting and worthwhile, wishing me the best of luck. All in all, recruitment began in September 2019 and ended in June 2020.

4.6.4. Participants

The seven participants were UK-based, adult South Asian women. Demographic details are shown in Table 1.

Table 1

Participant Demographic Information

Participant Pseudonym	**Age**	**Ethnicity**	**Immigrant Generation Status**	**Therapy Length / Total Therapy Sessions**	**Last Therapy Session**	**Type of therapy received**	**Therapist Ethnicity**
Ravinder	64	British Indian	First generation	3-4 months	August 1996	Bereavement Counselling	White British
Nazia	40	British Pakistani	Second generation	6 months	2015	Exploratory Psychotherapy	White British

Jasmine	26	British Indian	Second generation	8 years	2015	Exploratory Counselling	White Irish
Shivani	44	British Indian	First generation	2.5 - 3 years	Dec 2019	Exploratory Counselling	White European (Swedish)
Khadija	34	British Pakistani	Second generation	1.5 years	2017	Exploratory Counselling	White British
Fatima	37	British Pakistani	Second generation	1 year	August 2019	Exploratory Counselling	White British
Sabina	26	British Bangladeshi	Second generation	12 sessions	2019	Exploratory Counselling	Black British

4.6.5. Interview Schedule

Following personal interviews, I created an interview schedule to conduct semi-structured interviews with participants as recommended by Smith et al. (2009). This interviewing format allowed flexibility with questions including asking follow-up questions, which added to greater detail, depth and richness to the data. Questions in the interview schedule reflected the order of the research questions. Prompts were included in case participants struggled with a question, which functioned to further obtain relevant detailed information. Interview questions were discussed with my Research Supervisor to ensure clarity and familiarity with them, alongside checking phrasing for biases/assumptions and for any expectations that I may have had about outcomes (Farr, 1982).

I subsequently piloted the interview schedule on my initial participant. This was an opportunity to see whether the questions elicited material that answered the research questions, and in turn whether I could flexibly diverge from the questions and be participant-led. I produced a revised interview schedule (Appendix 10.4.) following discussion with my Research Supervisor about the initial interview. This provided learnings about reflexivity and the schedule itself such as the need to focus the interview questions more closely on the research topic. My Supervisor and I agreed to include the initial interview in the research as it still provided a detailed and insightful response to the research questions. Ethically, the initial participant was already informed about this process in a sensitive manner, which she agreed to prior to consenting to participate.

4.6.6. Interview Procedure

Following initial telephone calls with participants to confirm they met the study criteria and were interested in participating, I emailed them the participant information sheet (Appendix 10.5.) and confirmed the agreed time/date and venue of their interview. The first four interviews occurred face-to-face in a venue of participants' choosing. If they did not have a private space, I offered the option of holding interviews at either Metanoia Institute, the Centre of Counselling and Psychotherapy Education (CCPE), and an East London Osteopathic clinic, which I had prior secured. I purposefully chose venues that spanned across London to make it easier for participants to travel to depending on their location. Two participants opted to hold their interviews at Metanoia Institute; the third at CCPE; and the fourth in her home. Due to the COVID-19 pandemic, the fifth interview occurred via video consultation and the last two via telephone.

Before meeting each participant, I familiarised myself with my biases/assumptions uncovered from the personal interviews. This was to give me a better chance of recognising and bracketing them if they became activated during participant interviews. Prior to starting each interview, I invited participants to ask any questions they had about the information sheet or otherwise. Participants were then asked to sign a consent form to confirm they understood the purpose of the research, what was required of them and that

they were happy to participate (Appendix 10.6.). I then asked them to complete a demographics form (Appendix 10.7.). For remote participants, I emailed all the above documents, and asked them to complete and return the consent form alongside the demographics form before the interview took place if they were happy to go ahead. These participants were also given the opportunity to ask any questions beforehand. Semi-structured interviews were then conducted with each participant and recorded digitally.

After each interview, I informed participants that I may ask for a follow-up interview (as written in the participant information sheet) in case I needed further information/clarity on aspects of their interview after listening back to recordings. Only the last two participants required this, which they were happy with. I was aware of contention within research literature around holding a second interview, and held in mind the arguments both for and against this (e.g., Clare, 2002; 2003; Eatough & Smith, 2017), although wanted to ensure that I obtained full accounts from participants. Second interviews purposely occurred within two weeks of the initial interview to minimise alteration in narratives. This resulted in nine interviews altogether, which complemented Smith et al.'s (2009) recommendation of conducting between four-ten interviews (compared with number of participants) for a doctoral level research project. All interviews were between an hour and a half to just under two hours in length (including merging the two interviews for the last two participants). I emailed all participants to thank them for their participation following each interview. I subsequently wrote reflective notes in my research diary to help me process each interview prior to analysis. This included noting important non-verbal

communication from participants, reflecting on my subjectivity regarding how each interview impacted me, and being open about activation of potential biases so I could be mindful about them during analysis.

4.6.7. Transcription

I listened back to recordings to transcribe each interview, which included numbering all transcript lines (Smith et al., 2009). The transcripts comprised every word that participants verbally said alongside any mispronunciations and repeated words/phrases. Emphasised words were underlined, and square brackets were used to identify any laughter, emotion (including sighs) and significantly long pauses. Short pauses of a few seconds were represented as two or three dots. Although infrequent, any words/sentences that participants said in their mother tongue were transcribed phonetically followed by the English translation in square brackets. All of the above seemed important to include so the reader obtains a true sense of participants' experiences and a greater feel of their inner world. Any mention of participants' names during interviews was removed, including any names of people that participants mentioned, which were instead replaced with the nature of the relationship with the participant.

Once transcribed, I listened to each interview recording again to check transcription accuracy. I then emailed all participants their transcripts to check through alongside gave them the opportunity to change anything they wanted

before analysis. This functioned to allow participants to feel involved in the research process as far as possible and to have some control over the content. Only one participant did not respond back to me despite several attempts to contact her. I spoke with my Research Supervisor and the Head of Research at Metanoia Institute about this as a potential ethical issue. They advised me to use the interview as the participant had not withdrawn from the study and had initially expressed her consent to participate in the research.

4.7. Analysis

Although IPA does not present a singular way of analysing data, there are common steps across IPA research. I used the guidelines by Smith et al. (2009) to analyse the interviews although varied this slightly to suit my optimal way of working as described below. The main variation was that I chose to use a computer to conduct the majority of the analysis, which I found more manageable considering the volume of data.

4.7.1. Re-listening and Re-reading

Initially, I listened to each interview recording and read through its transcript at least twice. This brought me closer to the life-world of each participant. I became aware of and understood the flow of each narrative alongside imagined

myself back in the interview, thereby immersing myself in the interview atmosphere, which also gave me another opportunity for reflection.

4.7.2. Initial Commentary

The second stage of analysis comprised writing detailed notes in the right-hand margin from the interview transcript (Appendices 10.8. & 10.9.). These captured the descriptive, linguistic and conceptual aspects of each transcription line. Although typical of this stage, I was mindful to what extent I applied western psychological concepts/theories with which to interpret the data in order to be culturally sensitive in light of the research topic. Notes were made on both verbal and non-verbal iterations to show expressed points and the meanings they held, which included highlighting distinctive, emphasised words/phrases and emotional responses. Furthermore, I focused the commentary on both the particularity of each transcript line and its context in the entire transcript in order to obtain a true sense of participants' experiences (Smith et al., 2009). I looked over the initial commentary and included any other aspects that I felt had been missed. I also highlighted in green any comments that I felt reflected personal biases/assumptions in order to then interpret participants' experiences more closely. I also checked the commentary from the initial interview with my Research Supervisor who agreed with the content, except for the green highlights of my biases as my Supervisor felt those comments came from the participant's experience. I, however, kept the highlights to be cautious.

For the first two interviews, I followed Smith et al.'s (2009) recommendation of analysing each transcript in its entirely before moving onto the next one. However, I found this did not suit my bottom-up information processing approach and was negatively impacting the detail of analysis. I therefore chose to write the initial commentary for all interview transcripts before moving onto the next analytic stage. Although one could argue that this may have impacted the idiographic nature of each interview, I mitigated this by including at least a day's gap between moving to the next transcript as well as re-listened and re-read over the next interview and its transcript to enter back into the next participant's world. This allowed 'bracketing' of commentary from the previous transcript, allowing new commentary to emerge from the next transcript, thereby capturing the essence of each participant's experience.

4.7.3. Emergent Themes and Clustering

I then transformed the initial commentary into emergent themes in the left-hand margin from the transcript (Appendices 10.8. & 10.9.). This began the process of data reduction to get to its essence. I did a sense-check on these themes by reading back over the exploratory comments and the transcript, and also again looked for any potential bias to then revert to interpreting participants' experiences more closely. I subsequently copied the themes into a Microsoft Excel spreadsheet to begin clustering into subthemes. I clustered using abstraction (putting like with like), subsumption (an emergent theme itself becomes a subtheme as it brings together other emergent themes),

contextualisation (looking at the context/narrative elements, which felt particular to this study) and numeration (theme frequency). Themes that only appeared once were omitted. Due to each interview's length and my limited experience with IPA analysis, a vast number of subthemes were produced. These were further clustered until a final set of subthemes and superordinate themes was sought. This whole analysis stage was then repeated for each subsequent interview transcript (Appendices 10.10. & 10.11.). I ensured that I re-read the initial commentary for each subsequent interview prior to this in order to enter into the lifeworld of the relevant next participant.

4.7.4. Searching for Patterns Across Participants

The final stage of analysis involved creating a table of all subthemes and superordinate themes sought for each participant, which I printed out to search for commonalities among them (Appendix 10.12.). I decided that for a theme to be taken forward to the final stage of analysis, it needed to be present for at least half of participants rather than for all. This met Smith et al.'s (2009) recommendation of looking at the importance of recurrent themes across cases to ensure credibility of findings. An overall table of subthemes and superordinate themes was subsequently achieved (Appendix 10.13.), which were given appropriate titles and were supported by quotes from participants (Appendix 10.14.) to ensure that they pertained to the research questions.

The analysis occurred over a period of a few months. I kept in mind Smith et al.'s (2009) caution against developing mostly descriptive themes by positioning myself between a 'realistic' and 'suspicious' reading of the data (Ricoeur, 1970; Smith et al., 2009). This mirrored Halling's (2008) concept of 'disciplined spontaneity', which encourages researchers to adopt both structure and freedom to ride with the data wherever it may take the researcher, including to unexpected or uncertain/ambiguous areas. Yet, considering the subjective nature of interpretation, I acknowledge that different themes may be sought by different individuals, thereby highlighting there being more than one way to analyse the data. Nonetheless, I emphasise the validity of my interpretations.

4.8. Trustworthiness

I measured trustworthiness of the current research and its findings using Yardley's (2000) guidelines as recommended by Smith et al. (2009). I demonstrate below how I applied these to suit IPA research.

4.8.1. Sensitivity to Context

This initial guideline acknowledges the importance of context in qualitative research. Throughout this study, I have attended to the sociocultural context by, for instance, linking to theories and literature in relation to South Asian and western culture. Simultaneously however, I have carefully avoided being

influenced by these theories and instead kept an open mind to other interpretations that arise to allow new understandings to emerge. I demonstrate this in the literature review through my arguments against the stereotypes of South Asian culture, alongside in the analysis and discussion where I have diverged from what is 'known out there'. This has been supported by verbatim quotes from participants in the findings section.

This guideline further encourages consideration of both the researcher's and participants' social and cultural contexts. I have attempted to be transparent about this in the reflexive sections of this thesis and in the above ways that I have described trying to be aware of, and minimise, the influence of my biases/assumptions in relation to South Asian culture, especially due to my insider status. Meetings with my Research Supervisor and a Clinical Psychologist were also used to address any potential biases/assumptions inherent in this research including in participant interviews and interview questions.

Furthermore, I asked participants during their interviews what they meant if they used cultural terms, and gathered more information about their experience of any cultural phenomena they named. This facilitated obtaining greater insight into their personal narratives rather than assuming a shared cultural understanding as each participant may have had a different cultural experience than myself. I was also transparent with clients about the nature of the research and their understanding of this. Accordingly, participants were aware of the nature of a researcher-participant relationship as opposed to speaking to

another ‘fellow South Asian woman’ in a ‘friendship’ or ‘teaching’ style manner. Nonetheless, I have shown reflections in this thesis of how my presence in participant interviews may have impacted the process. Having kept a research diary since the start of the research process allowed me to identify and acknowledge any countertransference, reflections and assumptions which became activated and implicated into the research, further facilitating reflexivity.

4.8.2. Commitment and Rigour

According to Smith et al. (2009), ‘commitment’ refers to how attentive the researcher is to each participant during the data collection stage and how much care is shown when analysing each piece of data. During participant interviews, I used clinical skills such as empathy and reflection to ensure participants felt heard and listened to, relaying that their experience was important and meaningful. The significant amount and sufficiency of data collected also demonstrates rigour.

Commitment and rigour were moreover shown in the significant amount of time I spent analysing the data at a sufficient interpretative level, ensuring it was not ‘too basic’ (Smith et al., 2009) yet that my comments were grounded in the data. Being my first experience of using IPA, I was also proactive in understanding and familiarising myself with it: prior to data collection, I watched educational research videos about IPA; attended an IPA lecture by John McLeod; and attended a Research Network Conference held by the organisation Heron.

Furthermore, to check all stages of my analysis of the transcripts, I sent two transcripts from different participants to my Research Supervisor, a Clinical Psychologist who specialises in IPA research from the Anna Freud Centre, and to a second Clinical Psychologist who was one of my personal interviewers. All three clinicians provided positive feedback alongside guidance to further enhance my analysis. Using this, I checked back over the rest of the interviews to ensure a fuller analysis. My Research Supervisor and one of the Clinical Psychologists also checked the final themes to see if they were sound and answered the research questions, which they both agreed with.

It was also important that participants felt part of the research process. As mentioned above, I emailed participants their transcripts in order for them to check for accuracy and whether they were happy for all of it to be analysed. Following analysis, I sent participants the interview verbatim that would be used in the findings section in order to again check if they were happy with this. This allowed participants to have a sense of control over their content rather than feel 'used' by, or isolated from, the process.

4.8.3. Coherence and Transparency

This third guideline reflects the need for research to be persuasive in constructing a reality and being transparent about the research stages in the thesis write-up. I believe that I created a strong relationship and 'fit' between the

research topic, the epistemological stance and the methodology utilised as explained above.

Regarding transparency, I kept a clear record of all research stages, especially the data analysis, which includes annotated transcripts and emerging themes. This would allow anyone reading this thesis to follow these steps to understand how this study was conducted. Providing this dense description also ensures that the research findings are transferable to other contexts. Presenting annotated transcripts for more than one participant in the appendices shows that all transcripts had the same analytic depth. Accordingly, I argue against the criticism that IPA research has to rely on a reader's trust that the data is genuine and has been adequately analysed.

Moreover, I have included transcript verbatim in the findings section to support my interpretations and provide evidence for the themes sought. This would further enable readers to establish a closer relationship with the phenomenon under investigation (Halling, 2002). Transparency has also been upheld by detailing my experience and motivations for undertaking this research in my research diary, which I have also written about throughout the thesis.

4.8.4. Impact and Importance

This final guideline denotes that research should be impactful and important, not just because of what it has potentially repeated, but also to the field of

research itself. I believe I have formed new understandings about this current research phenomenon that were not previously known, thereby adding knowledge within society. This invites meaningful consideration within clinical practice, particularly when working with South Asian women alongside clients from other collectivist cultures who may access mental health services. Therefore, I believe that this research emphasises the great need for professionals to be aware of how navigating the interplay between therapy and everyday lives can impact both contexts for clients, ultimately linking research to practice.

4.9. Ethical Considerations

4.9.1. Ethical Approval

I obtained ethical approval for this research from Metanoia Institute's Research Ethics Committee (Appendix 10.15.) following submission of my research proposal. Throughout the research process, I have attended to ethical implications by following the British Psychological Society's (BPS) Code of Human Research Ethics (2018), and the Health and Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (2016).

4.9.2. Informed Consent

Participants were informed about the nature of this research at several stages including from the advert/flyer, the initial telephone consultation, the participant information sheet and before interviews started. At each of these stages, participants were invited to ask any questions. Before interviews began, I verbally checked with participants if they were happy for interviews to be recorded, which was also written in the participant information sheet and in the consent form which all participants signed (Appendix 10.16.). I informed participants that I would be using two recording devices in case of any technological issues.

As mentioned further above, although I had sent all participants their interview transcripts and verbatim to be used in the write-up to check if they were happy with the content, one participant did not respond back to me about either. This was despite my attempts to call, email and leave voicemails for her. As I was unsure whether it was ethical for me to continue to analyse her material for the purpose of the research, I sought advice from both my Research Supervisor and the Head of Research at Metanoia Institute. The latter advised that since the participant had not formally withdrawn from the study and had initially given her informed consent to participate, it would be fine to proceed with including her data in the research.

4.9.3. Withdrawal

Alongside written in the participant information sheet, I verbally informed participants that they have a right to withdraw from the research at any stage and did not need to provide a reason. I offered this flexibility to prevent creating any power dynamics between us if a restriction was in place.

Moreover, I chose not to offer any gift vouchers/money in exchange for participants' participation to further prevent creating any power dynamics between us, and also for it not to feel like a 'business' transaction. I instead showed that I valued their participation in a more humane way, i.e., through listening intently to their experiences and engaging them in the research process. I was also mindful that most participants commented on how the interview process helped them reflect further on their own therapy journey, and that they could see the significance of this research with regards to benefitting other South Asian women within mental health services. It therefore felt further incongruous to offer participants money in exchange for their participation as it seemed that this would be outweighed by the contribution they felt that their participation was potentially going to have on the psychological field.

4.9.4. Anonymity

I assured participants' anonymity as Smith et al. (2009) argue that assuring confidentiality is inappropriate as it implies that the data will not be seen by anyone. I used pseudonyms in all written documents, and altered any identifying information about clients and others they may have mentioned in

their interviews. Participants were also able to check any identifiable information in their transcripts and write-up verbatim. This seemed important for this client group in order to respect, and be sensitive to, the norm of privacy inherent in South Asian culture. One could argue that it may have seemed more powerful to attribute recognition to these women who participated in the research, for instance as co-authors, especially as South Asian women are often underrepresented and marginalised in the field. However, it was made clear to me during the interview and analysis stages that assuring anonymity was more important to participants than such recognition. For instance, one participant specifically asked me not to include someone that she mentioned in her interview within my write-up as she felt that if I did, then readers would automatically know who the participant is. Therefore, it felt important to me that I listen to any such requests of privacy from participants and ensure that I protect their livelihoods on ethical grounds.

Furthermore, all forms including demographic and signed consent forms alongside audio recording devices were kept in a locked cabinet. Transcripts, their analysis and interview recordings were held on a password-protected computer to which only I had access. Audio recordings and transcripts will be destroyed after five years of submitting this research in accordance with the Data Protection Act (2018) and General Data Protection Regulation (2018).

4.9.5. Potential Distress

During participant interviews, I remained consciously aware of, and sensitive to, any potential distress evoked within participants. Three participants became emotional, following which I showed empathy for the difficult aspects of their experiences which triggered emotion. I also offered them the option to stop the interview and recording to give them time to gather themselves, and to let me know when they were happy to recommence. I further encouraged participants to have a glass of water and tissues in case needed. At the end of each interview, all participants were debriefed and asked how they felt to check for any negative impact. I provided all participants with a list of signposting therapeutic support services (Appendix 10.17.) that they could approach if they felt affected by any aspects explored in the interview.

As the research topic also paralleled my experience of being a South Asian woman who had exploratory psychological therapy with a non-South Asian therapist, I was mindful of the impact that the research process was having on me. I was, for instance, aware that some aspects of participants' experiences differed to mine where I had assumed they would most likely be the same. These unexpected findings at times created reactions of surprise and even loss/sadness within me. It therefore felt important that I engaged in sufficient self-care throughout the research process. I did this by discussing such reactions with my Research Supervisor alongside journalling them in my research diary. This helped me to be continually mindful of staying open to differences in experience whilst reflecting upon my personal journey of therapy.

4.9.6. Impact of Context and a Shared Background

I was mindful that participants may not wish to disclose certain information during interviews. This was perhaps due to them being wary of potentially damaging family honour and fearing judgement due to negative stigma around mental health within collectivist cultures. Alongside monitoring participants for any signs of such discomfort, I encouraged them to share information only appropriate to the research topic/questions and emphasised anonymity. All participants were very open apart from one when discussing a certain aspect, which I handled sensitively.

I also considered that sharing cultural background with participants may have impacted their openness due to worries about being from the same community and concerns around confidentiality, as highlighted from my own personal interviews. This occurred with only one participant who I assured that I too am bound by the ethical code of conduct and confidentiality, and that my purpose was to ensure their safety and wellbeing throughout the research process. Although it did not arise, had any participant still wished not to disclose specific information, I would have respected their wishes and made a note of this for my reference. Moreover, participants and I agreed on how we could behave towards one another if we were to cross paths outside of the research context.

I actually found that sharing cultural background with participants significantly facilitated openness about their psychotherapeutic experience as shown by the length of interviews. Participants may have assumed that I understood their

viewpoint especially regarding South Asian cultural norms/values, and they may accordingly have been more open to also disclosing any negative experiences of psychological therapy. Participants may have also had hope that sharing their experiences with another South Asian woman in the counselling psychology and psychotherapy field would create positive change to the way therapy would be provided to other South Asian women as a result of this research.

However, the impact of participants' assumption of a 'shared experience' may have been them not feeling the need to expand on points they assumed I would know about. Perhaps they also wanted me to agree with and validate their experiences in the hope of feeling less isolated in their experience if this was how they felt. I attempted to alleviate this by informing all participants before their interviews that I may know of particular cultural experiences they might mention, but that my personal experience may differ to theirs, and therefore I will ask further into their individual experience during interviews, which I indeed did rather than assume generalised experiences.

4.10. Methodological Reflexivity

4.10.1. Personal Experience

Growing up between western and South Asian culture, I experienced some degree of South Asian cultural restriction as I fell privy to the path of obedience

and pleasing South Asian others. I did so to avoid creating difficulties around shame and honour that I saw others get caught up in. To some degree, I am grateful for this path as it enabled me to maintain self-respect and dignity even for myself, although I knew I needed to be careful about this personal view within this research. As therapy enabled me to break-free of cultural restriction, I wanted this for other South Asian women especially in my life. However, I realised I was vicariously trying to create this change through this present research. My personal interviews helped me become more aware of this as I then became conscious when such views were activated such as when participants did not experience a significant shift in their relationship to South Asian culture from therapy. I was mindful of my countertransferential reactions, which helped me bracket them during interviews, allowing difference in experience to emerge.

4.10.2. Interviews

'Cultural restriction' was something my Programme Approval Panel also invited me to consider as a parallel with respect to ensuring that no element of this research appeared 'restrictive'. I realise now that perhaps this stemmed from a westernised stereotypical viewpoint of South Asian norms. Yet, at the time, devising the interview schedule was challenging as I bore this in mind, which led me to create a schedule that was too broad as evidenced by the first interview going off tangent a few times. Yet, it was also perhaps influenced by an activation of the South Asian age hierarchy as I felt young in the present of a

much older female, which seemingly created a power imbalance between us that I struggled to recuperate at times.

I experienced difficulty in using the appropriate phrasing of language to settle on a revised interview schedule, which reflected my anxiety about 'getting it wrong' and misrepresenting South Asian women. I therefore felt a parallel process of South Asian gender dynamics as I felt I was carrying everything for the 'other', yet perhaps also a fear of being misunderstood and 'not seen'. Explicitly naming this in my research diary however helped in then revising the interview schedule. Although this produced more focused interviews, I still at times questioned whether interviews were 'good enough' perhaps also owing to being a novice researcher. I sought solace from my Research Supervisor's confirmation that interviews were answering the research questions. However, I also increasingly gained confidence with the interview process, which meant I used the schedule quite flexibly. I therefore found myself progressively adopting Kvale's (1996) stance of "wandering together with" (p. 4) participants, holding in mind that they are the "experiential expert" (Smith et al., 2009, p. 58), thereby putting less pressure on me, and more power to and trust in participants.

4.10.3. Analysis

Although I thoroughly enjoyed the analysis stage of the research as it mirrored my therapeutic stance, it was perhaps the most challenging. I felt increasingly uncomfortable with each analytic stage as it seemed I was going further away

from participants' experiences. However, by seeking supervision and reading Smith et al.'s (2009) IPA book, my feelings were validated as I understood this was part of the data reductive and interpretative process, which would eventually reflect participants' experiences, especially when adding verbatim into the findings section. On an unconscious level, I think I was worried about taking over participants' experiences. I realised that I needed to instead be the person to represent this as accurately as I could, whilst also reminding myself that I was involving and empowering participants in the research by inviting them to amend their interview transcripts. I also sought comfort from participants' comments of being thankful of the interview process as it enabled them to reflect over their therapy journeys, which they said they now understood better in conjunction with the experiences of their everyday life. This enabled me to also shift from feeling like I was intruding on participants' experiences to now respecting and honouring them.

Nonetheless, I felt the analysis stage needed a heightened awareness of my biases/assumptions. For instance, during and upon checking my analysis, I caught myself at times making westernised stereotypical interpretations by using words such as "restrictive" and "subservient", which I reworded to instead interpret participants' experiences more accurately. It therefore felt at times like I was fighting against western culture as holding the cards in defining 'strong and empowering' behaviour from participants' experiences. This was interesting as it seemed to parallel the growing part of me that was beginning to resent just how 'westernised' my clinical training and personal therapy had made me, especially as I realised from analysing their interviews that most participants still respected

South Asian culture after having had therapy, which was not my personal experience. By acknowledging such realisations and activation of biased views through entries in my research diary and discussions with my Supervisor, it facilitated me to acknowledge, challenge and alter some of my analysis.

Although I acknowledge that complete awareness and bracketing of personal biases/assumptions is not possible, by bringing awareness to these through my personal interviews, during coding and via my Supervisor and colleagues as mentioned, I attempted as far as possible to address these, allowing knowledge to be obtained that was closer to participants' individual life-worlds.

5. Findings

The above stages of analysis reaped a large amount of data, which led to the below overall master themes and subthemes in Table 2. Participants have been referred to by their pseudonyms. The considered selection of quotations used show each participant's voice and a consensus among their individual experiences (underlining in quotations reflects emphasised speech). Themes with a wider range of quotations reflect greater difference in experience among participant accounts compared to those themes that have fewer quotations where the experience was more shared/similar. In order to further demonstrate trustworthiness of the latter similarity in experience, I have produced a table of fuller participant quotations for each theme (Appendix 10.14.).

In writing this section, I have focused on participants' lived experiences and on interpretation of participants' experiences alongside the associations between these. Of further importance is the presence of overlapping between subthemes. Smith and Osborn (2008) encourage being aware of both convergence and divergence as an aim of IPA analysis. Throughout the analysis stage and writing of this section, I have been consciously aware of the potential need to combine such subthemes if not enough exclusivity emerged between them. Despite some overlap, I came to the conclusion that these themes were sufficiently distinctive and were placed under the most appropriate master theme that reflected participants' interpreted account. I would also implore the reader to bear in mind that there will be connections among themes, which to me, parallels the collectivist-individualist paradigm.

Table 2

List of Master Themes and Subthemes

Master Theme	**Subtheme**
1. Negotiating Self and Other	1.1. Therapy as Space for the Emotional Self
	1.2. Recognising Individuality
	1.3. Negotiating the Collective Role
	1.4. Integrating Collective Support to Facilitate Struggle with Individualism
2. The Challenge of Power Dynamics	2.1. Enactment of Power Dynamics within Therapy
	2.2. External South Asian Power Dynamics as Influencing Change
3. Finding a Sense of Belonging	3.1. Negotiating a Torn Cultural Identity
	3.2. The Pursuit of a Similar Tribe
4. Breaking Barriers	4.1. Challenged Acceptance of Therapy
	4.2. Encouraging Others into Therapy
5. To Share or Not to Share	5.1. Negotiating Openness in Therapy
	5.2. Negotiating Openness About Therapy

5.1. Negotiating Self and Other

This first master theme focuses on the way participants appeared to negotiate focusing on themselves and others through their therapy journeys. In particular, it was on the extent they felt able to develop and exert their own individuality alongside utilise more individualistic ways of managing their difficulties within and outside of therapy compared with more collectively-based focuses. Therapy provided a space for participants to consider their individual emotions, which they felt unable to do in their everyday lives. This seemed to allow them to

recognise themselves and others as individuals rather than only being part of a collective, leading them to want to exercise more self-focus in their everyday lives although this involved negotiation with focusing on others. Most participants also struggled relying only on themselves to initiate and maintain change outside of therapy, instead turning to cultural and collective forms of support either during or post therapy.

5.1.1. Therapy as Space for the Emotional Self

This subtheme looks at how all participants appeared to experience therapy as a place where they could express their emotional selves. They had difficulty doing this in their everyday lives as they felt that their emotions were not welcome and/or were burdensome to others. This was clearly reflected by Ravinder who sought therapy following her husband's death:

"with counselling, the best thing is that it doesn't matter who you are. You just need somebody and you wanna get rid of that pain inside. I used to feel that I had a physical hole in my heart. <u>That</u> didn't go away for a <u>long</u>, I could literally feel that hole in my heart. And er..and you can just <u>share your pain</u> with somebody and <u>really, really share</u> it. Whereas when it's your own kids, you can't tell them what you're going through, coz they're grieving themselves. They don't wanna know how horrible you're feeling. Whereas with her, you could just you know, tell her."

Ravinder's use of *"share your pain"* rather than to simply 'express' it was intriguing. I wondered whether this was influenced by knowing that her therapist had also experienced a bereavement, albeit much earlier. The ease of expressing emotions in therapy was therefore perhaps due to Ravinder assuming that her therapist would know how she felt. In mentioning her children, Ravinder appeared to also feel responsible in protecting her family from her pain and to hold them together, thereby focusing on others which she did not feel the need to do with her therapist. Furthermore, Ravinder seemed to not expect her emotions to have space or be welcomed in her general life when saying *"They don't wanna know"* and *"you can't tell them".* I wondered whether she had ever checked these assumptions with her family, instead feeling that she did not want to place this emotional burden on them. Sabina similarly felt *"a bit worried that [she] was like burdening friends"* with her emotions as she had nowhere else to express them until having therapy.

Like Ravinder, Fatima and Nazia also appeared to refer to their physical body as having held their emotions, subsequently feeling *"light and refreshed"* (Fatima) when released in therapy. Nazia's use of *"pressure-release valve"* appeared descriptive of her heart as carrying the weight of her emotions, with its valves only opening within therapy. Nazia further mentioned it being physically difficult to cry in her everyday life, which seemed due to family and an ex-partner criticising, and being unwelcoming of, her emotions, leading to emotional suppression until therapy. Regarding therapy, she made it clear however that "*it was more about being in that room"* that influenced her to express her emotions rather than her therapist's presence. This seemed to

emphasise her being habituated to the lack of an empathic 'Other' alongside lacking a safe space in her general life. This appeared further indicated by her self-encouragement as she *"mentally had said to [her]self OK yea this is the room that I can cry in".*

Jasmine described therapy as being *"more of an escape"* from suppressing her emotions in everyday life and be somewhere where she "*could go and just be that person and express how I wanted to express myself".* Using "*escape"* appeared to reflect Jasmine feeling trapped in her everyday life, yet also alluded to emotions being trapped within her as she was always told by family *"that you don't talk about your emotions"*. Like Nazia, this seemed habitual as Jasmine's above use of third person language reflected unfamiliarity with being *"that person"* who expressed her emotions. However, her switch to first person above indicates her having become used to her emotional self in therapy. This resembled Shivani's experience who developed more familiarity with her emotions in therapy as she was *"able to hear [her] own fears"*. Nonetheless, she appeared to have difficulty describing what this felt like, instead settling on the word *"nice"*. The latter term perhaps reflected her ongoing struggle to describe/identify her emotions due to habitually having suppressed them, instead focusing on others.

Jasmine's experience of free expression in therapy appeared similar to Khadija's experience of being able *"to discuss..everything with in any way that I wanted to, whether I wanted to curse, swear whatever"*. Anger appeared to be a

primary emotion that Khadija carried, which she could only express in therapy rather than in her everyday life.

All participants therefore appeared to consider therapy as a space for them to express their emotional selves. Participants felt they lacked the space for this outside of therapy, focusing instead on prioritising others' opinions of their emotional expression.

5.1.2. Recognising Individuality

Therapy appeared to facilitate all participants to recognise their individual sense of self as opposed to only having a collective self that stemmed from their roles of focusing more on the collective rather than themselves. This also transferred onto participants beginning to see others as individuals rather than assuming them to be only part of a collective. Ravinder's experience is most significant here as her assumptions of religious people were challenged when discovering that her therapist had had bereavement counselling despite being a nun. By initially telling her therapist that she *"should have accepted the will of God"*, I wondered whether Ravinder was also telling herself that she should have accepted her husband's death, which others were telling her to do therefore finding it difficult to acknowledge her individual experience. Using *"should"* further implied Ravinder having perhaps internalised the collective, authoritative voice, which was challenged when she became aware of her therapist's personally difficult experience. ('Internalised' or 'internalisation' refers to the

psychodynamic concept of 'taking in' or 'introjecting' another's attitudes/beliefs, such that it is considered as part of the self and one's personality (Klein, 1952)). This forced Ravinder to think on a more individual level, eventually understanding that one's reaction to situations *"depends on different personalities"*, therefore allowing her to also accept her and others' individuality. Shivani similarly began recognising her individual self, following her therapist's self-disclosure, which led Shivani to consider her boundaries in relationships. Her therapist's individual experience therefore encouraged her to contemplate challenging the strong South Asian idea of considering the collective, although she still struggled with this.

Nazia's tendency to always present as being strong to others was too challenged:

"it was good to put it in perspective, because then you can say to yourself..OK I don't have to be such a soldier, because actually this is <u>more</u>..this is, this is a lot of stuff to deal with."

Therapy enabled Nazia to acknowledge her difficult life experiences, thereby facing her discomfort of appearing vulnerable. Interestingly, she stopped at *"more"*: I wondered if she wanted to say that she realised she had been through more than what most people have had to deal with. Her switch in sentence however appeared to reflect her choosing to acknowledge only herself rather than bring others into her narrative with whom to compare herself against. Furthermore, Nazia gradually recognised others' desire for life choices, which

she had previously struggled with, showing greater acceptance of their individuality.

Jasmine's description focused heavily on her journey in recognising her individual self:

"I think before therapy, I didn't know me. Erm and I didn't know..who I was. I didn't know what I was about. I don't even think I really got what I liked or didn't like or erm..you know just per, personality traits. I don't think I knew any of those before. I think before I thought I was an angry person and I was..erm..an upset person or a sad person or a cry baby. And I think it was only kind of post-therapy, I was like no I, I can <u>be</u> those things at times, but it doesn't mean I <u>am</u> them."

It appeared that Jasmine previously only knew herself through others' impressions of her. Therapy facilitated her to acknowledge an internal depth that allowed her to realise she is not defined by these opinions, and instead that there are different parts to her. This subsequently paralleled her being able to see others' internal depths: despite others criticising mental health negatively, Jasmine identified them as being *"so lost or so confused and weren't..erm and were going through things, but didn't know how to say it"*. This portrayed her developed empathy in seeing others' individuality akin to herself.

Different yet somewhat similarly, therapy encouraged Khadija to reflect on herself and her problematic behaviours, which she realised had deeper

underlying reasons. By bringing this to her conscious awareness, Khadija voiced her needing to *"give [her]self that same courtesy"* of individualised support akin to what she provides her clients at work. At a deeper level of interpretation, Khadija also seemed to be advocating for therapy clients to be treated as individuals to combat her experience of feeling culturally stereotyped by both South Asian and non-South Asian therapists.

Acknowledging her individual self was a new yet difficult experience for Fatima as it *"made [her] very angry that all [her] life [she] had to..do things for everyone else."* This strikingly demonstrated Fatima's habitual focus on the collective, therefore remaining invisible to herself for which she felt angry due to the time lost being this way. Her anger appeared to lead onto her criticising her father for his deficient parenting role, which she instead fulfilled for her younger siblings. Yet, I wondered on a deeper level whether Fatima was trying to vocalise that her traditional South Asian father did not develop such skills as he considered rearing children to be a woman's role, thereby reflecting her understanding his individual socialisation/upbringing around gender roles, despite appearing angry about this.

Similarly, therapy appeared to encourage Sabina to understand her parents' difficulty in shifting South Asian thinking. She acknowledged this to be *"something that's in their nature"*, therefore recognising their individuality. Therapy appeared to further validate her opinions rather than only her parents', which helped Sabina separate herself from her parents' collectivist thinking and

recognise herself more. This was further evident in Sabina's increased use of first-person language similar to Jasmine.

5.1.3. Negotiating the Collective Role

Most participants attempted to introduce more focus on their individual selves in their everyday lives although negotiated this with their collective, other-focused role. This negotiation appeared dependent upon the level of disruption that focusing more on their individual selves brought to their interpersonal relationships, and the extent they felt an expectation and responsibility towards tending to others, indicating this experience being challenging. They therefore took a considered approach, which involved being able to incorporate both. Yet, for one participant in particular this degree of negotiation proved difficult.

The therapeutic journey appeared to facilitate Ravinder and Fatima to realise that they could choose how they focused on others in their everyday lives rather than feeling obligated to do this. Fatima began to support others with their mental health as she recalled how she "*felt so alone"* when she did this. Yet, Ravinder engaged in selfless service, a spiritual focused practice and supporting the environment, which led to others recognising her efforts including family. This shift in Ravinder occurred following being inspired by another South Asian woman to feel she could do more with her life *"Instead of just you know, cooking and cleaning and feeding your kids whatever"* although she said *"which is fine, you know nothing wrong with that either"*. The latter need to correct

herself was intriguing. I wondered whether Ravinder did not want to appear 'rebellious' by challenging her other-focused role, making it somewhat difficult for her to voice her opinion openly due to still being mindful of others, even perhaps me.

Somewhat similarly, Fatima found it extremely difficult to focus more on herself in her family life although felt more empowered at work, making the above negotiation of roles most ideal:

"when you're [short pause], when you're Asian and you're a woman, you're there to..please everyone else..serve everyone else, please everyone else. And so what <u>you</u> want becomes irrelevant [becomes emotional]."

This difficulty for Fatima was evident from her above pauses, repetitions and emotional state. A sense of feeling helpless, trapped and enslaved within the other-focused female role was apparent. I further sensed a hint of frustration in her not being able to focus on herself in the way she may have wanted to as she felt her family would not accept this. Interestingly, her use of third person language seems reflective of collectivism and perhaps mirrored her difficulty to create more self-focus in her life. However, her use of *"you"* can also reflect Fatima's desire to distance herself, and 'push away', from being other-focused.

This third person language and experience was also paralleled by Shivani and Khadija who expressed difficulty "to *shift the focus on yourself*" (Khadija). For Khadija, this process was *"still ongoing"* as she realised that focusing entirely on

herself meant bringing cultural difficulty and shame for her mother. She had currently settled on negotiating this by *"muting"* herself sometimes, which she felt *"doesn't take anything away from me..even though it's not..fair."* However, therapy enabled Khadija to let go more easily of holding sole responsibility for saving her relationship with her partner. She realised that he too held responsibility, enabling Khadija to be "*fairer to [her]self*".

This negotiation proved extremely difficult for Shivani to establish as she continued feeling responsible "*to save [her] marriage"*. Repeating and emphasising that she *"[needed] to get some help"* seemed to reflect the pressure she felt in maintaining a harmonious household. She also appeared to attribute self-blame by implying that the problem lay with her, instead focusing only on accommodating her husband's needs. Unlike Khadija, this did not shift for Shivani despite her therapist's efforts to encourage greater focus on her personal boundaries. The difference between both participants could be explained by their generational gap. Instead, Shivani ended therapy prematurely, choosing to accommodate only her other-focused role. I wondered whether she felt therapy was pulling her away from this in a way that was uncomfortable as she expressed fearing *"the sense of isolation"*, which perhaps reflected her idea of the lonely, individual quality of being self-focused.

Nazia, however, was able to consider her personal needs as a result of therapy. She vocalised these to friends in her everyday life after having previously focused more on their needs, allowing her to look *"forward to practising that more"*.

However, this negotiation of shifting towards greater self-focus was more challenging for Jasmine and Sabina. They experienced the repetitive transition from therapy sessions to everyday life as *"mind boggling"* (Jasmine) and *"quite tough at times"* (Sabina) due to difficulty transferring therapeutic self-focus into their everyday collectivist contexts. However, both participants subsequently engaged in a gradual process of negotiation, which involved realising that they needed to express themselves at a pace that their families could manage and understand. This allowed their families to 'see' their individuality more, thereby creating an optimal level of negotiation between self- and other-focus.

5.1.4. Integrating Collective Support to Facilitate Struggle with Individualism

Most participants felt that solely therapy was not enough to create desired change as it involved relying only on their individual selves. Participants therefore also sought collective forms of support either during or after their therapy, reflecting integrating both cultural elements.

Ravinder, Nazia, Shivani and Fatima either established or strengthened their relationship with their religion. They considered this as collective support, practised with others and individually. Nazia felt that her newly-developed connection with her religion facilitated regaining a stable self, following the end of her tumultuous romantic relationship:

"just like praying, going to like the Mosque and stuff, and just living this very simple existence was so much more helpful. Erm and..and I sti, I still continued therapy for a little while, but I, it just made me, you know all of the other stuff that I was doing was getting me back to myself."

I wondered whether Nazia's struggle in establishing stability through therapy was also partly due to her feeling that therapy added further turmoil: in feeling that it made her look at aspects of her life that she did not want to, perhaps she therefore felt alone in managing this in her everyday life. This desire for stability appeared further reflected in both Fatima and Shivani's religious experiences: whereas Fatima found that *"praying really grounds [her]"*, Shivani relied on religious support to develop *"the power within"* to create a more empowered, stable self in order to take more control in her life, which she found difficult to do through therapy.

Looking at this from a deeper level of interpretation however especially for Nazia and Fatima, I wondered whether they struggled with the 'being' nature of exploratory therapy, preferring instead the 'doing' nature of religion to combat reliance on only themselves. This was also mirrored in Jasmine and Khadija's experiences: Jasmine had coaching after therapy due to wanting to know *"what do I do next"* rather than only talking; and Khadija described therapy as a *"tool"* akin to something to be used practically, rather than a process of 'being' with one's self.

Additionally, Shivani, Khadija and Fatima also sought support from others in their everyday lives to facilitate change, which was clearly highlighted by Fatima as being *"very hard to do on your own*." Whereas Shivani and Fatima did this through social media and a befriender respectively, Khadija sought support during therapy from her circle of friends:

"I'm quite lucky in the sense that I've got some of that knowledge, background knowledge around er the purpose of therapy and how it works and I've got support outside in terms of my friends. But if that was my sole..tool to help me address my issues, it would definitely not have been fit for purpose."

Khadija appeared to have had prior knowledge of the therapeutic process, therefore felt aware of its limitations. By describing herself as *"quite lucky",* it seems she is suggesting that others who are new to therapy would not be aware of this and may leave feeling disappointed. This implied that she was ready to have another form of support at hand as she emphasised that therapy would *"definitely not have been fit for purpose"* as a *"sole..tool"*. Khadija's interview clearly portrayed her struggle with therapy's focus on individualism and its inability to offer her any culturally collective support. She appeared to fulfil this by turning to her South Asian friends, thereby integrating both individualist and collectivist support elements. This was further the case for Ravinder: although therapy helped her to thrive and feel more empowered in her everyday life, she still sought further support from her religious congregation and others who overcame life struggles to help her further manage the difficult experience of her husband's death, indicating difficulty doing this on her own.

Participants therefore appeared to integrate individual and collective forms of support in an optimal way to facilitate creating change in their everyday lives. I further wondered if this indicated a greater degree of strength in the idea of the collective, which participants seemed to have internalised from their general lives.

5.2. The Challenge of Power Dynamics

This master theme explores the experience and influence of power dynamics for participants throughout their therapy journeys. Cultural power dynamics appeared enacted in participants' therapy following which some dynamics shifted to create a more collaborative therapeutic space that influenced change for participants, although this was not the case for all participants. The strength of power dynamics in participants' everyday lives also seemed to influence the degree of therapeutic change they were able to make from and outside of therapy.

5.2.1. Enactment of Power Dynamics within Therapy

This subtheme explores how most participants appeared to experience a re-enactment of everyday cultural power dynamics in therapy, either within the therapeutic relationship or the work itself. The extent to which these were

challenged seemed to influence participants' view of therapy and appeared determined by the strength of power dynamics in participants' everyday lives.

Enacted power dynamics seemed strong for Nazia, influencing her to sway between two extreme power positions in therapy. One position appeared to reflect a vulnerable self, which developed from a previous relationship with a domineering South Asian partner. This was evident at times in therapy when Nazia wanted her therapist "*to tell [her] like what to do"* because her therapist was *"a grown up"* and *"a professional"*. This mirrored Shivani's experience who seemingly expected her therapist to create change for her, reflecting the powerless position she occupied in her marriage. These more vulnerably-presenting selves therefore appeared to show how participants placed their therapists in a more powerful, authoritative position, expecting them to create change.

Moreover, Nazia's use of *"grown up"* suggests that she felt childlike in her therapist's presence, and often experienced anger when she felt her therapist did not give her answers. This power dynamic appeared further reinforced by Nazia saying that it was due to the absence of an older female family member that led her to seek therapy. The powerful South Asian age hierarchy therefore appeared enacted here alongside an influence of the gender hierarchy as Nazia perceived it to be easier to talk to women than men.

Yet, her contrasting need to occupy a powerful position in therapy seemed to create a different challenge between Nazia and her therapist:

"my therapist was a white woman as well. And there was something really vexing about you know the level of erm fragility that they are allowed to have. And I always felt, there's a, there's, there's a shame associated with that as well, because you're like..as a brown woman, I have to be strong. So, I'm ashamed if I'm not being strong."

Nazia reflected feeling the need to combat the negative western view of South Asian women as being weak, leading her to always present as strong in her everyday life out of necessity as she felt that *"brown women don't have the luxury of being weak"*. She therefore appeared to feel pressure to occupy a stronger therapeutic position whilst holding anger towards her therapist's perceived 'weaker' position that appeared more permissible for white females to occupy. This seemed to create a divide as indicated by Nazia's use of *"they"* and *"I",* reflecting a somewhat strained therapeutic relationship. It appeared difficult for Nazia to be vulnerable in therapy as she felt this to be shameful especially in the presence of a *"white woman"*, indicating the potential challenge she had when occupying her above-mentioned more powerless position. I sensed Nazia carrying this responsibility for all South Asian women so as to not perpetuate stereotypes of them as weak as she said that *"all the brown women I know in their own way are so strong"*. Accordingly, Nazia appeared to be imploring South Asian women to be considered as individuals rather than under one stereotyped umbrella that seemed to be functioning to exclude South Asian women from mainstream western society.

Similarly, Khadija also experienced her therapist as holding the western view of South Asian culture being oppressive as she felt her therapist could not distinguish the nuanced way that Khadija's life differed to those who experienced greater repression from the culture. It appeared that her therapist therefore still considered Khadija as vulnerable/powerless in her family home as opposed to acknowledging Khadija's family's leeway for her life choices. Therapy left Khadija wishing that her therapist *"[appreciated] that you can still be grateful for something that pro, pro, is potentially still problematic, but it's still a step in the right direction"*. She therefore appeared to desire South Asian culture to be viewed intra-culturally rather than comparing it with a dominant culture, although it appeared she resigned to this being difficult to achieve. Effectively, both Khadija and Nazia seemed to be highlighting experiences of racism/being stereotyped within their therapy as enacted from their experiences of everyday life pertaining to greater power held by individualistic cultures. This appeared to also influence them giving further voice to their experiences due to concerns about this being further misinterpreted as signs of vulnerability.

Somewhat different to the previous participants, Fatima's relationship with her overpowering father appeared to create difficulty within the therapeutic work rather than the therapeutic relationship. Fatima found it *"very hard"* to *"say whatever [she] wanted to say"* to her father in therapy when encouraged by her therapist to imagine him there as she has always been "*told to <u>shutup</u> and..not say anything all [her] life"*, reflecting a strong presence of power dynamics in the therapy room. She appeared to also find it increasingly difficult to speak in this part of the interview, mirrored in her using shorter utterances and repeated

words as if she was ‘shutting up’ like in her therapy and with her father, thereby impacting her exercising her voice. She appeared to therefore be struggling to regain a sense of herself, instead coming across childlike in the presence of the strongly enacted age and gender South Asian power hierarchy, despite her therapist trying to provide Fatima with a different, empowering experience.

Jasmine and Sabina seemed to express early ambivalence about whether their therapist would hold an authoritative position akin to their experience of elder South Asian family members as being *“always right”* (Sabina). This was rather subtly stated by Jasmine:

“I think I needed somebody to just kind of explain to me what was going on or talk through it with me that wasn’t really er attached to me.”

Jasmine appeared unsure about whether her therapist would dictate her experience or whether they would work collaboratively to understand this. Her use of the term *“attached”* was interesting as usually one would use the term ‘objective’ to describe their therapist’s view, which I have personally heard clients using. It seemed to represent Jasmine’s desire to be free from feeling latched onto South Asian elders in her family due to reflecting the age/power hierarchy within which she felt like a child. Like Khadija and Fatima however (despite their above experiences), Jasmine and Sabina experienced more of a collaborative relationship with their therapists, thereby challenging power dynamics from their everyday South Asian lives.

5.2.2. External South Asian Power Dynamics as Influencing Change

This second subtheme looks at how the strength of South Asian power dynamics from participants' everyday lives influenced the degree of change they made from therapy. For all participants, it appeared that the stronger these collective power dynamics were, the more difficult it was to have control over creating change in their everyday lives as they experienced greater powerlessness.

Ravinder found it difficult to implement the "*little things to do"* suggested by her therapist owing to Ravinder holding onto traditional South Asian norms following her husband's death. As a daughter-in-law, she appeared to feel an expectation to follow these norms. This reflects the powerless position of females in the South Asian power hierarchy, where it seemed that Ravinder considered herself insignificant without the presence of her husband. Yet, through encouragement from her therapist, family and others that overcame difficult situations, Ravinder challenged this powerless position and gradually developed a resilient and powerful stance. This change may not have been possible had Ravinder's family not encouraged her to shift her powerlessness as she assumed that they strictly held traditional South Asian views. However, despite Ravinder having created change, she struggled to shift South Asian norms that were held strongly by elders in the community, which therapy facilitated her to realise were rigid and outdated. She acknowledged her powerlessness in the South Asian

age hierarchy when saying she was *"not strong enough to sit and argue with"* these elders and instead would *"mostly just end up crying"*.

A South Asian gender hierarchy was further present in Nazia's experience. She appeared to reflect relief in *"luckily"* being "*in charge of [her] own schedule"* which enabled her to consistently attend therapy. Nazia seemed to indicate that this would have been difficult had she felt overpowered if she was in a relationship with a man and therefore to implement change, which had occurred prior to therapy and resulted in Nazia losing her sense of power. Intriguingly, this points to her view of power and change as being easier to achieve on an individual level. Therapy facilitated Nazia to put boundaries in place within a new relationship that was initially *"scary"* for her to do, reflecting her fear of again being overpowered by a male resulting in her "*experimenting with him on different things"* to test her feeling safe with him. Yet, exercising and even acknowledging boundaries was difficult for Shivani despite her therapist's encouragement. She instead felt unable to *"find the courage to break out of the relationship"* with her husband upon whom it appeared that she felt dependent and powerless against, reflecting the strong presence of the gender hierarchy in her life at the time of therapy.

Similarly, although reflecting both an age and gender hierarchy, Fatima's experience resembled a further feeling of powerlessness and helplessness, which influenced degree of therapeutic change:

"my doctor at my organisation said, he said it in relation to the organisation, but I think it, it's relevant for home as well that you can..you can take erm..a dying fish out of a dirty pool and clean it up and get it healthy again, but if you put it back into the dirty pool, it's gonna die again..you know. And I, I think that's what it is like..you can have the therapy and you can..have the tools and everything, but you need to go back into..a clean pool or a clean environment..for a, for you to keep implementing those changes longer term"

The striking and emotive use of the above metaphor appeared to reflect Fatima experiencing therapy as only temporarily providing freedom from suffocating family power dynamics, which she had to keep returning to after sessions. The to-and-fro cycle reflected her feeling she was being given a lifeline only to then drown again. This provided insight into Fatima's constant need for therapy although change outside of therapy was not occurring. Interestingly however, therapy did create change for Fatima in her work context. This denotes how change was possible in areas of her life that were free of South Asian power dynamics and hence where she felt she could exercise power and control, like Nazia.

This latter point was further captured in Sabina's experience. She was able to understand that her parents' adherence to South Asian cultural norms/values meant their wishes differed from hers. This was despite her having constantly felt disempowered by them as her *"parents would always expect [her] to back down, because [she] is a child"* regardless of her adult age. The latter interestingly suggests that despite how old she becomes, Sabina will always be

considered a child in her parents' eyes rather than as an equal. Nonetheless, the above developed understanding was facilitated by her therapist who encouraged Sabina to realise where she was able, and not able, to exercise control.

However, Jasmine was able to gradually shift her position from being considered a child by her family to an adult as therapy facilitated her to adopt a more assertive position. Yet, Jasmine described this as only having been possible due to her mother being more accustomed to western culture and therefore being willing to *"have an open discussion"* about emotions, thereby seeing Jasmine more as an equal. This suggested that had her family members exercised more South Asian-inclined thinking, such a change in role may have been difficult to create.

Khadija's experience appeared to capture this subtheme wholeheartedly:

"if I wasn't resilient just in myself as a person, w, what, what then, because that therapy would not have met the needs."

In the greater context of her experience, Khadija alluded to only being able to create change in her life from therapy due to historically being *"allowed to"* by her South Asian family whereas "*the reality of the situation for so many of [her] friends was very different"*. She appeared to therefore suggest that one's resilience depended upon the strength of power dynamics in their general life, consequently being difficult to develop independently within the collective

context. This appeared reflected especially in Shivani and Fatima's above narratives in which it was difficult for them to develop courage and resilience when faced with powerful South Asian dynamics, and therefore to create whole change in their everyday lives. Yet, like Nazia, Khadija too alluded to it being easier to make change on an individual level rather than within a collective context where there is a power hierarchy.

5.3. Finding a Sense of Belonging

This master theme captures participants' experiences of negotiating their sense of cultural belonging as influenced by therapy. For many participants, therapy seemed to allow both their western and South Asian identities to be present in the same space. This facilitated a shift in participants choosing how they wanted to be identified. Although those from a first-generation immigrant background had a strong South Asian cultural identity, they also appeared to experience a slight identity shift. Accordingly, this appeared to encourage most participants to seek out similar others in their everyday lives who reflected their negotiated cultural identities, ultimately trying to establish a sense of belonging.

5.3.1. Negotiating a Torn Cultural Identity

This subtheme looks at how all participants appeared to experience therapy as enabling them to reflect upon and negotiate their identity between South Asian and western cultures, which involved some difficulty.

The similarity among UK-born participants Nazia, Jasmine, Khadija, Fatima and Sabina, was that they seemed to experience therapy as the one place where their South Asian and western identities could be held simultaneously. Their everyday lives had otherwise comprised them presenting either cultural identity depending on who they liaised with. They therefore often felt *"torn between two cultures"*, which were *"[pitted] against one another"* (Khadija), thereby feeling 'othered' and marginalised as they struggled to feel a sense of belonging to either one as *"the two [didn't] really mix"* (Fatima). The union of the torn cultural identities within the therapeutic space, however, influenced these participants to develop a stronger relationship to their South Asian culture, having previously been more distant. Accordingly, participants realised they had a choice over their identity, allowing them to *"pick and choose the bits that you want"* (Khadija) from both cultures. Instead of being culturally defined by others, they adopted a *"mixed"* (Khadija) cultural identity, leading them to use self-proclaimed labels of *"British Asian"* (Jasmine; Sabina) and *"Third Culture"* (Fatima).

Yet, for both Nazia and Khadija, their mixed cultural identities seemed further reinforced and influenced (respectively) from experiencing therapy as negatively stereotyping South Asian culture, akin to their experience of western culture in their everyday lives where they felt 'othered'. Although this led to greater respect for their South Asian culture, their exercised preference of a mixed

cultural identity appeared to facilitate avoiding meeting any stereotyped cultural judgements. Nazia's experience strongly depicted this as she chose to describe her identity as *"a desi [term for 'Indian'] woman but on, but on my terms*" rather than *"on patriarchy's terms"*.

The experience for first-generation immigrant participants Ravinder and Shivani however appeared different:

"I think our, our society so you know I wouldn't be worried about answering too many questions. For my friends or family there, I think they cannot think of coming out of the relationship, because for them..oh what's the society going to say? Or what's, what am I going to tell my close friend and you know. So I think I don't..share that sort of..worries with them, so it's very hard to tell..as to where I place myself." (Shivani)

Closely analysing the above, therapy looked to make Shivani realise that she was not obligated to meet South Asian societal pressures compared to her India-based counterparts. A sense of confusion seemed to arise from Shivani as to *"where [she would] place [herself]"* in relation to them, leaving her feeling lost and torn regarding her cultural identity. Parts of her narrative however depicted her trying to hang onto her South Asian cultural identity, which she said elsewhere had not shifted from therapy. Yet, therapy seemed to influence Shivani to realise that this had now shifted slightly although still skewed towards a South Asian cultural identity, which appeared more comforting for her.

Similarly, therapy also appeared to shift Ravinder's allegiance to South Asian culture. She began to question the more traditional and outdated South Asian norms/values following her therapist questioning these. However, like Shivani, Ravinder also seemed to struggle with distancing herself from her South Asian cultural identity. This was evident when she tried explaining traditional South Asian grieving norms as being *"a way of counselling"* and that by *"repeating the same thing over and over again and at some stage it should start to come out."* Yet, alongside this, perhaps Ravinder was also attempting to integrate both South Asian and western cultures to bridge the gap between them. She seemed determined to make her allegiance to South Asian culture clear again later on:

"my connection to my culture's always been strong. Always. Erm I question it. I get annoyed about it. But the conne, but that's where I'm at home. You know that's my comfort zone. That's where I'm at home."

Whilst this portrayed her strong South Asian cultural identity, it perhaps also suggests that Ravinder would struggle to feel a sense of belonging elsewhere as it is all she has ever known. I wonder if Ravinder and Shivani therefore felt some anxiety in slightly shifting from their South Asian cultural identity, instead preferring to abide strongly by it. By repeating and emphasising *"always"* and *"where I'm at home"*, Ravinder seemed to be convincing me or potentially even herself that nothing can shift her relationship to South Asian culture. Yet, her change from almost using the term 'connection' to "*home"* appeared to highlight that her attachment to her cultural identity has now shifted slightly although at a comfortable-enough place for her.

5.3.2. The Pursuit of a Similar Tribe

Connected to the previous subtheme, this second subtheme depicts most participants having felt determined to proactively search for people in their everyday lives who reflected their negotiated cultural identities, essentially realising they can make this choice. This was to feel understood by similar others and therefore a sense of belonging. For most participants, this search occurred after their therapy, indicating the influence therapy had on their sense of cultural belonging.

Following greater understanding of South Asian culture and subsequently adopting a mixed cultural identity, Jasmine stated that she "*wanted to find [her] tribe"* to feel better understood and therefore *"actively"* sought those *"that have that similar thinking"*. She previously seemed to feel stuck with only those who had South Asian thinking and felt she had "*no choice of the people that [she was] around".* Sabina similarly connected with similar others and found it *"helpful being able to have some friends who understand"* her mixed cultural background whereas "*before [she] would like just talk to [her]self."* A sense of relief in finding their tribe appeared apparent from these participants, indicating this being difficult to come by. This was also clearly reflected in Fatima's experience who described it as being a *"God-send"* that she found similar others that are *"balanced between the two"* cultures.

Furthermore, Khadija's experience depicted her looking for similar culturally-mixed individuals to help her fit in:

"it was like well I don't fit in here and I don't fit in here, so I kind of need to find my people that are weird and kind of mixed up like me. And when I started having these conversations, it turned out..practically every Asian girl I knew was having some sort of [laughs slightly]..you know nobody wanted to talk about it, but as soon as you give them one bean, they were like yea, yea me too"

Khadija's use of *"weird"* suggested that she saw herself as having an odd identity and hence feeling like an outcast. I wondered whether this was a form of self-criticism. Yet, I settled on *"weird"* as reflecting her perceived difficulty to find other *"mixed up"* people, akin to the previous participants. This appeared to shift to a shared experience among *"every Asian girl"* that Khadija came across, thereby subsequently feeling part of a newly-found ingroup. This gave a sense that these similar others each felt isolated with their own mixed cultural identities until given *"one bean"* of opportunity to express themselves. The above-mentioned feeling of relief is therefore also reflected here alongside being evident in Khadija letting out breath in her laughter. A sense of secrecy in having a dual cultural identity was therefore highlighted. I wondered if this came from these women fearing a threat to family honour and being labelled as rebellious if they deviated from traditional South Asian culture.

Ravinder and Nazia's experiences of wanting to find their tribe appeared to come from a more direct interaction with their therapists. The surprising

experience of having a nun as a therapist seemed to encourage Ravinder to realise that the status quo can be challenged, seemingly influencing her to challenge traditional South Asian norms/values (as mentioned above), and seek and liaise with others who also questioned these. Yet, she appeared to still feel a semblance of belonging, albeit also feeling annoyed, with those who still followed outdated South Asian norms/values as she used an oxymoron when saying *"we don't say anything against our own people."* I wondered whether it was difficult for Ravinder to detach completely from such a cohort to avoid feeling a sense of loneliness with a smaller, newer cohort of modern and challenging thinkers. Nonetheless, by using the term *"we"*, Ravinder appeared to be including and inviting me to perhaps join her tribe and begin to also question these same traditions. Her emphasised words suggested her wanting to now speak out against the once passively-followed, contradictory South Asian norms/values, and encourage others to do the same.

For Nazia, it was important to find someone who closely reflected her idea of a unique South Asian woman and therefore someone like herself who did not fit into solely a western nor South Asian cultural identity. In lacking this connection with her white therapist, she instead gained this with a subsequent South Asian therapist who she felt understood *"what it's like to be a woman of colour who's successful."* Nazia further describing her South Asian therapist as having *"a warmth"* and *"just more real"* reflected an experience of authenticity alongside feeling understood that comes with someone who aligns with one's way of thinking and being. In mentioning success, Nazia seemed to distance herself from those she felt stereotyped South Asian women as being weak and

unsuccessful, thereby connecting with those who represented a *"more real"*, holistic image/identity of a South Asian woman.

5.4. Breaking Barriers

This fourth master theme explores how exposure to therapy seemed to create a shift in participants' perceptions towards, and acceptance of, therapy despite the negative stigma attached to it within South Asian culture. Participants appeared to consequently be influenced to attempt bridging the gap between South Asian and western culture by encouraging other South Asians in their everyday lives to have therapy. This appeared ongoing for participants since finishing therapy, also showing the positive influence therapy had for them in some way.

5.4.1. Challenged Acceptance of Therapy

This subtheme depicts all participants appearing to experience a shift in perceptions of therapy after initially struggling to accept having it. Their struggle seemed influenced by the negatively stigmatised views South Asian culture holds towards therapy and mental health, alongside it considering that collective support should be adequate. The shifts in these views once participants engaged in therapy, indicated a need for familiarity and understanding of it. This subtheme was palpably portrayed in Ravinder's experience:

Ravinder: "I'm glad she came into my life. And that sort of changed my who, whole outlook, erm because I was you know 101% sure it wasn't gonna help. What's the point? I can't see the point. Why can't I have the tablets? I'll start to get better soon. Why can't I have the tablets?"

Researcher: "why do you think you were so kind of against it at the beginning?"

Ravinder: "we all just erm came together as a community..and we just helped each other. And that was my perception of..support. And er.. and to bigger, to some degree still is. But..and what I couldn't understand why none of it was working for me"

Ravinder's initial reaction reflected her demanding the 'quick and silent fix' of anti-depressant tablets rather than to betray South Asian culture by seeking external support from a foreign, western source. This seemed to show Ravinder struggling to accept that her difficulties were deeper than a physical issue from which she assumed she would *"get better soon"*. It appeared that realising the limitations of South Asian cultural support created confusion for her to the extent that it contributed to her contemplating having therapy. This led her to experience a complete change in mindset about therapy once benefitting from the process. This shift similarly occurred for Nazia who initially considered therapy as *"very self-indulgent"* and preferred South Asian cultural support, though saw therapy as her *"only option"* as she lacked family presence.

Jasmine and Khadija differed from the previous participants as their acceptance of therapy was challenged prior to engaging in it. Despite having been surrounded by negative South Asian cultural narratives around therapy and help-seeking, Jasmine and Khadija's exposure to mental health problems and therapeutic engagement among other family members encouraged them to be accepting and open to seeking therapy themselves.

Contrastingly, Shivani and Sabina had internalised stigmatised South Asian views about therapy, which initially made accepting therapy difficult. However, having therapy allowed Sabina to *"definitely [see] the benefit of it"* alongside acknowledging it becoming more normalised as she knew of other South Asians having it. Shivani's normalisation of therapy was further contributed to by being exposed to Counsellors in a previous workplace:

"when I was in a surgery, I thought oh maybe, maybe a Counsellor is like a qualified erm person, like a qualified medical person. So I thought OK, maybe talking to her will make a difference. Why not. So yea, that, that's how I got interested in er getting therapy, because I have, I was going through some problems or nothing over, over the top or nothing, but I thought maybe, maybe talking to someone..may help."

Shivani appeared to accept having therapy by equating therapists to medical professionals. Accordingly, she seemed to minimise the significance of therapy as 'breaking' from South Asian tradition, reflected in her phrases of *"why not"* and *"nothing over the top".* I further wondered whether Shivani was trying to

advocate that she did not need therapy because she was 'crazy', thereby combatting how mental health sufferers are viewed by South Asian culture, which enabled her to permit herself to have therapy.

Fatima's initial difficulty with accepting therapy appeared most strongly influenced by her experience that *"mental health just doesn't exist"* within South Asian culture:

"If it did, half the women would fall down. Erm..so..so I kind of already knew that and I, I was in a bad place mentally to know that there is a problem and I've..I've always had my shit together. So it..the fact that I was..not sleeping and erm crying all the time, and all of these things that I didn't recognise in myself, I could see there was a problem. Erm..but it was like it, it wasn't something that..the way that I was brought up, it, I, it, I went on with my western mindset of OK let's try this, it may help, it may not. And probably went in thinking it's probably not gonna help, but let me try anyway."

There was a strong sense of Fatima swaying between both her internalised western and South Asian views regarding therapy, although she clearly drew upon the former to make having therapy acceptable. Her intriguing use of *"half the women would fall down"* appeared to highlight the little/no exposure to therapy/mental health within South Asian culture. Yet, it also showed how introducing this appeared to be the only way to acknowledge the relentless duties/roles of South Asian women, making it otherwise difficult for South Asian women to seek support. This appeared somewhat reflected in Fatima's

experience as she seemed to need to provide an adequate reason as to why she needed therapy and to seek support outside of South Asian culture, demonstrated through pointing to unfamiliar changes occurring within her. She however increasingly became accustomed to therapy once undergoing it and experiencing its benefit.

5.4.2. Encouraging Others into Therapy

To attempt bridging the gap between South Asian and western culture, the experience of having therapy influenced most participants to encourage other South Asians in their everyday lives to have it, which continued post-therapy. Participants seemed to want other South Asians to also experience a normalising of therapy. Most participants tried encouraging family members, which Ravinder successfully did and which was reflected more so in Nazia's experience:

"I'm trying to convince my brother to go to therapy. And I, and I said to him look, he's had in the last sort of couple of years, three of his very close friends die. And I said look if you were talking to a friend and they said all of these things has happened to them, wouldn't you say to them that they needed some help to, professional help to deal with it? He was like yea, makes sense."

Nazia's use of *"convince"* denoted the persuasion needed to shift the negative stigma around therapy and mental health internalised by many South Asians,

including her brother. It seemed that she felt the need to convince him by using an objective and general example of a life experience rather than anything connected to South Asian culture, therefore being careful to not put him off therapy. Accordingly, she appeared to adopt a rather therapeutic technique involving shifting/switching his viewpoint which appeared to prove effective, highlighting the influence of therapy on her mindset.

Jasmine's experience appeared to reflect a domino-style impact as she encouraged her parents to have therapy who then went onto encouraging others. Most surprising for Jasmine was her first-generation immigrant father's reaction:

"he had, knowing now, has been like really, really open to it and he's like I'm really open to see a Counsellor, and he's actually..going to see one now. And he's erm really encouraging my step-brother to do it..erm and my step-brother had said yes I think. But I think it in that it was mo, that whole thing I think really only started from <u>me</u> being open"

Jasmine's shock at the transition in her father's interest about therapy appeared reflected in her initial difficulty to phrase her above experience. Her repetition of *"really"* also seemed to denote her shock alongside it perhaps being a way to allow the 'reality' of this shift to sink in further. The above-mentioned domino-style impact was again present as her father was now encouraging her step-siblings to have therapy. Although taking credit for this shift, Jasmine's emphasis on *"<u>me</u>"* appeared to reflect her surprise in being the force of this

change, and was therefore perhaps a way to allow this to sink in by emphasising it.

Looking beyond family, Khadija encouraged South Asian female clients at her workplace to take-up therapy whilst Fatima encouraged her friends. Fatima also hoped to *"start some kind of blog"* to address the *"massive need"* to support other South Asian women silently enduring mental health difficulties as she personally *"felt so alone"* when initially seeking therapy herself, thereby acting as a kind of torch bearer. Therefore, both participants appeared to want to create more opportunities to reach out to more South Asian women.

5.5. To Share or Not to Share

This final master theme looks at how shame inherent within South Asian culture appeared to influence participants' openness between both therapy and their everyday lives. Participants seemed to exercise a degree of silence around divulging aspects of their South Asian culture in therapy, although found it easier to voice topics considered taboo in South Asian culture. Concurrently, participants appeared to find it challenging to disclose having therapy and mental health issues to others in their everyday lives. There seemed an overall sense of participants feeling and fearing being judged/misunderstood within and outside of therapy, further contributing to dynamics around silencing.

5.5.1. Negotiating Openness in Therapy

This first subtheme explores most participants' struggle to openly discuss aspects of South Asian culture in therapy due to shame, although found it easier to voice topics considered taboo in South Asian culture. The idea of the non-judgemental therapeutic space appeared to be questioned as participants felt the need to silence and repress parts of their narrative. For most participants, this occurred as they felt the need to protect South Asian culture from being shamed when they sensed it would be negatively judged by their therapist. This was most poignant for Khadija:

"I was talking to a..white British woman about this massively complex situation. And maybe it's just my own..lived experiences that have made me feel quite guarded, but I was quite aware of the fact that you know I didn't wanna put on this circus show where oh my God everything is just so ridiculous, because of..culture and cultural differences, that even while I was..talking I had this..I had to almost kind of keep mys, give myself a, a pep talk 'yep carry on it's OK, it's OK to share, it's OK to share', because it, I was aware that it was just…everything I guess that you don't..want people to..it, there are a lot of clichés in there and I didn't want to feed into the problem"

Khadija depicted above the sense of responsibility she felt in not wanting to dishonour South Asian culture by perpetuating judgemental stereotypes held by those from an individualistic culture. This appeared to create a battle between two parts of her as Khadija attempted to negotiate her protective South Asian

part with the part who wanted to speak freely. Her above pauses seemed to reflect this, indicating her difficulty to describe something in a way that can be clearly understood rather than judged. Khadija's self-encouragement to *"share"* highlighted perhaps a sense of loneliness in being the sole person in therapy to attempt to represent South Asian culture to this 'other' person in a wholesome way, rather than it coming across as a joke and means of entertainment akin to her use of the term *"circus show"*. I also wondered here if she felt that her difficulties would not be taken seriously enough by her therapist.

Nazia, Jasmine and Sabina shared a similar sense of responsibility towards protecting South Asian culture from shame, although this pertained more specifically to their families. Their experiences resembled feeling *"shame maybe or guilt around talking about people"* (Jasmine) from their life: they felt they were *"making them wrong"* (Jasmine); were being encouraged to *"blame"* (Nazia) their families; and felt their family's behaviour would be considered a "*backwards way of thinking"* despite it being *"completely normal"* (Sabina) to them. Accordingly, these participants felt they *"couldn't be open"* (Sabina) so as to avoid their families being judged negatively, thereby preventing shaming/dishonouring them. Participants may therefore have carried into therapy the internalised shame of speaking about one's family outside of the home. Additionally, they seemed to experience their South Asian families/culture being viewed from a superficial and culturally comparative lens rather than intra-culturally and from their inner world akin to what Khadija and Sabina desired, further contributing to lack of openness.

Yet, Jasmine appeared to talk openly about her family in therapy once realising that her therapist held no such judgemental views. Fatima was also able to experience this in her therapy as she positively described her therapist as having been *"probably the most accommodating therapist that I've had that's willing to look into the ethnic issues and the cultural issues"*. Nonetheless, Fatima required encouragement from a half-South Asian befriender outside of therapy in order to be open about her culture as she *"didn't think anyone would get it"*. This seemingly came from Fatima's personal experience of being discouraged to show her South Asian side to non-South Asians outside of the home. She therefore seemed to have internalised shame for her South Asian self, instead considering it difficult for 'outsiders' to understand and therefore prone to negative judgement.

Contrastingly, topics considered taboo/shameful in South Asian culture appeared openly voiced in therapy. Nazia, Jasmine, Shivani, Khadija and Sabina discussed intimacy and relationships as they felt that therapy would not make them feel ashamed about this unlike in their general lives. Shivani had no problem discussing her sexual problems with her therapist because she *"knew she was a therapist"*. Similar to Nazia, Jasmine and Khadija, this highlighted a boundary that participants felt was palpably present between the therapeutic context and that of their everyday lives, which they considered would not overlap due to the importance of confidentiality in therapy. Sabina however did not feel this way with her subsequent South Asian therapist, demonstrating her lack of trust around privacy in South Asian culture.

This subtheme therefore speaks to the difficulty that participants seemed to experience in being fully open within the therapeutic space as they appeared to carry the collective concept of shame, although some managed to negotiate and shift this barrier for certain topics.

5.5.2. Negotiating Openness About Therapy

The second subtheme considers how shame and judgement influenced most participants' disclosure about having therapy and mental health issues to others in their everyday lives. Participants kept therapy a secret from their families and/or friends during having it, owing to them experiencing the taboo and shame inherent within South Asian culture around this topic. Those who eventually voiced this to others did so under particular circumstances.

Ravinder described not wanting everyone to know that she was having therapy and about it being virtually impossible to tell her family about her mental health difficulties:

"there was no way I could tell them how I feel like shit and whatever, and horrible thoughts are coming into my head. You just wou, you just wouldn't. I couldn't. And it doesn't matter how much you say you're not gonna be judgemen"

Ravinder's account alluded to her having had thoughts of a somewhat 'forbidden' nature, preventing her voicing this to her family. I wondered here whether these were thoughts around suicide/self-harm. This felt difficult for Ravinder to admit even in the interview where she seemed to allude to having experienced depression although described this as feeling "*like shit",* reflecting her carrying the taboo of mental health. I was also curious about her altering between using first- and third-person language. This seemed to reflect her attempt to distance herself from these 'forbidden' thoughts as if they were alien and 'wrong'/shameful to have. Written again in third person to perhaps also parallel collectivist ideology, the last line seemingly depicted Ravinder questioning trust in her family's ability to be non-judgemental. She seemed to be convinced that they would eventually judge her, therefore reinforcing her choice to have kept hidden both her mental state and having therapy.

Interestingly however and similar to Sabina, it was upon finding therapy helpful that Ravinder felt comfortable disclosing it to others in her everyday life. This seemed to coincide with both participants feeling more mentally stable, which they appeared to understand as reducing the likelihood for them to be judged as mentally unstable by their South Asian acquaintances. I therefore wondered here about the definition of 'normal' held by South Asian culture that appeared to factor in influencing participants' openness/silence.

The concept of normality appeared further in Khadija and Sabina's experiences. They described eventually telling people about having therapy because they were not requiring support for difficulties of a psychotic nature, but instead for

less severe mental health difficulties, therefore feeling there was less stigma attached to it. I wondered here about whether some participants understood mental health to be on a continuum. This appeared therefore to partly determine the degree of judgement and shame they felt they would receive, influencing openness with others.

Jasmine, Shivani, Khadija and Fatima spoke palpably about the sense of feeling dismissed by family/friends due to their judgemental views about mental health, making it difficult to be open with them about having therapy. Jasmine feared hearing that *"depression isn't a real thing"*, whereas Shivani lacked support from her husband whom *"doesn't believe in er counselling or therapy"*, and Fatima's mother dismissed her depression completely. There was a strong sense of mental health being experienced as non-existent and fictional, therefore leading participants to feel misunderstood, invalidated and ashamed. Khadija in fact spoke about this contradicting availability of support within South Asian culture, highlighting its capacity to create loneliness for participants in their mental health journey:

"it was like this comradery of like you know you're, we're all in it together, we're looking out for one another. And it had the opposite effect when you were trying to talk about things that are very taboo in the community."

The way in which Jasmine chose to gradually disclose her having had therapy appeared to be done in a considered manner:

"people away from me who don't know me, I've spoken about it. Whereas people that do know me, I haven't really been open about it."

"So when I'm kind of left..an empty slate, I can kind of say what I want. There's no expectations. I'm really open."

To me, this spoke to Jasmine's careful negotiation of openness: she seemed to consider older acquaintances as holding more negative judgement than newer connections, thereby feeling less shame from the latter yet 'othered' by the former. This presented an unfortunate inversion as one may expect the opposite scenario. Her description of *"no expectations"* spoke to her feeling of needing to be a certain way with those older South Asian connections rather than being accepted for who she is. I considered her metaphor of an *"empty slate"* as akin to new-born babies, which led me to wonder if she felt like a new person with her newer connections who knew nothing about her existence before they met. Having a sense of control seemed to be important here for Jasmine as she perhaps felt that she could control what new acquaintances thought of her, thereby guiding their judgement rather than being at the mercy of feeling shame from the negative judgement held by her older South Asian acquaintances. I further wondered here whether Jasmine wished she could indeed be born again to erase her experience of struggling with mental health, which she openly expressed as having had difficulty to come to terms with even now, reflecting her feeling ashamed about it.

The above two subthemes therefore show how, for most participants, openness about therapy and South Asian culture could not be integrated both within and outside the therapeutic context if a sense of shame/judgement appeared present. Alongside this seeming linked to concerns about shaming the South Asian family, it also reflected the internalised shame participants carried that contributed to silencing.

6. Discussion

The aim of this research study was to explore the experience of cultural difference for South Asian women who have had psychological therapy. This study was conducted to highlight South Asian women's experiences of therapy and of navigating this with their everyday lives.

The main and secondary research questions were as follows:

- What is the experience of psychological therapy for South Asian women?
- What is the experience of navigating the interplay between psychological therapy and everyday life for South Asian women?
- How does this navigation influence the way that South Asian women lead their lives?

Prior to detailing the discussion of the findings, I will provide an overview of them as a response to the above research questions. The overview also depicts the overall relationship among the themes sought, which is summarised below in Figure 1. This showcases the experience of participants mentioned in the previous Findings section and in this Discussion section.

The experience of therapy for participants was somewhat influenced by aspects of their South Asian lives that they carried into therapy. Some of these aspects were largely challenged by merely having therapy itself. Specifically, participants initially struggled to accept having therapy due to the negative stigma that South Asian culture places on mental health. Greater understanding

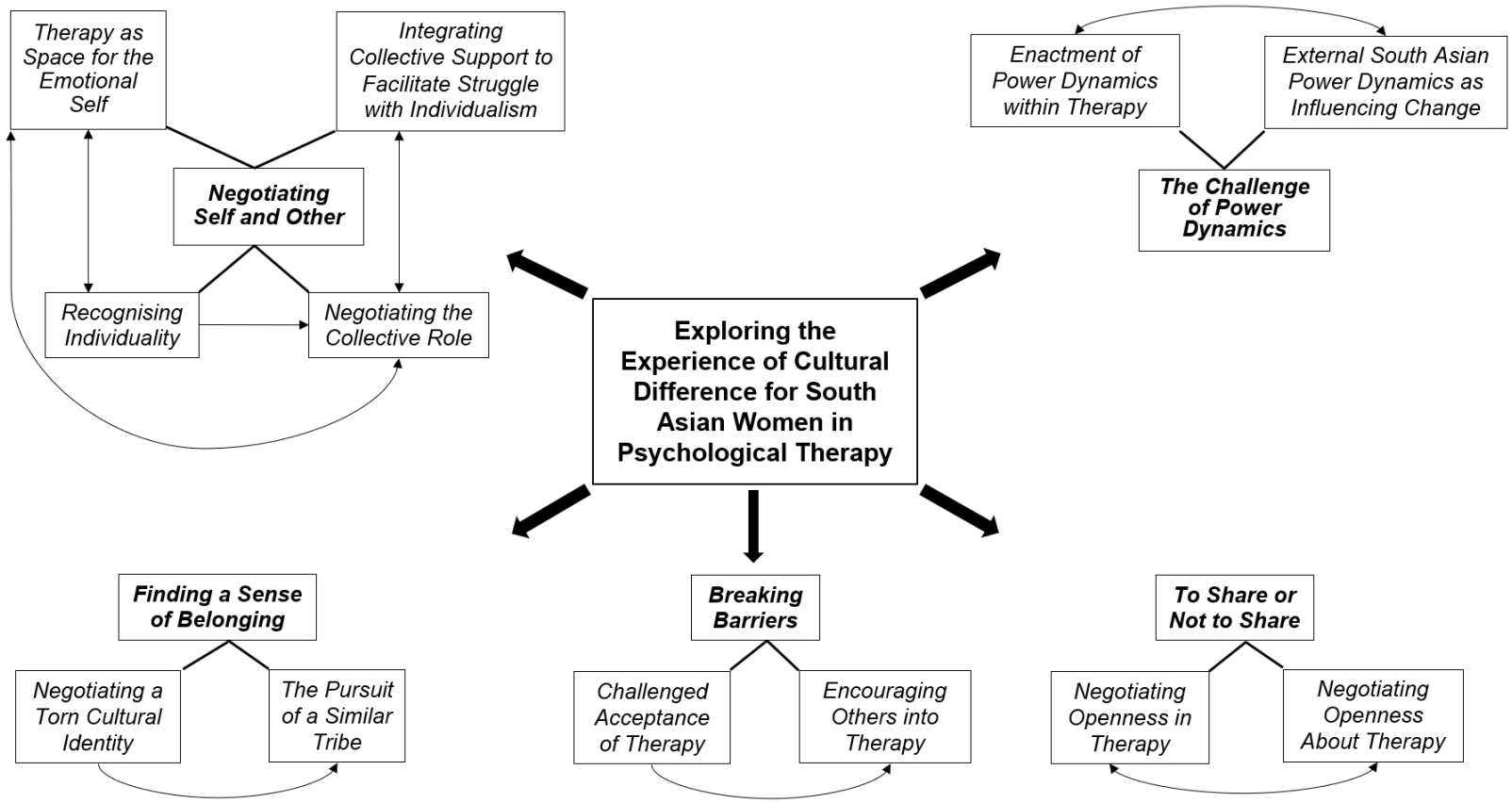
and familiarity with the therapeutic process however challenged this for participants who instead settled into, and accepted, the therapy space. This influenced them, both during and after finishing therapy, to advocate having therapy to other South Asians from their everyday lives in an attempt to bridge the separation in views towards it. However, shame/stigma and judgement influenced participants to struggle telling others in their everyday lives about having therapy themselves alongside in being open about South Asian culture in therapy.

Yet, participants experienced being freer with emotional expression and speech in therapy as it encouraged them to shift from thinking about the 'Other' to thinking more about themselves as individuals, which was difficult in their everyday lives, alongside facilitated them to see others' individuality. Participants' habitual collective roles however meant that transferring this more individualised way-of-being into their everyday contexts was challenging. They instead negotiated both to manage navigating any potential intrapersonal and interpersonal conflict. The strength of cultural power dynamics inherent within participants' everyday lives also appeared to impact both participants' therapy and the degree of change they felt they could implement outside of therapy.

Nonetheless, participants seemed to experience therapy as a place where they could negotiate, and therefore obtain greater clarity and empowerment over, their cultural identities. This was transferred outside of therapy, facilitating establishing a greater sense of belonging between South Asian and western contexts in their everyday lives, which continued for participants post therapy.

Figure 1

A Summarised Relational Thematic Diagram



Note. Unidirectional and bidirectional arrows depict a one-way or reciprocal influence, respectively.

I will now discuss each of the findings related to the five master themes in detail, relating them back to the research questions. I will draw from above and other existing literature to enhance this section. This will be followed by providing implications of the current findings for the field of Counselling Psychology, with an emphasis on clinical practice. I will then close this chapter by highlighting strengths and limitations of the current study alongside future research ideas.

6.1. Negotiating Self and Other

The first master theme highlights participants experiencing therapy as a space to connect to their individual sense of selves more compared to possessing mostly a collective, other-focused self. It appeared challenging to implement only an individual self, due to this inviting intrapersonal and/or interpersonal conflict in participants' lives. Navigating this with their everyday lives involved most participants finding a way to negotiate both selves to create change at a level adequate for them outside of therapy.

The opportunity to connect to their individual selves in therapy involved participants voicing their suppressed emotional selves. This coincides with the focus of exploratory therapies such as psychodynamic and person-centred therapies that facilitate individuals to connect more to their sense of selves. Aligned with participants' understanding, South Asian culture traditionally discourages emotional expression and considers hiding emotions to be a strength (Khalil, 2018; Laungani, 2002; Zane et al., 2008). This is similar to

other collectivist cultures such as East Asian cultures where emotional self-control is expected from individuals, comprising either not expressing or acting on emotions as this is believed to be better than burdening others with them (Kim et al., 2005). Kim et al. (2001) state that merely being away from the collectivist context however can allow one to let go of conducting themselves as emotionally strong and therefore experience less shame around expression. Tummala-Narra's (2013) point that some South Asian women experience more freedom to express emotions outside of, compared to inside, the home supports this. Similarly, current participants also appeared to keep emotional expression separate between therapy and their collective contexts, especially as it felt unwelcomed and therefore difficult to integrate into their everyday lives. Nonetheless, participants experienced largely for the first time, feeling validated as individuals, akin to Kohut's (1984) psychoanalytic theory of self-psychology. This finding therefore replicates previous studies where South Asian participants also experienced therapy as a safe space which encouraged emotional expression (Ashiq, 2017; Kalathil et al., 2011; Netto et al., 2001). A few participants in the present study appeared to further experience physical relief when disclosing emotions, replicating previous research (Bhugra & Mastrogianni, 2004; Hwang et al., 2008; Netto et al., 2001). Denial of this can often result in somatisation where South Asian women instead seek help for physical symptoms as this is considered less stigmatising and shaming than seeking help for mental health problems (Burr & Chapman, 2004). The importance of having an empathic and understanding therapist and therapeutic space is therefore indicated, which can encourage access to counselling (Kainth, 2021).

Furthermore, self-expression in therapy and ultimately developing their individual sense of selves seemed to establish stronger and more authentic selves, which enhanced self-value and self-compassion, replicating previous findings (Ashiq, 2017; Kalathil et al., 2011; Netto et al., 2001). This also forms a crucial aspect of some exploratory therapies such as humanistic therapy (Rogers, 1961). Other research found self-value and self-compassion to be a buffer against emotional distress, promoting wellbeing (Pauley & McPherson, 2010; Wood et al., 2008). Accordingly, this appeared to facilitate participants to be more understanding and compassionate towards other South Asians in their everyday lives, also viewing them as individuals rather than only part of a collective. One could argue that in considering others, participants still maintained their collective tendency to be other-focused. Yet, I offer another perspective in that showing compassion also to themselves allowed participants to recognise their interconnectedness and equality with others, ultimately seeing themselves as worthy of equal respect (Brown, 1999; Enright et al., 1998).

However, most current participants still upheld their other-focused collective tendency alongside attempting to transfer their stronger individual sense of selves from therapy into their everyday lives. This appeared an optimal way for them to navigate the discrepancy between the therapeutic context and their South Asian cultural roles. Guzder and Krishna (2005) also found this from their case studies of Hindu women who negotiated self- and other-focus, where some more easily introduced greater individualism into their everyday lives than others. It therefore appears challenging for South Asian women to shirk their

cultural gender role as they feel a responsibility and expectation to behave with others in mind, as expressed specifically by Fatima in the present study. Tummala-Narra (2013) also supports this process of negotiation as being a challenging one, which was evident in the similar experience of her therapy cases.

Nichter's (1981) argument can be supported here about South Asian women having to thwart their individual development/ambition as this challenging process of negotiation would still have involved some degree of individual suppression. Yet, Raval (2009) emphasises that choosing to maintain some semblance of a collective role does not infer the presence of intrapsychic enmeshment as suggested by psychodynamic theory. In line with this, Tummala-Narra (2013) critically challenges the application of the western model to those from collectivist backgrounds. Such a model views sense of agency as one assimilating to western mainstream culture and posits that individuation is a crucial stage of development that promotes healthy psychological functioning (Gupta et al., 2007; Majumdar, 2007). Instead, Tummala-Narra (2013) and Kakar (1985) state that human development in collectivism is more concerned with one's 'relational orientation'. In light of the current research, participants were fully aware of this discrepancy between cultures. They consciously acted in a way that satisfied both their autonomous and collective selves in order to avoid creating distress and disrespecting South Asian culture or appearing rebellious, as particularly highlighted by Ravinder. Raval's (2009) qualitative interview findings on South Asian women supports this point alongside Patel's (2017) IPA research: Patel's South Asian female participants displayed a

degree of self-sacrifice to protect them from experiencing any tension or conflict. This appears particularly relevant also for Shivani in this present study, who feared loneliness and isolation if she tried to emphasise greater autonomy in her life, reflecting the importance she gave to being a relational being.

Interestingly, Patel (2017) comments on this as giving precedence instead to the false self, thereby suppressing the true, authentic self. Like Tummala-Narra (2013) above, I would caution against applying such a western Winnicottian psychoanalytic concept to this research as it criticises the way-of-being inherent within South Asian culture, which still appeared important for participants in this current study to uphold. It is also important to note that it was an active choice for participants to create some semblance of change that suited them. This is supported by Ewing's (1991) argument that interpersonal engagement does not point towards an absence of autonomy. It instead highlights an awareness of one's own needs which are negotiated with others' needs. I therefore provide a contrasting view to Chirkov et al. (2011) who argue that collectivist individuals are passively trapped within this model without any scope for creating change, which this current research and Patel's (2017) research otherwise argues.

Moreover, participants actively sought collective support alongside their therapy to facilitate creating ideal change in their everyday lives, as also found by other research (e.g., Goyal et al., 2015). Participants appeared to experience difficulty and reluctance in relying solely on an individual way-of-being, thereby considering therapy as not enough on its own. Accordingly, rather than out of helplessness, negotiating their individual and collective selves in participants'

everyday lives may have arisen as a way to combat unfamiliarity with a primarily autonomous way-of-being, and hence the responsibility that comes with relying only upon one's self to create change. Although not conducted on South Asian participants, this was also found in much earlier research by Elliott (1985) and Llewelyn et al. (1988) where their participants described responsibility as being uncomfortable and unwanted, which particularly hindered their experience of exploratory counselling.

This coincides with Kainth's (2021) finding as her South Asian participants, who were international students in the UK, preferred a more directive approach to counselling and one in which they would be offered solutions. This type of directive work parallels the current research as most participants seemed to want some element of a 'doing' approach in their therapy. This may be explained by previous literature denoting that familiarity in being given solutions by authoritative South Asian family members, or collaboratively discussing and dealing with problems like in the more supportive element to South Asian family life, may have been expected from therapists (Goyal et al., 2015; Khalil, 2018). Jaouich's (2007) point is supported here regarding decision-making being a collective, collaborative process, thereby reinforcing the importance of considering the larger family context in therapy, supported also by Kalathil et al.'s (2011) findings. Roland's (1988) earlier observation further found that Indian therapy clients often collaborated with their family when making major life decisions.

Contrastingly, the current findings show that participants may have needed a form of support that was likely to be ever-present and not temporary like their therapeutic journey. They therefore seemed to navigate this by utilising mainly their social network alongside their religion where both would qualify as 'omnipresent' forms of support. This further highlights the difficulty for participants to rely on themselves to create change. This seems to support the psychodynamic theory that humans are hardwired to create attachments, and therefore are social and relational beings (e.g., Bowlby, 1969; Schore, 2003). Furthermore, the current findings contest Tummala-Narra's (2013) point that first-generation women are more likely to seek support from their cultural/religious networks as no such immigrant generational gap was found in the current study.

Wardak (2000; 2002), however, could argue that cultural and social means of support such as religion and family are considered social control mechanisms. They thereby act to maintain order in South Asian families by preserving one's honour. However, such control did not come across from current participants' description especially of their relationship to their religion. They actively chose to engage in this as it helped create the change they wanted and achieve further peace. Mayers et al. (2007) similarly found that clients use faith alongside therapeutic support as a further coping strategy. Other recent research also shows a positive influence of religion on mental health (Prajapati & Liebling, 2021; Stroope et al., 2022). Recent research on Chinese participants also found religion, spirituality and even speaking to family/friends as the preferred and most important form of help for their mental health issues

compared with seeing a professional (Chen et al., 2015; Na, 2018). This indicates some similarity of views with other collectivist cultures alongside appearing to be driven by East Asian beliefs about the etiology of distress (Na, 2018).

The above suggests that clients may draw upon collective coping strategies to promote congruence and preserve their cultural identity, alongside protect against feeling alienated when using services based on western ideology, possibly to feel empowered (Williams et al., 2006). This thereby criticises assessing client resilience according to western psychotherapy models (Patel, 2007; Tummala-Narra, 2011). This seems to coincide with literature showing that collectivist clients feel dissatisfied when religious needs are not understood nor met by mental health services, especially if religion is used to make sense of one's illness (Husain, 2020; Hussain & Cochrane, 2003; Incayawar et al., 2009; Mind, 2013). I therefore align with the importance that Patel (2007) and Tummala-Narra (2011) give to recognising that a client's resilience can be both individually and collectively influenced. Gater et al.'s (2010) study supports this as they found that depression among British Pakistani women improved with either a social intervention, or social intervention coupled with antidepressant treatment compared to medication alone. This coincides with Lambert's (1992) finding that therapeutic improvement can come significantly from extratherapeutic factors including social support, mirroring current participants' experience where they continued to access collective support post-therapy. This highlights Lambert's point about therapeutic improvement being dependent upon a client's resources and what they do outside of their sessions.

6.2. Challenge of Power Dynamics

The analysis further suggests that participants experienced an enactment of cultural power dynamics from their everyday lives within therapy. These power dynamics also seemed to influence the degree of therapeutic change participants felt they were able to make. The enactment highlights literature on how intrapsychic and interpersonal patterns from a client's life become mirrored in the transferential relationship within psychodynamic therapy specifically (Altman, 2010; Comas-Diaz, 2010). More specifically, such theorists allude to the enactment of social hierarchies and broader societal dynamics, as shown in the current study alongside family power dynamics. Two participants interestingly spoke about having felt unequal and inferior in the presence of their western therapists, replicating the experience of some participants in Netto et al.'s (2001) study. This paralleled their view of western culture as holding greater power which they felt stereotypes South Asian culture and women as weak. This coincides with literature showing that a fear of therapists holding stereotypical views about South Asian women, or of not understanding the complexity of their experience, can leads to concerns of not being taken seriously in therapy, implying presence of internalised gendered racism (Ashiq, 2017; Chhina, 2017; Patel, 2007; Prajapati & Liebling, 2021). Similarly, other previous research found that mental health professionals view South Asian culture as oppressive and inferior, and western cultures as liberating and superior (e.g., Burr, 2002; Khalil, 2018). Although largely unacknowledged, such

internalised stereotypes may partly originate from the British Colonisation of the Indian subcontinent, which led to the latter being viewed as inferior (Puri, 2020; Tharoor, 2018). This takes into account Proctor's (2002) analysis of the presence of three types of power within the therapeutic relationship: that of roles, history and society.

The experience of therapy for these current participants was further negatively impacted as these power dynamics appeared unacknowledged. Brown (2018) argues that when the therapeutic relationship considers the impact of the manifestation of power in the therapy process, it can ensure that the client does not experience therapy itself as persecutory. Otherwise, microaggressions and enactments can occur from which clients can experience marginalisation/traumatisation (Noronha, 2021; Rogers-Sirin et al., 2015).

Most participants in the present study also seemed to experience the enactment of their family power dynamics: they appeared to feel inferior in therapy akin to how they felt in their everyday life, mirroring the presence of authoritative hierarchies in South Asian families (Khalil, 2018; Tummala-Narra, 2013). This was further found within Pandya and Herlihy's (2009) research into British South Asians' perception of family therapy where one participant experienced a lack of equality as they felt their therapist focused mostly on the father's experience. This further shows how unexplored power dynamics in therapy can have a detrimental effect on the therapeutic relationship and a client's experience.

However, power dynamics appeared to shift for some participants in the present study as they instead experienced a good therapeutic alliance and a more collaborative therapeutic relationship. Research shows this to be important in achieving successful treatment outcomes (Bohart et al., 2002; Wampold, 2015). Interestingly however, and particular to Nazia and Shivani's experience, they preferred their therapist to hold an authoritative position as they appeared to want to be told what to do. This parallels authority figures being obeyed in South Asian families for their greater wisdom and knowledge (Khalil, 2018). Familiarity with this cultural norm may therefore explain why these participants expressed annoyance and helplessness when lacking direction from their therapist, who appeared to be trying to provide a more collaborative experience. Sue (1977) mentions the negative influence of this on the therapeutic relationship as therapists would lose credibility for clients if they do not act in a consistent manner according to cultural expectations. These clients would therefore be more likely to end treatment, which was indeed the case for both Nazia and Shivani. Addressing such psychodynamic transferential power dynamics may therefore facilitate the therapeutic process and reduce termination (Yasmin-Qureshi & Ledwith, 2021).

Furthermore, participants who experienced greater challenge in creating change from therapy in their everyday lives appeared to understand this as being due to experiencing stronger South Asian family power dynamics in which they felt more powerless, highlighting a correlational link. This signifies difficulty to navigate and integrate both the therapeutic and South Asian contexts due to potential cultural conflict. These participants therefore appeared to keep both

separate as a way to manage this. Guzder and Krishna's (2005) article highlights this finding very closely: their case studies experienced conflict in translating cultural change due to being faced with family pressure to maintain their traditional gendered roles. Yet, they also similarly found some of their female Hindu cases to be more able to create space for greater individualism in their general lives than others. Some of Patel's (2017) participants also experienced helplessness in challenging/escaping restrictions put in place by authority figures. They mostly felt they could only do this when their environmental context had altered. This especially reflects Fatima's experience from the current study who struggled implementing therapeutic change due to her going back to the same strict family environment, which rendered her therapy progress futile.

Research has also found that cultural conflict contributes to mental distress in ethnic minority groups (Singh, 2002; Tummala-Narra & Deshpande, 2018), particularly when one is inhibited from adopting values different to South Asian values (Hussain & Cochrane, 2002; Rao et al., 1984; Tummala-Narra et al., 2016). This can be explained by revisiting Wardak's (2000; 2002) above theory that social control mechanisms, such as the family, function to maintain order within South Asian families to protect family honour. Similarly, Kaduvettoor-Davidson and Inman's (2012) study supports this alongside the current findings: they found that less internal conflict was experienced by South Asian women when trying to negotiate their gender roles if their families were more supportive, also likewise found by previous research (Goyal et al., 2015; Khalil, 2018; Masood et al., 2015).

The findings of this present and above other studies therefore highlight that the emphasis on self-actualisation and autonomy, that is at the heart of some therapeutic approaches such as humanistic therapy (Welzel & Inglehart, 2010), are not generalisable to different cultural groups (Lerman, 1992). Lerman (1992) points out that achieving self-actualisation is difficult when feeling controlled, and therefore that such schools of thought should recognise the part that external influences play in one's construction of their own reality. This is further supported by Gupta et al. (2007) as her second-generation, South Asian British female participants experienced a powerful influence of the role of the wider Asian community on their lives. Literature points to fears around community rejection for collectivist clients and their families if one attempts to challenge cultural norms (e.g., Conrad & Pacquiao, 2005; Khalil, 2018). This implies that there may be a greater cultural hold/control upon South Asian individuals beyond that of the family household.

The current research and the above indicates participants' desires for a more autonomous way-of-being, further shown by Gupta et al.'s (2007) participants who experienced a lack of control due to parental restriction. Yet, I wonder if for some participants, such as Shivani, establishing autonomy was not as great a priority as maintaining cultural norms. This invites an intriguing argument that the extent to which a person is invested in their culture may influence the degree that they find deviating from such cultural norms worthwhile. Mines' (1988) argument is supported here in that such individuals may not feel passively trapped. They may be acting according to their wishes and perhaps

with their family's wellbeing in mind alongside attempting to avoid conflict as was found by Patel's (2017) research on South Asian women. Nonetheless, the current findings show support for Paulson et al.'s (2001) research which demonstrates the potential hindering nature of external barriers to therapeutic success, - in this case, that of power dynamics in participants' everyday lives - and therefore the difficulty in navigating both cultural worlds.

6.3. Finding a Sense of Belonging

Therapy enabled participants to explore both their western and South Asian cultural identities in the same space, and negotiate a degree of integrating both to reflect a truer, more authentic identity. This replicates recent quantitative research, which found that collectivist individuals with higher levels of Bicultural Identity Integration (BII) feel more authentic than those with lower BII (Mok, 2022). Research on East Asians further demonstrates that greater resilience is shown when they identify with and navigate both their eastern and western cultures (Choi et al., 2016). They otherwise tend to experience challenges in negotiating conflicting cultural values, impacting identity development (Cheung & Swank, 2019; Choi et al., 2016). Current participants' experience seems to parallel Bromberg's (1996) psychoanalytic concept of self-states where therapy allows space to integrate different states of the self to experience a more cohesive self. This current finding therefore challenges research showing that service users experience a negation of their cultural identity in therapy and feel they cannot discuss it (Prajapati & Liebling, 2021; Vyas et al., 2021; Yasmin-

Qureshi & Ledwith, 2021). Instead, it supports Tummala-Narra's (2013) point that exploratory therapies can facilitate ethnic minority clients to explore their cultural identity more deeply.

Current participants had otherwise largely felt torn between these two cultural identities in response to feeling discriminated against in their everyday lives for not belonging to a core culture (Wardak, 2000). They were instead 'splitting' their identity as a means to navigate two cultures in an attempt to fit in (Methikalam et al., 2016; Tummala-Narra et al., 2016; Vyas et al., 2021). This replicates qualitative studies which found that first- and second-generation South Asians move between differing identities depending on the cultural context in response to racial discrimination (Meetoo, 2016; Sundar, 2008; Vyas et al., 2021). Research on East Asian American biculturals shows them also experiencing racism and discrimination alongside challenges to their identity, often feeling stuck between both eastern and western cultures (Cheung & Swank, 2019; Hong et al., 2016; Thompson et al., 2016; Xia et al., 2013). However, some research has found that South Asians experience greater levels of discrimination and acculturative stress than those from East Asian cultures, influencing the former to report greater levels of anxiety and depression (Sorkhou et al., 2022; Tummala-Narra et al., 2012). Despite these differences, it further implies how social hierarchies control one's sense of belonging, where those considered as different are often 'othered' and marginalised (Ahmed, 2019).

This was not only experienced by most current participants within their everyday lives, but was sensed by Nazia and Khadija from their actual therapists whom they felt had internalised negative stereotypical views of South Asian culture. This seemed to pull both to protect South Asian culture, thereby developing a closer connection to their South Asian identity. This coincides with the above research showing that mental health professionals stereotypically view South Asian culture as inferior, highlighting the greater power inherent within eurocentric values infiltrated into mental health services (Burr, 2002; Khalil, 2018).

In fact, most current participants developed a closer connection to South Asian culture and felt prouder to have a part-South Asian identity, exhibiting an active desire to hold onto it. This supports Srinivasan's (2001) findings whereby the South Asian identity for her second-generation Indian-American female participants also appeared associated with the degree of pride they felt around their cultural heritage and history, rather than enforcement by family expectation and restriction. The therapy process for current participants therefore seemed to involve exploring the aspects of both western and South Asian cultural identities that participants valued, enabling them to let go of those that did not speak to them. La Roche and Maxie (2003) state that one's awareness of the complexity of cultural differences both within the therapeutic relationship and in general life can allow them to decide which values they wish to identify with. Current participants thereby appeared to develop a greater sense of freedom and control over their identity rather than being ascribed this by others. This mirrors the experience of Beharry and Crozier's (2008) South Asian female participants

who felt a sense of agency in depicting a truer identity. Methikalam et al. (2016) also state that therapy can facilitate a client to challenge introjected messages from society and instead think about how one truly views the self, as explored in Object Relations psychodynamic theory (Klein, 1952), and how then to navigate two cultures out of choice.

Erikson's (1968) psychoanalytic theory of psychosocial development proposes that healthy identity formation should occur within adolescence, otherwise one is left with an unresolved, passively ascribed/enforced identity. I partly contest Erikson's theory as the current research shows that this process can occur beyond adolescence as depicted by most participants, highlighting the fluidity of identity. Yet, Erikson's theory is viable regarding the process of exploration and formation of values/beliefs about one's identity that is needed for healthy identity formation. Psychological therapy appeared to facilitate current participants to achieve this, thereby asserting that individuals require time and a tailored process for this to happen.

However, western research shows that ethnic minorities in an individualistic society would experience most difficulty with having dual identities during adolescence as discussions about ethnicity are typically encountered in this period (Spencer & Markstrom-Adams, 1990). This may explain why the younger participants from the current study appeared to talk more about feeling torn between two cultures, and experienced greater solidarity in cultural identity following therapy compared with older participants. The latter instead seemed more settled, and experienced a lesser degree of identity negotiation from

therapy due to initially being most closely connected with their South Asian identity. I wonder whether this discrepancy can be further explained because these older participants were first-generation immigrants. They therefore would have already experienced dealing with cultural identity conflict when acculturating in the UK. They may accordingly have developed stronger personal agency in knowing how to manage any further potential conflict relating to this compared with those born in the country (Beharry & Crozier, 2008). This would suggest that the Cultural Conflict Hypothesis impacts more so second-generation immigrants as they may tend to experience greater discrepancy between attitudes of a traditional and modern nature (Bhugra & Jones, 2001; Phinney, 2003). This would support literature showing that second-generation South Asians experience more difficulties due to cultural identity and alienation, whereas first-generation individuals experience greater difficulties related to migration itself (Bhugra, 2002; Bourque et al., 2011). This discrepancy was also found among East Asians where second-generation immigrant youth tended to experience such unique challenges with identity compared to first-generation immigrants (Cheung & Swank, 2019; Choi et al., 2016). Contrastingly, Bashir and Tang (2018) found that their US-based South Asian participants from all generations were satisfied with their cultural identity, which included positively identifying with the mainstream culture with no issues. Yet, most of their participants were related to one another and therefore had similar experiences, and were also prepared to move to the US.

However, I wonder whether first-generation immigrants, Ravinder and Shivani's lack of shift towards identifying further with an individualistic identity was out of

choice or due to feeling an obligation to South Asian culture. Pertaining to the latter, Gupta et al. (2007) also found that their participants submitted to South Asian community power due to fearing loneliness if they abandoned it, thereby trying to prevent experiencing 'cultural mourning' (Gupta et al., 2007). Although Ravinder and Shivani's experience of identity had shifted ever so slightly, their stronger identification to their South Asian identity may have therefore functioned to avoid experiencing detachment, loss and therefore lack of belonging from South Asian culture.

This implies that individuation may not be ideal for people from collectivist cultures as it could lead to alienation (Gupta et al., 2007). Accordingly, one needs to bear in mind assumptions that South Asian clients who undergo psychological therapy want to become individuated as this may not be psychologically healthy for them. This supports literature denoting that maintaining one's heritage leads to better psychological health rather than assimilating especially when seeking enhanced family life (Moghaddam et al., 1987; Ryder et al., 2000). However, this contrasts with women who experience depression when feeling distant/ostracised by the host western culture when holding onto their original culture (Hussain & Cochrane, 2002). The contrast may be, as mentioned, due to a case of choice versus obligation.

Similarly, I too wonder whether current participants, including second-generation, negotiated both their western and South Asian identities due to not wanting to abandon their culture completely. They may have felt that complete assimilation into western culture was not possible as found by Mirza's (2017)

second-generation British Pakistani female participants. This appears to link with the experience of participants in Gupta et al.'s (2007) study who realised that there were benefits of having a greater South Asian connection due to the comfort it provided them. This goes hand-in-hand with Ghosh (1994) who states that other cultures' perception of one's ethnicity/race can threaten a South Asian woman's sense of self. This can leave her feeling like an outsider rather than as belonging to the culture in which she resides, leaving her to adjust psychologically.

Nevertheless, therapy seemed to have facilitated current participants to realise that they struggled to meet the individual expectations of both western and South Asian cultures (Tummala-Narra, 2013), ultimately therefore negotiating and integrating both identities within therapy. These were transferred into their everyday lives as participants felt determined to actively search for others who reflected this integration as a recognition of sameness (Mirza, 2017) and to feel better understood. Interestingly, this seems to parallel participants feeling understood in therapy regarding their cultural identity. Social Identity Theory (Tajfel & Turner, 1979) is applicable here, which proposes that the sense of belonging to a group is key to developing one's sense of identity, which in turn is responsible for creating sense of self. Being part of their new tribes therefore seemed to consolidate participants' negotiated identities further, bringing a new level of acceptance. This supports research findings whereby participants adapted their cultural connections as a way to feel more accepted and validated (Noronha, 2021).

However, Stets and Burke (2000) argue that the importance of a person's individual qualities reduces when in a group as they are forced to behave according to their group, which can trigger psychic tension as the self is repressed (English & Chen, 2007). Although this may be the case for some individuals within collectivist cultures (as shown within the first master theme's findings), it seems that current participants developed an identity that reflected more greatly who they felt they were. In support, Eng and Tram (2021) found that interacting socially with those from one's ethnic group was linked to experiencing a stronger ethnic identity, alongside it providing a way for ethnicity to be expressed and experienced (Alba, 1990). Current participants therefore actively exercised their agency and sense of self by choosing instead to be with a group which mirrored their attitudes and behaviour rather than passively falling into one, thereby combatting the prior experience from their everyday lives (Majumdar, 2007).

6.4. Breaking Barriers

Most participants further experienced therapy as a form of support that they were not willing to initially engage in. One reason for this appeared to be the idea that only collectivist support should be considered adequate. This view was mostly unique to Ravinder and Nazia in the present study, which parallels the view of Latino clients who only used psychotherapy when they exhausted their cultural resources (La Roche, 1999). Other literature shows that seeking outside support would indicate failure of the collective to resolve problems (Chadda &

Deb, 2013). Accordingly, current participants may not have wanted their family to be seen in a negative light. Nonetheless, the position of both participants from the current study in relation to this shifted as they experienced therapy as helpful.

Yet, the negative stigma that South Asian culture attaches to mental health and therapy appeared to be another reason for current participants' initial struggles with accepting therapy. Vast literature and research consistently show how such stigma/shame deters individuals from obtaining mental health support (e.g., Goyal et al., 2015; Pilkington et al., 2012), as also found among East Asian Americans (Cheon et al., 2016; Jang et al., 2017). Yet, Kainth's (2021) study shows that UK-based South Asian international students, assumed to have a stronger allegiance to South Asian culture, were open to seeking counselling despite stigma in their home country. Being away from their culture of origin and exposed to the western host culture may have allowed these students to feel freer from the negative stigma, and therefore willing to engage in therapy. Similarly, despite initial aversion, exposure to western values particularly of mental health appears to have somewhat given participants in the current study 'permission' to contemplate having psychological therapy. As western culture places less emphasis on viewing therapy clients as 'crazy' or mentally unstable unlike South Asian culture, this may have helped reduce the negative stigma/shame (Goel et al., 2022; Khalil, 2018). Similarly, Ashiq (2017) found that therapy helped alter South Asian women's perspective on shame in relation to feeling they were going against cultural norms by having therapy. This shifted self-blame, allowing them to further accept having therapy, potentially also

mirroring current participants' experience. Supporting this, Kainth (2021) suggests that giving counselling a try can challenge preconceived views about the process. This indeed occurred in the current research such as for Fatima and Sabina, as further found within Khalil's (2018) study despite participants initially feeling apprehensive and anxious to access services due to stigma. Like with Khalil's (2018) participants, such challenged views appeared to encourage current participants to become advocates for therapy as they wanted to share its benefits with other South Asians in their everyday lives. They therefore seemed to want them to also experience a shift in stigmatised views and acknowledge that psychological therapy is not only for those considered as mentally disordered.

Furthermore, previous literature shows that collectivist individuals will struggle to have a positive attitude towards therapy if they lack understanding of it (e.g., Chaudhry, 2016; Khalil, 2018). This was the case for most current participants who never had therapy previously, which contributed to their difficulty in initially accepting it despite this view changing overtime. In a way, trauma literature can somewhat loosely explain this in that if something is beyond the brain's processing capacity, it will be considered less desirable and even threatening to approach as a means of self-protection (van der Kolk, 1994). Yet, when that same phenomenon is understood and processed, it appears less threatening. Current participants therefore appeared to have experienced a similar process by initially viewing therapy as potentially threatening to for instance family honour and lacked understanding of it, although became more accepting once engaging in it and benefitting from it. This is also supported by Kainth's (2021)

participants who had a positive experience of therapy despite having initial misunderstandings about it, further found in recent research with East Asians (Liu et al., 2020). Other research also shows that increased familiarity with mental illness, either through education or experience of it, reduces prejudiced views and facilitates greater care towards mental health sufferers (e.g., Anagnostopoulos & Hantzi, 2011; Maulik et al., 2017), further emphasising current participants' tendency to encourage others to seek therapy.

Another underlying reason for participants' initial aversion towards therapy however may have been due to their negative experience of western society. Drawing from the above discussion of other themes, it appears that participants' experience of feeling 'othered' by western society and struggles to fit in may have led them to internalise a somewhat negative view of western culture. Social comparison theory is applicable here (Festinger, 1957), which denotes that one is less attracted to a group when comparisons between them and the other group are more divergent. Current participants may have therefore felt deterred from engaging in any behaviour deemed as western as they were made to feel very different due to their (part-)South Asian heritage. Vast research supports this which shows that South Asians' experience or fear of racism due to the eurocentricity of mental health services influences accessibility (Burr, 2002; Chew-Graham et al., 2002; Mind, 2013; Prajapati & Liebling, 2021; Williams et al., 2006). However, experiencing and recognising the value that therapy added to their lives appeared to have facilitated challenging participants' internalised views to some extent, inviting them to

encourage other South Asians towards therapy in an attempt to navigate and bridge the gap between both cultural contexts.

6.5. To Share or Not to Share

Where participants however struggled to navigate bridging the gap between both cultural contexts was in the content of what they discussed in therapy. Despite therapy being a space where in theory anything should be openly expressible, most South Asian women in the current study initially struggled being open about their family lives. This seemed due to fearing judgement and being misunderstood coinciding with wanting to protect their family from shame, which replicates the experience of Khalil's (2018) participants.

Inman et al. (1999) and previous literature (Gilbert et al., 2004; Zaidi et al., 2016) indicate that women from such collectivist cultures feel or are made to feel responsible in maintaining family honour. They are therefore reluctant to share any information that may compromise this, owing also to family privacy being highly valued. An association therefore appears present between high emphasis on traditional family values and concealment, also shown by Sen's (2019) quantitative research on students. This highlights Inman's (2006) findings whereby South Asian women felt an expectation to behave selflessly to maintain family peace/harmony, otherwise potentially creating relationship conflicts and ostracism. Jack's (1991; 2011) cross-culturally relevant notion of 'silencing the self' explains how women may exercise silence to maintain

intimacy and safety. This can otherwise be impacted in part through damaging family honour by shaming the family through disclosure, where current participants may have felt that only emotions were safe enough to express (as in the first master theme). Guzder and Krishna's (2005) argument is therefore supported here, that although therapy acts to create more open dialogue and encourage inner-world exploration, this can create upheaval for South Asian women who may instead choose to exercise silence.

Family honour therefore appears to strongly determine/dictate one's interpersonal behaviour (Dwyer, 2000; Inman, 2006). This brings to fore literature showing that the South Asian family potentially may be a risk factor for mental illness among women as such silencing means they may be unable to accurately disclose the reasons for their suffering, which may pertain to the family itself (Masood et al., 2009; Shankar et al., 2013). Literature further depicts this to influence suicidality among South Asian women, alongside somatisation where distress is presented in a more legitimatised way without feeling stigmatised/ashamed, therefore being more likely to protect family honour (Burr & Chapman, 2004; Chew-Graham et al., 2002; Hicks & Bhugra, 2003).

Contrastingly, current participants also actively seemed to not want their families to be judged negatively or misunderstood, influencing lack of disclosure about family life, rather than this being only out of obligation to protect family honour. This is supported by Rodriguez Mosquera et al.'s (2014) research where Pakistanis were impacted relatively equally by insults-to-parents as

insults-to-self. Non-South Asians however responded more negatively to insults-to-self, indicating a stronger emotional/relational connection to families among South Asians.

Similarly, there was a further sense that current participants were trying to protect South Asian culture generally. Some feared that their therapists would misunderstand and negatively judge South Asian norms, therefore potentially shaming their culture. Paulson et al.'s (2001) research found that feeling misunderstood was a hindering aspect within counselling for their participants. This indicates that participants may have experienced the therapeutic context as holding stereotypical views about South Asian culture. Accordingly, this presents a powerful implicit message about feeling 'othered' by, and inferior to, a westernised context, which may hold behavioural expectations about specific groups, reflecting transferential enactments from psychodynamic theory (Batsleer et al., 2002; Burman et al., 2004; Burr, 2002; Tummala-Narra, 2013). This may have therefore influenced current participants to be silent as they may have felt this was difficult to challenge. Chantler et al.'s (2001) research on women that attempted suicide and self-harm due to experiences such as domestic violence, highlights how issues such as sexism and racism intersect with mental health practice and policy. They caution against ascribing domestic violence as being characteristic of South Asian culture, which would otherwise contribute to the culture being further stereotyped as oppressive towards women, influencing further silencing when attempting to seek support. Khadija's experience in the current study alludes strongly to this as she did not want South Asian culture to come across as a *"circus show"* and open to ridicule,

therefore largely shut down conversation pertaining to it in therapy. This demonstrates that participants preferred the therapeutic context to view South Asian norms from their lens, i.e., as ‘normal’.

Alternatively, drawing on the fourth master theme, lack of understanding about therapy and therefore initial difficulty in accepting having it may have contributed to the above fear of judgement and thereby lack of openness. Kainth’s (2021) research highlights this as judgement was feared either from the therapist or society if participants viewed counselling negatively. Therefore, participants may have potentially internalised negative stigma that South Asian culture attaches to therapy, contributing to fearing their therapists judging them and their life, thereby influencing openness. Jasmine and Sabina in particular however gradually opened up upon realising that their therapist or therapeutic space held no such judgement, which may have coincided with them developing understanding about the nature of psychological therapy, thereby challenging their initial views. Interestingly, South Asian women may therefore also carry stereotypical views into therapy as highlighted within Moller et al.’s (2016) study.

Such stigma nonetheless appeared to influence current participants’ difficulty in disclosing their engagement in therapy to others in their everyday lives. They seemed to fear being judged as ‘crazy’ or mentally unstable, thereby appeared to protect damaging family honour yet also protect themselves from feeling invalidated and experiencing non-recognition, which some participants did experience. Some participants only disclosed this with a few others when their

fear of being judged reduced. This similarly replicates one of Ashiq's (2017) findings as her South Asian female participants only told others on a need-to-know basis about them accessing therapy, otherwise chose not to disclose this due to their cultural background. The taboo around mental health therefore highlights the stereotypical views towards help-seeking held by other South Asians in current participants' everyday lives, influencing them to keep therapy secretive outside of the therapeutic context.

Participants however did not fear negative judgement when openly discussing topics in therapy considered taboo in South Asian culture such as intimate relationships, as similarly shown in other research and literature (Kallivayalil, 2004; Khera & Ahluwalia, 2021). With therapy being a largely western discipline, the idea of discussing such topics seemed more permissible for participants than within the South Asian cultural context, also due to therapy being confidential. South Asian culture instead frowns upon this as it can negatively impact South Asian family honour, considered to be mainly held by South Asian women as mentioned above (Gilbert et al., 2004; Zaidi et al., 2016). The current findings replicate Zaidi and Shuryadi's (2002) research on the attitudes of Pakistani Muslim women towards arranged marriages in Britain: these women were torn between both western and South Asian cultural values as they were prohibited from expressing their sexuality in the latter culture although felt free to do so in the former culture, leading them to behave differently between both contexts (Shariff, 2009). Tummala-Narra (2013) states how this can influence women to feel isolated within the South Asian cultural context. This cultural conflict has further been supported by previous research

(Inman et al., 1999; 2001), again demonstrating taboo around topics such as sex and mental health within South Asian culture compared within western cultures (Khan, 2002; Thapan, 1997).

Cook and Dewaele's (2022) recent research provides similar understandings of the current findings despite being around use of language: their refugee participants were more easily able to express their traumatic experiences in English compared to in their original language. The former more detached language seemed absent of others' judgements, and therefore free of guilt and shame, allowing participants to express previously hidden parts of themselves. This is very closely linked to the current finding as current participants felt freer to discuss taboo subjects within a different cultural setting, allowing them to push boundaries of "what is sayable or tellable" (Espin, 2013, p. 221). Therefore, most participants challengingly navigated therapy and everyday life by negotiating openness between both, ultimately keeping both separate. This appeared to facilitate avoiding any shame being brought upon their families, whilst also allowing them to finally express parts of themselves in therapy that were repressed and disavowed in their everyday lives (Tummala-Narra, 2013).

Perhaps the most intriguing aspect from this theme is that it appears to provide a plausible reason for inconclusive findings on ethnic matching between therapist and client as indicated in literature (e.g., Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002; Shin et al., 2005). Although I looked out for whether the cultural background of therapists and participants influenced this finding, this did not appear to be the case due to commonality of experience

across the cultural dyads. Importantly, participants who mentioned seeing a previous or subsequent South Asian therapist also seemed to negotiate openness of topics: although they appeared to feel more culturally understood, most seemed to fear judgement due to seeing the South Asian therapist as similar to South Asian others in their everyday lives. Therefore, the current study highlights that clients may feel more comfortable with a certain ethnicity of therapist depending on what they wish to discuss. This is heavily supported by other recent research findings (e.g., Cook & Dewaele, 2022; Kainth, 2021; Khalil, 2018; Prajapati & Liebling, 2021), alongside by the following quote:

> some South Asian women choose to work with a South Asian therapist in the hope that they may feel better understood, especially with respect to their cultural background and native language, whereas other women may choose to talk with a non-South Asian therapist when they have concerns about privacy or about whether or not a South Asian therapist would negatively evaluate them if they don't identify with South Asian cultural values, and if they perceive the South Asian therapist as closely identified with South Asian values and norms. (Tummala-Narra, 2013, p. 193)

Khalil (2018) further points out from her findings that clients want to ultimately be understood rather than judged, which may involve having to navigate between therapists from whom they feel they can achieve this. She also highlights that having an ethnically-matched therapist to feel better understood does not guarantee that the therapist will actually have a solid understanding of

the cultural background. Not being able to achieve this may therefore contribute to creating dynamics around silencing from clients within therapy as well as in their everyday lives.

6.6. Overarching Trends

Some aspects of the above master themes seemed to overlap at times, which I mentioned is often expected in IPA research (Smith & Osborn, 2008). Most of the current findings appear to highlight the South Asian women navigating both therapy and their South Asian cultural contexts by making negotiations to find a balance that suited them. At times, such negotiation required them to consider their responsibility towards respecting South Asian culture, whether out of choice or not. Yet, it most often seemed that participants wanted to make this transition to also suit them, which meant neither abandoning South Asian culture nor implementing only their learnings/awareness from therapy. A sense of agency is therefore implied, which has been mentioned somewhat above, though which I feel is important to expand here.

Ahearn (2001) and Parker (2005) look at how having agency has traditionally been considered as an individual's attempt to go against and be free of any enforced structures and constraints. It appears that South Asian women have therefore been considered as lacking agency if they do not manage to sway from South Asian cultural expectations (Raval, 2009). This seems to have left western culture with the stereotypical impression that South Asian women are

repressed and oppressed (Burman & Chantler, 2003). However, scholars such as Hay (2005) provide, what looks to me, an alternative, more accurate view. They indicate that one's individual motivations and aspirations to act in ways that still respect social structures needs to be included in the understanding of what having 'agency' is. This therefore highlights and provides an explanation for the constant negotiations that the South Asian women from the current research came up against over their therapeutic journeys. They instead attempted to navigate and find a way that managed any conflict between their aspirations and South Asian cultural expectations, whilst remaining very much a part of their culture. Mirza's (2017) research highlights this in the way that her British Pakistani female participants upheld both individualistic and collectivist values that suited them, thereby contradicting the view that such women are victims of a patriarchal society. It is also important to note that no participant in the current study wanted to abandon their culture as often assumed by western civilisation. This goes hand-in-hand with Menon's (2002) argument about how South Asian women do not desire to contest or abandon their family structure, but that involvement in family life is actually what gives them a sense of power, purpose and meaning, as further supported by Mirza (2017).

In fact, some current participants shared their experience of western civilisation painting South Asian women, who want to make such a negotiation, as being 'victims' of an oppressive system. Focusing on the lives and experiences of these women in this research, however, allowed a more nuanced version and understanding of agency to be created. This was exactly recognised by Raval (2009) in her research on the way South Asian women negotiate their personal

desires with others' expectations. The same was also found among Korean and Filipino women (Nakamatsu, 2005). In fact, Nakamatsu (2005) provides another alternative perspective to the current study's theme on power: that although it appeared that participants were at the mercy of power hierarchies in their families, they may instead have had their own ways of dealing with this power, whether that was through confrontation, passive collaboration or disengagement, which again Raval (2009) too had found. For the current participants in particular, the first two feel relevant. Therefore, one can see these women in a sense as being agents of their own personal worlds as they consciously chose to navigate their personal and cultural contexts through negotiation despite this being mostly challenging. Therefore, this contests the above-mentioned commonly-held, western view of South Asian women as being repressed (Burman & Chantler, 2003).

Importantly, this would suggest that rather than viewing South Asian women from an experience-distant perspective as is often adopted by western society, an experience-near approach instead needs to be fostered (Geertz, 1983; Wikan, 1991). Considering the latter view, perhaps in the case of some current participants who did not shift much in their negotiations, the idea of taking action was not the most appropriate or desired option depending on their circumstances. This intertwines with Ahearn's (2001) definition of agency as being the capacity to act in a socio-culturally mediated way.

Effectively, one needs to be careful in misinterpreting a South Asian client's difficulty in engaging on an individualistic level in therapy as being a negative

outcome or as a symptom of South Asian cultural oppression/pressure. This way of thinking can be enticing as collective and coercive structures have been the focus for western social science (Gjerde, 2004). I therefore agree with Gupta et al. (2007) that the psychodynamic separation-individuation theory therefore needs to be applied with caution.

However, women who choose to adopt more individualism into their lives can be viewed as creating a new part of their identity (Mohee, 2012). This reflects current participants having acknowledged aspects such as theirs and others' individuality that they seemed previously less aware of alongside the helpful features of therapy, which enabled them to contemplate their cultural identities differently. This appeared to encourage freer speech and reflections over cultural differences, alongside how participants wanted their lives to be, thereby enabling them to become more empowered in making their respective negotiations (Ivey, 1995). Therefore, although navigating therapy with everyday life can be challenging particularly as each cultural context has its own expectations and norms, current participants seemed to ultimately find a balance that reduced experiencing great cultural conflict and dissonance (Festinger, 1957; Tummala-Narra, 2013).

6.7. Implications for Counselling Psychology

6.7.1. Consideration of Context

Overarchingly, the present study provides great insight into South Asian women's lived experience of cultural difference regarding how they experience and navigate psychological therapy and its interplay with everyday life. Therapists are invited to consider the complexity and diversity of this cultural interplay for clients, and therefore bring into their minds the everyday, between-session contexts, realities and challenges that women may have to face and endure through their therapy journey.

Negotiation appeared to be the main consistent pattern found within this present study. The South Asian female participants appeared to be navigating cultural difference by constantly negotiating their everyday South Asian lives with that which they were experiencing and implementing from therapy. This calls for therapists to consider the cultural context of South Asian clients carefully and even those from other backgrounds, as the external therapeutic context can greatly influence the therapeutic process. Specifically, an acknowledgement and consideration of the system within which a South Asian woman lives is needed. This involves her family and community, as this system can influence the degree of cultural conflict experienced (Kaduvettoor-Davidson & Inman, 2012).

Considering the lack of emotional expression typical within South Asian culture, the current research invites therapists to give space to this in sessions in order for clients to recognise, and connect more to, their individual sense of selves, which is characteristic of exploratory therapies. Yet, therapists need to

acknowledge that clients may not adopt an individualistic way-of-being or even be comfortable considering this to the extent that therapists may think or deem necessary if trained in a westernised model. This is despite clients experiencing relief from acknowledging their emotional/individual selves in therapy as shown in the current study. Rather than seeing what therapists may consider as 'little progress' and therefore as a 'failure' of therapy in creating change, therapists need to accept that the context of the South Asian woman may not allow for a great deal of shift. Instead, she may only make a shift that is comfortable for her to balance her responsibility to South Asian life and to obtain something from therapy uniquely for herself. This encourages therapists to allow themselves to be led by South Asian clients within therapy, and to understand that such clients may not see either a South Asian or a more individualistic way-of-being as more 'correct' than the other. In effect, the negotiation is that of trying to accept both in a ratio that feels adequate rather than abandoning either, namely accommodating both rather than assimilating (Gibson, 1988). This calls for a non-expert position (Anderson & Goolishan, 1988) from therapists, instead tailoring the therapeutic work to the clients' individual needs rather than using a blanket approach of trying to get them somewhere it is difficult for them to reach.

Considering a client's cultural context can empower clients by facilitating them to acknowledge where they are able to make change compared with focusing on where change is lacking. Accordingly, this calls for therapists to be mindful of their countertransference regarding any irritation/frustrations that may arise due to what they perceive to be a lack of shift/movement from South Asian clients.

By viewing therapy and what constitutes ‘change’ during therapy more from the client’s world, it will allow both therapist and client to acquire a greater degree of understanding and acceptance. This points to the notion of ‘Creative Indifference’ (Friedlaender, 1918, as cited in Mann, 2020), a principle in Gestalt Therapy used to steer the therapist and client away from a place of ‘knowing’ or familiarity, and instead to surrender to the between of the relationship, – the ‘void’ – giving birth to new and expanding perspectives for both therapist and client to explore. This would therefore facilitate overcoming cultural barriers, and instead pave the way for a more equalised and meaningful therapeutic relationship, and therapy journey for clients. Chantler (2005) highlights that once a client’s wider political, social and cultural contexts are engaged with in therapy, Rogers’ (1951) core conditions can be fully offered.

Alongside tailoring therapy to the client’s needs, looking more through the client’s lens would allow therapists to acknowledge support mechanisms/coping resources already available to clients, as highlighted in the first theme. Instead of pushing for more individualistic types of coping resources, therapists can instead consider how support can be equivalently sought from clients’ cultural connections and spiritual or religious practices, which are often central to the lives of those from collectivist backgrounds (Karasz et al., 2019). A metanalysis has found such culturally-focused interventions to be four times more effective than other generic methods, and linked to reduced drop-out rates from treatment (Griner & Smith, 2006). This would therefore validate and empower clients further (Kainth, 2021) alongside facilitate smoother navigation between the two cultural contexts (Beharry & Crozier, 2008). A point to mention here is

that such strategies may need to be addressed and exercised within exploratory therapies that may commonly avoid CBT-like interventions. This is due to the present study pointing towards South Asian clients sometimes needing more direct work alongside exploration, which in itself mirrors integrating collective and individual ways of thinking/working.

Pertaining specifically to psychodynamic therapy, one needs to be mindful of how much emphasis is put on the individual subjectivity of the client, the unconscious and concepts such as the Oedipus complex, and instead to shed light on the cultural meaning of psychic life (Chodorow, 1999; Kakar, 1989). This calls for therapists to consider how much they emphasise separation-individuation particularly in psychodynamic therapy, and therefore to include looking at helpful and positive perspectives to collectivism.

6.7.2. Power, Stereotyping and Discrimination

Furthermore, the current study invites professionals to be mindful of potentially holding any stereotypes/racial biases in relation to collectivist cultures, as highlighted quite strongly by some current participants. There is an understanding that psychological therapy training is largely eurocentric. Intrapsychic and interpersonal dynamics are therefore mostly viewed from this lens (Tummala-Narra, 2011), which can potentially pull therapists to pathologise South Asian clients as they may consider interdependence to be unhealthy and even view South Asian culture as inferior. Regarding other Asian cultures,

literature discusses how the white dominant culture often defines the identities of East Asian Americans, which makes them devalue, and feel ashamed of, their own culture, thereby also experiencing cultural racism (Link & Phelan, 2006). By therapists taking care not to fall privy to seeing these clients as disempowered and 'victims' to South Asian norms/values, it can enable therapy to be provided in a way that clients experience as non-discriminatory. This could facilitate clients to feel less 'othered' and marginalised in the therapeutic relationship, and can prevent South Asian culture being pathologised (Chantler, 2005; Gupta et al., 2007), encouraging openness/voicing from clients. Therapists can instead be more open-minded about the benefits of a South Asian way-of-life for clients, rather than holding any potential assumptions about individualism being the ultimate, more powerful way-of-being.

An importantly similar point here, also resulting from this present study, is for therapists to be aware of cultural and societal hierarchies and racial power dynamics from clients' everyday lives, and how these can become re-enacted in the transferential relationship within psychodynamic therapy. It is therefore imperative for therapists to be conscious of such power issues within cross-cultural contexts and dyads especially when subtle. Being aware of the co-construction of intrapersonal, interpersonal and cultural factors through the transferential relationship, even from utilising supervision, would therefore facilitate moving towards a more culturally competent practice (Altman, 2010; Tummala-Narra, 2009). This, and developing rapport and trust with clients, would create a safe space where both cultures and any conflicts between them that clients may experience can be explored in therapy alongside their feelings

around these (Tummala-Narra, 2013), as indicated by Noronha's (2021) participants. Therapists can therefore work collaboratively with clients on how to navigate South Asian and sociocultural power hierarchies that may be negatively impacting their ability to implement therapeutic learnings into their everyday lives, in a way that is beneficially and suitably tailored to their individual dynamics.

Understanding strong South Asian concepts such as family honour and shame can further encourage therapists to explore client behaviours around accessing therapy and open expression even when in therapy (Khalil, 2018). This in turn can prevent premature termination of therapy due to clients feeling culturally invalidated if such concepts are not acknowledged (Shariff, 2009; Sue & Sue, 2016) as was Nazia and Shivani's experience in this present study, which can negate the reality of one's personhood and identity (Sue & Spanierman, 2020). Accordingly, a more facilitative therapeutic practice can encourage South Asian clients to shift experiences of shame and feel more open to engage in therapy, thereby helping to bridge the gap between both cultures. This can also help to address dynamics around silencing/openness of certain topics between the South Asian and therapeutic contexts.

This bridging was experienced by participants in this present study in relation to feeling that their therapy allowed both their cultural identities to be considered in the same space. This was contrary to their prior experience of having to split both identities in their everyday lives due to discriminatory/racist experiences. Therapists are therefore invited to cultivate a therapeutic space that encourages

consideration and exploration of seemingly competing identities in order for clients to establish a truer/more authentic sense of their identity and sense of self. This would also require therapists to be aware of any personal biases around dominant identities in western cultures and instead be open to issues that different cultural groups face, further developing cultural competence (Cornish et al., 2010).

The above ultimately implicates training institutions and therapists to be aware of their training around culture in order to meet the needs of clients from different cultural contexts efficiently. This would include having awareness of issues around privilege, prejudice and marginalisation that can act as barriers to providing, and clients experiencing, effective therapy (Tummala-Narra et al., 2018).

Furthermore, participants in the current study emphasised wanting to change other South Asians' perceptions of psychological therapy. This was in an attempt to remove the negative stigma placed upon therapy and mental health by South Asian culture, and therefore to have others join in their experiences to enable greater sharing of experience. This implies that the field of Counselling Psychology needs to do more to educate those from collectivist backgrounds where there is stigma against therapy in order to facilitate greater understanding to bring both cultures closer together. In turn, this would further enhance openness between South Asian clients and those from their own cultural groups rather than feeling that they can only seek this from a new 'tribe', and therefore can promote a greater sense of belonging to a wider cultural network. Should

this prove difficult, therapy needs to allow for a safe enough space for clients to discuss any struggles with isolation and work collaboratively to manage this. This may require therapists to understand how certain cultural contexts may influence clients to switch norms/expectations and address clients' feelings towards this (Methikalam et al., 2016).

In essence, psychological therapists are called to be sensitive to what South Asian clients carry with them culturally into the therapeutic space. The present research has shown this to profoundly influence their therapeutic experience, and also how they navigate and manage this experience, which has largely comprised negotiating the application of their therapeutic learnings into their everyday South Asian lives.

6.7.3. Beyond South Asian Culture

Stepping beyond the South Asian cultural realm, the findings of the current study also have some implications for other Asian cultures, which has been somewhat mentioned in the discussion above, although is further highlighted here. Literature shows that East Asian culture also shares similarities with South Asian culture along the realms of social connectedness, importance of family, and responsibility of maintaining relationships, which can otherwise damage group functioning (Liu, 2018; Ying, 2022). Typically therefore, East Asians also refrain from seeking mental health support as it is associated with stigma and shame. In fact, the East Asian women in Na's (2018) research discussed being

socialised into holding negative attitudes towards westernised mental health treatments and to distance themselves from individuals with such issues. This calls for therapists to be mindful of how they also work with clients from other Asian cultures as they may experience similar difficulties with accepting psychological therapy, and prefer to utilise other informal support networks and coping mechanisms (Donnelly et al., 2011). Interestingly though, the East Asian women in Na's (2018) research negotiated their beliefs about mental illness following receiving education about mental health from university, anti-stigma campaigns and having personal experience of those suffering with poor mental health. This therefore strengthens the above recommendation that education about mental health is needed to breakdown such socialised attitudes towards mental health. Nonetheless, Na (2018) also supports the need for therapists to consider their interventions in regard to tailoring them to the particular culture that such clients come from.

Furthermore, it is also important to highlight the implication of the current findings to the broader umbrella term of 'culture'. In addition to resonating with other collectivist cultures, this study appears applicable to contexts where there are potential conflicts of culture pertaining to an individual going into therapy, and how their everyday lives may interact with this. For instance, consideration can be given to males who have inhabited a world where the culture of being 'macho' or 'tough' is valued. Yet, when they enter therapy, they are also invited to acknowledge their emotional selves, which may seem an alien concept. Similar can be spoken about military personnel who may find it difficult to accept and be open in therapy, and feel understood regarding military culture,

alongside experience difficulty in showing their vulnerabilities, which was exactly found by Stack (2013). Therefore, this invites therapists to be sensitive to potential cultural conflict/difference in its different forms in addition to the implications for working with South Asian women and those from other collectivist cultures.

6.8. Strengths, Limitations and Future Research

6.8.1. Novel Research Topic

Previous research seems to have often insufficiently attended to the interactional relationship between a client's internal and external worlds (Proctor, 2002; Totton, 2000). Accordingly, the present study offers a unique insight into exactly this for South Asian women. The strength of this research also lies in the somewhat broad nature of the research aim, which was considered to suit the novelty of the topic, and a way to avoid greatly restricting the research and narratives that participants shared. As such, this study explores participants' in-depth lived experiences, allowing therapists, researchers, therapy training organisations and future clients to understand what may be expected when clients engage in therapy, and how to work optimally with this. Research can also be conducted into therapists' experience of working with clients to navigate cultural difference with regards to the interplay of therapy with clients' everyday lives.

Furthermore, future research can home in on the more specific aspects of this research such as each of the themes sought. This could also include looking at aspects around race and religion, which arose in some elements of this current study. Other studies have also looked into how these concepts intersect along with factors such as class, age and socioeconomic status to influence one's experience (e.g., Karran, 2022; Vyas et al., 2021). Such intersectionality can be the main focus of future research to acquire a greater insight into extratherapeutic factors that may impede or facilitate one's experience of therapy. This can also include looking at any potential immigrant generational differences as the present study pointed towards some discrepancy in master theme three, which other studies have found (e.g., Inman et al., 2001; Tummala-Narra, 2013). Although it was not the focus of this present study, immigrant generational differences could not be analysed due to the uneven sampling of participants. Future research can also breakdown South Asian groups and study any differences among them in relation to experiences of, and navigating, cultural difference. This would encourage consideration of any heterogeneity that may exist between these subgroups.

A limitation of this current study is however that I relied on participants' descriptions and confirmation of them having received a westernised, individualistic model of therapy. Therefore, this study could be replicated to include better efficiency in screening for clients who received this model of exploratory therapy such as to search the therapists they worked with and their therapeutic modality.

6.8.2. South Asian Women as the Experts

A further strength is that the current study sought clients' experiences. This offers a more valuable contribution regarding our understanding of the therapeutic process, which often differs to therapists' experiences (Bohart et al., 2002). Accordingly, this has brought us closer to the worlds of South Asian women, which often remain hidden and neglected in research literature compared with other collectivist, ethnic groups. This indicates the importance of obtaining novel experiences by creating space for, and centring, such marginalised cohorts (Noronha, 2021).

However, the need for participants to have a good level of English for this research may have inadvertently contributed to excluding and silencing the experiences of those who were not English-speaking but who may have had interpreters in their therapy. This may have impacted the greater breadth and depth of experience that could have potentially been sought. Therefore, future research could include those who speak in their mother tongue to provide richer data where greater linguistic nuance can be obtained from both participants' expression and in the data analysis.

Future research could also study the experiences of therapy for newly-qualified South Asian therapists regarding how they navigated their everyday lives alongside having therapy during their training. Due to their training, their

experiences may provide a different level of detail regarding the interaction between their everyday lives and the therapeutic process, thereby adding to the present research.

6.8.3. Geographical Region

Another limitation of the current research is that participants were either from inner London or just outside of London. Despite having advertised over social media, a large geographical area was not spanned, although it can be argued that this contributed to the homogeneity of the sample. Future research could nonetheless consider branching out to other parts of England and the UK generally to be more inclusive of South Asian women from different locations. One can even potentially study any differences in experiences from South Asian women who live in densely South Asian-populated areas compared to those who do not. This limitation therefore may affect the generalisability of the results of the current study.

6.8.4. Reflections on Using IPA

Finally, using IPA allowed a deep and detailed essence, and understanding of participants' lived experiences of therapy and its interplay with their everyday lives to be obtained. However, IPA has been criticised for not challenging existing systems, which methodologies such as GT do. Some important aspects

arose from this current research that could easily challenge stereotypical thought inherent within individualistic culture and therapy, for which GT may have been more suitable. Yet, I still hold that it was more important in this research to obtain the nuance, essence and understanding of South Asian women's lived experiences, and to present this effectively rather than conduct a mid-level analysis and theorise participants' experiences. As mentioned earlier, IPA research can however eventually lead onto a GT research study (Smith et al., 2009), providing scope for future research. The current research hopes to nonetheless provoke thought and challenges to current thinking from those who read and hear about it. I, however, acknowledge that it may take time before true change is created.

7. Final Reflexive Thoughts

As I now bring this research to a close, I am more aware than since the reflexivity section in the Methodology chapter about the ways that I have shaped this research, but more so how the research has shaped me especially from the last few chapters.

I believe that only through constantly being mindful to not place great restrictions on the current research have such an array of findings been produced. Although being grateful for this, I was certainly initially overwhelmed by what appeared to be a mountainous amount of data from each participant. Based on the findings, I now wonder whether participants' openness reflected them perhaps seeing me as part of their new-found 'tribe', as I mirrored a balance between both cultures due to being South Asian and a professional in a primarily individualistic field. It seemed a mammoth task to reduce the data, and each reduction felt painful as I felt it was taking me further away from participants' experiences. In now reflecting over the themes and the way they have come together with each participant's voice shining through them, I can see how they highlight their experiences rather than my biases/assumptions. However, I acknowledge that my personal background and experiences have inevitably influenced the interpretations, for which I have tried my best to be aware of.

I was certainly surprised by the number of times the term 'negotiation' appeared in the findings. It made me hugely realise that I need to let go of my wish for

South Asian women to escape what I considered to be the restrictive clutches of South Asian culture, and instead break free into a western or more open life. Although my personal therapy helped me do this, it certainly is not the case for other South Asian women. Instead, it is a matter of navigating between both cultures in order to find a place that feels comfortable for them so as not to submit to either, but to build a new space where others and themselves are considered. This in fact is what tells me that this research's findings are not entirely driven by my biases or experiences, because they came as a surprise. Personally, it taught me to let go of the need to want more for the important South Asian women in my life and settle with the fact that they may just want to live that way because it is simpler, despite being painful for me to witness at times.

This research has certainly made me contemplate my own clinical practice as I believe my training was incredibly eurocentric, which may explain why I was personally very ready to break free from what I felt were restrictions from South Asian culture. Since this research and following further reflections, I have realised that there are elements of South Asian culture that are still beautiful such as the norm of togetherness and support. This is something that the current participants taught me. It made me since realise that I need to further tailor my counselling psychology and psychotherapy practice to clients from collectivist cultures, which I have started to do since conducting this research. I have been more mindful about how much I shoehorn in western theory and may pull these clients towards a more western way-of-being, because this may not benefit them in anyway, unless this is what they are looking for. I have therefore

found a more negotiated way-of-being as a practitioner, which has benefitted my clients in a way that would only have been possible through this research. I hope this sparks interest in taking up this practitioner approach for other colleagues and training institutions.

8. Conclusion

To conclude, the present study highlights experiences of South Asian women who have had psychological therapy in a way not previously explored. The findings reveal a different, more nuanced way of viewing and working with the many facets present in the interaction between therapy and everyday lives for South Asian women. This study points towards a myriad of connections between how power, identity, greater self-recognition, openness, belonging and acceptance are all experienced, navigated and negotiated by South Asian women between two cultural contexts. Therapists are invited to recognise that the therapy journey South Asian women embark upon is therefore multi-faceted and complex. It requires a sensitive, considered and individualised approach that also encourages awareness of any stereotypes, generalisations and pre-conceptions about South Asian culture that may otherwise influence clients' experience. In providing a greater insight into this under-studied cohort, this study therefore hopes to raise awareness about how to improve clinical practice for this client group and beyond, in a way that disrupts more individualistic, eurocentric ways of working. This research beckons therapists to bring into their mind clients' everyday realities that they encounter and that interact with therapy, which can comprise potential challenges/conflicts that they have to endure, navigate and grapple with in the spaces between therapy sessions. Therapists are recommended to bear in mind that clients from different cultures may not consider it most optimal to adopt changes within their lives to the degree that therapists may consider beneficial. Instead, clients may have to

negotiate this in a way that accounts for both themselves and others in their everyday lives to avoid creating disruption/conflict.

Hearing first-hand experiences of South Asian women meant rich, detailed and personal narratives were discovered. Their experiences have paved the way to alter clinical practice to accommodate other South Asian women, and others beyond this who experience cultural difference, effectively. My hope is that partaking in the research ignited a sense of empowerment for these women and the awareness to know that their involvement intends to make a difference to many others who contemplate engaging and do engage in mental health services.

The present study recommends a shift within training institutions. It necessitates cultural training to be made a core component in order to decolonise the current westernised, eurocentric nature of therapy training institutions. This would ensure that new cohorts of qualified therapists and clinical supervisors are adept in working and responding effectively and sensitively to cultural difference as well as to an ever-growing cultural society. Therefore, this calls for current therapists, supervisors and tutors to engage in adequate cultural training in order to create ripple effects of such training throughout the therapeutic field. The hope is to create a therapeutic environment for any client that is absent of pre-conceived ideas in order to make space for new narratives to emerge, and for clients to produce suitably desired, meaningful change in their everyday lives.

9. References

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10. Appendices

Appendix 10.1.: Table Showing Some Examples of My Biases/Assumptions From Personal Interviews

Bias/Assumption	What to look out for/change/adapt
I assume South Asian women only focus on others	I need to be open to participants who might also focus on themselves and ask how they manage to do this
Taboo topics are uncomfortable to talk about.	To be open-minded and inviting/encouraging if participants steered towards such topics as they may be fine to be open as well as be mindful if they do not wish to be open
I assume it is difficult for South Asian women to talk about aspects of family life due to fears of being judged and ostracised	I will explore their worries about this and will respect their views on this. Perhaps me also not being known to participants might help them open up more.
I assume honour and self-respect is held by women and assume that it is a big responsibility	Some participants may not feel this and may have acted in ways contrary to this. I need to be open to this.
I am assuming therapy may have been difficult for participants to manage with respect to difference in culture	I need to be aware that this may not be the case
I assume that mothers need to show they are bringing up their children correctly	I need to be aware that this may not be specific to South Asian culture, and that some participants may not think about this in terms of community or even at all
I assume that emotions are difficult to disclose in South Asian culture	Therapy may have helped participants with this, but they may still be guarded with me or not
I assume that daughters-in-law do not challenge their in-laws and find it difficult to make a difference	Some participants may do this. I need to watch out for any collusion with this and any need to avoid being a 'rescuer' if they say they are stuck with them
My judgement can make me think an interview will go a certain way	I need to ensure that I am open-minded and inviting of difference and change
I might be assuming that my interview will bring more clarity for participants	I cannot assume this as it might also bring more confusion. So I need to learn to stay with the mess and the unknown.

Appendix 10.2.: Questions Asked to Potential Participants to Check Their Suitability

1. *What is your age? (To determine if they are at least 18 years of age)*
2. *What type of therapy did you have and for how long? (If unsure, I will give them details about the nature of different types)*
3. *When did you finish your therapy?*
4. *What general issue were you being seen for? (To rule out psychiatric diagnosis)*
5. *What was your therapist's ethnic background, and were they qualified?*

Appendix 10.3.: Research Advert Flyer

***

A SPECIAL MESSAGE
TO
SOUTH ASIAN WOMEN

***

Have you had one-to-one counselling/psychotherapy with a qualified, non-South Asian Therapist and did you have at least 12 sessions?

If so, I would like to invite you to take part in my doctoral research about your…

Experience of Cultural Difference
When Having Had Psychological Therapy

The focus of this research is to look at your experience of having had counselling/psychotherapy alongside your everyday life as a South Asian woman.

If you would like to know more and/or are interested in sharing your experience in an anonymous way for the benefit of other individuals who may have therapy in the future, please do contact me.

Researcher Name: Charanjot Kaur Jheeta
Email Address: charanjot.jheeta@metanoia.ac.uk
Contact Number:

I look forward to hearing from you.

METANOIA INSTITUTE

Middlesex University London

Appendix 10.4.: Interview Schedule

1. What brought you into therapy?

2. What was it like going into therapy?

- Considering your culture. Upbringing. Influence of South Asian culture on your life before therapy.
- What did your family think?
- Thoughts about what it might be like?
- How did you go about finding a therapist?
- What was it like knowing that you would be working with someone who was not South Asian?
    - Did those thoughts change overtime at any point?
- What were your initial thoughts about your therapist?
    - Where do those thoughts come from?
    - Did those thoughts change overtime at any point?

3. What was the beginning stage of therapy like for you?

- What were your thoughts about your therapist?
- How did you find the way he/she was working with you?
- How did you used to feel when leaving your sessions and going back to your general life?

4. As your therapy progressed, what was it like managing both your general life/South Asian life and therapy?

- Could you describe the similarities and/or differences between having therapy and the culture that you harbour?
    - How did you manage this?

5. Can you describe if and how having therapy was impacting the way you led your life as a South Asian woman?

- Can you tell me whether you felt you needed to change anything in your life as a result of therapy?
    - How did you manage that change?
    - How did this change influence other aspects of your life? (e.g. relationships to self and other; relationship to culture)

[Prompts: Relationships to self, others and culture; challenges/conflicts present? What did you understand by this? How did you manage this?]

6. Can you describe if and how your life as a South Asian woman was impacting your therapeutic process?

[Prompts: Challenges/conflicts present? What did you understand by this? How did you manage this?]

7. What was the ending stage of therapy like for you?

- How did you feel knowing you would not have your sessions anymore?

8. How would you describe your relationship to your culture upon having finished therapy?

- Do you feel this was different to before you started therapy?

[Prompts: norms, values etc, identity as South Asian woman]

9. What has your life been like since having finished therapy?

[Prompts: Is it the same or different than before having therapy? And in what way? What meaning do you take from this?]

10. Is there anything we have not covered that you feel would be important to do so?

[We have come to the end of the interview, but I wanted to check with you…]

11. What has it been like to be interviewed due to the sensitive nature of what we were talking about?

12. Do you feel there is anything you have not said and perhaps felt you could not say?

Appendix 10.5.: Participant Information Sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET (PIS)

1. Study title

Exploring the Experience of Cultural Difference for South Asian Women in Psychological Therapy

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide whether or not you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like further information, you are very welcome to contact me. Thank you for reading this and for your time.

3. What is the purpose of the study?

The aim of the research is to look into the experience of cultural difference for South Asian women who have had psychological therapy. More precisely, it is to explore their experience of how different the culture of having psychological therapy may have been compared with their own culture, and how this was managed. I endeavour to complete this research in Spring 2020.

4. Why have I been chosen?

This research will recruit between 6-8 participants in total. You have been chosen as you have voluntarily shown interest in this research through either seeing my advertisement, through word-of-mouth or direct contact.

You have been deemed suitable for this research as you meet the following criteria:

- You are a South Asian female
- You are at least 18 years of age

- You have completed your psychological therapy
- You had a minimum of 12 therapy sessions
- Your Therapist was qualified
- Your Therapist was not South Asian
- Your therapy was one-to-one

5. Do I have to take part?

It is entirely your decision whether or not you would like to take part in this research. If you do decide to take part, you will be given this information sheet to keep along with a consent form which you will be asked to sign. If you do decide to take part, you are still free to withdraw from this research at any time and without giving a reason. Should you decide to withdraw or decide not to take part, this will not affect you in any way, and your recording and details will be wiped or destroyed.

6. What will happen to me if I take part?

If you decide that you have an interest in participating in this study, we will go through the consent form together so you are aware of what you are signing up to and you are clear about your rights as a research participant. You will be asked to sign the form confirming this. Thereafter, we will arrange to meet for an interview on a day, time and location that is convenient for you. This interview will be used to collect information to answer the research question, and will be recorded. Prior to the interview, you will be asked to complete a short form to obtain some demographic details. For the interview, you will be asked a few questions about your experience of how different the culture of having psychological therapy may have been compared with your own culture, and how this was managed. The duration of the interview depends on how much of your experience you wish to share, although it can last up to an hour. You may be asked to attend a 2nd interview to ensure that I obtain accurate and complete information.

Following this, I will transcribe the interview and will send you the transcript to check if you are happy with it. You are free to make any changes to the content at this point. During the write-up stage of the research, I may use short extracts from your interview to bring the analysis to life. This will again be sent to you to check you are happy with the content included.

To ensure quality assurance and equity, this research project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. If this happens, your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. What are the possible disadvantages and risks of taking part?

Taking part in this research may evoke some emotional distress as you recount parts of your psychological journey, which may have been emotional at that time. If this happens, I will provide you with organisations from where you can seek support.

8. What are the possible benefits of taking part?

My aim and hope is that the information we get from this study helps to improve psychological therapy for South Asian women and for other clients in general. Furthermore, although not guaranteed, you may find on a personal level that participating in this research helps you to strengthen the way you see things or you may look at things slightly differently.

9. Will my taking part in this study be kept confidential?

All information collected about you during the course of this research will be kept strictly confidential. Any identifying information about you such as your name and address will be removed and anonymised so you cannot be recognised. All data including transcripts and audio recordings of interviews will be stored securely on a password-protected computer. These will be destroyed after five years of submitting the research in accordance with the Data Protection Act (2018) and the General Data Protection Regulation (2018).

10. What will happen to the results of the research study?

Upon submission of the research, the research findings will be published as part of a Doctoral programme and will be presented in conferences. You can obtain a copy of the published research from the research repository section of the Middlesex University website: http://eprints.mdx.ac.uk/. As confirmation, you will not be identified in any report/publication. A short summary of the results of the research can also be emailed to you if you prefer.

11. Who has reviewed the study?

This research has been reviewed by the Metanoia Research Ethics Committee.

12. Contact for further information

For any queries/questions you may have, you are welcome to contact me on my details below. Alternatively, if you have any concerns/worries about any part of the research process and feel you would like to speak to someone other than myself, you are welcome to contact my Research Supervisor on the details below.

Researcher: Charanjot Kaur Jheeta

Research Supervisor: Dr Patricia Moran (c/o Metanoia)

Email Address: charanjot.jheeta@metanoia.ac.uk

University Address: Metanoia Institute, 13 Gunnersbury Avenue, Ealing, W5 3XD

Telephone Number:

University Telephone Number: 0208 832 3075

Thank you very much for showing your interest in my study.

Version Number: 1 **Date:** 17/02/2018

Appendix 10.6.: Consent Form

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

CONSENT FORM

Participant Identification Number:

Title of Project: Exploring the Experience of Cultural Difference for South Asian Women in Psychological Therapy

Name of Researcher: Charanjot Kaur Jheeta

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and I have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐
3. I understand that my interview will be taped and subsequently transcribed. ☐
4. I agree to take part in the above study. ☐
5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

_____	_____	_____
Name of Participant	*Date*	*Signature*
_____	_____	_____
Name of Researcher	*Date*	*Signature*

Appendix 10.7.: Participant Demographics Form

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

Participant Demographics Form

Please circle as appropriate

Title	Mrs Ms Miss
Surname	
First name(s)	
Full address	
Contact number	
Email address	
Date of birth	
Age	
Next of kin name and contact number *(optional)*	
Nationality	
Ethnicity	Indian Pakistani Bangladeshi Sri Lankan Other: ……
Religion	Christian Buddhist Hindu Jewish Muslim Sikh Prefer not to disclose Other:…….
Sexual orientation	Heterosexual Gay/Lesbian Bisexual

	Transgender Prefer not to disclose Other: ……..
Marital status	Married Engaged Co-habiting Widow Single Other:…….
Do you consider yourself disabled?	Yes No Prefer not to disclose If yes, please specify *(optional)*: …….
GP name	
GP address	
GP contact number	
Do I have your permission to contact your GP in the case of an emergency?	Yes No
Which language(s) do you speak?	
Date of migration to the UK (if applicable)	
Organisation name where you had therapy	
Type of therapy	
Total number of therapy sessions/Length and frequency of therapy	
Date of last therapy session	

Appendix 10.8.: Extract of Interview Transcript Analysis for Participant Three (Columns left to right: Emergent Themes, Transcript Line Number, Interview Transcript, Initial Commentary)

SA belief that MH is physical. SA others blamed her for MH. Developed self-understanding about psychological nature of issues rather than physical. Let go of blaming self for MH. Sense-making of development of MH problems. Unstable MH as developing over long period. Self-validation and understanding developed groundedness. Openness in therapy as grounding. Therapy as facilitated self-understanding and sense-making. Unstable MH situational rather than internal problem. Struggled understanding difficult emotions in therapy.	221 222 223 224 225 226 227 228 229 230 231 232 233 234 235	your head. Whereas from what I was starting to understand when I was doing it was that there were situational factors that brought me to this point. It wasn't just there was something wrong in my head or erm you know I was imbalanced or I was making it up. It was actually there were points in my life that got me to this point where I just didn't know how to express myself anymore. Erm and that, it just was a validation and I think that was a bit of peace in that. Erm and I think also a little bit of being able to freely open up was a peaceful thing as well. R: Yea, and so those situational factors, did you understand and become aware of those through your therapy as such? P3: Yes, a lot more so I know..erm..when I went to therapy..at that time like I think the first year or two maybe, I think I was really angry a lot and I never really understood why I was really angry. And it was only through therapy in talking about things I went through when I	Judgement from SA students. MH = broken, not right. 'broken' – cannot be fixed? Did pp feel disheartened? 'making it up' – pp was not believed by others. PP made sense of timeline in her life to understand why she got depression and overdosed. Challenged and proved others' negative comments wrong. How was pp expressing self prior to this to lead her to not know how to express self anymore? Became voiceless. Repeats sense of peace in seeking understanding and validation shows important to pp. PP able to freely open up rather than repress in therapy unlike in external life. Initially stayed on surface to check what T was like? Confirmed that therapy helped pp self-understand and sense-make. Start of therapy – "really angry", but lacked understanding of it. Talking about younger experiences in therapy facilitated understanding. Otherwise, pp saw it

Appendix 10.9.: Extract of Interview Transcript Analysis for Participant Five (Columns left to right: Emergent Themes, Transcript Line Number, Interview Transcript, Exploratory/Initial Commentary)

	247	met, because of a lack of understanding, because of the way	PP used to lack of understanding in society about SA culture. So T's behaviour not abnormal to her.
Lack of integration between west and SA cultures.	248	this..society is and the way services are set up, just life generally,	
Conflict integrating cultures.	249	whether it be school, friendships whatever, that it wasn't, it wasn't	Alludes to seeing this lack of understanding in lots of areas in her life. Does not surprise her. PP adapts herself to it ~ SA women.
	250	er..abnormal to me. There's always a small part of you I think when	
Adjusted self to western culture. [negotiated]	251	you are from, and this is something that I've discussed with friends	Sought solace with minority background friends to seek connection.
	252	from minority backgrounds and it does seem to be erm..quite..a	
SA self only shared with SA others.	253	pattern, a, a, the norm, because there's a certain part of you that you	PP did not need empathy from T.
Narrative resembles collectivism.	254	can only share with people that would understand that experience,	Alludes to only being able to obtain "genuine connection" and understanding about SA cultural topics with SA individuals. Segregation.
	255	because..it's not empathy that I was looking for. It wasn't	
	256	understanding I was looking for. It was a genuine connection and	"Part of you" – distant language. Collective language? Focus away from herself.
Seeking genuine connection.	257	erm..to delve into and..kind of dissect and, and, and make sense of	Believes she can explore, breakdown and make sense of her experiences by herself, without a T.
	258	an experience…I could do that at home by myself. Like if I'm gonna	
Can independently seek self-understanding.	259	speak to somebody about it..er they need to be able to guide me or	Alludes to her having been able to understand her process more if she had a T whom really understood SA culture "to an extent" and could work with it. ~ good-enough amount of knowledge.
Importance of 'good enough' cultural understanding in therapy.	260	understand that..pro..what has happened to an extent in order to be	
	261	able to guide me through that..with a level of understanding..and she	
	262	wouldn't have been able to do that. But equally..the experience I've	Confirms T did not have this skill.
Difficulty finding space to discuss SA self.	263	had with the one..erm Asian Counsellor, that was terrible, so I	But also could not do this with SA T which pp had. Sense of stuckness? Experiences kept hidden.

Appendix 10.10.: Extract of Analysis for Participant Two

Challenged fear of judgement and openness with others.			Therapy as limited support.			Letting go of internalised SA influence.				Respecting/recognising others' individuality.		
Challenging relationships with Others	**Challenged fear of judgement and openness with others.**	**Feeling more 'seen' by Others.**	**Made MH progress independently from therapy**	**Therapy as not enough support**	**Therapy did not meet needs.**	**Therapy facilitated letting go of cultural shame and power struggles**	**Shift in feeling inferior to others**	**Encouraging others to have therapy.**	**Paralleling therapy space in general life**	**Parallel in recognising others' individuality.**	**Struggle with the self/self-reliance.**	**Negotiated openness about therapy to others.**
Importance of strength/courage needed in confronting assumptions about Others.	Tentative/testing approach to articulating needs.	Began practising articulating her needs to others in general life.	Independently made positive steps for MH.	Therapy left her unsure how to create positive change in general life.	-ve experience of T.	Therapy as facilitating overcoming shame.	Criticised Others' ungrateful view on life.	Encouraging family to seek therapy.	Paralleled T's way-of-working with family.	Compassion shown to others.	Attempting to learn from friends how to manage romantic relationships.	Therapy disclosed to only few people.
Therapy gave pp courage to challenge assumptions of Others.	Checked for evidence in case T wrong.	Created balance between self- and other-focus.	No credit to therapy for independent positive steps for own MH.	Therapy did not facilitate how to move forward with anger and judgemental attitude.	Disagreed with T's way of working.	Therapy challenged pp's worry about others considering her powerless.	Was embarrassed about others in better position than her.		Recreation of self from therapy parallels recreating professional life.	Understands Others' preference to have roles as wife and mother.	Sense of not trusting herself when it comes to romantic relationships.	Aligns western and SA cultures together to commonly not disclose having therapy.
Challenged assumption of younger people not understanding her.	Shock from realisation in therapy.	Expressed emotions to others in general life.	Independently made positive steps for MH without therapy support.	Therapy as not enough. [x2]	Felt misunderstood by T.	Therapy challenged assumption that she cannot show weakness.	View of 'privilege' shifted to valuing things taken for granted.			Acknowledges choice involved in preferring typical SA female life.	Comparison with similar others allowed her to feel mentally stable.	
Held judgemental attitude towards others.	Need to test out Others' reactions to her expressing her individual self.	Understands balance between articulating needs forcefully and assertively.	Religion more helpful than therapy.	Therapy as unfulfilling.	Now questioning if T aware of her needs.	Therapy challenged her need to uphold strong persona.	Had tendency to compare self with others.			Importance of seeing another's individuality.	Others' reaction made her realise her shame was non-sensical.	
Obtained understanding of origin of anger and judgement of others.	Tests others to create safety for self.	Practising articulating her needs.	Sense that pp came to feel empathy for family independently, without T support.	Therapy facilitated clearer sense of knowing what type of support would be helpful.	Lack of care and support from T.	Therapy facilitated pp to overcome shame-based process.				Realised she objectifies others.		

Clustering emergent themes for participant two

Power Challenge.	Negotiating Openness.	Segregating self from other.	Space for the self.	Struggling to adopt different way-of-being.	Shifting SA Cultural Norms.	Sense of belonging.	Therapy as limited support.
Difficulty presenting a vulnerable self.	Tension between sensing judgement and openness in therapy.	Developed empathy for SA family.	Lack of space for self in general life.	Struggle with the self/self-reliance.	Challenged acceptability of having therapy./Normalising having therapy.	Re-evaluating relationship to SA culture.	Connecting deeper with religion.
Power struggle in therapy.	Able to share taboo SA topics in therapy.	Feeling more 'seen' by Others.	Having space for the self in therapy.	Struggling to stabilise different way-of-being.	Encouraging others to have therapy.	Struggling with acceptance in western culture.	Therapy as limited support.
Importance of self-control in accessing therapy.	Challenged fear of judgement and openness with others.	Appreciating recognising the self.	Struggling to use therapy space.		Letting go of internalised SA influence.	Connecting to Similar Others	
	Negotiated openness about therapy to others.	Respecting/recognising others' individuality.	Struggling with individualism of therapy.			Desire to create unique SA identity.	

Clustering clustered emergent themes for participant two

Appendix 10.11.: Extract of Analysis for Participant Six

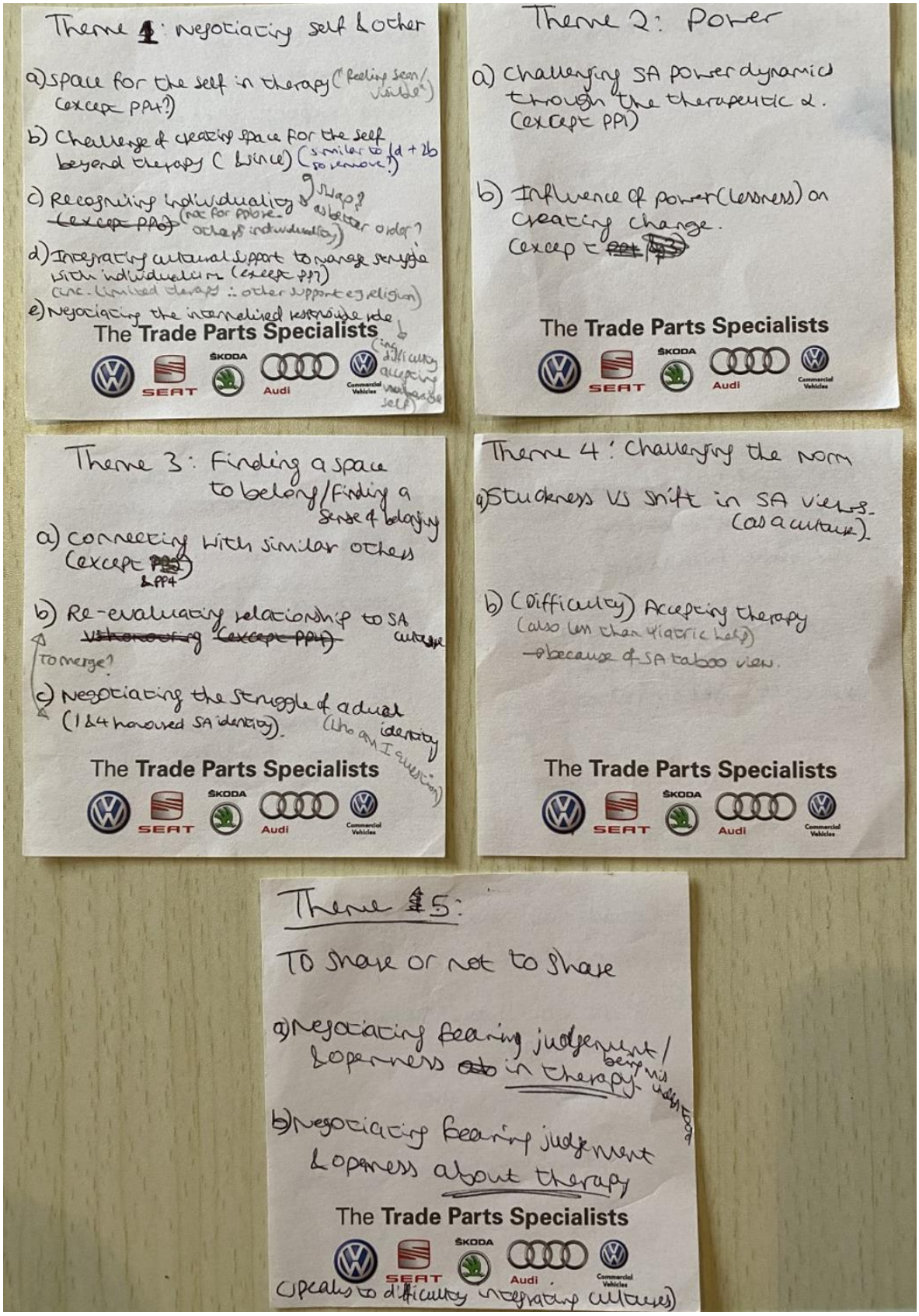
Re-evaluating relationship to SA culture.		Struggling with a dual identity.				Fear of judgement as impacting openness in therapy.				Ease of creating change on an individual level.	
Re-Evaluating ~ to SA culture.	**Difficult ~ to SA culture.**	**Figuring out an identity.**	**Managing the dual self.**	**Lacking acceptance/sense of belonging in western culture.**	**Accepting the vulnerable self.**	**Acceptance of the SA self as impacting openness.**	**Validation as facilitating openness about SA culture.**	**Importance of feeling culturally understood in therapy.**	**Shame as keeping SA self hidden.**	**Change as easier on an individualistic level. [~control]**	**Needing own space to create change.**
Pros/cons to SA culture.	Dislikes SA culture.	Pros/cons of identity shift.	Disagreement between cultural selves re. therapy. **[in 'Difficulty embracing therapy'?]**	Power of SA/religious acceptance with western culture.	Awareness of her vulnerable self.	Cautious about opening up about religion in therapy.	Took time for openness about SA culture. [x2] **[in 'Time'?]**	Felt understood in therapy.	Had kept SA self hidden in general life. [shame?]	Ability to make independent change.	Importance of own space to create change. [x2]
Embracing the SA self. [x5] **[BURNT ORANGE SHOULD BE IN THEME 3C]**	Difficult relating to SA culture.	Identity shift. [x2]	Difficulty integrating cultural selves.	Power with white, western culture. [x2]	Trying to accept her vulnerable self.	Worried about judgement re. religiosity.	Encouraged by similar other to share SA self in therapy. [x3]	Felt comfortable with T.	Ashamed to expose SA self in therapy and general life.	Independent work on the self as helpful.	No space in family life to create change.
Appreciates pros of SA culture.	Hates SA culture.	Identity.	Lacked cultural integration in general life.	Compromising/adjusting SA self to accommodate western culture. [x2]	Embracing emotional expression/vulnerable side.	Concerned about judgement for SA self.	Needing encouragement to share SA self in therapy. [x2]	Appreciated T's willingness to understand SA culture. [x2]	Parallel of hiding religious self like SA self due to non-acceptance in western society.	Only independent change possible.	Self-change difficult without change in life circumstance.
Difficulty embracing SA self fully.	Protected self from SA norms.	Confused identity. [x2]	Lived 2 cultural lives.	Focus on accommodating the powerful other.	Working with the vulnerable self.	Concern of judgement keeps SA/religious selves hidden [SA self as restricted in family and western culture/no space].	**Space for both cultural selves in therapy.**	Appreciated T's honesty in lacking SA cultural understanding.	Shame about/hiding SA self [SA culture honour-based]. [x2]	Therapy as shifting fear involving only herself/internal locus of control. [x2]	Able to take up space in therapy.
	SA cultural behaviour as -ve.	Difficulty describing identity.	Confusion between both cultural selves [confused identity].	Acceptance dependent upon powerful western culture [sense of belonging]	Difficulty accepting vulnerable self. [x2]	Fear of rejection by western culture.	Importance of courage and external validation for openness in therapy	Felt culturally understood in therapy.	Shameful SA self hidden in therapy.	**Sense of therapy lacking systemic focus.**	Repressed difficulties.

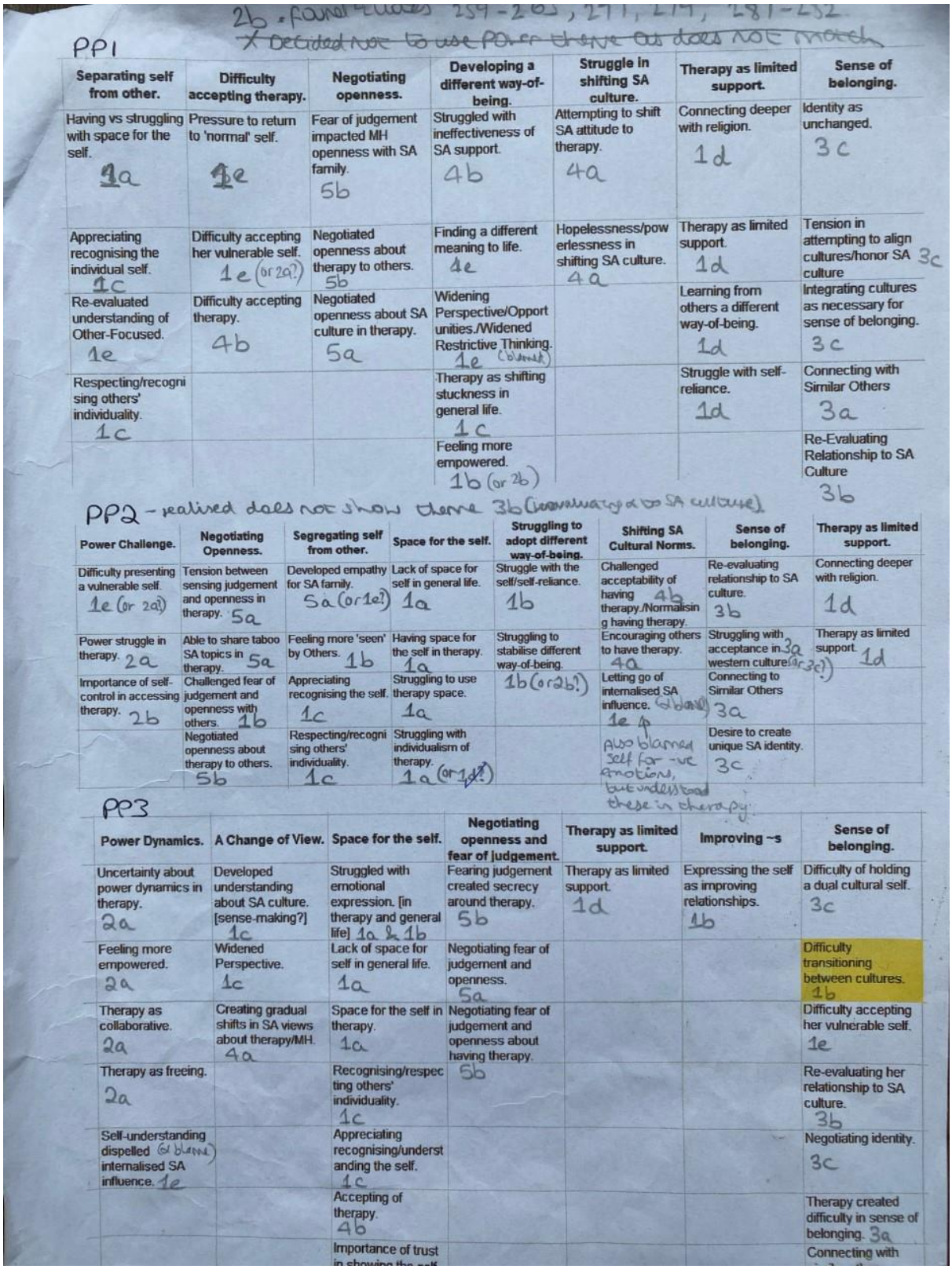
Clustering emergent themes for participant six

(Difficulty) accepting therapy.	Space for the self.	Managing Power Dynamics	Negotiating Identity.	Negotiating Openness.	Therapy as not enough.	Shifting SA views.
(Difficulty) accepting therapy.	Lacking space for self in general family life.	Difficulty maintaining self-agency.	Re-evaluating relationship to SA culture.	Fear of judgement as impacting openness in therapy.	Therapy as not enough.	Encouraging shift in SA views.
	Having space for self in therapy.	Therapy as collaborative.	Struggling with a dual identity.	Negotiating openness about therapy/MH with others.	Connected with similar others./Sense of belonging.	
	Shifted sense of 'other-focus' [doing this from empowered sense].	SA power impeding change.	Lacking acceptance/sense of belonging in western culture.		Religion connection as helpful.	
	Struggle with self-focus.	Powerlessness as impeding change.				
	Accepting the vulnerable self.	Developed stronger sense of individual self.				
		Ease of creating change on an individual level.				

Clustering clustered emergent themes for participant six

Appendix 10.12.: Comparing and Clustering Themes Further Across all Participants





2b - found quotes 259-265, 271, 274, 281-282.
~~Decided not to use PP1 theme as does NOT match~~

PP1

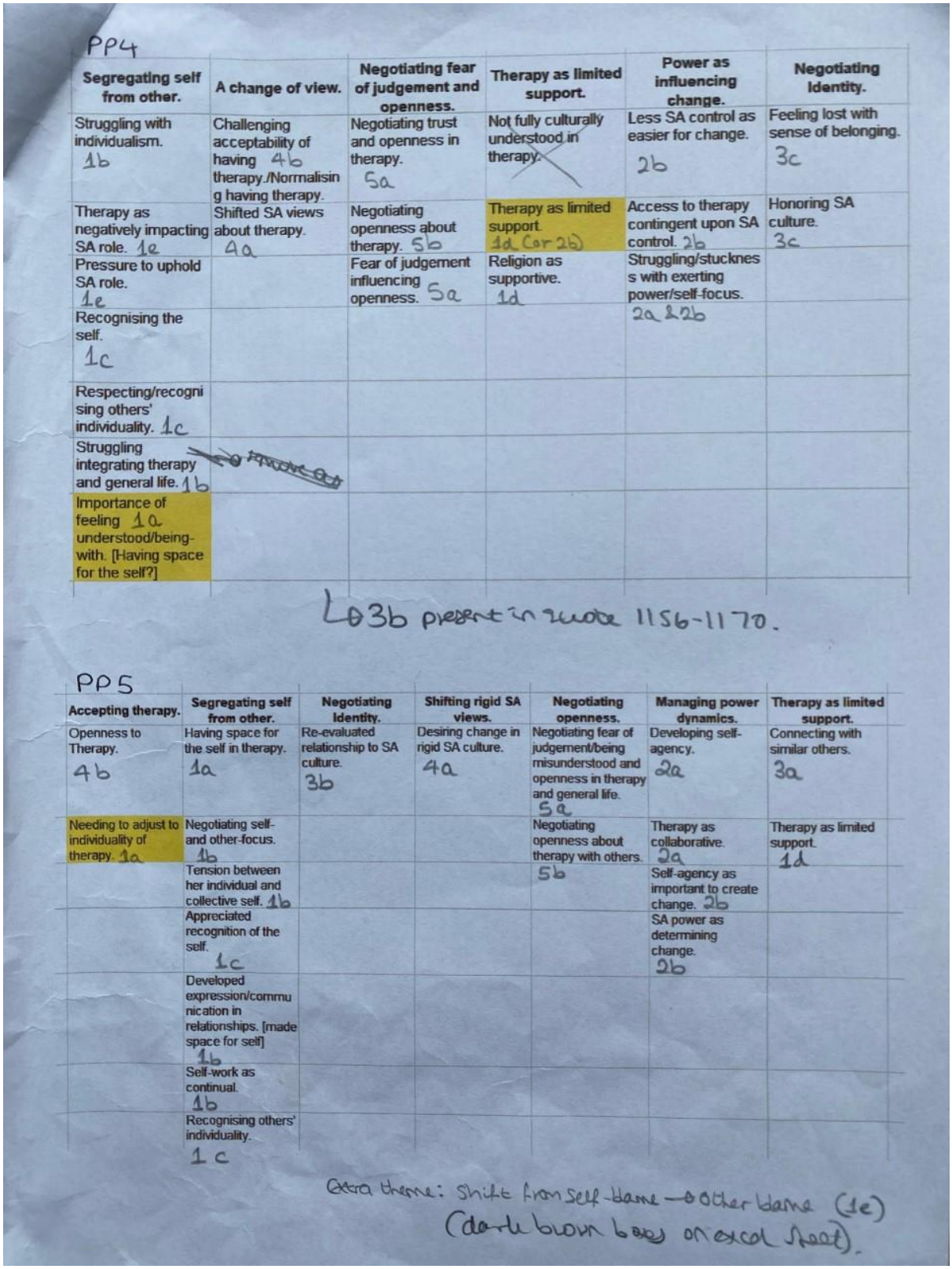
Separating self from other.	Difficulty accepting therapy.	Negotiating openness.	Developing a different way-of-being.	Struggle in shifting SA culture.	Therapy as limited support.	Sense of belonging.
Having vs struggling with space for the self. 1a	Pressure to return to 'normal' self. 1e	Fear of judgement impacted MH openness with SA family. 5b	Struggled with ineffectiveness of SA support. 4b	Attempting to shift SA attitude to therapy. 4a	Connecting deeper with religion. 1d	Identity as unchanged. 3c
Appreciating recognising the individual self. 1c	Difficulty accepting her vulnerable self. 1e (or 2a?)	Negotiated openness about therapy to others. 5b	Finding a different meaning to life. 1e	Hopelessness/powerlessness in shifting SA culture. 4a	Therapy as limited support. 1d	Tension in attempting to align cultures/honor SA culture 3c
Re-evaluated understanding of Other-Focused. 1e	Difficulty accepting therapy. 4b	Negotiated openness about SA culture in therapy. 5a	Widening Perspective/Opportunities./Widened Restrictive Thinking. 1e (blurred)		Learning from others a different way-of-being. 1d	Integrating cultures as necessary for sense of belonging. 3c
Respecting/recognising others' individuality. 1c			Therapy as shifting stuckness in general life. 1c		Struggle with self-reliance. 1d	Connecting with Similar Others 3a
			Feeling more empowered. 1b (or 2b)			Re-Evaluating Relationship to SA Culture 3b

PP2 - realised does not show theme 3b (connecting to SA culture)

Power Challenge.	Negotiating Openness.	Segregating self from other.	Space for the self.	Struggling to adopt different way-of-being.	Shifting SA Cultural Norms.	Sense of belonging.	Therapy as limited support.
Difficulty presenting a vulnerable self. 1e (or 2a)	Tension between sensing judgement and openness in therapy. 5a	Developed empathy for SA family. 5a (or 1e?)	Lack of space for self in general life. 1a	Struggle with the self/self-reliance. 1b	Challenged acceptability of having therapy./Normalising having therapy. 4b	Re-evaluating relationship to SA culture. 3b	Connecting deeper with religion. 1d
Power struggle in therapy. 2a	Able to share taboo SA topics in therapy. 5a	Feeling more 'seen' by Others. 1b	Having space for the self in therapy. 1a	Struggling to stabilise different way-of-being.	Encouraging others to have therapy. 4a	Struggling with acceptance in western culture. 3a (or 3c?)	Therapy as limited support. 1d
Importance of self-control in accessing therapy. 2b	Challenged fear of judgement and openness with others. 1b	Appreciating recognising the self. 1c	Struggling to use therapy space. 1a	1b (or 2b?)	Letting go of internalised SA influence. (blurred) 1e 4	Connecting to Similar Others 3a	
	Negotiated openness about therapy to others. 5b	Respecting/recognising others' individuality. 1c	Struggling with individualism of therapy. 1a (or 1d?)		Also blamed self for -ve emotions, but understood these in therapy.	Desire to create unique SA identity. 3c	

PP3

Power Dynamics.	A Change of View.	Space for the self.	Negotiating openness and fear of judgement.	Therapy as limited support.	Improving ~s	Sense of belonging.
Uncertainty about power dynamics in therapy. 2a	Developed understanding about SA culture. [sense-making?] 1c	Struggled with emotional expression. [in therapy and general life] 1a & 1b	Fearing judgement created secrecy around therapy. 5b	Therapy as limited support. 1d	Expressing the self as improving relationships. 1b	Difficulty of holding a dual cultural self. 3c
Feeling more empowered. 2a	Widened Perspective. 1c	Lack of space for self in general life. 1a	Negotiating fear of judgement and openness. 5a			Difficulty transitioning between cultures. 1b
Therapy as collaborative. 2a	Creating gradual shifts in SA views about therapy/MH. 4a	Space for the self in therapy. 1a	Negotiating fear of judgement and openness about having therapy.			Difficulty accepting her vulnerable self. 1e
Therapy as freeing. 2a		Recognising/respecting others' individuality. 1c	5b			Re-evaluating her relationship to SA culture. 3b
Self-understanding dispelled (& blame) internalised SA influence. 1e		Appreciating recognising/understanding the self. 1c				Negotiating identity. 3c
		Accepting of therapy. 4b				Therapy created difficulty in sense of belonging. 3a
		Importance of trust in showing the self				Connecting with



PP4

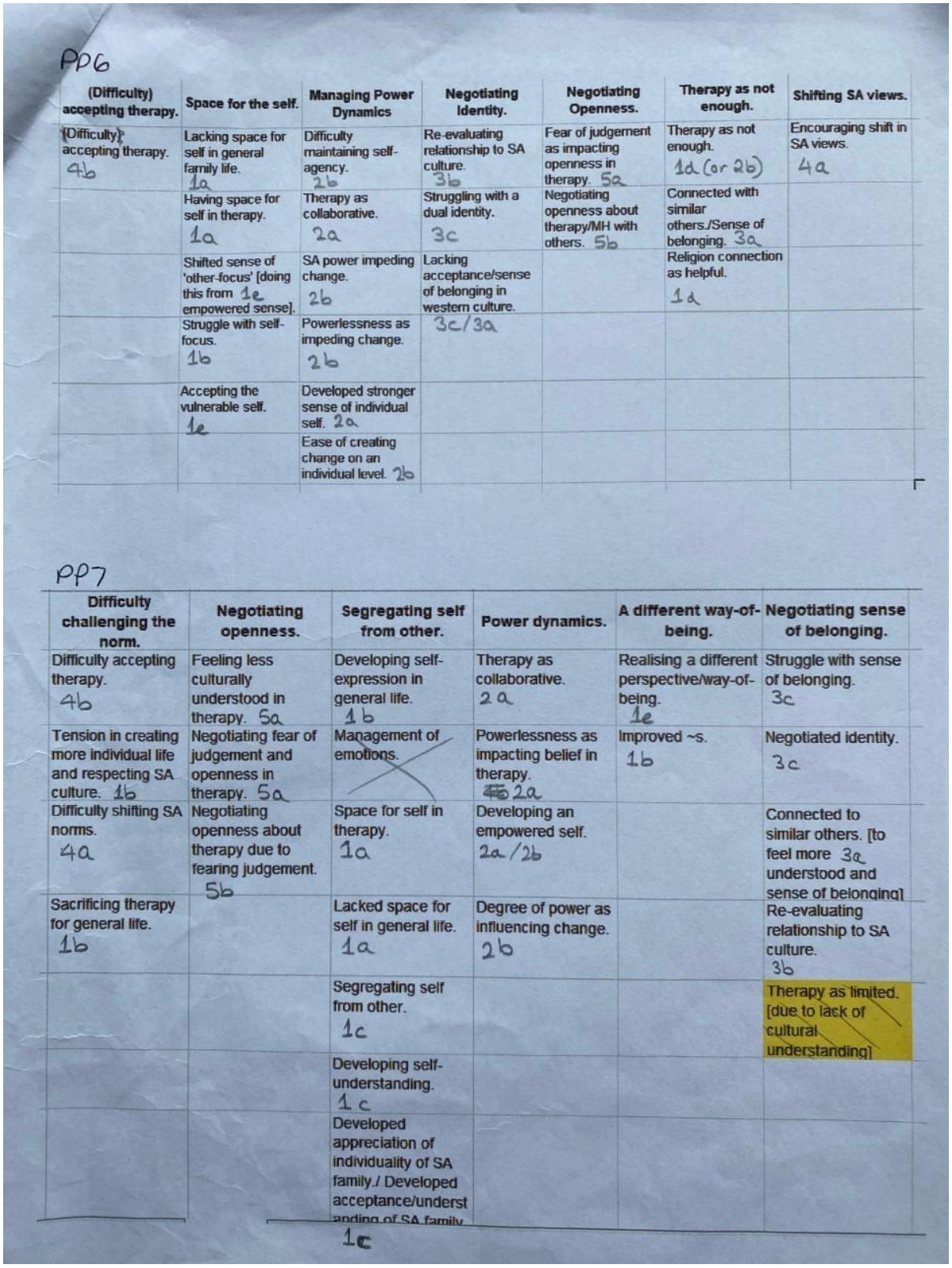
Segregating self from other.	A change of view.	Negotiating fear of judgement and openness.	Therapy as limited support.	Power as influencing change.	Negotiating Identity.
Struggling with individualism. 1b	Challenging acceptability of having 4b therapy./Normalising having therapy.	Negotiating trust and openness in therapy. 5a	Not fully culturally understood in therapy.	Less SA control as easier for change. 2b	Feeling lost with sense of belonging. 3c
Therapy as negatively impacting SA role. 1e	Shifted SA views about therapy. 4a	Negotiating openness about therapy. 5b	Therapy as limited support. 1d (or 2b)	Access to therapy contingent upon SA control. 2b	Honoring SA culture. 3c
Pressure to uphold SA role. 1e		Fear of judgement influencing openness. 5a	Religion as supportive. 1d	Struggling/stucknes s with exerting power/self-focus. 2a & 2b	
Recognising the self. 1c					
Respecting/recogni sing others' individuality. 1c					
Struggling integrating therapy and general life. 1b					
Importance of feeling 1a understood/being-with. [Having space for the self?]					

1b present in quote 1156-1170.

PP5

Accepting therapy.	Segregating self from other.	Negotiating Identity.	Shifting rigid SA views.	Negotiating openness.	Managing power dynamics.	Therapy as limited support.
Openness to Therapy. 4b	Having space for the self in therapy. 1a	Re-evaluated relationship to SA culture. 3b	Desiring change in rigid SA culture. 4a	Negotiating fear of judgement/being misunderstood and openness in therapy and general life. 5a	Developing self-agency. 2a	Connecting with similar others. 3a
Needing to adjust to individuality of therapy. 1a	Negotiating self- and other-focus. 1b			Negotiating openness about therapy with others. 5b	Therapy as collaborative. 2a	Therapy as limited support. 1d
	Tension between her individual and collective self. 1b				Self-agency as important to create change. 2b	
	Appreciated recognition of the self. 1c				SA power as determining change. 2b	
	Developed expression/commu nication in relationships. [made space for self] 1b					
	Self-work as continual. 1b					
	Recognising others' individuality. 1c					

Extra theme: Shift from self-blame → other blame (1c)
(dark brown box on excel sheet).



PP6

(Difficulty) accepting therapy.	Space for the self.	Managing Power Dynamics	Negotiating Identity.	Negotiating Openness.	Therapy as not enough.	Shifting SA views.
(Difficulty) accepting therapy. 4b	Lacking space for self in general family life. 1a	Difficulty maintaining self-agency. 2b	Re-evaluating relationship to SA culture. 3b	Fear of judgement as impacting openness in therapy. 5a	Therapy as not enough. 1d (or 2b)	Encouraging shift in SA views. 4a
	Having space for self in therapy. 1a	Therapy as collaborative. 2a	Struggling with a dual identity. 3c	Negotiating openness about therapy/MH with others. 5b	Connected with similar others./Sense of belonging. 3a	
	Shifted sense of 'other-focus' [doing this from 1e empowered sense].	SA power impeding change. 2b	Lacking acceptance/sense of belonging in western culture.		Religion connection as helpful. 1d	
	Struggle with self-focus. 1b	Powerlessness as impeding change. 2b	3c/3a			
	Accepting the vulnerable self. 1e	Developed stronger sense of individual self. 2a				
		Ease of creating change on an individual level. 2b				

PP7

Difficulty challenging the norm.	Negotiating openness.	Segregating self from other.	Power dynamics.	A different way-of-being.	Negotiating sense of belonging.
Difficulty accepting therapy. 4b	Feeling less culturally understood in therapy. 5a	Developing self-expression in general life. 1b	Therapy as collaborative. 2a	Realising a different perspective/way-of-being. 1e	Struggle with sense of belonging. 3c
Tension in creating more individual life and respecting SA culture. 1b	Negotiating fear of judgement and openness in therapy. 5a	Management of emotions.	Powerlessness as impacting belief in therapy. ~~5~~ 2a	Improved ~s. 1b	Negotiated identity. 3c
Difficulty shifting SA norms. 4a	Negotiating openness about therapy due to fearing judgement. 5b	Space for self in therapy. 1a	Developing an empowered self. 2a/2b		Connected to similar others. [to feel more 3a understood and sense of belonging]
Sacrificing therapy for general life. 1b		Lacked space for self in general life. 1a	Degree of power as influencing change. 2b		Re-evaluating relationship to SA culture. 3b
		Segregating self from other. 1c			Therapy as limited. [due to lack of cultural understanding]
		Developing self-understanding. 1c			
		Developed appreciation of individuality of SA family./ Developed acceptance/understanding of SA family. 1c			

Appendix 10.13.: Table Showing All Participants Meeting Subthemes

Master Theme	Subthemes	PP1	PP2	PP3	PP4	PP5	PP6	PP7
1) Negotiating Self and Other	a) Therapy as Space for the Emotional Self	*	*	*	*	*	*	*
	b) Recognising Individuality	*	*	*	*	*	*	*
	c) Negotiating the Collective Role	*	*	*	*	*	*	*
	d) Integrating Collective Support to Facilitate Struggle with Individualism	*	*	*	*	*	*	
2) The Challenge of Power Dynamics	a) Enactment of Power Dynamics within Therapy		*	*	*	*	*	*
	b) External South Asian Power Dynamics as Influencing Change	*	*	*	*	*	*	*
3) Finding a Sense of Belonging	a) Negotiating a Torn Cultural Identity	*	*	*	*	*	*	*
	b) The Pursuit of a Similar Tribe	*	*	*		*	*	*
4) Breaking Barriers	a) Challenged Acceptance of Therapy	*	*	*	*	*	*	*
	b) Encouraging Others into Therapy	*	*	*		*	*	
5) To Share or Not to Share	a) Negotiating Openness in Therapy		*	*	*	*	*	*
	b) Negotiating Openness About Therapy	*		*	*	*	*	*

Appendix 10.14.: Extract of Verbatim Quotes Across Participants Used to Represent Each Subtheme and Subordinate Theme. Example themes shown are 1.1, 3.2, 5.1 and 5.2 (Green highlighted quotes were used in write-up and sent to check with participants; red highlights represent participants that did not meet the theme)

Theme 1: Negotiating Self and Other

Subtheme:	Line no.	PP Supporting Quote (each row below for each pp)
a) Therapy as Space for the Emotional Self		***[PP1]***
	970-977	with counselling, the best thing is that it doesn't matter who you are. You just need somebody and you wanna get rid of that pain inside. I used to feel that I had a physical hole in my heart. That didn't go away for a long, I could literally feel that hole in my heart. And er..and you can just share your pain with somebody and really, really share it. Whereas when it's your own kids, you can't tell them what you're going through, coz they're grieving themselves. They don't wanna know how horrible you're feeling. Whereas with her, you could just you know, tell her.
	139-145	it allows you to be honest. That was the other thing, because..there you are, you know that whatever's said in that room is not gonna go anywhere..any further. You're not gonna be judged. And erm..you can be completely honest. You feel like sitting there sobbing your eyes out, she's not gonna say shutup, just let you, you know. Whereas other people try and comfort you, whereas all you wanna do is have a good cry or whatever. But I found that quite liberating.
		[PP2]
	577-587	P2: ..At the time it was good to have that pressure-release valve. So to have a space where I could go and coz I couldn't cry at all during the week, but I'd be able to cry in that room. So..but it was..I don't know, I sort of mentally had said to myself OK yea this is the room that I can cry in. It wasn't really to do with her, but it was more about being in that room and it being able to cry R: And why do you feel you couldn't do that kind of generally outside therapy? P2: Coz I physically couldn't do it. Like sometimes I'd be sitting there and I'd imagine if you just cry you'd feel all better, but it wasn't coming out. Yea
	1065-1068	just the sort of build-up anger over many many years. Erm y, you, you know and when you know I got really annoyed [laughs slightly] strangely enough with my family when they used to say to me that I have anger management issues.
	1155-1158	because my ex fucked me to such an extent that the first time I did express a boundary to a man after that, it was..scary for me to do it, because I was so like used to being punished for articulating my feelings.

	1128-1133 267	***[PP3]*** I think initially it was just kind of more of an escape..that me going to therapy was more of an escape, so more..somewhere where I could just..like talk and cry. I think a lot of the time at the beginning there was a lot of crying, and I could go and just be that person and express how I wanted to express myself. that you don't talk about your emotions
	1051-1052 [1051] [1052]	***[PP4]*** it felt nice..to be able to speak to somebody who understands and to be able to hear your own fears.
	140-142	***[PP5]*** to discuss..everything with in any way that I wanted to, whether I wanted to curse, swear whatever
	312-313 111-114	***[PP6]*** when we did the deep work, I did feel, even though it was tiring and I'd been crying, it, I s, I felt..light and refreshed. when I told my mum I was depressed and she was like "What do you have to be depressed about?". You know, there was just no sympathy. And so that's really hard to deal with actually.
	421-431 [423-424]	***[PP7]*** P7: So I guess I've always been someone who likes to talk, but it's only ever been with friends. And like when I was at uni, there came a point where..it felt like..sometimes friends weren't really enough or I was starting to feel a bit worried that I was like burdening friends by talking lots, because it felt like with some friends they had more outlets or they have like a closeness to their..parents, that they were able to talk about things in a way that I didn't really have. So I didn't really have that space before, which is why I found it really helpful. R: OK yea OK. And did you ever feel at any point that you were burdening the space in your therapy? Did any of those sorts of feelings come? P7: No, no, no definitely not.

b) The Pursuit of a Similar Tribe		***[PP1]***
	779-780	we don't say anything against our own people. That's one thing I do like about [names inspirational religious lady]'s son.
	804-806	So anything he doesn't like about our religion and the way we all behave, he's always. And everybody just sits there listening to him thinking oh it's Paji, but he makes sense.
		[PP2]
	1253-1260 [1257-1260]	R:..I wonder if you feel there's anything in her being kind of South Asian that is quite different to, to the woman that you had before, and whether that, whether that adds anything different for you? P2: Yea I think there's a warmth. You know she runs an incredibly successful business, so she understands what it like, what it's like to be a woman of colour who's successful. Erm..she is [pause], she's just more real.
		[PP3]
	1441-1447 1463	only in the last couple of years..where erm I feel like I've now found people..that have that similar thinking to me. But I've actually, I've actively gone out to find people that have that similar thinking, whereas before..kind of you have no choice in who your family is and you have no, at school you have no choice of the people that you are around. I didn't have anybody that was like me. wanted to find my tribe

		[PP4] ***N/A***
	1056-1062	***[PP5]*** it was like well I don't fit in here and I don't fit in here, so I kind of need to find my people that are weird and kind of mixed up like me. And when I started having these conversations, it turned out..practically every Asian girl I knew was having some sort of [laughs slightly]..you know nobody wanted to talk about it, but as soon as you give them one bean, they were like yea, yea me too
	1342-1345 [1344] [1345]	***[PP6]*** I end up having a lot of problems with Asian women, because of the, their Asian-ness and it starts to..grate on me. So to find ones that are very, very balanced between the two, it, it was a God-send really.
	279-280 286-293 [292-293]	***[PP7*** before I would like just talk to myself. I've got some brown friends now and that's helpful to me, because..they're, whilst you can have like your caucasian friends and you can maybe know it's not about colour with your friends, it is helpful to have somebody who you can be like oh my God my mum's going on at me about me getting married, and they just get it. Whereas some of your..like white friends might not really understand, because they don't have that family pressure and so it's just helpful being able to have some friends who understand that background.

Theme 5: To Share or Not to Share

Subtheme:	Line no.	PP Supporting Quote (each row below for each pp)
a) Negotiating Openness in Therapy		***[PP1]*** N/A
	306-311 [307]	***[PP2]*** it is not helpful er to just apportion all of that blame and that at their door. I just think it's better to have compassion. I don't know, but with compassion you also have to practice it, so if someone's telling you oh no, you should blame this person or whatever, I'm like oh you're supposed to be professional
	184-191 [184-185] [188] 1359-1368 1382-1385	***[PP3]*** I think there was a little bit of..shame maybe or guilt around talking about people that I had in my life. So going in and talking about my parents or talking in, about my mum or my step-dad or erm..the people that are closest to me, I think there was a bit of guilt in..im making them wrong. Erm whereas my therapist never..there was never that kind of conversation. Erm but I think I felt that, so I think for a really long time I kind of touched the surface on what was going on with me I could relate to her where she had the Irish background, so she..for her it was the same thing, you grow up with a lot of shame around sex and you grow up a..a lot of shame around body image, and about what you wear and what you don't wear. Erm and that it's a taught thing that you should be shameful about this and that you should have modesty to some extent about certain things. Erm but that conversation I think was..at that point I had nobody to speak about, and that's the conversation when I got my shoes off..and I got comfortable. having that one person to be able to speak to about things with no shame and no guilt and there was no judgement was a massive deal. Erm and I think that really had a really, really big impact.
	1204-1207 [1207]	***[PP4]*** R: How it feel talking to your..non-South Asian therapist about your sexual problems? P4: Mm..it was fine. I didn't have any problems discussing with her at all, but like I say I knew she was a therapist

		[PP5]
	284-293	I was talking to a..white British woman about this massively complex situation. And maybe it's just my own..lived experiences that have made me feel quite guarded, but I was quite aware of the fact that you know I didn't wanna put on this circus show where oh my God everything is just so ridiculous, because of..culture and cultural differences, that even while I was..talking I had this..I had to almost kind of keep mys, give myself a, a pep talk 'yep carry on it's OK, it's OK to share, it's OK to share', because it, I was aware that it was just…everything I guess that you don't..want people to..it, there are a lot of clichés in there and I didn't want to feed into the problem
	143-151	if it was a friend and I told them all this stuff that was, how I was feeling in my relationship, because I wanted to..erm...save the marriage erm or you know the engagement whatever it was at that stage erm I..didn't want them then to then, I didn't want to feel then that I was informing their opinion of my partner. So to be able to just..have open and honest chats, and also talk about my..childhood and make these links..and know that if I never wanted to see her again that would be fine and it would just stay in that room and it's just very private.
		[PP6]
	218-222 [220]	it was her that..encouraged me to open up and to talk about these things coz a, at one point I wasn't even willing to open up and talk about them, because I didn't think anyone would get it. So it took for another person…exposed to that culture if you like to some extent to encourage me to open up.
	191-194	she was probably the most accommo, and like I said I've had a lot of therapy, she was probably the most accommodating therapist that I've had that's willing to look into the ethnic issues and the cultural issues.
		[PP7]
	765-780 [766] [770-771]	I couldn't be open, but there were certain parts that I didn't think they would understand. So some of the cultural thi, issues surrounding kind of like erm..where I, the, the way I'd been raised the kind of like the man's place is to work and the woman's place is in the house. And I understand that that's maybe quite erm a more traditional or some people might say backwards way of thinking, but to my family that's completely normal. And so I sometimes would feel uncomfortable maybe raising some issues, because of erm the fact that if they didn't understand that cultural nuance maybe they would have a judgement. Erm and so that's the thing. It wouldn't be that I wouldn't speak at all about my family, but I maybe would speak about certain things. Erm that said on the flip side with my South Asian therapist, I didn't feel comfortable opening up about like relationships with erm..like my partners, because I felt like you know if I'm erm speaking to a South Asian therapist, they might be more judgmental about me dating for instance if they're from the same community.

b) Negotiating Openness About Therapy		***[PP1]***
	154-157	there was no way I could tell them how I feel like shit and whatever, and horrible thoughts are coming into my head. You just wou, you just wouldn't. I couldn't. And it doesn't matter how much you say you're not gonna be judgemen
	393-394	Well not everybody knew that I was having counselling. Mm I didn't want everybody to know.
	419-420	the following year my younger brother died and then my mum had counselling. Because I started to tell you know that how helpful I found it.
		[PP2]
		N/A
		[PP3]
	710-716 [710]	depression isn't a real thing was the biggest thing that I think I..was kind of, not told, but heard. Erm so I think with all of that, I just kind of expected them not to really get it..of what I was going through or what I would say. Or I was really scared that..if I said something then what am I gonna hear back? Am I gonna be told that I'm not valid or what I'm going through is a load of crap. I don't think I knew at that time how to handle any of that.
	890-892	people away from me who don't know me, I've spoken about it. Whereas people that do know me, I haven't really been open about it.
	924-925	So when I'm kind of left..an empty slate, I can kind of say what I want. There's no expectations. I'm really open.
		[PP4]
	178-188	P4: Yea I suppose it was my choice. I didn't want to tell anyone. I do, I did tell after that when I speak to friends then I, then they do know that I take therapy, but yes not my family..as such, no. R: Why do you think that was? P4: I think it's just because that my husband so my fam, my immediate family here is my husband and my two sons. My husband is er not the sort who believes in therapy. He doesn't believe..speaking to an external person makes any difference
	[186]	to your life whatsoever. He doesn't believe in er counselling or therapy or anything like that. So there was not much point telling him, because I knew that he would not be supportive of this [laughs slightly].

	1399-1400	I suppose I choose not to..tell him, because m, my fear or my worry is that he won't understand.
	66-69 1153-1158	**[PP5]** it was like this comradery of like you know you're, we're all in it together, we're looking out for one another. And it had the opposite effect when you were trying to talk about things that are very taboo in the community. there's like a range of..talking therapy, because..like if I mention depression or anxiety, my family would be a lot more kind of like "Oh yes that's very much a thing and you need help with it". But then to then say..I'm hearing voices or I'm seeing things, that's a whole, whole other ball game. So I think it's stigma around that kind, that kind of thing
	108-114	**[PP6]** P6: Er..I only told my sisters. I didn't tell my parents. R: Yea OK, and why do you think that might have been? P6: Because they were never going to get it. Erm..I think it was probably af, a while after that when I told my mum I was depressed and she was like "What do you have to be depressed about?". You know, there was just no sympathy. And so that's really hard to deal with actually.
	114-118 160-162	***[PP7]*** I guess I was having a lot go on in life and so I didn't necessarily want to…tell lots of people what was going on in life. But then when things kind of were a bit more stable for me, I then did say oh I'm going to see like my, you know when I also realised the benefits I was getting, I did like mention it to a couple of friends, and it seemed a bit more normal at that point I didn't mind telling people. Erm I think because there seemed to be that differentiation between I'm not going to see a Psychiatrist coz I'm not like crazy, it, I felt OK with saying that to people.

Appendix 10.15.: Research Ethics Approval

METANOIA INSTITUTE

13 North Common Road
Ealing, London W5 2QB
Telephone 020 8579 2505
Facsimile 020 8832 3070
www.metanoia.ac.uk

Charanjot Kaur Jheeta

31st July 2018

Dear Charanjot,

Re: "Exploring the Experience of Cultural Difference for South Asian Women in Psychological Therapy."

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as Chair of the Research Ethics Committee.

Yours sincerely,

Peter Pearce
Chair of Metanoia Research Ethics Committee

Registered in England at the above address No. 2918520
Registered Charity No. 1050175

Appendix 10.16.: Confirmation of Consent

METANOIA INSTITUTE

Research Supervisor Confirmation of Consent

Name of student: Charanjot Kaur Jheeta

Name of research project: Navigating cultural contexts: Exploring the experience of cultural difference for South Asian women in psychological therapy

This is to verify that as Research Supervisor for the above research project I have seen proof that appropriate consent has been obtained from the participants used in the project.

Supervisor's name: Dr Patricia Moran

Signature: Patricia Moran

Date: 24 August 2022

Appendix 10.17.: Support Services Provided to Participants After Interview

Organisation Name and Website	Brief description	Address	Contact Details
Metanoia Counselling and Psychotherapy Service (MCPS) http://www.metanoia.ac.uk/therapy/metanoia-counselling-and-psychotherapy-service/	Low cost service in West London; provide up to 6 months of therapy	13 North Common Road, Ealing, London, W5 2QB 13 Gunnersbury Avenue, Ealing, London, W5 3XD	**0208 832 3080** Shea Holland Email: Shea.Holland@metanoia.ac.uk Milena Norgate Email: Milena.Norgate@metanoia.ac.uk
Women and Girls' Network http://www.wgn.org.uk/	Provide free counselling in London to women who have experienced violence, or are at risk of violence	Several London areas - Contact for details	0808 801 0660 Email: info@wgn.org.uk
Nafsiyat http://www.nafsiyat.org.uk/	Provide intercultural therapy in over 20 languages	Unit 4, Lysander Mews Lysander Grove, London, N19 3QP	0207 263 6947 Email: admin@nafsiyat.org.uk
The Awareness Centre https://theawarenesscentre.com/	Low cost service; provide open-ended, long-term therapy in more than 25 different languages	41 Abbeville Road, London, SW4 9JX	0208 673 4545
FreshStart Psychotherapy http://www.freshstartpsychotherapy.co.uk/	Low-cost service in Central London; provide therapy for up to 2 years	Centre for Counselling and Psychotherapy Education, Little Venice, London, W2	0207 691 7638
Phoenix Counselling http://www.phoenix-counselling.co.uk/	Low cost service in East London	591 Heathway, Barking, RM9 5AZ	0208 984 9887
The Maya Centre https://www.mayacentre.org.uk/	Free therapy service for women	Unit 8, 9-15 Elthorne Road, London, N19 4AJ	0207 272 0995 Email: admin@mayacentre.org.uk
Samaritans www.samaritans.org	Offers listening support 24/7 both over-the-phone and face-to-face	Various areas – Contact to be put through to someone in your area	116 123 (UK)