

***Locating culture in experiences of therapy:
Accounts of Asian women***

**A thesis submitted in partial fulfilment for the
degree of Doctorate in Clinical Psychology**

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Jo-Anne Scordellis

ABSTRACT

Prior research suggests that people from ethnic-minority groups, in the UK, are under-represented in their use of mainstream psychotherapy services. This finding includes women of south-Asian origin. Recent epidemiological studies have suggested that while Asian women's use of psychotherapy services remains low, their incidence of self-harm and parasuicide behaviours, in the UK, are on the increase. This suggests that these women are not accessing help for psychological distress even though such distress is present. One prevalent idea for why this may be is that mainstream models of psychotherapy practice remain euro-centric and are therefore experienced as either irrelevant or incongruent with the values and experiences of Asian women. However, there has been little research to directly access the individual accounts of Asian women who have experienced therapy. Through the use of a grounded theory methodology this study elicits and analyses such accounts.

It reports findings from six Asian women who were being seen for therapy. The aim of this study was to consider the potential role of self-described cultural identity within experiences of therapy.

Participants highlighted the importance of culture in their understanding of their psychological distress, their routes into, and experiences of therapy. Accounts of the role of culture were both complex and diverse and this study does not offer simplistic conclusions for how models of therapy can become more inclusive. Rather, the findings are used to inform service development and to argue for broader approaches to culture within models of psychotherapy practice and research. Culture should be reflected upon in practice and be given more consideration than mainstream models may accord it, however these accounts emphasises that therapists should work from clients' individual understandings, experiences and needs.

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1. INTRODUCTION

This chapter outlines literature informing and providing a context for the research question addressed in this study. It begins by presenting a literature postulating that individuals from ethnic communities are over-represented in their admissions to psychiatric units but under-represented for referrals to psychotherapy services. Hypotheses and research findings advancing ideas for why ethnic communities are under-represented in their use of psychotherapy services are then presented and critiqued. This is followed by a broader critique, and consideration of the problems with conducting, and drawing conclusions from, psychological studies relating to issues of ethnicity and culture. Ways of addressing some of these difficulties and the gaps that exist within the research literature are considered. Finally, the aims and rationale for the present study are outlined.

1.1 Use of Terminology

Before moving into the main body of the chapter, the reader's attention is drawn to the issue of terminology and the problems of assumed homogeneity.

Problems in defining ethnic and cultural groups are numerous (Fernando, 1995), and in much of the literature diverse cultural and ethnic communities are often grouped together into a homogenous 'immigrant' category. Where attempts are made to separate out ethnic communities, the literature tends to ascribe them to broad categories of either African-Caribbean or Asian origin, again tending to treat these two discrete groups as homogenous in their make-up. A critique of the implications of such assumptions and definitions are given in section 1.8. However, the emphasis of the literature used in this study is on research written about people of Asian origin in a British context. 'Asian' is used to refer to people who identify with, or whose countries of origin are, in the Indian subcontinent, i.e. India, Pakistan, Bangladesh or Sri Lanka (including those peoples who migrated to Britain from East Africa but whose origins lie in the Indian subcontinent). The researcher does not imply that this is a homogenous group of people, and thus acknowledges the wide variations in language, religion, culture and historical experiences that exist within this grouping. Where the researcher cites literature that does not specify ethnic groups, the term 'ethnic communities' is used, while the term 'indigenous' is used to refer to the white, British population whose culture and heritage developed within Great Britain.

These terms have been taken from those suggested by the Confederation of Indian Organisations (Webb-Johnson, 1991). They remain flawed, have limitations and are not shared by all. The researcher's aim is merely to clarify the terminology used in the presentation of the following literature.

1.2 Under-representation of Ethnic-community Users of Clinical Psychology Services

The British literature suggests that access to, and use of, mental-health services for individuals from ethnic communities is different to that of the indigenous community. Broadly, research suggests that people from ethnic-community groups are less likely to receive services offering psychological interventions but are more likely to receive medication or in-patient treatment (Webb-Johnson, 1991; Hopkins and Bahl, 1993). Black people are also more likely to experience compulsory treatment and police involvement (Lewis, Croft-Jeffereys and Davis, 1990; Francis, 1989; Pilgrim and Rogers, 1994; Mama, 1992). In summary, ethnic-community groups are over-represented for serious mental illness but under-represented in their use of primary and secondary mental-health services, including clinical psychology. Research specifically on individuals from Asian cultures also demonstrates low referrals to, and use of, psychotherapy services (Camping 1989; Ilahi, 1988). These differences in service uptake may suggest racist practices within mental-health services (Littlewood and Lipsedge, 1997), and mental-health services have increasingly been called upon to consider whether they are culpable of institutional racism (Fernando, 1991).

1.3 Institutional Racism

As a profession, clinical psychology should be concerned with addressing inequalities in the access to, and use of, its services. This is especially so in light of evidence-based practise and clinical governance which aims to provide equity in health-care, and monitor standards of service provision. (See also the 1994 Mental Health Task Force calling for services to adapt to the needs of ethnic communities in Britain.) Given the inequalities in the uptake of psychotherapy services, clinical psychology, as a profession, must consider whether it is culpable of institutional racism.

The MacPherson Report (1999) defines institutional racism as ‘the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin’ (cited by Majid, 2001, p86).

Given the low uptake of psychotherapy services by people from ethnic communities, questions need to be asked about how clinical-psychology services can provide models of service that meet the needs of a society that is multi-cultural in its make-up. Part of this process needs to include the exploration of why ethnic communities are under-represented in their use of psychology services. The next section introduces and critiques hypotheses and research findings commonly cited in explaining this under-representation.

1.4 Reasons Cited for the Under-representation of Ethnic-community Users of Psychotherapy Services

1.4.1 Lower Levels of Psychological Distress

Some commentators have suggested that the under-representation of ethnic communities in psychology services may reflect an absence of need. This hypothesis is particularly associated with individuals from Asian communities. For example, Cochrane and Stopes-Roe (1981) conducted a community survey on people of Indian, Pakistani and white, British origin in Birmingham. They used a self-reported measure of psychological symptoms and found significantly lower rates of symptomatology among patients of Indian and Pakistani origin than among white, British subgroups. Raleigh and Almond (1995) state that a common reason cited as an explanation of such findings is the idea that the family and community-support systems assumed to be characteristic of Asian culture reduces the risk of mental illness. However, Webb-Johnson (1991) and others, including Durvasula and Mylvaganam (1994) and Lloyd (1992), caution that false and over-simplistic conclusions about the levels of psychological distress in British Asian populations could be drawn from findings such as those cited by Cochrane and Stopes-Roe.

Researching levels of psychological distress is fraught with methodological problems, and findings are often contradictory. For example, Bangladeshis in Britain are reported to experience higher levels of psychological distress than their indigenous neighbours (MacCarthy and Craissati, 1989). This distress is reported as being associated with chronic deprivation, language difficulties, poor and overcrowded housing, unemployment, social isolation and racism. Fatimilehin and

Coleman (1988) argue that such findings should be expected given the literature and research which shows that significant social, political and economic disadvantage is experienced by ethnic-community groups. Given theories that link psychological distress with such socio-economic factors (e.g. Brown and Harris, 1978) and the literature which considers the potential negative impact on psychological well-being of acculturation (Baker, 1999), immigration (Landaou-Stanton, 1990, as cited by Baker, 1999) and the experience of racism (Fernando, 1991), one could logically hypothesise that ethnic-community groups would be experiencing levels of psychological disturbance as great as, if not greater, than the indigenous population.

The idea that Asians are more psychologically robust is also challenged by the above-average incidence of serious mental illness among members of ethnic communities (which include people from Asian communities). Shaikh (1985) studied psychiatric admissions of Asian and indigenous patients in Leicestershire. The study revealed no substantial difference between the groups in the number of compulsory admissions or in the length of stay in hospital. However, the diagnoses applied to the Asian patients were significantly different from those applied to the indigenous patients. The Asian sample contained a higher proportion of patients diagnosed psychotic. Worryingly, treatments administered to these two groups also differed. Electro-convulsive therapy was given to Asian patients diagnosed as schizophrenic more frequently than indigenous patients with this diagnosis. Shaikh's findings suggest racist practices (in diagnosis and treatment) and that mental-health problems within the Asian community often remain unreported and undetected until they escalate to a crisis stage, which necessitates in-patient treatment. This latter conclusion is also supported by findings about the rates of self-harm, parasuicide and suicide in young Asian women. The suicide rate in Asian-born women in Britain aged 15–24 years is more than double the national rate, and in Asian-born women aged 25–33, it is sixty per cent higher (Raleigh and Balarajan, 1992 and Raleigh, Bulusu and Balarajan, 1990 as cited by Raleigh and Almond, 1995). Young Asian women also have high rates of attempted suicide (Merrill and Owens, 1986 as cited by Raleigh and Almond, 1995) and high rates of self-harming behaviour (Marshall and Yazdani, 1999). The reasons for these high rates of suicide and self-harming behaviour are not yet fully understood (Brown, 1998) but what is clear is that the psychological distress thought to be reflected by such behaviour has not led to an increase in referral rates to psychotherapy services (Marshall and Yazdani, 1999).

1.4.2 Preference for Accessing Alternative Sources of Support

Another idea hypothesised within the literature is that ethnic-community groups prefer to access alternative sources of support and therefore do not present to mental-health services. For example, Durvasula and Mylvaganam (1994) cite Sue and Morishima (1982) who found that Asians¹ prefer to utilise family support and traditional health-care channels (such as physicians) over the use of mental-health facilities. Krause (1989) and Aslam (1979) also discuss the importance of the role of religious specialists and alternative practitioners in providing (mental) health care for Asian populations in Britain.

However, Lloyd (1992) cautions against viewing the use of alternative sources of support as an explanation for the under-representation of ethnic-community groups' (voluntarily) accessing of mental-health services. Citing Helman (1990), Lloyd argues that there is evidence to suggest that the use of 'alternative practices' is just as much a practice of white, British culture as it is of ethnic-community groups, and therefore cannot be viewed as an adequate explanation.

As has already been mentioned, another idea is that Asians support each other within their extended families and therefore do not want or need to access mental health-care support. This is linked to the concept of the extended family, where a household may consist of parents, grandparents, children with their spouses and their children. This type of extended family has been prevalent in the cultures of the Indian subcontinent. However, by no means all Asian households, either in the Indian subcontinent today or in Britain, are of this type. Brown (1984) revealed that only sixteen per cent of Asian households in Britain are extended families, and the researcher found no research to identify if, and how, these extended families support the mental well-being of the individuals within them.

1.4.3 Characteristics of Asian Culture Acting as Barriers to Accessing Services

'Characteristics' of specific cultures have also been looked at in the literature as possible causes of the under-utilisation of services. Sue (1994) presents beliefs within Asian communities that strong feelings should be restrained, and that

¹ This is an American study and, in that context, the ethnic grouping Asian usually includes people from South East Asia, e.g. China, Vietnam, Korea and Japan.

focusing on distress is unhelpful. Curren (1986) interviewed Pathan² women living in Bradford, and she discusses the discourse of fatalism and the reoccurring theme in these interviews that things happen because of the direct will of God. Curren (1986) suggests that, given this construction of the meaning of events, these women did not seek explanations for their unhappiness or ill-health, which may have implications for mental-health help-seeking behaviour. Rack (1982) discusses how mental illness may also be viewed as shameful within Asian cultures and this stigmatisation may be an important barrier to seeking help. However, and again, caution must be exercised about drawing conclusions from this research. Stigma is attached to mental-health problems within many cultures – including Western cultures – and it is unsatisfactory to explain the low uptake of psychotherapy services merely in terms of the characteristics of Asian culture.

1.4.4 Somatisation of Psychological Distress

The literature reports that people from ethnic-community groups are more likely to describe physical symptoms when presenting psychological disturbance (Fenton and Sadiq-Sangster, 1996). This observation has been forwarded as part-explanation for the lower rates of referrals made by general practitioners (GPs) of ethnic-community patients to psychology services than of white, British patients. The argument follows that people from ethnic-community groups are more likely to experience or report somatic presentations of anxiety and depression, and therefore diagnoses of affective disorders are often missed. However, the validity of this argument has been questioned. For example, Weiss, Raguram and Channabasanna (1995) studied the manifestation of depression in south India and found a tendency to spontaneously report somatic symptoms but to also identify depressive symptoms when probed. So, patients were more immediately aware of their physical symptoms but could also identify depressive symptoms when probed. There is also no concluding evidence from the present literature that Asians ‘somatise’ more than other ethnic groups. One study in Manchester found no significant difference in the reporting of somatic symptoms between Asian and white, British groups of patients although the white British patients were more likely to attribute their complaints to psycho-social causes (Bhatt, Tomenson and Benjamin, 1989 as cited by Webb-Johnson, 1991).

Webb-Johnson (1991) argues that it is now widely recognised that all cultural groups have a tendency to present emotional difficulties with somatic symptoms. She argues that it is often maintained that ‘somatisation’ is a reflection of social

² Pathans are a culturally distinct group of people who originate from the north-west of Pakistan and eastern Afghanistan.

class and educational background, and that such stereotyping of somatisation is derisory and implies that it is unsophisticated. It has been argued that somatisation may be a normal coping mechanism for people who are experiencing psychological distress (Chakrabarti and Sandel, 1984 as cited by Webb-Johnson). Nevertheless, this stereotype of somatisation and the 'lack of psychological mindedness' that is associated with it may impact on clinicians' practices (Fernando, 1995). Bal (1987) found that both Asian and white, British general practitioners were less successful at recognising psychological symptoms in Asian than in white, British patients. Webb-Johnson argues that in cases where only physical symptoms are presented, it is the professionals' duty to make an assessment beyond these presenting symptoms, and thus develop a system of practice based on the clients' needs. This introduces the role of the assessors and gate-keeping professionals.

1.4.5 The Role of Gate-keeping Professionals

Professionals, as gatekeepers to services, have been targeted for filtering out people from ethnic-community groups who may otherwise have received psychological services. Goldberg and Huxley (1980) discuss factors that may play a role in this process, and they include preconceived (racist) ideas about the suitability of individuals for psychological help. The researcher is unaware of any research that has specifically investigated the processes which may be occurring between professionals and clients in such situations. Nevertheless, there does appear to be differences in the referral rates to mental-health services between white, British-born individuals and individuals from ethnic-community groups. For example, Lloyd (1992) found that general practitioners are most likely to diagnose anxiety and depression in white, British-born women and least likely to diagnose it in women from all ethnic minorities. Bhui, Strathdee and Sufraz (1993) found low GP involvement in Asian patients admitted to a psychiatric hospital (even though many of the patients had Asian GPs); a large proportion of the admissions came through emergency services, such as casualty.

These findings suggest that, as gatekeepers to mental-health care, GPs may not be sufficiently responsive to the needs of Asian patients. Finally, such assumptions and perceptions about Asian individuals not being appropriately served by psychological interventions may be held by Asian as well as white professionals. One study of psychotherapy services highlighted the reluctance of Asian doctors to refer their Asian clients to psychotherapy (Ilahi, 1988). This may reflect that service providers – irrespective of ethnic origin – who have been trained in Western models of health-

care are likely to subscribe to racial stereotypes which become a part of practice and service provision.

1.4.6 Other Hypotheses

Other issues that have also been considered and viewed as explanations of under-representation of ethnic-community group users of psychology services include language barriers (Flaskerud and Liu, 1990), lack of ethnic match of therapist (Terrell and Terrell, 1984) and lack of appropriate and accessible information about existing services (Sulemanji, 1999).

This short summary of some of the main areas of research investigating issues of ethnicity and use of psychotherapy services has had two main aims. Firstly, to acquaint the reader with some of the issues under consideration in this area of clinical research. Secondly, to demonstrate the difficulty in drawing clear conclusions from the existing body of research. Much of the research has contradictory, incomplete, and non-generalisable findings. Nevertheless, conclusions are drawn from such research and can lead to powerful, simplistic and/or incorrect stereotypes which inform practice. In the following section, a broad critique of such research is presented.

1.5 Is Mental-health Research Harmful to Black and Ethnic-minority People?

There is a growing body of literature which has begun to question the direction of some of the research that investigates issues of 'race', ethnicity and culture in relation to psychological constructs and practice.

Patel (1999) argues that some of the research on mental health, ethnicity and culture is fostering negative stereotypes, and therefore perpetuating racist practices within the mental-health systems. Both Aitken (1996) and Patel (1999) argue that this is because much of this research places the 'problem' within the ethnic groups considered. This was demonstrated in the literature reviewed in section 1.4 of this chapter. Many of the reasons considered on the question of why individuals from ethnic communities were under-represented in their use of psychotherapy services position the answers within the ethnic communities rather than considering models of service provision and mental health research. Patel cites epidemiological research on psychoses, in particular cannabis psychosis amongst African-Caribbean people,

as an example of particularly damaging research. That cannabis psychosis has become so associated with African-Caribbean people leads Patel to argue that such research has the potential to foster negative stereotypes of Black and minority ethnic people thus perpetuating racist practices within the mental health system. Patel concludes with the question, 'Is mental health research harmful to Black and minority ethnic people?' (p. 11)

An alternative to investigating what it is about ethnic communities that leads to low use of psychotherapy services is the investigation of psychological models of practice and research. Criticisms are increasingly being made that clinical psychology, in its research and practice, has failed to be reflexive (Aitken, 1996; Patel, 1999). Patel argues that research in this area needs to begin to position Black and minority ethnic people as experts of their distress, whose own theories, concerns and priorities are starting points for research strategies. Aitken argues that other professions, such as psychiatry, have more frequently been called to account for the re-enactment and reproduction of racialised ideas. She states that there has been a lack of such reflection in psychological theorising, research and practice.

Aitken (1996) draws on arguments made by Fernando (1991, 1988) that psychology, in parallel with psychiatry, evolved in a specific socio-historical-political context which reflects predominantly white, male, Eurocentric, middle-class perspectives excluding and/or problematising the knowledge and experiences of people who fall outside of these ascribed social categorisations. This point is illustrated by Newland (1998):

An implicit assumption is that social context influences all themes related to race and culture. Given that clinical psychologists live in a multicultural social context, the question arises as to the extent to which social context is reflected in the practice of clinical psychology. Put simply are there current practices of clinical psychology which are racist?

(Newland, 1998, p. 5)

It must therefore be considered that people from ethnic-community groups are not accessing psychology services because of the inherent racism within the services. Psychological practices could be experienced as overtly racist or merely irrelevant and removed from the real-life experiences of people from ethnic-community groups. The latter is a belief expressed by participants in Fatimilehin and Coleman's

(1998) study on the views of African-Caribbean families towards child and family-psychology services. The participants, who it should be noted had not used the services, expressed the view that (child) psychology services are the domain of white, middle-class culture and have little or no relevance to the experiences of African-Caribbean families.

The following two sections expand further on the argument put forward by Aitken and Patel that psychology has failed to be reflexive in its use of models of research and clinical practice. The first section (1.6) considers models of research, the second (1.7) models of clinical practice.

1.6 Critiques of the Models of Research

1.6.1 Problems with the Claim of ‘Value-free’ Research

Fernando (1995) questions the dominance of the model of scientist-practitioner within clinical psychology. This model, which he argues privileges positivism and quantitative methodologies, places research and therapy as entities, which exists outside of those engaged in the process. The aim is the production of objective, value-free and universal findings. Aitken (1996) argues that far from producing value-free research, this model, in denying the impact of power differentials in the research (and therapy) process and the influence of preconceived ideas shaped by social contexts, can serve to reinforce racist ideas.

Fernando (1988) argues that the prevailing political context must be taken into account in examining the effects of mental-health research published in scientific journals. He states that it is naïve to assume that research on issues involving race is value free when conducted in a racist society. The conclusion drawn from this is that researchers must aim to be reflexive in their conceptualisations of research, the aims and methods that they employ to elicit findings, and to be wary of how such findings could be construed. For example, should findings be considered generalisable with the aim of claiming the universality of theories? The issue of the universality of models of psychological distress and interventions is considered below.

1.6.2 The Issue of Universality

The assumption of the universality of findings has led to the application of Western models of mental-health disorders to other groups without first seeking to validate those disorders in cross-cultural settings (Thakker, Ward and Strongman, 1999).

This brings into question the validity of studies that use Western diagnostic criteria to assess psychological distress in other ethnic groups (see Derasari and Shah, 1988). The aim of producing universal findings has led to psychological research often treating factors such as race, gender and socio-economic group as variables to be factored out or controlled for. When ethnic-community groups are treated as independent variables, diverse ethnic-community groups are treated as homogenous. However, the suggested role that culture plays in conceptualisations of psychological distress indicates that neither of these positions is desirable. The importance of culture is emphasised by Meldrum (1998) who argues that cultural differences across communities may shape meanings and experiences of psychological distress and where such variables are ignored the validity of such research has to be questioned. The argument that some psychological research has positioned experimental neatness above validity has been argued:

[Psychology] has certainly produced a vast amount of research impressive for its neatness and precision but often having no external referent. Methodological refinement seems to have become an end in itself.

(Sinha, 1993, cited in Fernando, 1995, p. 44)

Dwairy (1999) argues that Western psychological theories create an illusion that the principles embedded within them are universal and applicable cross-culturally. She argues that this is not the case, and that social structures such as religion, language and culture all impact to differing degrees on theories of development, personality and psychopathology. Thakker, Ward and Strongman (1999) argue that there is evidence to suggest that the current criteria for mental disorders, as found in the *Diagnostic and Statistical Manual of Mental Disorder*, iv (DSM-iv), may not be universally applicable. They cite Draguns (1995) and Kleinman and Cohen (1997) as demonstrating important differences in the manifestations of psychiatric disorders across cultures. Thakker et al. (1999) argue that this reflects limitations in our current approaches to conceptualising psychological distress. They argue that a constructivist and relativist approach to understanding mental disorders allows for a more sophisticated interplay between psycho-physiological functions and socio-cultural variables. The latter is often ignored in current conceptualisations. The view put forward by Thakker et al. (1999) is reflected in Okasha's (1999) statement that

culture is a major determinant that does not only colour the definition of health and disease, but also colours the disease and determines when and where help is sought.

(p. 930)

Approaches to research directly impact on approaches to clinical practice as reflecting ideas of evidence-based practice. However, where the 'evidence' can be accused of being conceptually flawed, so too can the practice born out of it. A brief introduction to critiques of current clinical practice is given in the next section.

1.7 Critiques of Clinical Practice

Aitken (1998) argues that in our professional training, clinical psychologists learn to position our therapy encounters as operating outside of wider social contexts in which racist, sexist and heterosexist assumptions and practices are realised. She reminds us that this may not be the shared understanding or experience of our clients. In a study exploring if issues in the therapeutic relationship relating to ethnic and cultural factors are readily discussed in the supervision of clinical psychologists, Dennis (1998) notes the lack of emphasis and time given to this topic. In not acknowledging the impact of wider social contexts within the therapeutic encounter, Comas-Diaz and Jacobsen (1991) argue that empathic and dynamic stumbling blocks are missed which may be reflected in the high drop-out rates recorded for individuals from ethnic-community groups.

The lack of attention given to cultural differences, the assumed universality of findings in research and the psychological theories that such research generates is implicated in the criticism of psychological practice. Varma (1998) argues that therapeutic approaches, such as cognitive behaviour therapy and psychodynamic therapy, are not universal in their ability to aid people who are experiencing psychological distress because they are culture specific, having developed in a particular culture at a particular time. For example, Durvasula and Mylvagnum (1992) point out that Western models of psychotherapy often emphasise the individual with the aim of achieving self-actualisation. They argue that this aim, and the way that meaning is constructed in these forms of therapy, may be undesirable to individuals from different cultures where the preoccupation with the self is less prevalent.

Cognitive-behaviour therapy, psychodynamic and systemic therapies also reflect contemporary Western conceptualisations of mind-body dualism. Thakker et al. (1999) argue that this concept of mind-body dualism is highly influential in Western ideas of health but does not fit with other cultural constructions of health. They suggest that for an individual from a Western culture, depressed mood may be experienced only in cognitive and emotional terms with little or no attention paid to somatic symptoms. In contrast, an individual with a more holistic understanding of mind and body would be more likely to attend to somatic symptoms and view them as part of a totality of experience. Thakker et al. (1999) argue that differences across cultures in somatisation probably represent these differences in conceptualisations of health and distress. A position that encourages the universal applicability of Western psychotherapies may not only effect how relevant psychology is experienced as being by the clients from ethnic-community groups, but may also lead the therapist to pathologise culturally acceptable and adaptive beliefs.

A final criticism levelled at psychological theories of distress is their emphasis on the individual and the relative lack of emphasis placed on people's social contexts (Orford, 1998, 1992). As was stated earlier, the social context of many individuals within ethnic-community groups may have a very real impact on their psychological well-being. Therapeutic approaches which do not recognise such issues and/or deny their importance may be experienced as unhelpful or irrelevant to the individual concerned. Traditional models of therapy remove the individual's experiences from the social and political context in which they develop and treat them in isolation.

Central to these criticisms is that equality cannot be achieved by treating everyone the same, irrespective of their background and culture. This colour-blind approach, placing the therapist as an objective scientist, often results in everyone being treated as white, thus leading to inequality rather than equality. Caines (1986) refers to this as cultural chauvinism.

Approaches in transcultural therapy have attempted to offer alternative models of therapy. The aim of transcultural therapies have been that individuals' problems are recognised as being inextricably linked with the wider social context, and therapists are encouraged to broaden their focus to include an examination of individuals' interactions with their political and social environment (Kareem and Littlewood, 2000). However, criticisms have been made of transcultural therapies for advocating simplistic and potentially flawed solutions such as ethnic matching of client and therapist (Burman, Gowrisunkur and Sangha, 1998).

Examples of good practice in the use of Western psychotherapies have been documented in cross-cultural settings; an example is Masalha's (1999) experiences of using psychodynamic psychotherapy in a Palestinian setting. However, a problem with research that considers issues of culturally sensitive practice is that it often uses prescribed outcome measures of therapy success or it reflects anecdotal observations of therapists. Few studies have directly accessed user perspectives on their experiences of therapy with the issues of culture or ethnicity being considered. One reason for this may be the difficulty in defining and investigating culture. This is considered in the next section.

1.8 Dilemmas in Investigating 'Culture'

The literature increasingly points to the importance of individuals' culture in their conceptualisations and experiences of psychological distress. Yet research investigating the interplay between culture and psychological distress is scarce or marginalised; 'found in cross-cultural studies often associated with the replication of findings in some remote or exotic part of the world' (Betancourt and Lopez, 1993).

Many of the problems in research when addressing issues of culture stem from the problems in defining sampled groups of people and how the data produced from such research is then understood. When culture is the construct under investigation, it is often defined by preconceived notions of ethnicity or race. They are treated as equivalent to culture, with the three terms 'ethnicity', 'race' and 'culture' being used interchangeably. Ethnicity and 'race' are also subjective, imprecise, fluid and racist constructs, yet they are often used as definitive and static measures in psychiatric and psychological research (Burman, Gowrisunkur and Sangha, 1998).

Satisfactory ways of managing the investigation of culture have not been developed, and confusion concerning its definition has been an obstacle to progress (Betancourt and Lopez, 1993). However, the need for psychological research that addresses issues of culture, especially in psychological practice, grows as society becomes increasingly multicultural in its make-up (McGovern, Furumoto, Halpern, Kimble and McKeachie, 1991 as cited by Betancourt and Lopez, 1993).

Patel (1999), and Burman, Gowrisunkur and Sangha (1998) suggest that the issue of culture needs to be addressed by exploring and using the constructs generated by individuals' narratives. These cultural identities should be viewed as fluid and

dynamic, with conclusions drawn from such research aiming to reflect accounts which can inform psychological knowledge but not claim universal, representative and generalisable findings (Patel, 1999; Marshall and Yazdani, 1999). Such a position reflects constructionist ideas of psychological theories where knowledge is viewed as localised and relative rather than absolute (for a more complete description of constructionist epistemology, see section 2.1.4).

Burman et al. (1998) also argue that culture cannot be separated from gender. They argue for a broadening in the conceptualisations of culture to include issues such as class and gender. Phoenix (2001) also argues that culture (in the UK context) should not be considered the condition of ethnic communities, and that the study of the conceptualisations of culture must also include those owned by the white majority (as cited by Majid, 2001).

These arguments for participants' accounts to inform the constructs of culture are reiterated by Patel (1999) who states more generally that there has been a lack of mental-health research aimed at eliciting the views of the ethnic communities on their own situations and experiences.

1.9 Examples of Recent Research

Attempts to address some of the criticisms levelled at research on issues of ethnicity and culture have led to the use of constructionist epistemologies and/or qualitative methodologies within research studies. Some recent examples are given below.

Haworth (1998) carried out research on mental-health professionals' accounts of working with clients who are from ethnic communities; she used a Q-methodology (utilising both quantitative and qualitative data) but took a social constructionist position. She argues that an appropriate perspective on researching and understanding issues of race and culture in mental health is offered by a social constructionist position, as it emphasises the interpersonal context of human experience thus providing more appropriate foundations for the development of culturally enriched conceptualisations of psychological processes. Her findings also echo some of the arguments put forward in this chapter that clients from ethnic minorities cannot be assured of receiving appropriate non-discriminatory treatment from the mental health services. Haworth's conclusion was linked to her finding of a dominant account that all presentations are equivalent to white presentations of

mental health problems and the potential for the cultural chauvinism of mental-health professionals as mentioned earlier.

Hiller and Kelleher (1996) argue that qualitative approaches are more suitable than other approaches (for example, quantitative) when researching issues of 'culture' as they more readily allow the investigation of participants' meanings and experiences, an area of research that has been neglected (Patel, 1999). A range of qualitative methodologies have been employed by researchers to investigate a wide range of issues relating to culture:

Patel (1998) employed a grounded theory approach exploring experiences of black therapists in their work with white clients. She found that a dominant theme to be therapist's aim of integrating their black identity with their professional identity of being a clinical psychologist. Patel concludes that such integration is achieved through the aim of reducing potential differences in these two aspects of identity and that this is usually achieved through the adoption of practices (in dress, language, attitudes) from the dominant (white) culture.

Marshall and Yazdani (1999) used discursive analysis of accounts of young Asian women to investigate constructs of self-harm and the location of culture within accounts. Their findings are complex but suggest that experiences of self-harm are shaped by culture but remain individual, thus requiring clinicians to work from the understandings and perspectives of their clients. The findings from Marshall and Yazdani's study are explored in more depth in the discussion chapter of this thesis.

What unites the aims of the studies cited in this section are their attempts to elicit participants' constructs, meanings and experiences, and to view the results as expanding theory rather than being representative of universal laws.

However, research specifically investigating issues of culture in the experiences of therapy from users' perspectives remains scarce. Rennie has conducted a series of grounded theory studies into aspects of client's experiences of therapy (e.g. Rennie, Phillips and Quartaro, 1988; Rennie, 1990, 1992) but these do not directly address issues of culture.

The researcher is aware of only one study specifically eliciting a client's account of their experiences of therapy in relation to issues of race, culture and difference: Aitken's (1996, 1998) thesis investigated a 'black' woman's experiences of

engaging in therapy, and this involved independently interviewing both the client and her white therapist four times over an eleven-month period. The data was analysed using a discursive methodology. This study allowed for the processes underlying the negotiation of difference, particularly differences in race, to be explored. It also gave a voice to a black client, which allowed Aitken to consider how therapists can aim to reduce the reproduction of social inequalities within the therapy encounter. One of Aitken's main conclusions was that this requires therapists to be reflexive in their practice and this was further explored during the process of the research where the difficulties and complexities in being reflective were considered. The emphasis on reflective practice was further emphasised by Aitken and Burman (1999) who devoted a follow-up paper to the Aitken's studies which reflected on the process of a white woman (who was also, at the time, a trainee clinical psychologist) taking a feminist perspective in conducting research on a black women's experiences of being a client being seen by a clinical psychologist. In writing this paper Aitken and Burman demonstrate processes of reflexivity in research that are suggested by commentators such as Patel (1999).

In Aitken's (1996) thesis she argues that if models of psychotherapy practice are to be inclusive, more research needs to investigate client experiences of therapy and how the issues of culture are negotiated within it.

The aims of the present study were developed within the context of the literature reviewed. To aid the reader, a summary of the main points made in this chapter are given below, and this is followed by the final section describing the research question.

1.10 Summary

- Within Britain, individuals from ethnic communities are under-represented in their use of clinical psychology or psychotherapy services. They are over-represented in numbers for serious mental-health problems as indicated by admissions to psychiatric units and rates of diagnosis. Connected with this, Asian women within Britain have higher-than-average rates of suicide, parasuicide and self-harming behaviour. Asian women's use of statutory psychotherapy services remains low.
- A number of hypotheses have been investigated within the literature to explain the low use of psychotherapy services. The findings of such research are often

contradictory, and this, along with methodological problems, makes meaningful conclusions difficult to identify.

- Some of this research investigates aspects of ethnic cultures as explanations for low use of psychotherapy services, and in doing so can be culpable of siting the problem within groups of service users rather than models of service provision. This can promote racist practices, thus being harmful to the participants who take part in these studies and subsequent users of services.
- Broad critiques of research on issues of race, culture and ethnicity are that they lack reflexivity, claim to be value free, do not take account of participants' constructs or meanings, and findings are often treated as if they are generalisable and representative.
- Some models of clinical practice which emerge from psychological research result in everyone being treated as 'white' and 'Western'.
- There is a need for mainstream psychological theories informing clinical practice that can account for culture. However, 'culture' is a difficult concept to research, often being treated as equivalent to race and ethnicity. Recent suggestions are that culture can most meaningfully be investigated through the use of participants' accounts of their own cultures. It has also been suggested that concepts of culture should also be broadened to include factors such as gender and socio-economic class. Culture should not just be considered a condition only of people from ethnic communities. Finally, culture should be treated as a dynamic construct.
- More recent studies that have investigated issues of culture have employed qualitative methodologies and constructionist epistemologies. The result is that studies are beginning to generate findings from participants' narratives of experiences and meanings. The findings of such data are viewed and presented as contextual.
- There remains a lack of research eliciting users' experiences of therapy with the issues of culture being investigated.

1.11 Aims of this Study

The broad aim of this study was to investigate south-Asian³ women's constructs of their cultures, and how these related to their experiences of therapy. The intention was not to generalise from these accounts to broad formulations of Asian women's experiences of therapy. Rather, the aim was to inform further research and models of therapeutic-service provision by grounding the findings in the meanings and experiences reported by Asian women engaged in the experience of psychological therapy.

The researcher is aware that she has used a broad ethnic grouping to provide the sample frame for investigating culture in this study. There are problems with this, and the researcher considered some of these in section 1.8. However, she also wanted to produce data that may facilitate the addressing of issues of inequality in service provision. The reasons for using the sample frames of 'women' and 'south Asian' are as follows:

The researcher was aware of the ideas put forward by Burman, Gowrisunkur and Kuljeet (1998) who suggest that culture needs to include constructs of gender, i.e. accounts of Asian cultures may be different for men and women within those cultures. She is also aware of the research findings that demonstrate increasingly high rates of self-harming and suicidal behaviours in women from south-Asian cultures in Britain. By including women in this study who 'belong' to Asian ethnic groupings, the aim was to consider possible reasons for why women within that group may not be accessing psychotherapy services. For example, it was aimed to elicit within the accounts of the experiences of therapy, ideas relating to these women's experiencing of accessing psychotherapy services and whether or not they experienced therapy as culturally congruent. However, throughout the study, the researcher aimed to reflect upon the problems of what Phoenix (1987) calls the normalised absence or pathologised presence of black women in research. This is considered further in the discussion section.

Finally, the researcher was also aware of the geographical context of this study in the city of Leicester. The official estimate from the 1991 census states that 23.7% of

³ In the UK context, the use of the ethnic category 'south Asian' refers broadly to those peoples whose familial or cultural backgrounds originate from the subcontinent of India, Pakistan, Bangladesh and Sri Lanka. The term Asian is broad and heterogeneous; diversified along the lines of religion, class, migration patterns, language, traditions and identifications with regional areas 'back home', places that may be urban or rural (Woollett, Marshall, Nicholson, and Dosanjih, (1994).

Leicester's residents came from Indian, Pakistani or Bangladeshi communities (Indian is the largest at 22.3%, and many of these individuals migrated from East Africa). In some parts of the city, the clinical psychologists attached to community teams will be serving a population where there is an ethnic majority of south Asians. However, anecdotal evidence from discussions with clinical psychologists within the region (and the researcher's difficulties in accessing an adequate number of participants) suggested that their contacts with clients from the Asian community were very low, and this tied in with the national literature cited in this introduction.

The overall aim was to sample in a meaningful way, and, though the researcher imposed a cultural category of south Asian on the participants, the interviews were used to elicit participants' own constructs and meanings of their cultures.

Finally, participants' accounts have been analysed using a grounded theory approach. The ultimate aim of such an approach is the generation of comprehensive theory from purposively sampled sets of relevant cases. Such comprehensive theory was not achieved in this study; however, a model illustrating the accounts of the women who took part in this study was produced. How this model informs clinical-psychology service provision is considered in the discussion section.

2. METHOD

The introduction section presented a rationale for a qualitative methodology to be used as the form of enquiry in this study. In this chapter, a brief overview of qualitative methodologies is provided. This is followed by a description of grounded theory, as the form of qualitative enquiry used in this study. The rationale for using grounded theory as a methodology for data collection and analysis is presented. This is followed by an outline of the procedures that were followed in the present study. A description of the participants and the sample frame is provided, followed by data-collection-and-analysis procedures. Finally, issues of validity, reliability and reflexivity are considered.

2.1 Qualitative Research

Qualitative methodologies are diverse in procedures and epistemological stances (Madill, Jordan and Shirley, 2000). While diverse, qualitative approaches are increasingly being used in applied-research settings including clinical psychology (Elliot, Fischer and Rennie, 1999). McLeod (2001) argues that this increased use of qualitative approaches ties in with a shift in the focus of research to looking at participants' subjectivities. However, while qualitative approaches to research are increasingly being used, it is argued that they remain marginalised within the wider research discipline of psychology.

Craig (1996) points out that this marginalised position of qualitative research is echoed across health-care settings and cites the place of qualitative research within the culture of 'evidence-based practice' as being confirmation of this. Craig (1996) asserts that qualitative-research projects have difficulties with ethical committees and in gaining funding because of misunderstandings of, or lack of agreement with, the aims and the epistemology that they propose.

This resonated with the researcher's own experiences in conducting this study, and it became important to understand the position of qualitative research within the wider arena of science and competing claims to knowledge. A full review of this issue is beyond the scope of this study but the researcher highlights some of the main points about qualitative research and its place within the wider research context below.

In the context of searching for status and recognition (Warner, 1996), psychology as a 'science' grew in its attachment to numbers and methodologies that quantify. This allowed for the development of statistically validated universal laws governing relationships between 'cause' and 'effect'. Central to such a view of science is what is called the positivistic or realist epistemologies (Madill, Jordan and Shirley, 2000). The aim of such science is to uncover objective truths through the falsification of hypotheses generated from theory. Indicators of quality are measures of reliability (i.e. repeatability), validity (i.e. does the study measure what it purports to measure) and quantification allowing for statistical analysis. These quality indicators are set with the aim of removing error and striving for a position of objectivity.

Parallel with this academic context is a professional one. Clinical psychology is a profession whose practice claims to be informed by research evidence (the dominant model of training is scientist-practitioner), and, in a medical context, in which psychology is vying for status (Pilgrim and Treacher, 1992), quantitative research is often seen to hold more sway than qualitative methodologies. Studies employing qualitative approaches may be viewed with scepticism and as not being scientific (for example, Morgan, 1998). Given these contexts, contemporary approaches to qualitative research originated in other disciplines, such as sociology. More recently, however, psychologists have begun to play an active role in developing qualitative methodologies.

Within psychology, questions regarding the appropriateness of having the quantitative-research paradigm as the dominant model for investigating psychological phenomena have been raised. This links in with postmodernist ideas of relativity (Henwood and Nicolson, 1995) and the feminist critiques of dominant psychological theories that began to emerge in the latter half of the twentieth century (Griffin, 1995). There has also been an upsurge of interest in exploring participant subjectivities and how meanings are constructed through language and experience (Parker, Georgeaca, Harper, McLaughlin, and Stowell-Smith, 1995). Within debates of methodology, qualitative research is often counterpoised to quantitative methodologies. However, as qualitative approaches have become increasingly recognised, issues have shifted from quantitative-qualitative debates to more fundamental debates of epistemology and conceptualisations of truth (Wiggins, 2001). Epistemological debates take place across and within qualitative methodologies. For example, Madill, Jordan and Shirley (2001) demonstrate that a grounded-theory study can be understood from three broad epistemological stances: 'realist, contextual constructionist and radical constructionist'. McLeod (2001)

points out that their paper illustrates the complexity of terms like ‘objectivity’ and ‘reliability’ in a field in which there are competing epistemological traditions. Equally, Parker (1994) asserts that not all quantitative research assumes a positivist position.

Although qualitative research should not be considered as a unitary concept, there are unifying themes that link most forms of qualitative research. Firstly, it is generally undertaken in a naturalistic setting, as opposed to a laboratory or controlled setting (Flick, 1998). Secondly, data tends to be non-numeric and may include interview scripts, written texts and visual material. Thirdly, emergent theory is preferred to *a priori* theory (Denzin and Lincoln, 2000), with the emphasis on the development of theory from a grounding in the data (Henwood and Pidgeon, 1992). Finally, the issue of interpretation within the research process may be explicitly acknowledged through the use of reflexivity. Positions on reflexivity, reliability and validity will differ according to epistemological stance and methodology employed. The constructionist position taken within this study will be considered in more depth later in this chapter. The methodology employed is grounded theory, and this is described below.

2.2 Grounded Theory

In this section, the origin of grounded theory as a methodological approach to research in the social sciences is presented. This is followed by a critical review and consideration of the current developments in the application of grounded theory methodology, particularly in applied psychological research.

This section is included as it explicates the ideas that shaped the methodological design, data analysis and data interpretation within this study.

2.2.1 Origins of Grounded Theory

Grounded theory was described by the sociologists, Barney Glaser and Anselm Strauss, in their book, *The Discovery of Grounded Theory* (1967). Here, Glaser and Strauss argued that there was an over-emphasis in the field of sociology on the verification of a few ‘grand’ theories, and that this was leading to impoverished theory which did not fit with the real world. With the aim of building innovative theory, they proposed turning method ‘upside down’, using qualitative data as a source for developing, rather than verifying, theory. The theory would be grounded

in the data with a focus on research pertaining to the experiences of attributed meaning and understanding. Grounding could be achieved through the use of specific methodological techniques, most notably the use of constant comparison and theoretical sampling (described in section 2.5).

In its original form, grounded theory was presented as a systematic, creative methodology. Glaser (1992) argues that it is this creative element (and a flexibility within the approach) that allows it to remain an inductive, discovery-orientated methodology which simultaneously 'liberates and disciplines the theoretical imagination' (Henwood and Pidgeon, 1992). For Glaser, the induction aspect of grounded theory was central to what the approach stood for.

More recently, it has been argued that grounded theory also has deductive elements built into it (Rennie, 2000; Henwood and Pidgeon, 1995; Charmaz, 1995). This has led to what is referred to as the 'inductive–deductive' debate. Related to this is a second debate concerning which epistemological position best fits with grounded theory, the 'epistemological debate'. These two debates are considered below.

2.2.2 Criticisms and Current Developments

Inductive–Deductive Debate

A significant division in how grounded theory is conceptualised resulted from the revisions to the original methodology. Some researchers asserted that the original method was confusing, difficult to implement and theoretically top-heavy (Morse, 1994). In an attempt to make the method more accessible (Corbin, 1998), Strauss and Corbin made revisions and developed a procedurised version (see Strauss and Corbin, 1990). New steps in the procedure were introduced and processes for each of the steps in the grounded theory methodology were made explicit, according to Strauss and Corbin's understanding.

However, Glaser (1992) argued that this strictly procedurised version of grounded theory 'forced' the data through rigid procedures rather than letting themes and categories creatively emerge from the data. He also reacted against Strauss and Corbin's inclusion of hypothesis testing which they had integrated into the strategy of constant comparison. This shifted grounded theory from a purely inductive process to one having deductive elements. Glaser (1992) suggested Strauss and Corbin had lost the essentials of the grounded theory method, with procedure taking precedence over the data.

However, many theorists argue that grounded theory cannot be purely inductive even when the original methodology is followed (for example, Henwood and Pidgeon, 1995; Charmaz, 1995). Charmaz (1995) argues that the researcher will inevitably bring their own biases based upon their experiences, and this will shape how he or she interprets the data, which, in turn, will influence the emerging theory. In other words, the researcher will bring working hypotheses to the research. Although Glaser and Strauss' (1967) original version of grounded theory noted that 'the researcher does not approach reality as a *tabula rasa*' (p. 3), there was still an expectation that the researcher would be passive and that the data would capture the 'real' experiences and present them objectively as truths. This ideology reflects the realist epistemology of the original text; hence the notion of the 'discovery' of theory from the data. However, Charmaz (1990) asserts that, in reality, researchers create an account of the data rather than discovering order within it.

2.2.3 Epistemology

This has led to the argument for the development of a constructionist revision of grounded theory (for example, Charmaz, 1990; Henwood and Pidgeon, 1995). This attempts to explicate the interaction between the researcher, participants and data in constructing meaning. Charmaz (1990) asserts that the researcher has a perspective from which they interpret and construct meaning within the data. This 'researcher perspective' would include factors such as the researcher's own experiences, their prior knowledge of the research topic, and the values they bring to this.

Instead of Glaser and Strauss' (1967) notion of 'discovery' of theory, the constructionist revision has sought to resolve this difficulty by referring to the 'generation' of theory (for example, Pidgeon, 1996). The generation of theory has therefore been described as a constant flip-flop between data and interpretations (Henwood and Pidgeon, 1992).

The methodological strategies of analysis in social constructionist revisions of grounded theory do not differ significantly from those proposed by Glaser and Strauss (1967) but there is a greater acknowledgement of that which the researcher contributes to the data and the interpretation.

Rennie (2000) asserts that these related debates of 'inductive–deductive' and epistemology stem from the simultaneous co-existence of constructionist and realist

positions in grounded theory. His revision is the assertion that grounded theory is a form of methodological hermeneutics⁴ which, he states, allows for the positions of realism and relativism to be reconciled in their co-existence.

McLeod (2001) argues that grounded theorists (for example, Glaser and Strauss 1967; Strauss and Corbin, 1990; Charmaz, 1995; Rennie, Phillips, and Quartaro, 1988) have developed their own distinctive but related methods of grounded theory. McLeod asserts that these developments and differences in methodology can be viewed in the same way as Lincoln and Denzin's (1994; 2000) notion of the qualitative researcher as *bricoleur*:⁵ namely, that qualitative researchers need to know about methodological issues rather than learning to conform to step-by-step instructions on the implementation of grounded theory.

A secure basis in relevant aspects of the philosophy and sociology of social science supplies the basis for making methodological choices appropriate to the task in hand. Useful findings do not result from following a recipe but from knowing what each step in the recipe is intended to achieve.

(McLeod, 2001, p. 208)

McLeod's position is not one of methodological anarchy, but supports the notion of rigour coming from an understanding of the approaches employed and the research undertaken.

2.2.4 Reasons for Using Grounded Theory in this Study

There were four main reasons why grounded theory was considered to be the most suitable qualitative methodology for this study.

Firstly, grounded theory is considered to have developed a good track record for usefully investigating clients' accounts of psychotherapy (for example, Rennie, 1990, 1992, 1996).

Secondly, grounded theory emphasises the exploring of meanings of experiences (McLeod, 2001), and this taps into the central aim of this study which is to explore

⁴ Hermeneutics was originally the science of the interpretation of scriptures. It is the process of interpreting a text (Collins Concise Dictionary, 1989; McLeod, 2001).

⁵ The meaning of the *bricoleur* in French popular speech is 'someone who works with his, or her, hands and uses devious means compared to those of the craftsman'. The *bricoleur* is practical and gets the job done (Weinstein and Weinstein, 1991, p. 161, cited in McLeod, 2001, p. 119).

the meanings attributed to the experiences of therapy and its interplay with the self-described cultures of Asian women.

The third reason relates to the wish to produce a piece of research *for* women, instead of *on* women (Henwood and Pidgeon, 1995a). The researcher does not claim that this study would fit with all the philosophies of feminist research; however, there is a desire to be sensitive to the ideals held in such research. Henwood and Pidgeon (1995a) argue that grounded theory, particularly constructionist revisions of grounded theory, offers a methodology compatible with philosophies of feminist research. They highlight the methodology's aims to locate theory in participants' worlds and its goal of breaking out of the confines of predetermined theory, often androcentric.

The final reason for using grounded theory is that it is considered to offer a systematic approach to conducting qualitative research. Dingwell et al. (1998) argue that this provides the scientific rigour required in applied health-care research which is now influenced by ideas of evidence-based practice (see Craig, 1996; Dingwell, Murphy, Watson, Greatbatch and Parker, 1998).

2.3 Procedure Employed in the Present Study

2.3.1 Participants

Six women of South-Asian origin took part in this study. All the participants were engaged in ongoing therapy with clinical psychologists working in the two Leicestershire Healthcare Trusts. Three of the participants were being seen in an adult mental-health setting, and three were being seen within a medical-psychology setting. Participants' cultural and religious identities were self-described and are detailed in table 1.

Cultural identity	Religious identity
East-African Asian	Muslim
Western Asian	Muslim
Western Asian	Hindu
Indian	Hindu
East-African Asian	Muslim
Gujarati	Hindu

Table 1: *Self-described cultural and religious identities of the participants.*

The religion of individuals is given in recognition of the role it played in self-described cultural identity. The participants' ages ranged from twenty-two to sixty years. Two of the participants were born and brought up in Britain, two of the participants were born in East Africa and the other two were born in India. The minimum number of years any of the individuals had lived in Britain was twenty years.

Two of the participants spoke English as a first language. There was diversity in the participants' confidence in their ability to understand and express themselves in English, though all of them had their therapy conducted in English.

2.3.2 Sample Frame

The broad aim of the research was to conduct a study of Asian women's experiences of therapy, and of the role that culture plays within it. The sample frame aims to allow for the purposeful sampling of individuals that can generate data meaningful to the research question asked. In this study, the sample frame was made up of women of South-Asian origin being seen for ongoing therapy by clinical psychologists within adult mental-health and medical-psychology settings.

Use of South Asian as a Construction of Ethnic/Cultural Grouping

The use of South Asian as a means of constructing an ethnic/cultural group was discussed in the introductory section. However, it should be kept in mind that in the UK context the use of the ethnic category 'South Asian' refers broadly to those peoples whose familial or cultural backgrounds originate from the subcontinent of India, Pakistan, Bangladesh and Sri Lanka. The term 'Asian' is used in a broad and heterogeneous sense. It is recognised that it is diversified along the lines of religion, class, migration patterns, language, traditions and identifications with regional areas 'back home' – places that may be urban or rural (definition from Woollett, Marshall, Nicholson, and Dosanjih, 1994, cited in Marshall and Yazdani, 1999).

This ethnic/cultural definition of South Asian provided the sample frame but within the interview the women were asked to provide their own construction of their cultural identity, and this also allowed them to talk about the importance, or otherwise, of their gender identities.

Experience of Psychological Distress

No specific mental-health disorder was targeted in the study. Psychological distress requiring therapeutic input was the criteria for inclusion. The settings of adult mental-health psychology and medical psychology were targeted as they offer individual therapy of diverse orientation across a range of client presentations.

Being in Therapy

All the participants were being seen for ongoing therapy at the time they were interviewed for this research. This was considered to be more ethical than contacting people after they had completed therapy. It reduced potential interference in termination issues, and as the participants were still engaged in therapy, any pertinent issues that arose out of the research interview could be addressed by the participant with their clinical psychologist. From the perspective of the research, this also had the advantage of accessing participants who were able to talk about something they were actively experiencing at the time. Finally, as some of the participants were at the beginning of their therapy experience and others were moving toward ending, issues relating to processes across time could also be considered.

English-speaking

A further inclusion criterion within the sample frame was for the participants to be English-speaking. This reflected the fact that therapy (within the context of the local National Health Service psychology practice) is usually conducted in English. It is English-speaking clients that make up the majority population seen in such settings, even within ethnic minority groups. A definition of English-speaking was that the participants' therapy was being conducted primarily in English.

Exclusion Criteria

The researcher excluded participants if they were too distressed to be interviewed or if they were not able to give informed consent.

Variables Not Considered

The therapeutic orientation of the clinical psychologists whom the participants were seeing was not considered as a variable. This was because 'therapy', in this study, is constructed from clients' accounts of their experiences rather than therapists'⁶ accounts of what they are offering.

⁶ The terms therapist, psychologist, clinical psychologist and clinician are used interchangeably in this study.

Number of Participants

In line with the recommendations of Turpin, Barley, Breail, Saige, Slade, Smith and Walsh (1997), a minimum of five participants were targeted in this study. Saturation of the data, which should determine the number of participants in grounded theory research (Glaser and Strauss, 1967), was not achieved in this study. Saturation occurs when analyses of additional data sets reveal no new categories, themes or relationships among them. The implications of saturation not being reached, and reasons for this, are considered in the discussion section.

2.3.3 Recruitment

The researcher approached thirteen clinical psychologists. Information about the sample frame, the aims of the study and an outline of the initial topics to be covered in the interviews was provided. Potential participants were then identified by clinical psychologists from their current caseloads, and were informed of the research. Identified clients then chose whether or not they wanted to be provided with further information from the researcher. If, after the research was explained to them, they still expressed an interest in taking part, they were asked to consent to be interviewed. This process provided the pool of participants.

According to Glaser and Strauss (1967), the selection of participants in grounded theory should be directed, rather than random – that is, they should be theoretically sampled according to the emerging data. In this study, each individual who volunteered was accepted as a participant. This reflected the small number of potential participants (as might have been expected from the points raised in the introduction). The participants were therefore not theoretically sampled. The participant sampling which took place was convenience sampling (Silverman, 2000), and although not purposeful it does provide information about the numbers and the characteristics of those Asian women being seen at the time. Clinicians did not filter out potential participants, and only three potential participants who were approached by their clinical psychologist declined to take part in this study.

2.4 Data-collection Procedure

2.4.1 The Use of Interview Data

Individual interviews were chosen as the means of obtaining participants' accounts of experiences of therapy. Individual interviews provided a relatively safe environment in which participants could discuss personal and potentially sensitive issues. The need to generate a trust in an interview situation is highlighted by King (1996). This can enhance the depth of the data provided by the participant and also facilitates the interviewer's use of empathy as a research tool in more fully accessing understanding of participants' accounts (Stiles, 1993).

2.4.2 Interview Design

Interview as a method of data collection is used by grounded theorists as a 'directed conversation' and not as a 'closely controlled, monitored and measured pseudo-experiment' (Pidgeon and Henwood, 1996). This reflects the flexibility required in grounded theory methodology, which allows for the follow-up of emerging themes and the focusing on particular issues in more depth. In practice, this means that the interview questions are contained within a guide rather than a schedule, as the sequencing of questions depends on the process of the interview and the answers of each individual.

An initial interview guide was devised prior to data collection which was based upon the researcher's own ideas of what topics needed to be covered to consider the role of culture in the experience of therapy. This guide can be found in appendix 1. The two broad areas that questions covered were as follows.

Firstly, questions were asked about how the participants constructed their own cultural identity (or identities). This focused on the words they used and the meanings these words held for the participants. Many of the participants also spontaneously talked about how they personally related to their cultural identity, and further, new questions evolved out of this data. An example was asking participants about their affective response to the culture with which they identified, i.e. does it make them feel proud, confused and/or angry? (These were words descriptive of emotions used by the participants.)

The second set of questions aimed to explore in what way, if at all, their culture figured in their therapy experience. Participants were asked to talk about the experience of therapy in relation to proximal processes and wider contextual issues. The proximal processes refer to what they experienced as happening ‘in the room’ between the therapist and themselves, and what meanings they attributed to this. Wider issues of the therapy experience included asking participants about access to services and their experience of distress.

Coding of the first interviews led to the evolution of the interview guide. In latter interviews, attempts were made to focus questions more on the proximal therapy issues. This aimed to enrich the themes and emerging categories which related to those processes in the therapy experience which allowed for culture to be considered, and if necessary made explicit. This development of categories by searching out new data to test or enrich current themes is an example of theoretical sampling within the data (Glaser and Strauss, 1967).

For ease of explanation, the questions have been separated out into two sections – culture and therapy experience. Within the interview situation, however, effort was made to ensure that the relationship between culture and therapy experience remained the key focus.

At all times, the interviews remained flexible. This enabled participants to choose what and how much they wanted to say, while also allowing emerging data to determine further questions (Smith, 1995).

2.4.3 Interview Procedure

Three participants chose to be interviewed in their homes and three in health-care settings. At each location, the interview procedure was similar.

Prior to the interview, participants were provided with a letter of invitation (see appendix 2) and an information sheet (see appendix 3) outlining the nature and purpose of the study. The information sheet and the process of the interview were discussed before the interview commenced. Participants were assured of confidentiality and reminded that they could withdraw from the interview at any time. They were encouraged to share any concerns they had about the interview and the use of their accounts in the data corpus. If they agreed to be interviewed and to

allow the interview to be audio-taped, a consent form was signed (see appendix 4). The interview then took place and lasted no more than ninety minutes. After the interview, participants were asked if they still agreed to their accounts being used in the data corpus. Participants were invited to contact the researcher after the interviews if they wished to discuss any aspect of the process or the conversation.

2.4.4 A Need for Flexibility in the Data-collection Procedure

Research in an applied setting often means that there has to be some flexibility within the procedures and methodology. These exist to accommodate the realities of applied research. The following section explains how the procedures in this study were impacted upon by factors which were not considered in the initial research design. It also goes on to explain how these issues were addressed.

Having partners present during the research interview: The procedure intended interviewing participants alone. Four of the participants agreed to this but two asked for their husbands to be present. It was explained to the researcher that the participants saw their therapists with their husbands present. These women were being seen for individual therapy but having a spouse in the room obviously impacts upon the experience of therapy. For these women, the therapy experience involved having their husbands present, and it was therefore considered appropriate for the research interviews to reflect this. The desire to have their husbands present was explained by a want for emotional support and also help with language difficulties that they sometimes experienced.

Within the interview procedure, the emphasis was on interviewing the women and establishing their accounts of therapy. The husbands' discourse was not coded nor used in the data corpus, as they had not given written consent for what they had said to be used, and because the research question was concerned with women's accounts of therapy.

Charmaz (1995) recommends that notes reflecting on the process and content of an interview be taken after it is completed. This was done after all the interviews, and included reflections on the experience of conducting the research interviews with the husbands present.

Equipment failure: One of the six audio-taped interviews could not be fully transcribed due to microphone feedback distorting the sound. It was decided that it

was not appropriate to ask the participant to repeat the interview as it would have involved taking up more of her time and energy, and, in any case, the interview could not be replicated. The parts of the account that could be heard on the tape were transcribed, and this, along with notes taken immediately after the interview, formed a set of field notes. As field notes can be used as sources of data in grounded theory research (Glaser and Strauss, 1967), it was considered appropriate to keep this interview as part of the data corpus.

2.5 Data Corpus

The final data corpus was comprised of five audio-taped interviews (transcribed verbatim) and one interview represented by the researcher's field notes.

The researcher transcribed the first four audio-taped interviews (including the damaged audio-tape). Due to time constraints, a secretary transcribed the last two audio-taped interviews.

The transcripts and field notes of the six interviews are included in an addendum, which is bound separately. Pseudonyms have been used to maintain participants' anonymity and potentially identifying information has been altered. The recorded interviews were transcribed verbatim, in accordance with Strauss and Corbin's (1990) description, although verbal hesitations and pauses were not included. This enabled the transcript to be ready for the process of analysis. Before going on to describe the analysis, ethical issues and how participants were protected is considered.

2.6 Ethical Considerations

Ethical approval for the study was sought from the Leicestershire Health Ethics Committee. A copy of the letter granting approval can be found in appendix 5. It was recognised that the sample frame used meant that participants were potentially vulnerable, both as a consequence of their psychological distress and their experiences of therapy (which may have been associated with negative feelings). A number of procedures were followed to ensure that the participants were protected and respected, and though some of these have already been alluded to, they are set out in their entirety in this section.

Confidentiality of the participants and those clients approached to take part in this study was protected by various methods. Clients could choose whether or not they wished the researcher to be given their name as a potential participant; individuals' psychiatric and/or psychology notes were not seen; all the data were stored securely and presented in a way which preserved anonymity. Every effort was made to change identifying information (including the names of the therapists) but, as a further precautionary measure to protect the identities of both the participants and their clinical psychologists, the transcripts can only be viewed for the purpose of examination or with the written permission of the researcher. (Analytic issues relating to confidentiality are considered in the results and discussion sections.)

Those involved in the research were informed about its purpose and were offered the opportunity to get feedback on the results if they wanted it. Participants were asked to provide their consent at the beginning of the interview and were reminded that they could stop the interview at any time and withdraw consent.

Although the participants could stop their interviews at any time, the researcher ensured that the interviews lasted no longer than ninety minutes and brought it to an earlier close if the participant showed signs of fatigue or distress. Two interviews were terminated after sixty minutes due to the participants experiencing physical symptoms of pain; the implications of this are considered in the discussion section.

2.7 The Grounded Theory Analysis

The data analysis drew from procedures described by a number of sources. In line with the constructionist stance taken in this research, the form of data analysis outlined by Charmaz (1995) is most closely followed. However, ideas from the original source (Glaser and Strauss, 1967) and more contemporary accounts, such as Rennie et al. (1988) and Henwood and Pidgeon (1995), were also used.

The first stage of the grounded theory analysis was the open coding of each interview transcript (and the field notes attached to one of these transcripts). Open coding involves the generation of low-level categories to describe relevant features of the data (Henwood and Pidgeon, 1995). An example of the open coding of part of a transcript is given in appendix 6. In these initial stages of labelling chunks of meaningful data (Rennie et al., 1988), descriptive terms were taken directly from the text to ensure a close fit – that is, the codes were grounded in the data. As codes continued to emerge, each meaningful chunk of data was compared to them and

fitted into as many of them as possible. When data did not fit a pre-existing code, a new category was created to represent them. Through this method of constant comparison both within and across accounts (Glaser and Strauss, 1967), codes were continually reviewed and revised.

Codes were initially recorded on the transcripts and then transferred to index cards. This allowed for the visual grouping of codes and how they related to each other. The index cards recorded the codes through the use of descriptive labels, usually taken directly from the text. The locations of the code within the transcripts were also recorded, using line numbers and, at times, direct quotes.

Index cards were also used to write memos reflecting on ideas and thoughts that the researcher had about the codes. These were things such as the names codes were given, the properties or themes they contained and the ways they related to each other. From these initial and often descriptive codes, more conceptual categories were formed. As described by Charmaz (1995), the aim of these conceptual categories is to go beyond description to a more abstract and dynamic labels and groupings. Charmaz (1995) suggests that this involves outlining a category's themes, considering the conditions under which it arises, the consequences of it existing in relation to the research question, and how it relates to other categories. Rennie et al. (1988) suggest that at this stage, the language used to label a category may move beyond the language of the participants, as the researcher aims to construct meaning across accounts. These categories emerged from the use of the strategies of constant comparison (between cases, instances, codes and categories), memos to elaborate on verbatim text, and use of negative case analysis. Negative case analysis is a manifestation of the method of constant comparison as it seeks to systematically explore differences in the expanding data corpus (Henwood and Pidgeon, 1992). The term negative case refers to those aspects of the data where 'things go differently' (Perakyla, 1997) – that is, the data does not fit with the emerging categories. Such cases are regarded as a resource within grounded theory, as they provide an opportunity for the richness of the developing theory to be further refined and enhanced. Therefore, the researcher attempted to actively seek out negative cases and integrate them into the account of the data.

As codes kept reappearing in the text, they were used as a means of sifting through data that came later. Charmaz (1995) refers to this as 'focused coding', which is the searching out of data that fits prior codes and expands upon it. This takes place once

codes have moved to a more conceptual level and as they move toward saturation (with no new themes emerging from the data).

The final aim of a grounded theory study is to build theory through the identification of a core category linking all the other categories together.

As all the categories in this study did not become fully saturated, the generation of complete theory was not possible. The implications of this are outlined in the discussion section.

However, clear links between the categories were identified, and, though not fully saturated, the categories demonstrated a diversity of data. A core category relating to all the categories was also identified. The model, presented in the results section, offers the researcher's construction of the participants' accounts of the role of culture in their experiences of therapy.

2.8 Concern for Scientific Rigour

The diversity of methodologies and, more significantly, the epistemologies within qualitative research have led to debate about which criteria substantiate scientific rigour (Madill, Jordan and Shirley, 2000). There have been a number of publications offering guidelines and ideas about what these criteria should be but this research was primarily informed by the ideas postulated by the following: Madill et al. (2000); Elliot, Fischer and Rennie (1999); Turpin, Barley, Beail, Saige, Slade, Smith and Walsh (1997); Henwood and Pidgeon (1992).

These publications are located within psychological research and are particularly relevant as they use either grounded theory or clinical psychology doctoral research to guide their suggestions. The four broad issues which these papers discuss are epistemological stance, validity, reliability and reflexivity. Madill et al. (2000) argue that the ways in which the last three issues are addressed is shaped by the epistemological position that is taken. These issues, and how they are addressed in this study, are presented in turn.

2.8.1 Epistemological Position

In the data-analysis section, it was stated that this research is positioned within a constructionist epistemology. A general outline of the constructionist revision of

grounded theory was given in section 2.2.3. In this study, the constructionist stance allies itself with what Madill et al. (2000) refer to as 'contextual constructionist'. (See their paper for how this is differentiated from a realist and a radical constructionist stance.)

This study acknowledges the constructionist stance where the researcher cannot be completely objective, and where meanings attributed to experiences (both by participants and researchers) are shaped by social context and the constructs of language.

This has implications for what data are believed to represent and what conclusions are drawn from it. For example, the accounts provided by the participants in this study are viewed as a product of the interaction between interviewee and the researcher within a particular situation. As a result, the accounts given would have been influenced by various factors. For example, two factors that the researcher was very aware of was her potentially perceived alliance to the participants' therapists through her professional identity, and the impact of her being a white woman asking Asian women about their experiences of culture. The importance of these variables (relating to identity) was highlighted within these women's accounts of their experiences of therapy. It related to their desire to make sense of their therapists' cultural and professional identities. This in turn had a significant impact on how comfortable they felt talking about cultural issues in relation to their psychological distress, and the degree to which they felt they could be understood. This is explained further in the results section, but the point is that it would be naïve to assume that the same processes were not occurring in the research interview or that these processes will have impacted and shaped the accounts that were given. This does not detract from the usefulness of the data but does acknowledge that there could be multiple accounts produced by the same participants.

A constructionist stance also has implications for how the issue of the generalisability of the findings is considered. This will be considered in the discussion section.

Finally, a constructionist stance has implications for the consideration of what validity and reliability constitute. The ways in which this study has considered and managed these two issues are now presented.

2.8.2 Validity

Within a realist context, the issue of validity is concerned with truth and objectivity, with attention given to issues such as representative samples and how objectively to 'measure' the phenomenon under study. A constructionist stance states that meaning is contextualised, and, therefore, truth and objectivity in this form cannot be achieved. However, the concept of validity still exists. The use of a number of strategies (termed by Elliot, Fischer and Rennie, 1999, as 'credibility checks') outlines how validity has been built into this grounded theory study.

Firstly, it is recognised that the findings should be grounded within the data – that is, the study should demonstrate a close fit to the data (Henwood and Pidgeon, 1992; Elliot, Fischer and Rennie, 1999; Turpin et al. 1997), thus enhancing the validity of the account that is given (Rennie, 2000). The data analysis (as was described in the analysis section) employed within this study aimed for built-in validity. The use of open coding of fully transcribed accounts allowed for a comprehensive treatment of the data, which meant that each aspect of the data was initially included in the analysis (Silverman, 2000). This was further supported by the use of negative case analysis; that is, the use of data that did not initially fit emerging codes and categories. Highlighting negative cases and incorporating them into the overall model aimed to generate a 'conceptually rich, dense and contextual grounded theory' as recommended by Henwood and Pidgeon (1992). Then, the use of constant comparison encouraged an immersion in the data that aided a grounding of the interpretative findings. This is demonstrated through the use of quotations to support the generated model and the categories within it. The inclusion of transcripts and field notes within an addendum acts as a further check, allowing for the quotes and notes to be viewed in context. This allows the reader to evaluate the fit between the data and the researcher's interpretation of that data.

A common form of validation is referred to as respondent or member validation (Smith, 1996). This involves the researcher taking their findings back to the participants who supplied the original material and seeking their views on the interpretation that has been made. While this demonstrates inclusion and democracy, it can be problematic. Smith (1996) highlights that participants may feel loath to disagree with the researcher. This could be for a number of reasons, not least the perceived power differential between the researcher and participants. Henwood and Pidgeon (1995) also point out that as meanings are situationally

based, a second interview becomes another data stream that can be incorporated into the final data set but cannot offer a superior check of validity. For these reasons, respondent validation was not formally used. However, for ethical reasons, the participants were encouraged to contact the researcher if they wanted feedback on the overall results. At the time of writing, none of the participants has requested feedback.

Finally, validity is assessed by the overall coherence of the study – that is, how well it hangs together. Coherence includes providing an understandable explanation of the phenomenon under study, internal consistency and an awareness of rival interpretations (Stiles, 1993). Attempts to evaluate coherence involved the use of peers in the qualitative research support group who coded segments of transcript (allowing me to compare my own coding) and with whom results were discussed.

2.8.3 Reliability

In positivistic epistemologies the concept of reliability can be described as the extent to which the same results will be obtained if the research is repeated (Madill et al, 2000). That is reliability is concerned with replicability. The constructionist position would state that this is not possible and at times not even desirable (Madill et al, 2000). However, transparency of the methodology employed, raw data and the reflexivity of the researcher are required. The research process should be tracked through the write-up supplemented by the use of transcripts, memos and codes. Such an audit trail leaves the research open to scrutiny and a replication of the methodology (Henwood and Pidgeon, 1992).

2.8.4 Reflexivity

Merrick (1999) states that a commitment to reflexivity suggests that the research topic, the design and the procedure, together with the personal experience of doing the research, are reflected upon and critically evaluated throughout. Merrick cites Wilkinson (1988) as identifying three types of reflexivity; personal, functional and disciplinary. Wilkinson's personal reflexivity is about acknowledging who the researcher is, and how personal interests and values may influence the process of research from the initial idea to outcome. Functional reflexivity entails a continuous critical examination of the process of research aiming to reveal assumptions, values and biases. Disciplinary reflexivity involves reflecting on larger issues that include research methodology and questioning psychology itself.

The researcher has attempted to be reflexive throughout the process of conducting this research, and issues of functional reflexivity are considered throughout this paper. However, the researcher is also aware that commentators such as Lynch (2000) have argued that reflexivity is not necessarily a virtue. While not agreeing with that position, the researcher acknowledges the second part to his argument that reflexivity does not offer guarantees of privileged knowledge.

Nevertheless, steps were taken to facilitate reflective practice throughout the process of doing this research. This was primarily the use of supervision sought from a qualitative research support group. This group discussed a broad range of issues, including the researcher's perceptions of the interviews, how her values might be impacting on the analysis. In addition, personal considerations, such as her affective responses to aspects of the research, were considered. What follows is an example of an issue that was tracked over the time of the research process. Through monitoring the objective was to make it explicit and to manage the impact that it had upon the way the research was conducted and accounted.

One of the themes preoccupying my reflections was my⁷ ongoing concern and anxiety about being an 'outsider' looking in – that is, being a white woman investigating and representing Asian women's accounts of culture and therapy. Many of my earlier concerns reflected the reactions of others to this research, and I was surprised (and in retrospect, naïve) about how politically contentious the aim of locating culture within the therapy experience was perceived to be. These concerns did not come from Asian women, nor from psychologists working in the research and practice areas of cross-cultural therapy (who I made pains to contact as the research ideas developed). However, others appeared suspicious of both my subject area and the methodology I sought to employ. As I had no prior experience of conducting qualitative research, nor research in the areas of race and culture, I was battling with the anxiety of trying to argue positions while they were still at a developmental stage within my own mind. In retrospect, this process can be seen to have been helpful as it enabled me to question my motivations and clarify what I wanted to research and why. However, it did make the process of conducting this research anxiety-provoking, which will inevitably effect factors such as the analysis.

⁷ In recognition of bringing the personal into the research account, first-person terms are used in this section.

As the interviews commenced, my fears and anxieties reduced, and I was impressed by how seemingly candid these women were in talking to me. The issue of my being an 'outsider' (a white woman) was discussed openly in three of the interviews, and came up in relation to how it mirrored the women's experiences in therapy. The results section considers how these women constructed this issue; in relation to the research, my conclusion was that my being an 'outsider' had both advantages and disadvantages. The accounts I heard were different to those I would have heard if I was an observably Asian woman, just as they would have been different if my gender had been male, or if I had been of a different age or if I had not been allied to the profession of clinical psychology.

I did struggle with particular aspects of the analysis. While aiming to keep my construction grounded, I had also to become aware of, and reflect on, a number of my own racist assumptions and consider how they were impacting on my understanding of the accounts. This is expanded upon in the discussion section.

Researcher in Context

To briefly set myself as the researcher in context, I am a twenty-six-year-old white female in her final year of clinical-psychology training. I came to this research with ideas about therapy which stemmed from many sources but most directly from my personal experience of therapy and my own clinical practice, which has been mainly informed by ideas of being a 'scientist practitioner' employing a generic orientation (although, it was mainly informed by cognitive behavioural therapy). At the time the research was being conducted, my ideas about therapy were being challenged by a clinical placement working with a psychoanalytic supervisor.

My ideas on culture were equally informed by personal and professional experiences, as well as wider societal concepts. At the time I was developing ideas for a research project, I perceived there to be heightened media interest in issues of race and culture within a 'modern' Britain. This was in the wake of the Steven Lawrence inquiry and the consequential MacPherson report (1999) highlighting institutional racism. This, along with my increasingly uncomfortable feelings about the rhetoric of 'bogus' to describe asylum-seekers and other examples of societal racism, led me to consider how racist my own professional practice might be. I began to pay attention to the fact that in my five years of clinical practice, I had seen very few clients from an observably ethnic community. Discussions with other

clinicians led me to realise that this under-representation was the norm, even in cities such as Leicester. Hence, the review of the literature that introduces this study.

As a final point, my interest in the issues of culture, its fluidity and how it relates to self-identity and psychological practice undoubtedly stems from my own experiences as a child and teenager. I had lived abroad, immersed in what were very foreign and alien cultures (i.e. different to what I perceived to be my family's culture and my culture 'back home'). Nevertheless, I developed a strong and lasting personal attachment to these cultures and they formed a central (though not necessarily observable) part of my self-identity. I therefore went into this research with a notion of the importance of negotiating culture in therapy but had few clear ideas about how clients would account for the experience, or indeed the need for culture to be addressed. My understanding, and construction, of the accounts given to me by the women who took part in this study are presented in the next section.

3. RESULTS

This chapter provides an account of the analysis of the six interview transcripts (one of which was incomplete and supplemented by researcher field notes). A model made up of one core category and five main categories was generated from the analysis of the data. This model is pictorially represented in figure one and described in the accompanying text. The model introduces the core category and the five main categories; it also illustrates how the categories are understood to relate to each other. After the presentation of the model each category, and the themes contained within them, are described in turn. The themes are illustrated through the use of interviews data, which is presented as indented paragraphs in italicised text. Each excerpt is followed by a reference to its location in the transcripts.

To aid the reader a summary is given at the end of each description of a main category. The summary outlines the main themes contained within the main category and how it is understood to link into the core category; relationships between categories are discussed throughout the text.

3. The Model: Locating culture in Asian women's experiences of therapy

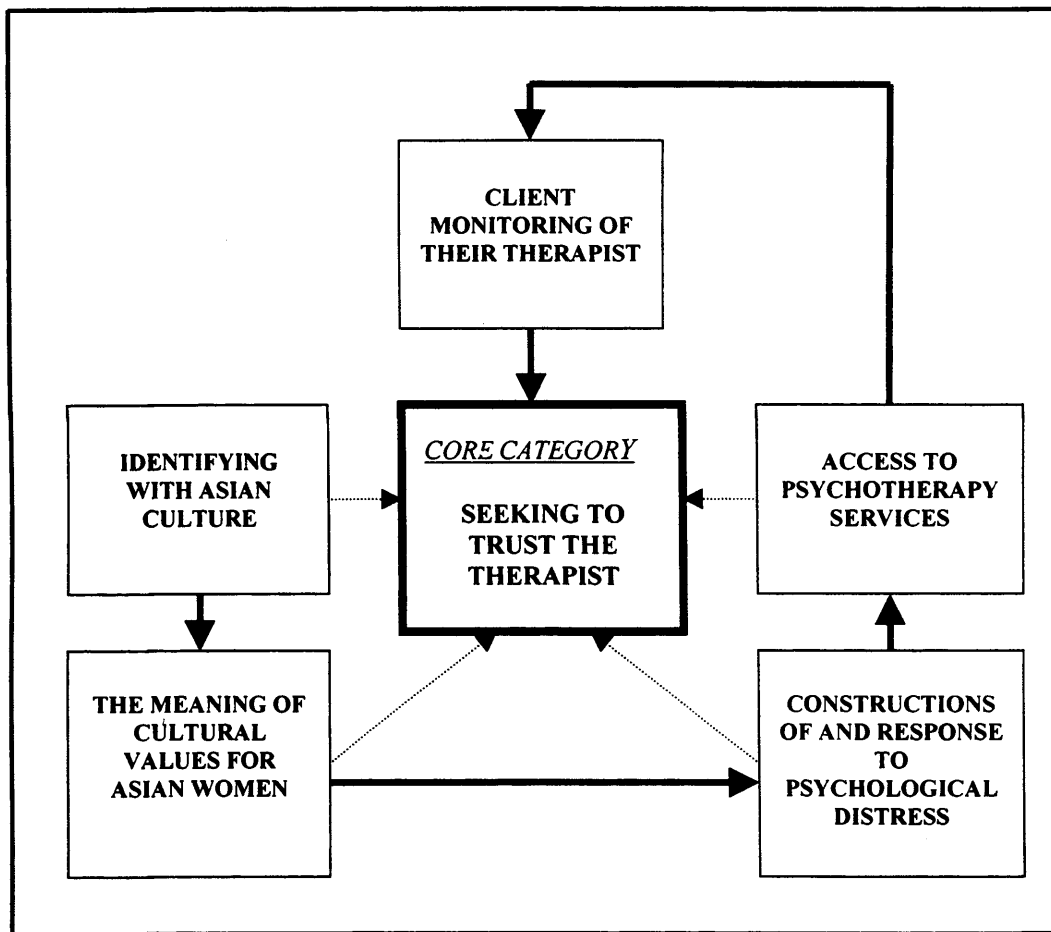


Figure One: A pictorial representation of the categories and the relationships between them, as interpreted in the analysis of the six accounts.

Figure one illustrates the core category and its relationship with the five main categories. There are two parts to this model. The first is called the '*consequential loop*' and is represented by the movement denoted by the blocked arrows. The second part to the model demonstrates a higher level of abstraction within the analysis, and relates to the issue of seeking to be understood. The relationships between categories in this part of the model are illustrated through the use of dotted lines. These two parts to the model will be described in turn.

The consequential loop: The consequential loop is understood as being grounded within the data. It illustrates the themes that these women identified as being the most pertinent aspects of their culture that relate to experiences of psychological therapy. The first category in this consequential loop is the category called

'Identifying with Asian culture'. As with all the categories this is described more fully in further sections. For the purposes of describing the consequential loop it relates to an identification with Asian culture, that is Asian culture(s) being an important part to these women's self-described cultural identities. The consequence of this identification with Asian culture(s) is the experience of cultural values impacting on how these women view themselves and construct ideas of 'appropriate' behaviours. In turn, these values impact upon the women's individual *'Constructions of and responses to psychological distress'* which in turn impacts upon *'Access to psychotherapy services'*. Participants described bringing these cultural values and experiences with them to the therapy experience and through the process of *'Monitoring their therapist'* they were extremely concerned with *'Seeking to trust the therapist'*. An important part of this seeking to trust the therapist related to questioning whether the therapist could understand them and the complexity of ideas relating to their culture that they bring with them. They also sought to trust that the therapist would be non-judgemental of them as individuals and their being part of a cultural context that may be different to the therapist's.

To aid the reader an example illustrating this consequential process is as follows. Meera identified with Asian culture, one of the cultural values that she identified as being particularly pertinent to her experience of therapy was that women should 'put up with' psychological distress. The part of her construction of psychological distress that was informed by this cultural value led to her feeling that it was weak and indulgent to get help from an outsider. She emphasised the power of this cultural value by talking about how she actually worked within healthcare services, was trained in western models of practice, yet had still felt reluctant to seek help for her psychological distress. She linked these cultural values with her initial unwillingness to accept psychological help and described having needed a crisis before she was willing to engage in psychological therapy. Through the process of monitoring her therapist she assessed how much she could trust her therapist to understand and not judge her, particularly in relation to issues about her Asian culture, how she positioned it as having impacted upon her experience of psychological distress and her initial ambivalence about seeking help. This consequential loop illustrates the issues of culture that these women described bringing into their experiences of therapy and that are understood to directly link with a need to seek the trust of the therapist.

The second part of the model illustrates analysis at a higher level of abstraction, that is it is less grounded within the data but comes from the researcher's interpretation

of her analysis. There is a dotted arrow connecting four of the main categories with the core category '*Seeking to trust the therapist*'. One facet of this trust was a desire to be understood by the therapist. These accounts of therapy illustrate that the seeking of trust in the therapeutic relationship relates to these women's constructions of their cultures and roles of culture in their conceptualisations of distress. Each category is taken in turn and its abstract link with the core category is described.

The first of these main categories is '*Identifying with Asian culture*', and this illustrates the importance of Asian culture in these women's constructs of self-described cultural identity. However it also illustrates the diversity, complexity and individuality of these constructs. The need for the importance of this facet of the participants' identities to be understood within therapy, in all its complexities, directly impacts on the desire to assess whether or not the therapist can understand them. These women's constructs of Asian were diverse and individual, as was their relationship with their cultural identities. This calls on the therapist to be aware of culture but not rely on stereotypes or generalised approaches. The same issues arise out of the category the '*Meaning of cultural values for Asian women*'. Particular cultural values were described as pertinent to these women's experiences of therapy but again there was diversity in the descriptions of these values and the meaning of these values to each of these women. Again, there was a desire for the therapist to understand the role of these values, the sometimes ambivalent feelings they evoke in the clients, but while not being judgmental or critical of the women and their cultures. Hence the arrow directly from this category to the core category. The same desire to be understood individually but within the context of their culture comes from the category, '*Constructions of and responses to psychological distress*' which while individual are formed within a cultural context and shaped by the responses of the community in which the women live. The final category of '*Access to psychotherapy services*' is also interpreted as having a direct link with a desire to trust the therapist. Routes into therapy were diverse but often determined by a crisis. Participants described feeling vulnerable and ambivalent about seeking help from a psychologist and the consequence of this was a desire to gauge the trustworthiness of the therapist, in this link trust went beyond understanding to seeking to feel safe and confident that the therapist would not hurt or abuse them in anyway. '*Client monitoring of their therapist*' was not contained within this second part of the model as this illustrates the processes through which participants seek trust. The aim of this second part to the model is to illustrate a more direct linkage between individual categories and the desire to seek trust of the therapist thus emphasising the centrality

of the core category within the model. Individual categories are now illustrated in more depth:

3.1 The Core Category: *Seeking to trust the therapist*

The core category generated by the analysis of the data is named 'Seeking to trust the therapist'. Concepts relating to the participants' trust of their therapists permeated the accounts. The researcher has interpreted a number of constructs as being related to the idea of trusting the therapist. These include constructs of feeling safe, feeling understood and an expressed confidence in the therapist. These are illustrated below.

Constructs of Trust

Meera: First time I was quite hesitant because first you've got to get to know a person but you've got to find out, to know. I know she's a professional person and about confidentiality, as I have asked you. Okay it takes a while and a few things that make me so ill and have been bugging me, I didn't tell her those in the first few sessions. So slowly it was about confidence setting in the interview, then a bit more coming out that was hurting, hurting me that I couldn't even mention to anyone. So a bit more and a bit more was there and this was when I realised that, how helpful it was, how it makes sense. It started being from an assessment about memory. Now the assessment is done and I was waiting on the decision because I now don't wish to go back to work but I think I don't want the psychology to finish because I'm really genuinely finding it helpful.

Jo: What is it that's helpful?

Meera: Giving me room. I know that I can trust her, she will not go to the next door neighbour or she'll not go to another person in the community or anywhere to talk about it.

(Meera: 264–283)

Although Meera knew her psychologist was a professional, she describes a need for a confidence to develop before she could begin to disclose hurtful issues. The researcher interpreted her use of the word 'confidence' in this quote as being connected to a developing trust in the therapist or the experience of therapy. Meera then goes on to use the word trust to describe a facet of her relationship with her therapist, and she relates this to the experience of knowing that what she says will remain confidential.

Seeking to trust the therapist was also related to ideas of wanting to be understood by the therapist. The following quote illustrates this idea:

Ayesha: Because I've talked to her for so long and because Leyla comes from the Asian background she can understand the culture, she knows where I'm coming from. If I say to her, 'Well this is my Mum and this is what she is saying and it's hurting me, you know'. I love my Mum and she [the therapist] knows where I'm coming from. If she didn't know anything about the Asian culture she'd probably think well, why not just walk away from your Mum? But she knows I can't do that, it's just been a lot easier.

(Ayesha: 325–334)

Ayesha views her therapist as sharing important aspects of her own cultural identity (Asian and Muslim; see Ayesha: 18–36) and she uses this information as an indication of how well the therapist might be expected to understand her. She describes a fear that if there is not a shared culture between herself and her therapist, the therapist may not understand her and that this could adversely effect the advice or empathy that she receives from her therapist.

Another important construct of trust that was interpreted within the analysis of these accounts relates to the idea of feeling safe.

That's it, she's not going to, I don't know, if there is this dark secret I've told it's not going to pop up anywhere and there is no danger of it coming out or being held against me.

(Sandi: 685–687)

The lack of danger that Sandi describes implies a feeling of safety. The researcher interprets this as Sandi trusting her therapist to not use against her the vulnerability she feels in the process of disclosure. Sandi expresses the importance of this feeling of being safe a number of times, and usually in the context of having a trust in her therapist.

Sandi: Yeah because I'd really built up to say stuff and then was just referred on and I think that is why sometimes I find it difficult to talk to Debbie, it's about times when I don't open up.

Jo: Fear that she might pass you on or abandon you?

Sandi: Yeah, but now I've got this far I feel less frightened of that.

(Sandi: 775–780)

This idea of the client trusting that they will be safe was also illustrated within other accounts. Meera pointed out that it was her trust of her therapist that led her to trust me, allowing her to feel safe enough to talk to me:

Meera: But it was difficult to open up before about painful aspects of my life. I knew it but then I could relax, I could talk about it and then when I go to the shops I don't feel like I wish I hadn't said that. This is one of the best things about it, all these weeks I've been coming. I've not felt at all that any aspect of my life that I've talked about, that I wish I hadn't said this to her. And that's positive, and that's why when she asked me, she explained about your interview and all, and I felt like these things because I feel like you couldn't abuse this any way.

Jo: And that reflects on your relationship with Leyla?

Meera: Yes, very much so.

(Meera: 572–584)

Trust of the therapist cannot be taken for granted: Interpretation of the narratives suggested to the researcher that the participants did not automatically trust their therapist in a way that allowed them to be fully open about what they were thinking or feeling.

Client trust of their therapist developed over time, and the clients played an active role in seeking information about their therapist as measures of trustworthiness.

Jo: You said earlier that you felt able to do that because of the rapport and I'm interested in how that rapport or I think you said trust, came about. What was it that allowed you to start to trust?

Meera: First time that I came I was very hesitant. I came because I had to, not for treatment, just wanted to get it out of the way and she had the job of assessing me. But what really helped she didn't pick up a paper and pen and like a doctor sitting for the prescription and okay in, out, now, next. So she had time for me, so she sat and talked as someone that I could really trust, someone that listened and made my thoughts whether fatalistic or what, I was allowed to really just roll them out and she was just, it's a very personal thing. I found it very comforting.

(Meera': 311–325)

Meera's experience of her therapist as 'trustworthy' is related to her therapist's behaviours of providing time, listening, accepting, and not judging her narrative. Interestingly, Meera juxtaposes this with the behaviour of the doctor picking up a pen and paper in readiness to diagnose and prescribe. The main category 'Client monitoring of their therapist', expands on these ideas of the client monitoring the therapist's behaviours. However, this illustration emphasises the interpretation of an active role being played by the participants in gauging or seeking to know the trustworthiness of their therapist.

Disclosure as a consequence of trust: The analysis of the accounts generated the theme that it is the feeling that the therapist can be trusted that facilitates client disclosure. It is the importance of this experience of disclosure that makes the seeking of trust central to this model of these accounts of therapy.

Jo: So what is it about seeing Debbie that's been, what is it like to see Debbie, what is that experience like?

Sandi: Initially it felt like a panic attack, was like getting over like, I don't know what I'm going to talk about until I get in there, but afterwards it's like a sense of achievement because I've been able to look at some things and plus I don't know I'm such a dark horse. It makes me feel better knowing that I am sharing those feelings that I probably wouldn't with anybody it's like talking to her and actually letting her know what is going on inside, which I usually keep private.

Jo: Right, so it's like at first there is anxiety then there is this thing about sharing a part of you that you don't share with other people and then at the end some sense of achievement - I've done it I got through it, okay. Can you tell me a bit more about what happens in the room that helps you share things with Debbie?

Sandi: Mmm.

Jo: Did you feel like the moment you met her, I can share things with this woman?

Sandi: No because it takes me ages to trust people, especially as I really don't know her. But as I feel comfortable, more trusting I'm able to talk to her, yeah.

(‘Sandi’: 336–357)

Sandi does not automatically trust her therapist, and actually comments on how long it takes her to trust people. However, as she develops a feeling of trust, a feeling of being more comfortable, she is able to share things. Sandi makes a point of saying that her sharing of things in this way is a rare thing; she actually describes herself as a ‘dark horse’, perhaps suggesting that she holds what she experiences as difficult or painful ‘secrets’. She describes the outcome of disclosure making her feel ‘better’ and providing her with a sense of achievement. This reminds us that disclosure for clients can often be a difficult and tentative process.

That disclosure is experienced as positive by clients is also expressed by Meera who likens this process to that of a healing experience:

It has been a very positive because it's just I feel some healing process started and that's why I, it's so much. I shouldn't say it like this, it's not same as, but so much like when you sit in a confessional to a priest, although it's nothing that I've done wrong in my life that I'm going to talk about. In case that happens in my life, I have to be a strong woman and put up with things and

now when I sit and talk to her, every time you come you feel one extra layer you peel off and that helps.

(Meera: 606–614)

And Ayesha comments on how it has contributed to her being more open with others in her life.

I think its helped me gain my confidence a lot more now I can talk to you very openly, do you know what I mean? Whereas before I couldn't talk to anybody not even my family. I couldn't say this is how I'm feeling, I've had a really bad day or I want to shout or I want to scream you know?

(Ayesha: 515–520)

Diverse experiences: It should be noted that seeking trust is the core category and that there was diversity in the accounts with regard to the level of the trust experienced in the therapeutic relationship. Fareeda describes her struggle to make herself understood in her use of English and the researcher interprets this as also effecting her level of trust in her therapist:

Fareeda: In English, that's it. Because I wasn't brought up here, I was from Africa. My English and your English is a bit different. What I speak and you speak is a bit different isn't it?

Jo: Yes. Sometimes when you are talking about some things.

Fareeda: What I want to tell, what it is sometimes I explain wrongly. See what happens inside, I can explain quickly when it is in my own language.

(Fareeda: 160–169)

Linguistic difficulties in expressing complex feelings and experiences were described in three of the accounts, and this is expanded upon in the main category 'Client monitoring of their therapist'. However, Fareeda goes on to describe how her difficulties in sharing understandings were not just linguistic. She illustrates differences between her ideas for how she can feel better and those ideas that she associates with her therapist:

Jo: One of the ideas of talking in psychology as well is that?

Fareeda: It takes it out, it comes out, I understand that.

Jo: But it doesn't always work for everybody and I wondered, it doesn't work for you?

Fareeda: It doesn't work for me, no. Its easier if I just stand outside, sitting by myself and just listen to my God tapes or doing my beads.

(Fareeda: 349–357)

The culture of psychology, perceived as advocating the idea that things should be talked about, ‘taken out’, is not something that was experienced as helpful by Fareeda. For her, emotional peace was sought and found more readily through listening to her prayers and concentrating on her prayer beads. Keeping the pain inside, where she felt it could be contained, was preferred to ‘letting it out’, where it often led to feelings of panic, and this seemed to be connected with her feeling that she cannot trust that her can therapist help her.

Fareeda: When she [therapist] talks I get panic attacks all the time because I'm thinking.

Jo: You get panic attacks?

Fareeda: Yes that's why I calm down myself. When she talks to me I just pray to God's name only.

Jo: Why is it difficult to talk to her?

Fareeda: I don't know. Because I feel like they're not going to help me, that's what I think. There's no way of getting better like this, that's what it is.

(Fareeda: 241–249)

Fareeda's description of her therapeutic relationship is not just with her psychologist, it also involves a number of other health-care workers; hence her use of the word ‘they’. Her lack of trust in her therapist and other health-care workers is illustrated by her belief that they are not going to help her and that she will not get better.

A summary of the main themes contained within this core category, ‘Seeking to trust the therapist’ is provided overleaf.

Summary of the core category: Seeking to trust the therapist

- Constructions of trust within this model pertain to feelings of safety, ideas of being understood, feeling secure and accepted by the therapist.
- The consequence of trusting the therapist is an increased willingness to disclose difficult thoughts and feelings. Most of the participants described this process of disclosure as helpful and healing.
- Trust of the therapist was not automatically present, and was not present in all of the accounts of the experiences of therapy. It was something described as developing over time and was measured against therapist behaviours.

The idea of seeking trust permeates the researcher's construction and understanding of these women's narratives of their experiences of therapy. It links in with every other main category and the centrality of this core category is pictorially represented in the model shown in fig. 1.

3.2 Main Category: *Client monitoring of their therapist*

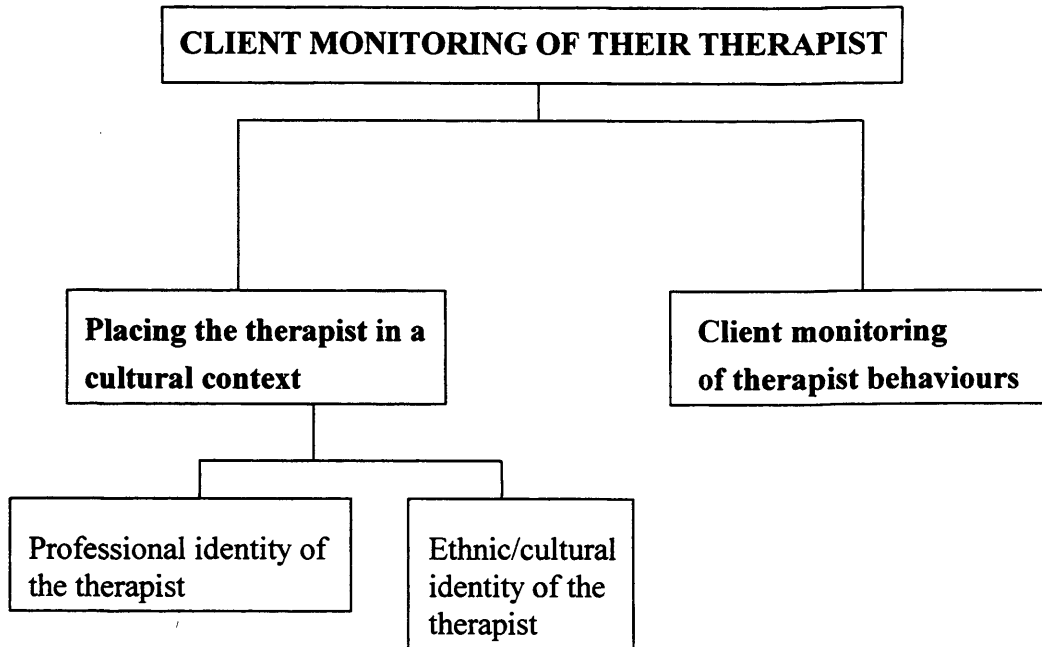


Fig. 2: *Client monitoring of their therapist.*

As was described in the core category, ‘Seeking to trust the therapist’, the accounts of these women’s experiences of therapy places them as active contributors to that experience. This is particularly in the monitoring of therapist behaviours and responses, which are taken to indicate whether or not ‘trust’ of the therapist is experienced. The main category that describes this process is, ‘Client monitoring of their therapist’. A diagram of this category is presented in fig. 2.

This category is made up of an intermediate category, ‘Placing the therapist in a cultural context’, within which there are two subcategories: ‘Professional identity of the therapist’ and ‘Ethnic/cultural identity of the therapist’.

A second intermediate category also makes up the main category and is named ‘Client monitoring of therapist behaviours’.

The themes and consequences of these categories are described overleaf.

Intermediate Category: *Placing the therapist in a cultural context*

A client behaviour interpreted in the analysis of these accounts was that of seeking to place the therapist in a cultural context. Cultural context refers to the perceived professional and ethnic identity of the therapist.

Subcategory: *Professional identity of the therapist*

The researcher uses ‘professional’ as an umbrella term to unite a number of constructs. Within the narratives, participants described aspects of their therapist’s identity that related to them either being a professional or behaving in a professional manner, thus being part of a professional culture. The meanings and consequences of these constructs are illustrated below.

The therapist’s position within a professional culture means that they can be viewed as an ‘outsider’: The participants talked about the benefits of their therapist being perceived as an outsider. The term ‘outsider’ was used to differentiate the therapist from family, friends, neighbours and others in the clients’ communities. The researcher interpreted the condition of being an outsider as part of belonging to a professional culture.

But the fact that you can talk about what’s painful to you, what’s hurting you and to somebody that’s not experienced that emotionally or personally with you, so she has time and she is listening to it and it helps, somehow, to think your thoughts through and, and your taking a back seat from your own situation. Somehow, I find it very helpful because if she was part of my family or community then at some level she would have experienced that, but she is someone that is completely outside.

(Meera: 294–303)

The therapist being perceived as an ‘outsider’ allows for a distancing effect to enter into the sharing of psychological distress. Meera describes a process whereby sharing distress with an ‘outsider’, who is not perceived to be directly part of that pain, allows her to also ‘step back’, something which she describes as helpful.

Another element to this construct of the therapist as an ‘outsider’ is the idea that the therapist is in a better position to tolerate the distress of the client. This is because the therapist is perceived as being able to keep a professional distance. The following quote from Sandi’s transcript elaborates this point.

That's the part about counselling because you know even I if you talked to, like I don't know, your most trusted friend and like sometimes it just becomes chit-chat or it could come out somewhere along the line or whatever. I've got that safeguard of knowing that basically I'm just an allotted hour, so I have that safeguard there and that makes me feel quite comfortable as well because I'm not to Debbie, it's like it's an appointment, it's her job and after me someone else is going to walk in and after that someone else will probably be there.

(Sandi: 670–678)

The researcher interprets Sandi as implying that because the therapist is performing a job she can be trusted to take the client's concerns seriously. The conversation does not just become 'chit-chat', and can be trusted to be confidential. And, unlike a friend or an 'insider', the therapist has other clients who also have psychological problems. For Sandi, the idea that she is one of many clients is important. Her full narrative suggests that this is because she feels uncomfortable when she experiences being focused on too closely. The experiences of space and distance in her relationship with her therapist, alongside the experiences of intensity and intimacy, are important for her to feel safe in her relationship with her therapist.

Sunita also points out that the therapist being an outsider is important, and makes him easier to talk to because she does not have to worry about burdening him. She contrasts this with talking to her family whom she wants to protect from her problems.

It does. It feels better to talk to outsiders than your family. Yes, they'll start worrying that I've got a problem and they are both aged as well, so I don't want them to worry about me. They've worried so much for me.

(Sunita: 737–739)

Confidentiality: Linking into the idea of the therapist as an outsider is the issue of confidentiality. The theme that the therapist's position within a professional culture means that confidentiality can be trusted was salient. The following segments of transcript illustrate this point.

Or that she isn't going to go down the pub and say, you know her?

(Sandi: 697–698)

I know I can trust her that she will not go to the next-door neighbour or she'll not go to another person in the community or anywhere to talk about it.

(Meera: 283–285)

Jo: You don't like it? Is it better to talk with someone just one-on-one?

Ruki: Individually, individually.

Jo: Individually?

Ruki: Privately. Jo: Yes?

Ruki: Yes, yes. And suppose someone asked me ----- and I have to tell them all my past history ----- and personal things. That's why I just refused to do the thing with so many people.

(Ruki: 117–134)

Ruki's transcript was effected by microphone distortion; the accompanying field notes elaborate on the point that Ruki is making in this segment of transcript.

Ruki was very concerned about confidentiality and was initially hesitant to be taped. She explained that she was quite a prominent woman in the Asian community and that she did not want to be recognised. She explained that she felt ashamed of how ill she had become, and that she did not want to share these things with other people in her community. She was invited to join a therapy group for Asian women but had refused because she did not want to share her experiences with other Asian women, preferring the confidentiality that comes from one-on-one therapy.

(Ruki's interview, researcher's field notes: 514–520)

Confidentiality was interpreted as holding a prominent position in these accounts of seeking trust. The analysis suggested that this might be connected to values that were perceived to be held by Asian culture; some of the participants experienced their culture as stigmatising psychological distress, and they did not want others to know of their difficulties. Others experienced their distress as shameful or felt that it was something that should be kept private. These themes are expanded upon in the main categories, 'The meaning of cultural values for Asian women' and 'Constructions of, and responses to, psychological distress'.

Non-judgemental?: The scientist-practitioner model of psychological practice is one of objectivity, and an aspect of that model is the therapist claim of being non-judgemental (for example, Pilgrim and Treacher, 1992). However, these participants' accounts illustrate that clients do not assume this, even though it may be the desired behaviour of a professional.

Sandi: It's about being judged as well that comes into it.

Jo: By Debbie?

Sandi: Yes.

Jo: What do you imagine she would judge you on?

Sandi: Don't know anything I'm saying I suppose.

Jo: So that she could think badly of you, or are you able to talk to Debbie about those sorts of feelings?

Sandi: Don't know, hasn't really cropped up.

Jo: But they are there in the room?

Sandi: Yeah.

(Sandi: 464–473)

Meera also describes the importance of not feeling judged by her therapist, and it is her confidence that she will not be judged that she connects to the enabling of her to talk more openly.

She will not judge, she'll just listen to all this and maybe make me look further inside and maybe to initially draw from my own inner strength, but she was there, your own personal thoughts and experiences you could really, you could bring it up.

(Meera: 306–310)

Subcategory: *Ethnic/cultural identity of the therapist*

A second aspect of the therapist's identity that was contained within the participants' accounts was their perception of their therapist's cultural identity. The analysis suggested that this was important as the participants described it as having an impact on how they related to their therapist. The analysis generated two main themes related to the cultural identity of the therapist: the language spoken by the therapist and the client desire for a shared cultural understanding with their therapist. These two themes are described, in turn, below.

Language: Fareeda (see illustration in the core category) and Sunita talked about the language spoken by their therapist and how it differed from their own first language, leading to problems in understanding and in their expression of their difficulties. The analysis linked this in with the clients' monitoring of their therapist's cultural identity (with language being viewed as a property of culture).

Jo: Are there certain things that you struggle to talk about in English? But it can be easier to talk?

Sunita: When it's my own language.

Jo: Because you're having to think in Gujarati and translate it into English?

Hard work?

Sunita: Really hard work.

(Sunita: 465–474)

The segment of transcript used in the core category to illustrate Fareeda's difficulties in making herself understood are echoed in this segment from Sunita's account where she talked about having to work hard at making herself understood when she has to talk in English. Given the importance of disclosure (as identified

within the analysis of the accounts) and that this disclosure is, in part, dependent upon a belief that the therapist can understand the client and her experiences, language difficulties may play a role in blocking the development of a trusting therapeutic relationship.

The desire for a shared cultural identity? Not all the participants struggled with the language of their therapy. However, the consideration and impact on the client of the therapist's cultural identity was described and identified as significant within the analysis:

Yeah, that [perceived culture of the therapist] makes a difference. But on the other hand, when we were talking, she, I saw her as a professional woman, as a psychologist not as an Asian woman, so if you had been my psychologist, if, I think it would have been okay. It, I think it may have helped because, I don't have to explain away a lot of things about my culture, yes I'll be honest with you, but a lot of things you might be learning about my culture you are on your way to find out, where as she already comes from that culture, that background, so it's, so it doesn't take us that long to come to that conclusion, that decision which you and me it would. You would have to put a lot more work in and I would have had to put more work in.

(Meera: 405–421)

(Meera was seeing an Asian therapist)

Initially, Meera finds the issue of therapist's cultural identity difficult to talk about. This may be because she is talking about this to a white woman who she knows is training to be a clinical psychologist. However, she makes the point that if she were to see me (a white woman) for therapy, she believes there would be more work to be done in my understanding of her culture. Meera's desire for cultural understanding links into the importance of her (Asian) culture in her self-described identity, and in her understanding and experience of her psychological distress (see main categories 'Identifying with Asian culture' and 'Constructions of, and responses to, psychological distress'). As with Ayesha's narrative (illustrated in the core category), Meera describes an anxiety about whether a non-Asian therapist could understand her because they would not be perceived as sharing cultural understandings. Meera goes on to specifically highlight the importance of a religious understanding of her therapist as an example of a cultural understanding that she experiences as relevant to her therapy.

She saw my name and immediately knew I was Muslim and as she also knew I'm a Muslim and religion must be quite a big part of my life so we didn't cover that all that ground that we would had to have done.

(Meera: 430–434)

Meera's self-described cultural identity included her experiences of being a Muslim. She assumed, from her therapist's name, that her therapist was also a Muslim (see Meera: 452–455). This assumption of a shared cultural understanding allowed Meera to feel that her therapist would immediately understand the importance of religion in her own life. She explained that she would not be able to make the same assumptions about my cultural background, perhaps leaving her with questions about my ability to understand her experiences and values within a therapeutic context.

From her [therapist] name I already know [that she is Muslim]. But for example Jo sitting here I don't know where she is from. I know you are white but from your name I don't know if you are a practising Christian or not. I don't know if you're from York or London or where you're from. I'm, I don't know anything about you, but Asians when they. Like I said I'm from East Africa but I'm still Asian and Asian like Leyla, okay? So there is a lot in common, even if it's not in common we can tell from names and everything whereas I don't place you, if I come to you for clinical psychology assessment then its okay I don't need to place you anywhere, you are the one who has to place me somewhere because you are doing my assessment but all the while your doing it I'm thinking about you.

(Meera: 465–478)

There is an acknowledgement by Meera that 'officially' she does not need to place my cultural background; the onus would be me to 'place' her. However, she is thinking about where I am from, what values I might hold and in what culture she can place me. The fact that she is actively engaged in thinking about this suggests that it will impact on how she relates to me, and this links into ideas of trust. Meera uses information about me to assess how much I can be trusted to understand her, and in this instance that information relates to issues of the perceived culture of the therapist.

Ayesha also articulates this concern about not being or feeling (immediately) understood by a non-Asian therapist:

Jo: So in a sense what you're saying is it's coloured by culture but it's a universal experience, so in theory if you were seeing me in therapy I'd have an inkling of that universal experience so it could work but it would be different?

Ayesha: Yeah you would understand a lot of things. The only difference is because of the cultural background I think it takes, it would have taken you longer to understand everything, everything else I could put to you and you would probably say the same as Leyla but I'd be thinking, ' Yeah but you

don't understand my culture,' and then it would be like have to keep explaining it. (Ayesha: 592–603)

This suggests that clients work to assess the extent to which they hold shared cultural experiences with their therapist. Both Ayesha and Meera suggest that my culture is more removed from their culture than the culture of their Asian therapist. They imply that they would still be able to work with me, and that I could still be trusted to understand to an extent but that more work will be required, and that implicit, shared cultural understandings cannot be trusted to exist.

Ayesha also illustrates another reason why it had been beneficial for her to see an Asian therapist:

Jo: So you said your mum couldn't tolerate you not going back. Was Leyla as an Asian woman able to tolerate that you left him?

Ayesha: Yes.

Jo: And do you think that helped that she, as an Asian woman, supported your decision, said 'That's okay'?

Ayesha: Yeah it made me feel like, it felt like this great big weight had been lifted off my head, that an Asian and the fact that she is Muslim as well to say 'That's okay'.

(Ayesha: 569–577)

Ayesha viewed Leyla's reassurances about her leaving her husband as being the reassurances of an Asian, Muslim woman, not just the reassurances of her therapist. As her mother and some others in her cultural community did not approve her actions (see Ayesha: 98–103), Leyla's reassurances take on an added meaning of cultural acceptance.

However, the accounts contain contradictions about the desire for a therapist to be culturally matched. Sandi said that she believed it would have been more difficult for her to see an Asian therapist. When asked why she said:

Don't know probably because of the taboo that there has been around a lot of issues that have been really blatant right within the Asian community.

(Sandi: 521–523)

I'd be more embarrassed with an Asian counsellor.

(Sandi: 529)

It could be argued that Sandi, although of an Asian ethnic origin, was culturally matched with her white therapist as she described herself as Asian-Western.

However, the analysis suggested that although a shared cultural understanding of the client with the therapist was desired, so too was the desire for the therapist to also be an outsider (as has been described in the subcategory, 'Professional identity of the therapist'), and Sandi's account may be illustrating this point.

It is difficult to make clear interpretations about therapist and client cultural match. Saturation of the category did not occur, and each participant who explicitly talked about the culture of their therapist described their perception of their therapist's cultural identity as being preferred. In other words, Ayesha and Meera, who were both seeing an Asian therapist, stated that they would prefer to see an Asian therapist. Sandi, who was seeing a white therapist stated that it could be more difficult seeing an Asian therapist.

The same pattern occurred across the accounts for preferred gender of the therapist (see *Sunita: 330–334; Meera: 392–401*). Sunita was seeing a male therapist and stated that she felt that this was easier than seeing a woman. Meera was seeing a woman and said that she would not have got as far with a male therapist.

These findings may represent an unwillingness of the participants to be critical of their current therapists, or it may represent the existence of a good therapeutic alliance between most of these participants and their therapists.

Nevertheless, the analysis suggests that the desire to feel understood and trust the therapist is what underpins the participant's concerns with therapist identity, and that perhaps some sense of shared cultural identity (as a route to understanding) may be preferred.

Intermediate Category: *Client monitoring of therapist behaviours*

The second intermediate category within this main category of 'Client monitoring of their therapist' is termed 'Client monitoring of therapist behaviours'. This category illustrates the idea that the participants were monitoring their therapists' behaviours, and that these behaviours were being assessed in terms of trustworthiness. Behaviours identified as 'helpful' linked into the constructs of trust outlined in the core category. On the whole, the consequence of trust was client disclosure. When behaviours were not experienced as helpful, they were described as leading to the withdrawal of the client. Transcript illustrations of these ideas are given below.

Examples of therapist behaviours engendering client trust:

The importance of the therapists' listening and analytic skills were described:

I think it is because she listens, she does very little talking but she is there and she'll listen to it all I could be blabbing all morning but she listens and makes sense of it. She is very deep in her thought and when you've finished she'll go back to something you could have said right at the beginning of the session, you know?
(Ayesha: 524–531)

And she's been very professional about it, she's heard, she's listened and she's made a really good assessment of how she saw me.
(Meera: 341–343)

The fact that she is listening as well. Yeah because she's like, if I've stopped talking she'll just pick up on the exact part that I've left off or if I say something she'll make a point of asking me more about it and so that helps because I know that she has listened to me and she is probing more and that helps actually because otherwise I just sit there 'schtum'.
(Sandi: 272–277)

In the segment of transcript below, Sandi also describes how these behaviours of her therapist enabled her to gain deeper understandings for herself:

Jo: You were really adamant that it is a very useful thing, very helpful thing, it's very hard to answer but what is it that makes it useful? Sandi: Firstly, I look at things that I have denied for so long, like that I've wanted to look at for so long or understand or haven't had the capability of understanding either so in that sense it's been useful because I've been able to tie, usually after I've seen Debbie, usually takes a couple of days, usually able to address it myself and look at it a bit more myself.
(Sandi: 414–422)

Sandi also highlights the importance of her therapist giving her room to withdraw from a subject if she wants to (see below). Her therapist's sensitivity to this is contrasted with the behaviour of her boyfriend, and she experiences this as allowing her to revisit a subject once she begins to feel more comfortable about talking about it.

I can talk, sometimes the atmosphere is relaxed because if I was talking to my boyfriend he'd probably go on at me just to finish if off instead of letting me just change the subject and in there I can change a subject so I don't, so I can just change subjects. She isn't going to dig away at it, but most of the time we go back to the subject anyway because I feel more comfortable opening up.
(Sandi: 359–370)

Another behaviour that was alluded to was the therapists' talking about limitations or difficulties⁸ in what they could offer. The two examples of difficulties given below both illustrate the therapist being aware of Eurocentricities in their service provision.

She was very conscious of it, so some tests are not really developed for Asian women.

(Meera: 552–553)

Everything was fine but when I asked him if they had the handouts in Gujarati, so that I can talk to my family and friends as well. He said he would try to find whether they had got the leaflets in Gujarati. So the following week he told me that there were not Gujarati leaflets.

(Sunita: 22–28)

For Sunita, this issue led her therapist to talk about alternative sources of help that she may find helpful, such as a therapy group being set up for Indian women (which would be conducted in Gujarati). It was explained to Meera that her educational background meant that cultural bias on her tests was minimised. The analysis generated the idea that it might be important for therapists to be aware of such issues and talk openly with their clients about them.

Finally, therapist behaviours indicating empathy were also present in the narratives.

He was very understanding. Some people, they just think that sometimes if I have a very bad headache, they go, 'It's all in your mind.' But they don't realise.

(Sunita: 339–341)

Yes, Felicity she's a very nice lady, very nice, very nice lady. She understands all my, all my pain very nicely.

(Ruki: 215–217)

The therapist behaviours mentioned so far were construed as helpful by the participants. An example of therapist behaviour leading to the withdrawal of a client is given below.

Jo: So you went to see the GP because you were struggling?

Sandi: Yeah I was really depressed and was doing self-injuries so I was in a bit of a block there, stuck in that. Went there had an initial assessment and talked to somebody there and they just passed me over to the counselling

⁸ There were few examples of difficulties being experienced in these accounts of therapy. On the whole, participants were very positive about their experiences. The reasons why so few difficulties were mentioned, and the implications this has for the analysis, are considered in the discussion section.

centre. So I went there for about two weeks but that was like nothing, that was a bit intimidating that was.

Jo: In what way was it intimidating?

Sandi: I don't know it's just it was quite intimidating because she was just there. But seeing Debbie, you can sort of interact and she interacts back, she talks back to you. But there it was just like you could be talking to a brick wall.

(Sandi: 253–264)

Sandi experienced the lack of feedback from her first therapist to be quite intimidating, and she alludes to this contributing to her dropping out of therapy even though she wanted help.

Fareeda does not talk about wanting to drop out of her therapy, nor does she explicitly state that she finds her therapist's behaviours unhelpful but her narrative contains indications that she does not feel understood by her therapist, and that she is not finding the advice she has been offered helpful:

Jo: How did you feel about being told to see her?

Fareeda: As I said, I'm not doing anything. I've got a cassette to listen to for panic attacks.

Jo: A tape?

Fareeda: She asked me how many times I had listened. Because it makes me more depressed, I listened one or two times. I don't know, something happens to me inside and I get up and switch it off.

Jo: Does it make you more depressed because you're concentrating on it more, do you think?

Fareeda: I don't know why because I'm just told to listen to it.

Jo: But it's not working anyway?

Fareeda: No, it's not working.

(Fareeda: 125–138)

A summary of the main themes contained within this category and how the main category links with the core category is provided overleaf.

Summary of main category: Client monitoring of their therapist

- The category illustrates clients' concerns to place the therapist in a professional culture. This was particularly relevant to wanting the therapist to be an 'outsider', and as a way of ensuring confidentiality. These constructs were associated with feelings of trust.
- A desire for a shared culture with the therapist was also expressed. This was illustrated by concerns that the more culturally different the therapist from the client, the more work that would need to be done to bridge that cultural gap, potentially leading to blocks in the therapeutic relationship. However, there was diversity within the accounts as to whether this meant that there should be client-therapist ethnic match. Sandi's account offers an illustration that ethnicity does not automatically match cultural constructs of self-identity, and that a desire for a shared culture between client and therapist does not necessarily mean a shared ethnicity. The primary interpretation was that these themes related to a client wish to be understood by their therapist.
- The category also illustrates examples of therapist behaviours that are monitored and assessed as indicators of therapist trustworthiness. Trustworthy behaviours were associated with client disclosure, and behaviours experienced negatively were associated with client withdrawal.
- This category links into the core category through ideas of the client seeking to judge the trustworthiness of the therapist, using information about the therapist to assess how well they demonstrate understanding and professionalism.

3.3 Main Category: *Identifying with Asian culture*

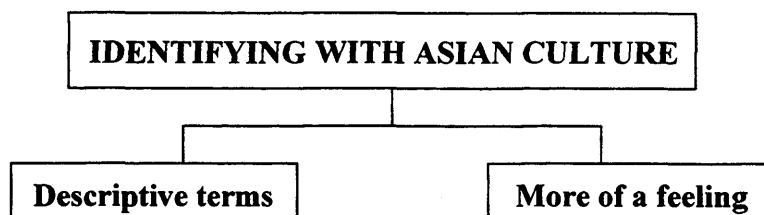


Figure 3: Identifying with Asian culture

This main category, ‘Identifying with Asian culture’, contains two subcategories, pictorially represented in fig. 3. The subcategory, ‘Descriptive terms’, provides an account of the words used by these women in describing their cultural identities. The subcategory, ‘More of a feeling’, aims to represent the complexity of the answers given to the questioning of self-described cultural identity and to illustrate the emotional response that was associated with the participants’ descriptions of their cultural identity.

Although there was diversity across the accounts in relation to the terms used to describe cultural identity, a unifying characteristic was the idea of being ‘Asian’. The meanings of what it is to be ‘Asian’ are analysed in more depth in the main category, ‘The meaning of cultural values for Asian women’. However, the present category is concerned with descriptive terms that demonstrate the heterogeneity and complexities of ‘culture’ and its relationship with identity.

Subcategory: *Descriptive terms*

Within the interviews, participants were asked to provide their own words to describe their cultural identity. Participants drew from a number of constructs on which they could hang their self-described cultural identity, but four main ones were identified in the analysis. The following segment of transcript sets out these four constructs:

I think it's like three different sections of defining myself really. Because I was born in this country, I was brought up in this country, defining myself in my childhood years I was born in an Asian family, with parents that have Asian background. But I have that Western side of me as well which comes from my friends and that and because I was born and brought up in X, it's a very English community there were very few Asian families there at the time

so it's not like I was in a class full of Asian children, it was English children with maybe one or two Asian children in one class. So I think there are two sections, the Asian girl that was Western, but at home I was the Asian girl that was Asian, because religiously I've had a strict upbringing.

(Ayesha: 18–32)

This quote highlights all four of the constructs: place of birth and where brought up; familial background, in this case described as Asian (in other accounts, the place of the parents' birth/and or the nationality of the parents was given, such as East African Asian, or Indian); religion, which Ayesha goes on to describe as Muslim; finally, the concept of being 'Asian'. Not all of the participants used all four of these constructs to directly describe their cultural identity, although the four constructs permeated the accounts in relation to the issues of culture. An example of this was Sandi, who did not describe her religion (she was Hindu, but not a practising Hindu) as directly informing her self-described cultural identity. However, it did come into her discussions of what the Asian culture, community and religious holidays meant to her.

Sandi: Well I suppose for years I haven't interacted a lot with the Asian community or with the culture even when I have wanted to but there is no one to share it with at the same time so that makes me feel quite isolated

Jo: And lonely perhaps?

Sandi: Yeah especially like times, like Diwali or somebody's birthday you can just image everybody is going to the temple and really getting into it.

(Sandi: 311–316)

The idea that 'Asian' culture runs across and incorporates different religious and national cultural boundaries was also present.

There were Muslims, but came from different backgrounds because there was like different castes of Muslim and born in different places different ages so we were all very different and there was X she was a Hindu woman but when we all talked about it, it made me realise it's not a religious thing it's just the Asian culture it's what the Asian culture is.

(Ayesha: 413–421)

Like I said I'm from East Africa but I'm still an Asian, still, and Asian like Leyla [the therapist].

(Meera: 473–475)

Subcategory: *More of a feeling*

The quote used to illustrate the four constructs used for self-described identity also demonstrated the complexity of describing cultural identity. This complexity was often tied in with affective responses to the questions of cultural identity. The idea that it is something more easily 'felt' than described in concrete terms was identified. The following segment of a transcript illustrates this idea:

Sandi: You've got me thinking now, don't know it's like even when you get those questions like when you get application forms and it says categorise your origin and I always put like Indian on it, Indian Asian.

Jo: Indian Asian?

Sandi: Yeah or well, don't feel very Indian Asian though.

Jo: Right.

Sandi: Probably more Western Asian don't know how to say it, don't know, it's a bit confusing you know.

(Sandi: 20–28)

The concepts of cultural self-identity are expressed as confusing. For some of the participants, this was about not having the words to describe something that was hard to grasp onto. For others, affective responses came from being given the wrong words or having the issue of cultural identity addressed in simplistic terms.

I think it's always been very strongly that I am an East-African-Asian, even when I fill in questionnaires asking me for my ethnic group and the questionnaire always says are you English? Are you Pakistani? Are you Bangladeshi? Or black other? So I just say I'm black other because I'm not from there. So yes very important for me where I come from.

(Meera: 36–42)

Affective responses were not just present when participants described their cultural identity. The issue of cultural identity and what it meant to them also evoked emotions for participants; this is illustrated by two examples: firstly, participants carried cultural identities that were rich, complex and at times described as holding contradictory positions. On the whole, this was not viewed as problematic. However, problems were described when the women felt that they were expected to squash or deny important facets of their cultural identity, and ultimately parts of themselves. Ayesha illustrated this idea in her narrative:

But it was never a case of because we were Muslim, 'No you can't go on a school outing or no you can't attend that class or no you can't do this.' We did talk about it but we were allowed to do everything we wanted to do. Then I started working and that was all English friends but I could say to my parents, 'This is how things work out this, this is how it should be done in England,

and they understood everything and that was okay. It was once I got married that things changed. I had to, it was very difficult and I had to put that English side of me aside and I had to shut the book on it and I couldn't. I found that very difficult.

(Ayesha: 35–46)

Finally, there was a theme in Sandi's account related to problems of not belonging or feeling a lack of real connection with her self-described cultural identity. The following quote illustrates this:

When I went to the Punjab bit, it's like I knew it inside out and you know sort of like you know your mannerisms, how you behave I wasn't totally naïve to all that and how to greet elders and like the way you spoke to them and all and I find myself being in touch with it but also at the same time it was like a façade.

(Sandi: 162–167)

The summary of the main themes and how it is understood to link with the core category is given below.

Summary of main category: Identifying with Asian culture

- This category aims to illustrate the complexities and individuality of concepts of culture. Although seemingly concrete terms (such as 'Asian') were employed to describe individuals' cultures, the meanings of such terms differed and were used differently by different participants. The idea of 'culture' relating to 'more of a feeling' than a definitive construct was illustrated. This feeling was interpreted as having aspects of connectedness or attachment to cultural values, and the difference between 'knowing' a cultural norm and feeling attached to it was illustrated.
- The link of this category to the main category is an interpretative one. The researcher interprets the diversities and complexities of self-described culture as relating to a desire to be understood. These participants' self-described cultures were varied and could not have been assumed by the use of predetermined ethnic or cultural categories. Therefore, to be understood by the therapist, an individual's construct of their culture, and what it means to them must be explored on an individual basis. This, perhaps, requires the therapist to have knowledge of and be familiar with client's cultures, but more importantly, not make assumptions about their client's culture based on ethnicity. Culture, how it relates to self-concepts and psychological distress cannot be viewed simplistically, and the idea that clients are seeking to trust that their therapist can understand this is generated in the analysis of the data.

3.4 Main Category: *The meaning of cultural values for Asian women*

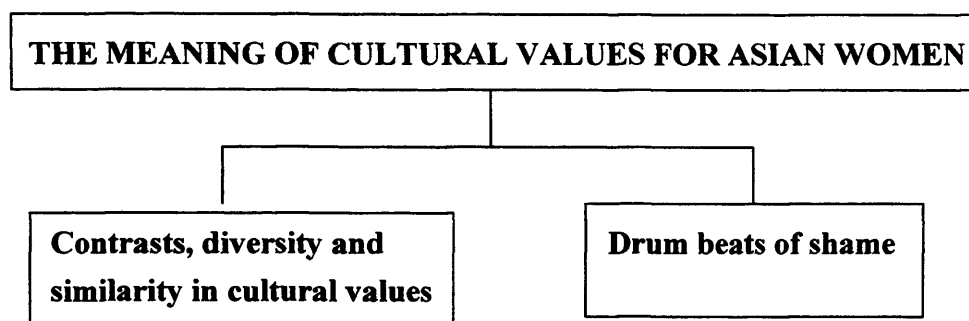


Fig. 4: *The meaning of cultural values for Asian women.*

The previous main category illustrated the complexities and individuality of concepts of culture, and began to demonstrate that terms such as ‘Asian’, often used definitively, may mean different things to different people. Differences and similarities in the meanings ascribed to perceived values in the Asian culture are further illustrated in the present main category, ‘The meaning of cultural values for Asian women’. This category illustrates examples of what being Asian meant to some of these women. The category refers specifically to Asian women, reflecting the gender of the participants but also that the values of Asian culture described in the accounts were interpreted as being placed in the context of gender values specific or particularly relevant to women within that culture.

The values that are illustrated below were often described by participants as being connected to their understanding of their psychological distress. So the described values were often described negatively, and the researcher interprets this as a reflection of their perceived place within the experience of psychological distress.

This main category is made up of two subcategories, ‘Contrasts, diversity and similarity in cultural values’ and ‘Drumbeats of shame’.

The themes and consequences of these categories are described below.

Subcategory: *Contrasts, diversity and similarity in cultural values*

This category illustrates how cultural values were talked about. This was often in the language of contrasts, comparing Asian cultural values with ‘other’ cultural values, particularly, but not exclusively, Western. The category also provides some concept of the diversity of accounts with regard to values seen to be held within Asian culture, and how their meanings differ between participants. However, even when illustrating diversity, the category also demonstrates similarities across accounts of Asian⁹ cultural values; this simultaneous existence of diversity and similarity is particularly well illustrated by the value described by Meera and Ayesha of Asian women being expected to, ‘put up with’ or ‘accept’; both women describe this value, using the same language but the meaning that it carries differs between the two. Before this is illustrated the idea of contrasts is described.

Contrasts: Within the accounts, values experienced as being a part of Asian culture were described and sometimes compared to perceived values in other cultures.

When I asked Ruki about how she had felt about seeing a psychologist she said it was okay but that if she was living in India she thinks she would not have had to have seen one. When I asked her why, she said it was because the community back home was very supportive, she would have had lots of relatives to help her and as an older woman she would have been respected and looked after. Although she has lived here for thirty-eight years, she did not feel that she had the same support here and felt that old people were not as well supported in English culture.

(Field notes taken from interview with Ruki: 529–537)

Ruki identified differences between her culture and the culture she construes as being English. These differences, particularly relating to social support and respect for older women, were important to her as she struggled with a number of physical and psychological difficulties. Other participants also used contrasts as a means of illustrating cultural differences.

Your English friends, you can have a laugh and a joke and you come out and you say things. Whereas in the Asian culture you know you don't joke about sex, you don't joke about boyfriend, you don't joke about anything even, you know like having a good laugh with a man in the street if it's another Asian

⁹ The category illustrates ‘Asian’ cultural values as participants were interpreted as placing the values they were talking about within an ‘Asian’ context. Participants who described their culture as also containing Western elements did not describe Western cultural values in relation to their immediate community and their constructs of the values most immediately impacting upon themselves. To the surprise of the researcher, participants also denied or played down potentially problematic aspects of Western culture (in the UK context) such as racism. This is considered further in the discussion section.

man it's seen as totally uncalled for, 'Look at her she is flaunting herself,' but I had that part of my life where I got on just as well with men as women. To put close on that door it was really hard.

(Ayesha: 138–148)

Ayesha contrasts her construct of Asian culture with the culture she shared with her English friends. In this segment of transcript, she is talking about the difficulties of carrying her Western values into her marriage to her Indian husband. Sandi also talks about her experience of Asian cultural expectations being different to her Western values. She illustrates these differences using the term 'battle':

Sandi: There's always been a battle between the two in there, that's why, I don't know, I'm sorry can you say that again?

Jo: I think it was about how do you identify that cultural background, how do you make that decision about your cultural background? Is it a decision or is it just . . . How does that come about?

Sandi: Oh right, see what you mean. I think it's just there, it's not a decision.

Jo: There's been this sort of battle within you or other people?

Sandi: Other people especially like people from my own culture [Asian]. Plus there is like from experience, when I went to India three years ago and there I was too Western to be Indian. Like I didn't fit in there because I was, like all the cultural differences, because there is so much I don't know. So that came into it as well, plus I suppose my way of thinking was a bit too much for them at that time.

(Sandi: 47–63)

Diversity and similarities: Meera's account also contains issues about culture. A theme in her narrative is her anger with the idea or value that women should 'accept' or 'put up with'. She construes this value as being a part of her (Asian) culture.

For example, in this culture, I'm proud to be in my culture but there are things you just accept and put up with and like another thing, I don't think people think I'm assertive, at work I am, but in other context outside of work I'm maybe sometimes let people walk all over me because you shouldn't be assertive. A women must accept, I mean this is another thing, thank God my husband is nice, he's really good, but in many ways you put up with a lot of shit, excuse me.

(Meera: 125–133)

Meera's construct of 'putting up with' relates to issues of responsibility and being a woman who is performing the multiple roles (at times duties?) of a mother, daughter, wife and professional. The demands of all these roles and the idea that she should fulfil them she perceives as being a consequence of women being expected to be 'accepting' or 'putting up with'.

Ayesha's narrative also uses the phrase 'putting up with' and 'accepting' in relation to cultural expectations of women. As with Meera, she positions these expectations within Asian culture. However, Ayesha's use of these constructs has different consequences to those expressed by Meera: the potential for the abuse of women.

The Asian culture expects a woman to put up with everything, the Islamic religion doesn't. The Islamic religion gives a woman the highest position there is, and as a Muslim woman he should never have even tapped you [me] on the hand, never mind beat you [me]. And because they talked to me and said if I took that to an Islamic court they would put the divorce through for you and no way is that woman going to come back to that marriage and that made me realise that it wasn't my fault no I shouldn't carry on and take beatings.

(Ayesha: 173–182)

All this stuff about it being a man's world. Well that's the Asian culture in Islam women are actually put on a pedestal.

(Ayesha: 876–878)

Ayesha distinguishes Asian culture from the culture of Islam, and she uses what she perceives to be the different values of Islam as a way of breaking out of an abusive marriage.

This subcategory aims to illustrate the importance of cultural values within these narratives of psychological distress and experiences of therapy. The issues illustrated (lack of support (Ruki); expectations of others (Sandi); having too many demands (Meera); being abused (Ayesha)) were issues that these women took into their experience of therapy and which they also related to culture.

The model of the accounts links these issues in to the participants' desire for their culture to be understood by their therapists; for their therapists to understand that their experiences occur within a cultural context. However, the idea that their experiences were more than just 'cultural' or went beyond the boundaries of culture was also present.

I could never understand why a woman from the Western culture could put up with that why is she stopping? But as time goes on, and like I know that everything that happened. I was always made to feel it was my fault and I deserved what I got and I should be ashamed of it and because I was ashamed of it I couldn't say to another person this is what he is doing and then I realised it doesn't matter if you're Asian, English whatever it's that thing that's been put into your head that 'I've beaten you up and you deserve it,' it does make you feel ashamed.

(Ayesha: 581–591)

It is not only the culture that I come from but also my personality. I put up with a lot, endure a lot so much so much pain before you say out, that's how I am.

(Meera: 827–829).

These quotes are interpreted by the researcher as illustrating the need for an individualistic understanding of these women's experiences, how they view the interplay between culture (or not) and the stories that they bring to therapy.

Subcategory: *Drumbeats of shame*

Within this main category, 'The meaning of cultural values for Asian women', is a subcategory entitled 'Drumbeats of shame'. This category illustrates a specific process of 'shaming' that was described within a cultural context, and which was identified as significant within the analysis. It was interpreted as significant because it was viewed as linking in with the desire for confidentiality to exist in the therapeutic relationship, and for the therapist to be an 'outsider'. The meaning of drumbeats of shame is illustrated below.

Meera describes an idea that in her (Asian) community, (private) information about individuals is often shared or gossiped about, and when this information relates to psychological difficulties or other behaviours that are viewed as shameful, the desire to keep this information private becomes paramount.

Meera: She [the therapist] will not go to the next-door neighbour or she'll not go to another person in the community or anywhere to talk about it.

Jo: So that was a real worry for you?

Meera: A big worry.

Jo: That the community would find out?

Meera: Yeah, because the community, some things they know, some things they don't. But you don't want people to sort of, you know, because in the community, well I am part of the community. I know that if anything happens to anybody it's like drumbeats, gets round very fast, okay?

(Meera: 282–291)

Meera alludes to feeling deeply uncomfortable about this process of gossip; Ayesha construes it in stronger terms: as malicious and shaming.

Everything comes back to the cultural side of it you see? You hear now that a lot of girls do up and go, you know and then you hear as well the stigma that is attached to that girl. Forever, because she could go away for a week and like there would be malicious gossip then ten years on it will still be there.

(Ayesha: 375–377)

Ayesha relates this process of shaming to the value of women being expected to put up with abuse. In this quote, she describes the process of stigmatising women who do not conform to the value of 'accepting', and who leave abusive relationships. However, Ayesha's experiences are that leaving an abusive marriage can lead to abuse through community gossip. She finds this gossip particularly difficult, as she experiences it as being used by women against other women.

Everybody turned round to my mum and said what is the big deal, she should be able to take it. I think it was that day that my heart really broke into two because how can another woman say that to me? I'd gone back for the sake of the kids but inside those words were going round and round.

(Ayesha: 220–225)

This gossip is described as effecting not just the individual but her family as well:

Because like in the English culture, if parents don't like something their children are doing then they just pack their bags and go, whereas if my parents didn't like something I was doing they'd make it, they'd make sure if they didn't like it they'd let me know but it would be up to me whether I upset them or keep them happy but the point of saying well if you don't like it I'm going would never come into it 'cause that would be like 'Oh their daughter has left home,' everything comes back to the cultural side of it.

(Ayesha: 366–377)

Ayesha illustrates the idea that a woman from her culture would not be able to leave family (against their will) without the community criticising her. An interpretation of this is that the shame or stigma attached to the woman for such behaviour would also be attached to the woman's family. Ayesha contrasts this with her perception of English culture. Sandi also describes her mother's concerns about the community's view of her and her sisters.

For example my mum right for years she would like, oh right she didn't want us to do something in case the community came back to us with it – and in India I suppose I was more open minded. It had something to do with my cousin, I was basically telling her right to make her own decision, sort of being thrown on her, but she was like 'No the family makes that decision,' and I'm like I can't understand that.

(Sandi: 67–73)

This authority of the community and family over individuals is something that Sandi describes finding difficult to understand. However, she has experienced it as being a facet of her family's culture.

A summary of the main themes contained within this category is given overleaf.

Summary of the main category:

The meaning of cultural values for Asian women

- This category illustrated examples of cultural values that were described by the participants as forming a part of their understanding of their psychological distress.
- Asian cultural values were contrasted with 'other' cultural values such as 'Western', and described or experienced as different by these participants.
- Although there were similarities in the cultural values described by participants, their experiences and the meanings that they attributed to these values differed between individuals.
- Asian cultures are often described as providing supportive environments (thus protecting individuals from psychological distress (see introduction and Ruki's account)), however a possible flip-side to this community support is the experience of shaming through gossip, as described in Meera's, Ayesha's and Sandi's accounts. The 'power' of this shaming and the perceived effectiveness of the gossip is interpreted by the researcher as linking into the themes of desired confidentiality of therapy and a desire for the therapist to be an outsider (although perhaps an outsider who shares some aspects of the client's culture). These themes were illustrated in the main category, 'Client monitoring of their therapist'.
- The present main category is interpreted as linking into the main category of 'Seeking to trust the therapist' through the construct of seeking understanding from the therapist. The present category, although not saturated, suggests that cultural values and experiences will inform clients' understanding of their psychological distress. However, these values cannot be understood simplistically, nor applied generically, and require the therapist to facilitate an individual exploration of their client's understanding of the place of culture in their experience of psychological distress.

3.5 Main Category

Constructions of, and Responses to, Psychological Distress

A main category, 'Constructions of, and Response to, Psychological Distress' was generated within the analysis. This category is made up of two subcategories, 'Community constructions of, and responses to, distress' and 'Personal construction of, and responses to, distress'. The relationship between these two subcategories is shown in fig. 5.

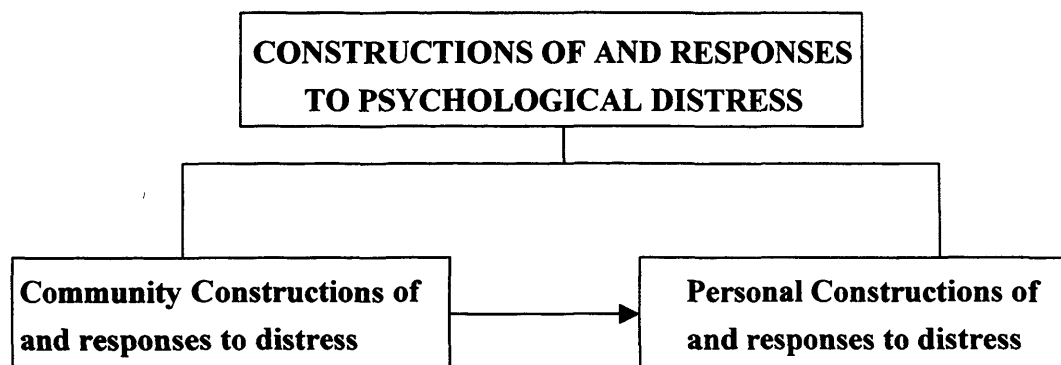


Fig. 5: *Constructions of, and responses to, psychological distress.*

The idea of 'community' and 'personal' constructions and responses to distress as existing separately came from the analysis of the accounts. However, there was also the idea that the community responses become internalised as cultural values, thus effecting personal responses, and the arrow going from the 'Community' subcategory to the 'Personal' subcategory denotes this. Community responses also included the responses of more immediate family, who were seen to be concerned and/or to share some of the values of the community as a whole.

Subcategory 1

‘Community’ construction of, and response to, psychological distress

Community constructions of psychological distress

The ‘community’ is interpreted as referring to the Asian community (communities) made up of people who identify with Asian cultural values. As was suggested in the main category, ‘The meaning of cultural values for Asian women’, these values went some way to inform participants’ understanding of their psychological distress. This category illustrates examples from the accounts, demonstrating how the community were perceived to understand and respond to psychological distress. The accounts refer to these women’s specific experiences of the community’s response to their distress but also their experiences of the community’s response and understanding of psychological distress more generally.

Descriptions of psychological distress being connected with ideas of religion and madness was identified in the analysis.

Sandi: Like a lot of people that chat about it, say oh no someone’s done something to you through some sort of black magic, which is really weird but they don’t acknowledge that it’s like a mental problem or there is some underlying psychological cause or whatever.

Jo: They see it as something external, how do you think that comes about why do they? Sandi: Over-religious.

(Sandi: 226–233)

Not a full shilling because I know when I went to see the psychiatrist in X when I was on my antidepressants even though my in-laws knew what was happening to me they used to go round saying to people, yes she is in a mental hospital which is for depression.

(Ayesha: 779–783)

An interpretation of construing psychological distress in concepts of religion and madness is the idea of ‘othering’ those who experience it. Ayesha describes her experience of her psychological distress (which she viewed as a consequence of her abuse) being treated as a psychiatric illness not just by the Asian community but also by mental-health services.

They admitted me twice and then when I took the overdose because he threatened me not to say anything about him he said it’s her, she has been suffering from depression since she had the children and I was just being piled up with these antidepressants.

(Ayesha: 283–287)

Ayesha was not offered counselling or therapy while she was in her relationship with her husband. The researcher considers the interpretation of the psychiatric services also being involved in the process of 'Othering' Ayesha by viewing her distress as a psychiatric illness rather than exploring possible reasons for what may be a 'normal' response to contextual circumstances (in her case abuse).

The analysis also identified a denial or dismissal of the existence of psychological distress as being construed as a part of Asian culture. This was particularly in those accounts where the participants were being seen in an adult mental-health setting (as opposed to those being seen in medical psychology). This non-acceptance of psychological distress also impacted on community responses to distress (illustrated below).

Community responses to psychological distress

We (Asian community) just don't accept that we suffer from psychological difficulties.

(Meera: 58–59)

I suppose my experience is that in Asian communities things like this are just brushed under the carpet and it's like, I don't know how to give you an example, whereas I didn't, I didn't face up to it till later, like when I told my mum I was seeing a counsellor. She was quite, she was pleased with me but... annoyed with me at the same time. One bit because she was pleased I was getting help but annoyed because somebody else was you know things that are private should be kept private within your own four walls. I do know lot of Asian don't sort of like believe that mental-health problems can exist. It could be a religious thing, there is no room to be depressed you've got to get on with it.

(Sandi: 744–755)

Sandi associates her mother's response with cultural values, and it is difficult to disentangle whether it is her mother who believes mental-health problems should be kept private, the community/culture in which she lives, or both. However, the idea that mental-health problems should be kept private is present along with the idea that such problems do not 'really' exist. Sandi positions the latter idea within the beliefs expressed by some Asian people she knows. Similar difficulties in disentangling Ayesha's mother's views about psychological distress from the views Ayesha believes to exist in the Asian community occurred in the analysis:

Jo: Do you have any ideas why there are so few Asian women seen in psychological services? Ayesha: I think, like I say, there is a stigma attached to what others will say. My mum thinks I see my psychologist because there is

something that is wrong with me. She thinks I'm seeing a doctor where there is all these mentally ill people, there is something wrong with my head and I think a lot of people won't want to understand the difference between a psychologist and a psychiatrist and why you go there, you go there to talk to somebody.

(Ayesha: 757–767)

Meera constructs ideas of shame being associated with seeking the help of a therapist as being culturally relative. She contrasts the 'therapy culture' of America with her own.

Meera: Look at the examples from America everybody has got a therapist. You listen to Oprah Winfrey programmes, I just seen one before I came here, and it's just fashionable there to go to a, not to a shrink, as it is, but to a psychologist, to be in therapy. Whereas still it is such a shame where I come from, if you need it because somehow whatever difficulties you are in anything you are in yourself, through religion or whatever.

Jo: So you would – in your culture there is finding help in religion, in the community family and to go to an outsider is?

Meera : Shaming, it's a shame. If you can put up with it as long as you can but when you do something about it and get help.

(Meera: 638–651)

Meera echoes the idea, also expressed in Sandi's narrative, that in Asian culture mental illness can be thought of as needing to be dealt with by the individual, either by putting up with it or through accessing support through religious beliefs, but that accessing the help of 'outsiders' or mental-health workers is not so readily accepted.

However, the existence of such cultural values is not generic. The analysis identified that immediate family would also be very supportive of some of these women and their distress.

Jo: Do you talk to your husband about it?

Meera: I have, I have and again because I explain to him why I needed to come here. But the fact that when I go home I feel a lot more at ease and he sees that I'm really getting the benefit of it.

(Meera: 597–601)

Sunita: Right. My mum had a knee replacement last year in July. I mean she does as much as she can, she doesn't rely on me but still because I live there and my dad is nearly eighty, I have to help them both and I work part time.

Jo: It sounds like you're carrying a lot of things.

Sunita: But I live with them, it's my responsibility. What if I was living on my own, who would look after me now?

Jo: So they look after you as well?

Sunita: Yes they do as much as they can and I do as much as I can.

(Sunita: 275–286)

Subcategory: *Personal constructions of and responses to distress*

Personal constructions of distress were varied, reflecting the diversity of presenting problems experienced by these women. Distinct contrasts were identified in the analysis between the experiences described by those women being seen in a medical-psychology setting and those in an adult mental-health setting.

All the women who were recruited from the medical-psychology setting were being seen for pain-management difficulties (this presentation was not targeted, and people are seen for other reasons in the medical-psychology department). The analysis of the accounts interpreted these women's (Fareeda, Sunita and Ruki) accounts of their psychological distress as being located in experiences of extreme physical pain, which had no medically diagnosed cause.

I couldn't bear the pain. I was screaming and shouting. It was awful.

(Sunita: 234–235)

Jo: What I'm wondering as well is if you've been feeling quite depressed or quite down?

Sunita: With my pain? Yes, now I do. Last week I was really feeling that I might end up in a wheelchair because they told me it was major surgery.

(Sunita: 221–227)

I tell her these pains, she said it might be because of the panic attacks. It wasn't the panic attack. Because of the pains and the panic attacks I go to sleep at night and then get up at four o'clock and go to work and come back. Still I was this bad and I wasn't coming and sitting down or going to sleep. But if got worse now he just says I'm sitting down now in the house or lying down.

(Fareeda: 295–306)

Her reasons for seeing a psychologist were to try and cope with non-specific pain which had become debilitating. The doctors had said that they did not know what was causing the pain so had sent her to the psychologist to see if that would help her to develop strategies for coping with her pain. She said that she found seeing the psychologist a helpful experience as she felt the psychologist understood her and was able to give her some advice, which helped.

(Field-notes from interview with Ruki: 555–561)

The analysis left the researcher questioning whether the experience of psychological distress for these women came from the pain itself or from the fact that they did not have explanations for the pain that allowed them to make sense of it and understand

what it would mean for their health. Tolerating 'not knowing' why the pain was present and what it might mean appeared to add to the distress of these women.

Ideas of loss were connected with these experiences of psychological distress and pain. For Fareeda, this related to giving up her job and independence.

Fareeda: What is this body, that's what I want to know. I was working now I'm out of a job. I was working, then I was going to doctors and the hospital. I was going for two years now to the hospital and they have done nothing. And it gets worse. Now I'm out of a job. I've got a house. I have to pay a mortgage. My car is sitting there.

Jo: And you can't use it?

Fareeda: I can't. I get dizzy. I was so worse, you know, I was so dizzy all the time. So if I'd drive the car I would have killed somebody. That's why I put my car outside and I'm not going to drive anymore until I get better.

(Fareeda: 216–228)

Ruki (who had been a writer) also talked about experiences that the researcher interpreted as relating to strong feelings of loss. When she refers to her heart she uses it as an expression for the depth of her feeling.

What's happened to me in my heart, in my mind? Do you understand that? Because I was doing all these things before and now I can't do anything, I can't write and I can't sit down longer and I can't write any longer.

(Ruki: 190–193)

The analysis of the accounts suggested that the women seen in the medical-psychology setting positioned their distress less in experiences of culture and cultural meanings than those women being seen in adult services. This may be a product of the salience of physical pain but also a product of the interactions in the interviews with these women. The researcher actively withdrew from asking some questions and ended two of these three interviews (with Fareeda and Ruki) prematurely because of the obvious pain and distress that these women were in.

However, the constructions and responses to distress held within the narratives of the women seen in adult services (Meera, Ayesha and Sandi) were interpreted as being more readily connected to cultural constructs.

The researcher interpreted Meera's understandings of her psychological distress as being related to carrying multiple and demanding roles. As has already been illustrated (in the category, 'The Meaning of Cultural Values for Asian Women') Meera described cultural expectations as shaping her beliefs that she should fulfil

such roles, even at the expense of her health. Meera experienced a stroke and that led to her being referred to the psychologist; however, the researcher interprets her understanding of that stroke as being construed within psychological concepts of stress and external demands exceeding the personal resources required to meet them.

I was really good at it and happy not to bother people in the team, not to bother colleagues. In fact have them look up to me, always do that, I know so much and I must help everybody and I was doing a really stressful job so the stress is building up in there. Not only that but also had teenage children and have to deal with them and what was happening but you get family quarrels. Okay, so I was dealing with that plus the job, so a lot of things going on and I had a mild stroke, I had a blood clot that started it so I think this is when I started being ill. Even when I ill they had to tell me look how long do you think you can go on for like this because I always used to push myself a lot and I would never accept that I am not well.

(Meera: 87–100)

Ayesha situated her distress in psychological terms and viewed it as a consequence of the abuse she had endured in her marriage. The meaning of this abuse was shaped by cultural values (as illustrated in the category, ‘The Meaning of Cultural Values for Asian Women’) which was interpreted in the analysis as having formed an important part of Ayesha’s therapy. In Ayesha’s conceptualisations of her distress, she makes a point of distancing her understanding of her distress from psychiatric understandings, and this is interpreted as her positioning the cause in the context of experiences rather than in herself.

I went to my GP and he remembered me apparently from the last time I’d come to my parents because I’d ended up in hospital. So he remembered who I was and it was then he started talking to me and then he said I think you should see a psychologist, would you like to see somebody to help you? I said well I don’t want to see a psychiatrist because I’m not mentally ill. I said like four years I’d been in and out of psychiatric hospitals because every time he beat me up he’d take me.

(Ayesha: 273–281)

Sandi’s distress was situated in experiences of self-harming behaviour, feelings of acute depression and paranoia.

Yeah I suppose but I can feel my emotions being driven, suppose that’s sends me a bit loopy sometimes, I did go through a short period where I was starting to believe all this stuff about like somebody has done something to you, like this paranoid me out for quite a while but I think I got hold of that because it wasn’t really, like if it was that it would be hitting me anywhere at any time but the only time I knew things were getting to me was when I felt them getting to me.

(Sandi: 571–578)

During the analysis of Sandi's account, the researcher was struck by how her description of her relationship with her Asian culture (strongly ambivalent and with a lack of connectedness) appeared to mirror her description of her relationships with significant people in her life, such as her mother. However, the aspects of her presentation that might be understood within a cultural context had not been something that she had discussed in her therapy, and the significance of culture to her experiences of distress remain the interpretation of the researcher with little direct grounding in Sandi's account.

A commonality that was interpreted as occurring across the narratives of the accounts of therapy was the idea that these participants had felt that getting help was not a choice but a necessity of either circumstances or levels of distress.

I don't think I had a lot of choice, I would have seriously injured myself.

(Sandi: 402–403)

I was in a corner otherwise I would have put up with this a lot longer, supported the pain for longer.

(Meera: 175–177)

Meera described this need for a crisis before she felt she could get help in cultural explanations of being expected to 'put up with' her distress. However, Sandi described it as being a more personal fear of being honest with herself.

You know when I said earlier that friends wanted me to see a counsellor and I said no, it was like a fear of making it real, being honest. Don't know why I said that, it's just come into my head, before it was easier just saying I'm getting by until the point that I need help.

(Sandi: 764–768)

These illustrations of needing a crisis before seeking help leads to the description of the final category within this model, 'Access to Psychotherapy Services'. Before illustrating the themes contained within the final category, a summary of the present category is presented.

Summary of the main category:

Constructions of, and Responses to, Psychological Distress

- This category illustrated the theme, generated within the analysis, that individuals' conceptualisations of psychological distress are, in part, informed by wider cultural conceptualisations of psychological distress. Within these accounts, such cultural conceptualisations were described in relation to Asian-community responses to psychological distress.
- Community responses and constructions of distress were diverse. The majority of participants talked about an unwillingness to acknowledge psychological distress within the Asian community, and that there is stigma attached to such difficulties. However, this stigma of psychological distress was also interpreted as emanating from some of the responses from psychiatric services that were described in some of the accounts.
- The idea that there is stigma attached to experiences of psychological distress was interpreted as linking into the need for a crisis to occur before help was sought by these women.
- Given the stigma or shame associated with the experience of psychological distress, the desire to have a trusting relationship (i.e. understanding, non-judgemental, confidential) with a therapist becomes significant. It could be argued that this is the case for all clients, irrespective of the culture that they come from but, as was illustrated by Meera's account of the shame, within Asian cultures, that can be associated with getting psychological help (as contrasted with American culture) – the belief that the therapist can be trusted is perhaps not as automatic as it would be in cultures more accepting of psychological constructs of distress and process of getting help, and disclosing information may be more tentative or difficult?

3.6 Main Category: Access to Psychotherapy Services

This main category illustrates the routes into therapy as described in these women's accounts. The routes were varied. As has already been described, most of these women experienced some form of crisis before seeking help or being referred to clinical-psychology services. Only one participant directly asked for counselling and that was Sandi (250–252); she described having to be assertive about what she wanted and needed in the way of help. All the other participants were referred to clinical-psychology services either by their GP or other health-care workers.

Sunita: I went to see a physiotherapist and she recommended it's not her business, so she would refer me to a psychologist. I didn't know they involved a psychologist.

(Sunita: 4–7)

Ayesha: As the GP said, 'As much as I would like to spend half an hour with you I don't have that time,' as a GP you know at the beginning you know he said you come at this time and I'll spend ten fifteen minutes with you but I think he realised himself you really need someone who can listen to you for a good hour someone you can see regularly and that's when plus I had to start filing for divorce and I wasn't ready to do that and he my ex-partner filed for custody of the children and I said to my GP this is what's happening and he said well you're not in a state to see a solicitor but you should go and talk to somebody and X is not a psychiatrist, she is somebody who will listen to you and someone who will give you advice on how to do what next how to go out into the world how to confront everything, it's like just been really helpful.

(Ayesha: 305–319)

The role of the GP in recognising his limitations and the needs of Ayesha was of great importance to her. Time was taken to probe Ayesha's presentation (she went to the GP complaining of headaches and inability to sleep) and to talk through options with her. The differentiation between a psychiatrist and a psychologist was also important to Ayesha. The GP's understanding of this was essential to Ayesha's belief that her difficulties had been appropriately heard, validated and understood.

However, not all the participants described having a good understanding of why they had been referred to a clinical psychologist or what the clinical psychologist would offer to them. When Sunita was first referred to her psychologist, she was unclear about what the purpose of this would be.

Jo: What was your image of a psychologist before you went?

Sunita: Something like a lecturer. I didn't think he'd be giving me all these handouts.

Jo: You were expecting him to kind of?

Sunita: To give advice and or he might of said that I'm not doing enough exercise or not eating the right food and things like that.

Jo: Is that what doctors have said to you?

Sunita: Yes, the doctors they just tell me to eat the right food and do plenty of exercise and things like that.

(Sunita: 162–171)

After meeting with her psychologist, Sunita was able to match some of the ideas of therapy with ideas that she learnt from yoga, thus allowing her to bridge what could be viewed as cultural differences in constructs of distress.

Jo: So Ben was trying to help you to think more positively?

Sunita: Yes.

Jo: And you said that your sister does yoga and there are similar ideas in that?

Sunita: Yes and I joined yoga classes as well.

Jo: What sort of things did they say?

Sunita: The things they say, you always think positive, do your yoga and before you go to bed, you just tell it I don't want this pain anymore and I want it to leave my body and things like that.

(Sunita: 111–124)

Sunita: Yes. Like I was going to yoga classes and she put all this in my mind. X would have done something else to put in my mind.

Jo: So like the yoga class, they give you ideas in your head and Ben.

Sunita: He would put different ideas, in differing ways into my mind.

Jo: And how would those ideas help you?

Sunita: I could cope with the pain and like sometimes, if you've got a cut on your finger, if you keep thinking about it, you get pain but if you forget about it, you might not realise that you've cut your finger.

(Sunita: 144–152)

However, it may have been beneficial for Sunita to have had the role of a psychologist more clearly explained to her by her referer before she was sent to psychological services for help. The lack of clarity that she had about why she was being sent to see a clinical psychologist would potentially impact on her trust of the therapist. This would be particularly so if she had felt coerced into seeing a psychologist when her understanding of her problems did not match psychological constructs of distress. In her case, differences in conceptualisations were, to some extent, bridged, but this was not the case with the researcher's interpretation of Fareeda's account (see illustration in the core category).

Fareeda's account illustrates the need for a development of a shared understanding of psychological distress between the client and the therapist. This brings up the issue of who it is (therapist or client) that makes compromises in their understanding

of psychological distress (the onus is often on the client, yet these accounts suggest that what the clients seek from their therapist is some understanding and validation of meanings that they attribute to their experiences of psychological distress). Fareeda's difficulties should not be interpreted as a consequence of Asian cultural constructions of distress, but perhaps in individual differences in understandings of her experiences. The researcher would hypothesise that a number of clients in all psychological settings would have different understandings of their distress to that of their therapists (particularly so in a medical-psychology setting), but it is whether these differences are acknowledged and how they are negotiated that allows for the consideration of the impact of cultural values on the experience of therapy to be considered.

Summary of main category: Access to Psychotherapy Services

- The need for gatekeepers to monitor and be aware of the potential existence of psychological difficulties is something that should exist cross-culturally. However, ideas were generated within the analysis of these narratives of there being reluctance within Asian culture to recognise psychological distress or to view it as shameful. The need for 'gatekeepers' to be sensitive to these ideas is important as it means that they may be more likely to probe somatic presentations, and also counsel patients in the services that may exist to help them, including services offered by clinical psychologists.
- There was diversity in the experiences of referral to psychology services, but one theme that was identified within the analysis was that not all clients are adequately informed about what psychology services offer before they are sent there. This can be confusing, and potentially distressing for clients who are seeking to have their experiences understood.

4. DISCUSSION

This chapter contains a discussion of the results and the research process. First, the interpretation of the results is expanded upon and considered against wider psychological theory, research and mental-health practice. The chapter continues by considering the implications of this study for models of psychotherapy practice. Next, the research as a whole is critically reflected upon both evaluatively and reflexively. The final section provides some directions for further research, which would extend the current study. However, before moving into the main body of the chapter, the reader is reminded of the aims of this study.

4.1 Aims of this Study

The aim of this study was to investigate South-Asian women's constructs of their cultures, and how these did, or did not, relate to their experiences of psychological therapy. The intention was not to generalise from these accounts to broad formulations of Asian women's experiences of therapy, but rather to inform further research and models of therapeutic practice by grounding the findings in the meanings and experiences reported by these women. A social constructionist perspective was adopted as the way of conceptualising the knowledge produced in this study, and the author acknowledges the interpretative nature of her findings, which must be considered as both artful and political (Denzin and Lincoln, 1994). This chapter represents one interpretation of the findings, and additional interpretations are possible.

4.2 Interpretation of the Results

To aid the reader, the discussion of the results in this section is organised through the use of the main categories. Each main category is discussed in turn; broader discussions relating to the overall model are considered in subsequent sections. Before moving into a broader discussion of the research findings, a brief summary of the overall interpretation given to the main findings is provided.

These accounts of therapy are understood to illustrate that the seeking of trust in the therapeutic relationship is central to these accounts of therapy. Significance of trust within this model relates to these women's constructions and experiences of psychological distress. A facet of this was the cultural context of that distress. The accounts refer in particular to the construct of 'Asian' culture, which is conceptualised as crossing cultures of religion and nationality. An interpreted theme

generated in the analytic account is the women's complex feelings about their relationship with their cultures. They describe seeking in the therapist an individual who could understand the cultural context of their distress, but not privilege generalised notions of Asian culture above the individual and unique narratives that the clients hold. Trust allows culture its place in these women's accounts of their psychological distress, and ultimately allows their unique individuality to be brought to the therapy agenda and talked about openly. It is this open disclosure and the sense of feeling understood that was identified as the most 'healing' aspect of therapy.

4.2.1 Main Category: *Identifying with Asian culture*

This category illustrated the complexities and individuality of concepts of culture. Although seemingly definitive terms (such as Asian or Western) were used to describe individuals' cultures, the meanings of such terms differed and were used differently by different participants. The idea that an individual's cultural identity is experienced more as a 'feeling of belonging', as differentiated from 'knowing', was also illustrated, thus suggesting that a person's connection with their cultures can be difficult to articulate.

Three main issues relating to this category are picked out for further discussion. The first of these is that a concept of 'Asian' culture crossing religious and national boundaries existed. The second issue that will be elaborated upon is the theme of individuals simultaneously holding multiple cultural identities (such as Asian and Western). The third issue to be expanded upon relates to the theme that cultural identity is more of a feeling of belonging than a definitive description. Discussion of each of these themes is presented in turn.

The concept of Asian culture crossing religious and national boundaries: Although there were differences in descriptions of what it meant to be Asian, there remained the idea of 'Asian' culture existing and incorporating differences, while also being differentiated from other cultures, such as Western. These women situated many of their experiences and values within their Asian culture. This included their experience and understanding of their psychological distress.

This finding has implications for therapists in their practice, as it requires them to be open to understanding the concept and experience of Asian culture from their

clients' perspectives. The importance of Asian culture in these women's accounts of their experiences of therapy suggests that psychological formulations of emotional distress need to account for clients' experience of distress within a cultural context. The findings suggested that an important part of the experience of feeling understood by a therapist comes from the exploration of wider contextual factors that impact upon the client. These include cultural values and experiences.

In the introduction chapter, the idea that psychotherapy practices 'whiten' out cultural differences was discussed; that is models of psychological practice often deny difference or aim to treat everyone equally – in doing so, perhaps demonstrating a cultural chauvinism. This study suggests that clinicians need to resist such practice, and reflect on issues of cultural difference. However, the idea that psychologists are 'trained' to minimise the place of culture became pertinent, and was demonstrated within the analysis of the data in this study.

During the analysis, the researcher often found herself re-enacting this process of minimising difference between her own cultural experiences and values, and those described by the participants in this study. For example, when Meera spoke about the (Asian) cultural expectation that women should fulfil multiple roles and demands (she described herself as having to be like 'superwoman'), the researcher was struck by the similarity of her narrative with the narratives of multiple expectations of women in Western cultures, both academic and personal. While this evoked a sense of empathy within the researcher, she had to remind herself that Meera sited this experience within her concept of a distinct Asian culture. To 'whiten' her experiences or view them as equivalent to the experiences of all women would minimise aspects of Meera's narrative. An example was her experience of power differentials between men and women within Asian culture, which she distinguishes from the state of power differentials between men and women in Western cultures. This example serves to emphasise that researchers and practitioners need to work hard at being reflective in their practice. While this tendency to 'whiten' experiences may be contributed to by the training experience of clinical psychologists, other research suggests that it may be a more universal phenomenon. Fine, Stewart and Zucker (2000) found a dominant 'discourse of equality' in their study exploring white women's discourses about 'race' in the US. This view of everyone as equal had the result of 'whitening' experiences. Fine et al. point out that this denial of difference leads to the refusal to hear about important issues, such as power differentials within wider society. Their study perhaps serves

to reinforce the need for clinicians (particularly white clinicians?) to be reflective in their work with clients from ethnic minority groups.

The need for therapists to consider contextual factors of culture is further emphasised by Ayesha's account, which illustrates issues of gender power differentials that were also included in Meera's account. Ayesha held two simultaneous accounts of the abuse that she endured in her marriage. One of these (a conclusion she came to after she had begun therapy) was that the physical abuse of women in marriages exists universally (i.e. cross-culturally), and thus has 'universal' psychological effects, such as feelings of shame and experiences of depression and anxiety. However, the second parallel account of her abuse emphasises that it took place within an (Asian) cultural context. Within this account, the issue of the powerlessness of abused women was emphasised as being in an Asian cultural context. The shame and stigma associated with the consequences of abuse were seen as not just emanating from the abuse itself but from community responses to that abuse. Ayesha suggested that as a white therapist I would be able to understand her abuse in a universal sense, but she indicated an anxiety about my ability to understand the importance of cultural context in shaping her experiences. One could hypothesise that a therapist would more readily engage with Ayesha's 'universal' account but in doing so miss important aspects of her experience relating to cultural context, thus leaving Ayesha with a feeling that she had not been fully understood.

This example was used to emphasise the importance of exploring clients' difficulties within the cultural context they sit them within. This allows the client to feel understood and have their story validated while also providing the possibility of exploring alternative stories about psychological distress (for example, Ayesha's story of the universality of abuse). If such validation is to occur, the therapist must be reflective in their own practice, and be willing to make conscious their own assumptions and narratives about culture, thus exploring how these may serve to deny differences between cultures that may be pertinent to their clients' experiences.

Simultaneously holding multiple cultural identities. The second main issue highlighted by this category is the finding that these women held multiple cultural identities. These cultural identities were also relational (e.g. Ayesha's account of her 'Western behaviour' with her friends at school as a contrast to her 'Asian behaviour' at home) and fluid (Sandi's oscillation between feeling quite close to, and then quite distant from, her Asian culture). It has been suggested that this holding of multiple

cultures within identity can create a condition of cultural clash¹⁰ which has been implicated in experiences of psychological distress through processes of cognitive dissonance, conflict and stress (Marshall and Woollett, 2000). However, in this study, the holding of multiple cultural identities was not directly implicated in experiences of psychological distress. Distress only became an issue when individuals described having to deny facets of their cultural identity or when they felt isolated from aspects of their cultural identity. The holding of multiple cultural identifications in, and of itself, was not described as problematic. This interpretation is echoed by Marshall and Woollett (2000) who, through the analysis of young people's video diaries, argue that normal processes of cultural identification incorporate the synthesis of multiple cultures. The findings of this study and the study by Marshall and Woollett challenge conceptualisations of psychological distress that emphasise ideas of cultural clash (for example. acculturation). However, as Sandi's and Ayesha's accounts suggest, the need to explore how people relate to different aspects of an individual's cultural identity may be usefully considered within the therapy situation. For example, Sandi's experience of a 'battle' existing with some people in her Asian community over her (Western) behaviour was in contrast to the acceptance of her multiculturalism expressed within her network of friends. The conclusion to be drawn from these findings is that cultural clash should not be assumed, but where facets of an individual's culture are challenged or not understood distress may occur.

Cultural identity is 'more of a feeling of belonging' than a definitive description. The final theme contained within this category that is considered further is the idea that cultural identity is more readily experienced as a 'feeling of belonging' rather than something that can be definitively talked about. This theme came particularly from Sandi's narrative, but the complexity of cultural identity, as described by the other participants, suggest that language may be limiting as a means of communicating cultural identity. This suggests that in both research and therapeutic practice, issues of culture should not be explored solely within the confines of language. With regard to psychotherapy practice, Krause (1998) suggests that therapists need to take an ethnographic stance. She suggests that this should include direct and indirect questions about culture, but will also require the therapist to observe actions of the client in the therapy room, their mode of dress and the way their client interacts with the therapist. This information, along with discourses about culture, can help the therapist to develop an understanding of their clients'

¹⁰ 'Cultural clash refers to those individuals who are multiply positioned in terms of identifications and who are assumed to experience conflict, discomfort, cognitive dissonance or stress.' (Marshall and Woollett, 2000, p. 119)

cultures over time. With regard to psychotherapy and psychological research, Griffin (2000) suggests that culture needs to be investigated using data that does not just include narrative data sets. Marshall and Woollett's (2000) teenagers'-video-diaries study provides an example of such research. The findings from their study and the benefits of using multiple forms of data (in their case, video diaries alongside interview data) are discussed in the next section.

4.2.2 Main Category: *The meaning of cultural values for Asian women*

This category illustrated cultural values particularly pertinent to these women in their accounts of their experiences of therapy and their understanding of the distress that led them there. As with the previous category, the themes contained within this category demonstrated diversity both in the values described as being held within Asian culture and how the meanings of such values differ between participants. However, themes of similarity were also present, particularly with reference to the theme of women being expected to 'put up with' or 'accept' difficult, overly demanding or distressing situations. However, before expanding upon the themes that are present within this category, attention is drawn to the absence of narratives relating to Western values.

Narratives about Western culture were present to some extent. For example, Ruki referred to lack of respect and support afforded to older women in Western culture. However, apart from that, there was an absence of the discussion of Western cultures within the participants' accounts (except as a point of contrast to Asian culture), and how the values emanating from Western culture impacted upon these women. It should be remembered that two of the participants described their cultural identity as Asian-Western, and all six of the participants lived in a wider society that can be construed as being primarily informed by Western cultural values, so the absence of data with regard to Western cultures was of surprise to the researcher. The contents of this category may reflect the questions asked in the interview which, though aiming to keep culture broad, were in the context of asking Asian women about their experiences of therapy. In attempting to give the researcher what they believed she was looking for, participants may have omitted any narratives they had about the values of 'Western' culture and how they understood them to have impacted upon their experiences of therapy and instead concentrated solely on 'Asian' culture. Equally, they may not feel (or be unaware) that they are impacted upon by Western cultural values. However, a third reason suggested in wider

commentaries and research should also be considered. This relates to invisibility of dominant cultures in narratives around culture.

Phoenix (2001) as cited by Majid (2001) emphasises the need for research on culture to incorporate investigations of constructs of culture within dominant cultures as well as minority cultures, and this is an important point to consider because, as researchers, we are subject to the same biases as society as whole: namely, a preoccupation with the cultures of minority groups with a lack of regard for dominant cultures. An example of how this effects narratives of culture is considered provided by Marshall and Woollett's (2000) study.

Marshall and Woollett (2000) interviewed a young Indian Hindu woman living in Birmingham. Part of that interview concentrated on asking her about her cultural identity. Their findings echoed the findings in this research – that is, there was a lack of referents to Western culture given in the interview account provided by their participant. However, they contrast the contents of her interviews (which concentrates on issues of Asian culture) with the video diary she kept which contained obvious referents to Western culture (they give the example of her talking about the significance of her T-shirt having a Hindu symbol on it, while she is also wearing jeans – culturally symbolic of Western youth cultures – and simultaneously listening to Madonna). Marshall and Woollett conclude that dominant cultures are talked about less explicitly than minority cultures, yet they may still contribute important factors to cultural identity.

This process of not being explicit about dominant cultures may have been why the participants in this study did not talk about the role of Western values in their experiences of distress, but may also have impacted upon the questions that I asked. I note (in retrospect) that within the transcripts, I did not question women about the possible impact of Western values upon them and, as in research, such biases need to be considered in psychotherapeutic practice as well. As Phoenix emphasises, culture should not just be considered a condition of minority groups, and if culture is to given more prominence in models of therapeutic practice, culture should be considered broadly encompassing dominant, as well as minority, cultural values and experiences.

With regard to the presence of themes within this category, Asian culture was referred to generally but more usually in reference to particular cultural values that were construed as problematic for these women. This was either in seeking help for

their psychological distress or contributing to their experiences of distress. The narratives particularly link ideas of women being expected to endure distress and multiple demands with the consequential experiences of psychological distress that these women suffered. In the cases of Meera and Ayesha, the link between these expectations and the psychological distress they experienced was clear, as was the perceived power differentials between men and women within cultural contexts. However, there was an absence of narratives from those participants seen in medical psychology (Fareeda, Sunita and Ruki) around these issues, highlighting their positioning of their distress firmly within physical conditions.

The researcher is aware that the distress of those seen in medical psychology could be viewed as having psychological as well as physical causes, and that there may have been elements of the somatisation of emotional distress. This remains a hypothesis. Nevertheless, both Sunita and Fareeda spoke about their overwhelming anger, frustration and distress at not having issues of their health care addressed satisfactorily. As was stated in the results section, their narratives were not so much about the more immediate experience of therapy with their psychologist, but were broader as they talked about their experiences with medical staff more generally. As this was not directly related to the research question, much of their narrative with regard to these issues was not included in the results section, but both women had experienced invasive and exploratory surgery. This had left them in physical pain and with questions about what was wrong with them. Issues of powerlessness were strongly indicated in these women's narratives and such powerlessness needs, perhaps, to be understood within a cultural and certainly a political and socio-economic context. Therapy and medical consultation was difficult due to language problems, and the researcher is left wondering if the experiences of Sunita and Fareeda may have been different if they had been white, middle-class and articulate in the English language. While issues of loss and anger, as associated with their physical pain, may have been considered in therapy it is not clear whether contextual issues, including experiences of powerlessness were included. Broadening the discussion out from Sunita's and Fareeda's experiences, the researcher notes that such contextual issues are often not considered in mainstream models of psychotherapy practice. However, models of practice advocated by theories of community psychology advance a political and contextual stance in the offering of both formulations of psychological distress and interventions (Orford, 1992, 1998). The findings in this study suggest that such contextual models of practice may have important ideas to contribute to the therapy of women in circumstances such as these. This is because they highlight contextual issues and allow for clients to

explore and potentially act on those issues (for example, see Holland, 1998, who advocates a model of psychotherapy that involves community action along with a part-contextual understanding of distress). Given their experiences, it is not surprising that Sunita and Fareeda were both seeking understanding and a sense of validation from their therapists.

Another theme contained within this category is that of Asian cultural expectations emanating and being upheld by a wider Asian community.

The themes of shame and stigma were introduced in this category, and the ways in which they are used to constrain behaviours was illustrated in the sub-category of 'Drumbeats of shame'. Marshall and Yazdani (1999) also identified the importance of experiences of shaming and stigma within British-Asian women's accounts of Asian culture in their research findings. They used interview data to explore young Asian women's constructs of self-harm, and how they understood culture to play a role within their personal experiences of self-harming behaviour. As with the accounts in this study, issues of shame and honour shaped women's constructs of acceptable behaviour, and, as indicated by Sandi in the present study, the act of being shamed (in her case because she 'rebelled') impacts not only on the individual but also on the standing of the family within the wider community. So, to 'strike out' and 'rebel' against cultural expectations was understood to carry powerful penalties.

Again, this category has implications for therapeutic practice. Firstly, the power of shaming and the perceived effectiveness of the gossip seen as communicating this links into the themes for the desire for the confidentiality of therapy and a desire for the therapist to be an outsider – that is, not an immediate part of the client's community (and therefore not perceived as sharing the same values as that community, although an understanding and, better yet, an experience of such values is seen as important).

Secondly, the therapist may also need to understand their client within a cultural context which contains particular values; clients may not be able to, or be unwilling, to behave in ways that may be therapeutically indicated – such as leaving an abusive marriage. This extends ideas of trust beyond understanding to being able to trust that the therapist will provide a culturally sensitive practice, and will not make suggestions for solutions that are culturally incongruent. Solutions or interpretations in therapy need to be culturally sensitive and relevant to the client's experiences. For

example, Ayesha was eventually able to leave her abusive marriage because of understandings that she developed about Islam and the place of women within Islam. It was important for her therapist to explore religious beliefs with her in her therapy, and not dismiss them or translate them into discourses of psychological theories.

The third issue that arises out of this category, and which impacts upon therapeutic practice, is the therapist understanding, tolerating and not judging the ambivalence the client may feel about her (Asian) culture. Three of these women explicitly link a part of their psychological distress with their experiences of (Asian) cultural values. The feelings that this evokes in them needs to be explored, but neither they nor their culture should be viewed simplistically nor criticised by the therapist. As Sandi explained in her narratives, such criticisms of her culture – coming from people who have not directly experienced it – leads her to feel defensive and protective, thus not allowing her to safely explore her own feelings of ambivalence.

4.2.3 Main Category: *Constructions of, and responses to, psychological distress*

Personal constructions of and responses to psychological distress were varied, and the role that culture was perceived to play in the constructs of distress also varied. In the narratives of Ayesha and Meera, culture was identified as playing a dominant role in their understanding of their distress, and they talked about this in their therapy. Sandi's experiences can also be understood within a cultural context, although she had not explicitly discussed issues of culture with her therapist. Those participants seen in medical-psychology services made less-explicit links between their psychological distress and their culture; however, culture was discussed within their therapy usually as an issue of language.

The three participants who were being seen in adult services used mainly psychological constructs as a means of explaining their distress, although the distress was experienced through both psychological and somatic symptomatology. In the cases of Sunita, Fareeda and Ruki (those participants seen in medical psychology), there was also a combination of psychological concepts and somatic concepts used in their descriptions of their distress, but the latter was more heavily emphasised by their understanding of their distress as emanating from experiences of physical pain. This brings into question the (false?) dichotomy between emotional and physical symptoms. A recent study by Malik (2000) with British Pakistanis and Pakistanis emphasised that south-Asian cultural constructs of

psychological distress are more holistic in nature – that is, the division between the physical and the psychological is not as greatly emphasised as in many Western conceptualisations of distress.

However, the researcher questions whether the accounts of distress in the present study would significantly differ (in relation to emphasis given to somatic and psychological understandings of distress) from accounts provided by people of Western cultures. There may be an argument for exploring commonalities in the account of psychological distress across cultural communities (making explicit narratives in dominant as well as minority cultures) rather than starting with the expectation of cultural differences.

Individual constructs of psychological distress will also have been impacted upon by the very experience of being in therapy. Unlike Malik's study, this study does not provide constructs of psychological distress that may be expected in a wider population. What it does do is provide constructs of psychological distress as described by Asian women who have experienced it and who are being seen for psychological help.

Descriptions of community constructions and responses (understood as being informed by Asian cultural values) to distress were less diverse, and there were three main themes generated from the analysis. The first of these was the denial of psychological distress; the second was to view psychological distress within constructs of religion; the third to view psychological distress as a psychiatric disorder. The latter two themes can be seen as relating to ideas of 'bad' and 'mad' respectively, and the researcher interprets the processes underlying these themes as acting to 'other' those with psychological difficulties. These three themes relating to constructs of psychological distress are not just found within Asian cultures; Ayesha's account of mental-health-services' treatment of herself reminds us that services may also be culpable of 'othering' people. However, in terms of therapy, it is important for the therapist to recognise that the clients' (in this case) experience these 'othering' constructs of psychological distress within a (Asian) cultural context.

Given these constructs of distress, it is therefore not surprising that issues of shame and stigma are attached to experiences of psychological distress. The shame and stigma attached to such distress can make it more difficult to talk about within the family or with members of the wider community. Add to this the idea that it is

wrong to seek help (for psychological distress) from outsiders, and it becomes clear that accessing help may be difficult and may create strong feelings of ambivalence in women from Asian cultures. These same themes were found in Marshall and Yazdani's (1999) study. They point out that the silencing of Asian women's psychological distress is further exacerbated by Western ideas of Asian culture being 'problem free' – this refers to the ideas introduced in the first chapter that there is a prevalent belief that south-Asian cultures contain 'less' psychological distress than other cultures. The dominance of such a belief within mental-health services, combined with the silence of Asian women within their own community, can perpetuate myths about levels of psychological distress within British-Asian communities, and may play a role in the under-representation of women being seen by psychotherapy services.

The issue of the 'silencing' of Asian women experiencing psychological distress should be something tackled by mental-health-service providers, and in recent years there have been many examples of specialist statutory and non-statutory mental-health services being set up specifically for women from Asian backgrounds (for example, 'No. There is no problem here' a programme based in Swindon and funded by the Department of Health through the Wiltshire Health Authority). The researcher is unaware of studies considering the efficacy of such services in bridging gaps between Asian women and psychotherapy services, but the issue of service provision in a local (Leicester) context is considered in section 4.2.5.

Therapists need to be sensitive to the issues contained within this category, including the role that culture may play in Asian women's experiences of psychological distress. However, the diversity in these women's accounts reminds us of the importance of therapists working from their clients' perspectives and needs rather than generalised or stereotypical notions of Asian culture. Time should be taken to check assumptions and construct a meaning around the clients' narratives. It is this level of understanding that clients are interpreted as seeking.

4.2.4 Main Category: *Access to psychotherapy services*

This category was mainly concerned with the roles of gate-keeping professionals. The themes contained within it particularly related to the need for gate-keeping professionals to be sensitive to cultural issues that may be 'blocking' women's access to services. These can be issues both in the patients' cultures but also issues within the services provided (for example, a lack of therapeutic services offering

language-appropriate services). With the advent of primary-care groups and GPs becoming commissioners of services, such service-gaps should be identified and addressed, particularly in areas where culturally appropriate practice should be emphasised through high numbers of individuals from ethnic minority groups.

A second issue that arises out of this research and is perhaps relevant to referrers and clinical psychologists taking up those referrals, is the appropriateness of psychotherapy services for Asian women. As was indicated in the introduction chapter, ideas that Asians are 'less sophisticated' in their understanding of psychological distress are present within health-care settings (Fernando, 1995). Although this idea may not be stated in such crude terms, subtle practices may serve to reinforce such ideas. For example, Asian women may find themselves more likely to be put on medication or offered practical support rather than being referred to, or taken up by, psychological services. This research demonstrates the complexity and sophistication of these women's constructs of their psychological distress, and ideas that Asian (women) cannot engage in psychological therapy need to be challenged.

Finally, the reader is reminded of the link between this category and the main category of seeking to trust the therapist. Routes into therapy were diverse but often determined by a crisis, and participants described feeling vulnerable and ambivalent about seeking help; the consequence of this was a desire to gauge the trustworthiness of the therapist. In this link, trust went beyond understanding to seeking to feel safe and confident that the therapist would not hurt or abuse them in any way. This was because some of the participants – most notably, Sandi, Ayesha, Fareeda and Sunita – had experienced difficulties with services as part of their route into therapy: Sandi had been referred to non-statutory counselling services and had to be re-referred to statutory services when her first experience of therapy 'failed', Ayesha had been treated with medication and in-patient admissions, and both Fareeda and Sunita had been refused further investigations into biological causes of their pain until they had engaged with psychological services. These findings and the accounts of these women suggest that routes into therapy need to be considered and discussed as a part of the therapy itself, as they effect issues of engagement and trust.

4.2.5 Main Category: *Client monitoring of their therapist*

As a whole, this category was concerned with the processes by which participants judged the trustworthiness of their therapist. The categories that have been

explained before set up precedence for a desire to be able to trust the therapist. This category explains the processes underlying how this seeking of trust occurred. A number of conclusions can be drawn from this category. One is the importance of the professional nature of the therapist. This was particularly relevant to wanting the therapist to be an 'outsider' and in ensuring confidentiality (both themes that were emphasised by cultural issues). This, along with the less than clear-cut conclusions about client-therapist cultural match, has implications for service provisions. These will be discussed with direct relevance to service provisions in Leicester (as based on the experiences of the researcher who worked within an adult community team in Leicester); however, the points raised are applicable to service provision nationally.

Within the city of Leicester, there is a number of voluntary-sector Asian women's counselling centres. Due in part to resource issues, but also to a desire to provide culturally sensitive practice, many referrals for Asian women to mental-health services are redirected to these Asian counselling centres. Such re-direction to non-statutory services is common practice nationally, and the centres within Leicester have worked hard to provide culturally sensitive practice, and in many ways offer a more complete service for the women in their communities than that offered by the statutory service. For example, they offer counselling in languages other than English. These services are sited within the communities they serve, and the therapy offered is by Asian women (usually voluntary counsellors) for Asian women. In some ways, such services are inclusive and echo the call for specialist services for ethnic-minority groups (Fernando, 1995).

However, the researcher argues that by sending Asian women to these services, when they have been referred to statutory services, misinformed ideas of culturally sensitive practice take precedence over individual needs. This process of passing on Asian women to these voluntary services (which have been set up to compensate for gaps in statutory services) serves to further 'whiten' statutory services, allowing culturally sensitive practice to become the focus of voluntary services, which are unsupported by health-care and social services. This further silences the needs of Asian women in the mainstream services. The referral of Asian women to such specialist services may be inappropriate on a number of levels, but with regard to the findings in this research, the desire to have someone who is an 'outsider' and viewed as a 'professional' brings this practice into question. As the researcher did not interview women being seen in the voluntary sector, it is not known how they perceived the help they got there and the counsellors that they saw. The aim of this discussion is not to state that women should not be referred to specialist cross-

cultural services. However it is to emphasise that assumptions about what culturally sensitive practices comprise cannot easily be made. For example, it is not necessarily about client-therapist ethnic match, a factor often argued for in practice and research (for example, Terrell and Terrell, 1984); in fact, the findings in this research suggest that some clients will ask to see a therapist of an observably different culture to their own. The importance of service providers attending closely to their clients' agendas and their specific needs should guide the care that is offered, and statutory services need to further develop inclusive practices.

The themes illustrated within this category also inform models of therapeutic practice. The aims of these women within therapy, as interpreted by the researcher, were to feel understood by the therapist. Participants illustrated reflective practices of their therapists as indicating their trustworthiness. Listening and analytic skills, the discussion of difficulties in the therapeutic relationship, and validating the client's understanding of their problems were all illustrated as positive behaviours. The goals articulated by clients often related to disclosure and developing deeper understandings. Interestingly, therapeutic models of practice and therapists' agendas often emphasise processes of change, with issues of trust and client disclosure often being taken for granted. None of these participants actually used the word 'change' in relation to their experiences of therapy, yet the idea of being understood permeated the accounts. Of course, the experience of feeling understood might lead to change but the participants' emphasis on feeling understood, and the lack of discussion around the explicit theme of change was of surprise to the researcher.

The participants also described themselves as active contributors to the experience of therapy. Again, therapeutic models often emphasise that it is the therapist who is the active one, often doing 'something' to the client (empowering them, teaching them skills, offering interpretations or formulations). Again, the emphasis that these participants gave to their roles in their experiences of therapy was of surprise to the researcher, and reminds us, as therapists, that our clients' experiences of therapy may be fundamentally different to our own.

The overall conclusion drawn by the researcher is that these findings are more congruent with reflective models of practice, and that the interaction between the client and the therapist needs to be more fully explored and understood within a cultural context. This will be expanded upon in section 4.3, 'implications for psychotherapy practice'.

4.2.6 Core Category: *Seeking to trust the therapist*

The core category was seeking to trust the therapist, and this category was discussed throughout the results section. One would expect that all accounts of therapy may have this as a central theme, though, as has already been stated, the issue of trust between therapist and client is not often explicitly talked about within models of therapy. However, the centrality of this category is understood as relating to the process of locating issues of culture within these accounts of therapy. Seeking to trust that the therapist will be sensitive to (and understand) cultural issues but not privilege them above the individual is central to this model. This is especially so given the diversities in the accounts contained within this model. Simplistic solutions to culturally sensitive practice cannot be found in this research. However, the very diversity of the accounts reminds us to use clients' own constructs of culture, and this is also echoed by the overall findings of Marshall and Yazdani (1999). They too found diversities in accounts of the role of Asian culture in experiences of self-harm, and they too, emphasise that individual client understandings should take precedence over generalised notions of Asian culture. Marshall and Yazdani cite Phoenix (1994) in reminding us that socially constructed groups of people cannot be approached as representing homogeneity: 'it is important to recognise differences and commonalties between people who are socially constructed as belonging to the same group as well as across groups' (Phoenix, 1994).

4.3 Implications for Psychotherapy Practice

Mainstream models of psychotherapy practice (for example, cognitive behaviour therapy and psycho-dynamic therapy) which explicitly incorporate ideas of culture are rare (systemic models of practice do perhaps lend more attention to ideas of culture; for example see Burnham and Harris, 2001). Ideas of culture in psychotherapy practice have more readily been considered in cross-cultural models of therapy (for example, Krause, 1998) and models of reflective practices (for example, Pedersen, 1995). An example of reflective practice comes from Pedersen (1995) who argues that counsellors who presume that they are free of racism seriously underestimate the impact of their own socialisation, and that racism often emerges as an unintentional action. It is the very unintentionality of racism in psychotherapy that highlights the need for models of practice and the training of clinical psychologists to incorporate self-challenging reflective practice. Pedersen's ideas fit with the researcher's experience of conducting this research, which called

on the researcher to be reflective and challenge a number of her own racisms in order to more accurately reflect the narratives of these women in her analysis. However, being reflective in both clinical practice and research can be highly demanding, and this is illustrated in Aitken's (1996, 1998) study (as introduced in the first chapter). In tracking the process of therapy across time from the dual perspective of a 'black' client and 'white' therapist, Aitken demonstrated the complexity involved in the therapist's reflexivity, and she highlights a number of issues that became pertinent in this process (for example, therapist disclosure as a way of allowing the client to feel safe enough to expose her own internal world). The therapist in Aitken's study commented on the lack of clinical supervision she received that specifically addressed the issues of difference and 'race' that were being dealt with in the therapy. The therapist indicated that Aitken's research interviews provided some function of the required supervision. If useful reflexivity in practice is to take place, it will require appropriate clinical supervision but such appropriate supervision may be scarce. Dennis (1998) conducted a survey of 108 clinical psychologists' British experiences of supervision, with particular emphasis given to whether ethnic and cultural issues were addressed. Dennis' findings suggest that while issues of ethnicity and culture were discussed superficially, more open and challenging discussions around factors such as racist assumptions and the exploring and negotiating of cultural differences were less readily attended to. Dennis argues for an increased awareness in relation to issues of culture to be attended to in the training and practice of clinical supervisors. As has already been suggested, such practices should consider cultures of all clients (including those from dominant cultures), and the findings from the present study suggest that more culturally aware clinical practices should become the norm. Krause (1998) further elaborates this position.

As was stated in section 4.2.1 , Krause (1998) argues for ethnographic skills to be employed within the practice of psychotherapy. She argues that such practices should be employed with all clients, as the very nature of psychotherapy involves the meeting of two people from different cultures. In practice this means being cautious but curious. An aspect of Krause's ideas of practice that relate particularly well with the findings of this research is that the therapist must work to check that understandings are shared, be curious about misunderstandings and work to negotiate differences; this means learning how to ask about culture, and central to this practice is therapist reflection.

To do this she (the therapist) must take on board the most difficult methodological conundrum, namely that ethnographic questions are not

unfettered. Like other questions and communications they are anchored in the personal and the professional context of the one who asks and the assumptions she makes about how those to whom the questions are addressed can hear them. It is the therapist's responsibility to make these assumptions explicit to herself because self-description and reflexivity are the best tools she has available to access and understand cultural difference.

(Krause, 1998, p. 174–5)

Krause (1998) also reminds us that psychotherapy creates a tension between understanding clients as much as possible from the 'inside' (that is understanding the client's problems from the client's perspective) and the need for the therapist to be receptive to the aspects of the client's life and self-perceptions, which the client does not see. The first part of this tension (understanding clients from the inside) fits with the theme contained within this study of 'seeking to be understood'. However, the accounts also contain themes that relate to the therapist enabling clients to create deeper and new understandings – an 'outside' understanding. This process was described by Ayesha, Meera and Sandi who talked about the importance of the analytic skills of their therapists, and how these allowed the development of their new understandings of their psychological distress. As Krause states, the challenge in therapy is to negotiate the balance between this 'inside' and 'outside' understanding, and the accounts within this study suggest that clients respond well and feel safer to explore outside understandings when, and if, they feel understood and validated in their narratives.

The final issue relating to psychotherapy practice that is drawn from the main findings of this research is that culture should play an important part in models of therapy but should not be privileged over the individual needs of the clients. Given the diversity in the accounts of culture, each individual that we see in therapy must be understood as holding complex cultural identities that will have impacted on their route into, and experiences of, therapy. Gordon (1996) highlights the importance of treating every therapy encounter as cross-cultural, and that therapists need to be aware of this, particularly if the client appears to be of the same culture as themselves. Therapy should always be treated as an encounter with the unknown, and therapist assumptions should be challenged and reflected upon.

In this sense all therapy is, or should be, intercultural; we do not deny differences but nor are we mesmerised by them.

(Gordon, 1996, p. 207)

This statement by Gordon links in with Sandi's conclusion about her understanding of her psychological distress and her experiences of therapy: that culture has played a role in her experiences of distress and therapy but that, ultimately, it is about her as an individual.

I might be able to take that thin line away and realise that it's not all about culture, it's about me. It's about me, it's not to do with culture or community but my own, I suppose I feel a loss with it, like I said earlier, I feel isolated. Yeah take the whole external factors away and what's left is me and I suppose I can only talk about what I know and I don't always know what I know sometimes.

(Sandi: 490–496)

As a final reflection, these women were being seen in mainstream clinical-psychology services, and on the whole their experiences of therapy were positive. This perhaps challenges the notions of mainstream therapeutic practice being inaccessible or culturally incongruent; however, the therapy cited also involved sensitive negotiations of differences and it might be important to conduct a similar piece of research with people who dropout of therapy. This would enable the exploration of which, if any, processes in their experiences of therapy contributed to this. Given these women's accounts and the importance of feeling understood, difficulties in the negotiation of cultural differences between therapist and client could feasibly contribute to dropout from therapy.

4.4 Evaluation

This section begins by linking in with an issue that was introduced in the first chapter, and asks whether the findings from this study could be construed as having harmful implications for Asian women through clinical psychological understandings of Asian culture. This is in relation to understanding of culture and the role it may, or may not, play in experiences of psychological distress. The section then goes on to evaluate the study more broadly, critiquing the research process and considering the limitations of the subsequent findings. A short section is then included on issues of reflexivity, expanding upon the introduction of this issue, which was contained within section 2.8.3. Finally, ideas for further research to expand on this study are suggested.

4.4.1 Are the findings from this study potentially harmful to Asian Women?

Within the first chapter, the issue of research findings having the potential to be harmful was considered. An argument advanced by Patel (1999) was introduced. This was that incorrect or simplistic conclusions can be drawn from mental-health research with ethnic minority groups and that these can serve to reinforce negative stereotypes and racist practices. Part of Patel's argument stems from the fact that many studies site causes of mental illness within the minority cultures in which they exist, and this concern is compatible with the concern expressed by Phoenix (1987) of there being a 'normalised absence or pathologised presence' of black women in research – that is, research either 'whitens' black women through treating them as equal to all other participants, or concentrates research upon them thus often siting pathology within their cultures. The tension between not being culpable of either of these positions while also conducting a meaningful piece of research for Asian women with the aim of informing psychotherapy practice was present throughout the process of this research.

In managing this issue, it was helpful to draw on examples of research and commentaries with similar aims to the present study. The study by Marshall and Yazdani (1999) outlined in sections 1.9 and 4.2.2 was helpful as is complimented a number of the findings in this research and, as with this research, their aim was to meaningfully inform service provision for Asian women rather than site pathology within Asian culture. A paper by Burman, Gowrisunkur and Sangha (1998) was also helpful as it provided a clarity to the issue raised by Phoenix (1987), while also advocating the need to address, through research, differences in service provision to minority groups which, they argue, may require the experiences and accounts of minority groups to be researched.

Within this study, aspects of Asian culture can be understood to have contributed to these women's experiences of distress, and – for some of them – an initial reluctance to seek help from services. However, the implication of this is not that Asian culture is pathogenic. Marshall and Yazdani (1999) emphasise the importance of making this statement as within Western cultures minority cultures are often called to account in explanations of mental-health problems among people from those cultures. In their study, Marshall and Yazdani interviewed service providers (as well as the Asian women service users) and found a prominent discourse of Asian culture being pathogenic. The prominence of such accounts led to the reproduction of simplistic notions of culture and the act of 'cultural blaming'.

Understanding a client and her problems within a cultural context does not equate to cultural blaming, and within this research the importance of the therapist not criticising but being able to reflect the ambivalence of feelings these women had about their culture was important. As Sandi explained, culture blaming leads to feelings of defensiveness which does not allow the client to explore her own feelings of ambivalence with regard to her culture. Culture blaming also privileges culture above the individual, or, using Gordon's term, we become 'mesmerised' by culture at the expense of the person.

A second issue also means that the findings in this study should be considered with caution. These women were asked about the role of culture within their experiences of therapy, and by virtue of this, their experience of psychological distress. Aspects of Asian culture that they experienced as pertinent to their distress were discussed; however, these women were not explicitly asked about positive aspects of their Asian culture and neither were they asked about the role of Western culture in their experiences of distress. Aspects of Asian culture were interpreted as playing a role in these women's understandings and constructions of their distress (and their experience of therapy), but this does not imply that Asian culture is any more pathogenic than any other culture.

Finally, the diversity of these accounts with regard to culture and the role of culture within psychological distress reiterate that cultures cannot be viewed simplistically nor as homogenous. Neither can assumptions be made about their impact upon an individual, as each individual has different experiences and makes sense of these experiences in different ways.

4.4.2 Critical Reflections on the Research Process

The method section introduced issues of quality standards and explicated the ways in which issues of validity and reliability were understood and addressed within this study. The significance of the research aims within the wider context of psychological research and psychotherapeutic practice was discussed in the introduction section. The processes involved in the procedure and the explanations for how they were carried out were set out in the method section. The aim of this was to provide a transparency and permeability by which the study could be judged. Further specific issues that relate to evaluation of this research are given below.

The use of grounded theory: The reasons why grounded theory was used as the method to inform data collection and analysis were given in the method chapter. It was also explained that a social constructionist understanding of grounded theory was taken in this study. The aim of using grounded theory was to situate the findings within the meanings and stories provided by the participants. Through the direct use of transcript data in the results section and the inclusion of the full transcripts in the addendum, the aim is to make accessible the data from which the researcher's interpretations were made. These sources allow others to access the data, thereby permitting the reader to examine the basis for claims made by the researcher, and to consider whether any subsequent interpretations are reasonable. While the interpretative nature of these findings has been discussed, the degree to which interpretation should be taken was difficult to gauge. For example, Pidgeon (1996) argues that researchers using grounded theory who do not theorise beyond their immediate data can stifle theory development. However, the balance between keeping the findings grounded while also moving theory beyond the immediate data can be difficult. As a researcher new to the use of qualitative methodologies, and with the aim of representing the participants' accounts, I was hesitant in being too interpretative. Nevertheless, attempts were made to link these findings with wider research findings and models of psychotherapy practice, thus expanding upon the model produced by the analysis.

Pidgeon refers to theory development, and while this research can be seen as informing further theory development, the product of this research was one model of Asian women's experiences of therapy and the location of culture within it. This study does not claim to have produced a theory. Part of the limitation of this study relates to the time and resource constraints in which it was implemented. Issues relating to this are considered below.

Selection of participants: As was noted in the method chapter, theoretical sampling was not used to recruit participants in this study. Similarly, participants were not re-interviewed during the process of data analysis. This situation arose out of pragmatic limitations. During the period of this study, there were very few clients within therapy who fitted the sample frame outlined in the method section, and those who were interviewed could not be re-interviewed due to time constraints. The very small number of potential participants supports the research findings that Asian women are under-represented in their use of psychotherapy services. However, the lack of theoretical sampling has implications in terms of the developed model. Theoretical sampling helps to fill out categories, and to discover variation within

and between them (Charmaz, 1995). Therefore the model developed in this study may not be as rich, dense or conceptually grounded as it would have been if theoretical sampling had been carried out. This also effected the saturation of the categories. As none of the categories reached a position of full saturation, the model must be considered informative but incomplete (the issue of saturation is expanded upon below).

A second issue for consideration relates to the use of the interview data in the generation of the model. As has been stated, the findings in this research are based upon the accounts of six women; however, all six of these accounts did not equally contribute to the generation of the model. As was explained in the method section, two of the interviews were terminated prematurely (after sixty minutes) because of the physical pain being experienced by the women concerned, and not all of the data collected was relevant to the aims of the research. The accounts of Meera, Ayesha and Sandi were more readily drawn upon, and it is important to note that these women were being seen in the more 'traditional' therapeutic setting of adult-mental health. These three women also experienced fewer difficulties with language. The accounts of Sunita, Fareeda and Ruki (who were being seen in a medical-psychology setting) were more concerned with being seen in general health-care settings, with less emphasis given to the more immediate experiences of therapy. Although this does not invalidate the model, it changes the way in which the data must be viewed. From a grounded theory methodological perspective, the more frequent inclusion of data from some participants rather than others is less important than if this was a content-analysis study; however, a number of the categories, particularly relating to issues of culture, drew mainly upon just three accounts, and this reiterates the localised nature of these findings.

A third limiting factor in the recruitment of participants was that all the participants were women who had, at some level, engaged in therapy. This may be part of the reason why these women were, on the whole, positive about their experiences of therapy. For this model to be expanded upon, it would be important to talk to more women and include those who have dropped out of therapy.

Saturation: The fact that categories were not saturated has already been mentioned, but the impact of this on the research findings is now considered in more depth. Rennie, Phillips and Quartaro (1988) have suggested that saturation of categories generally occurs after the analysis of five to ten protocols, and although the six participants recruited in this study provide an adequate number for the purposes of a

thesis (see Turpin, Barley, Beail, Saige, Slade, Smith, and Walsh, 1997), it is clear that six participants was not enough for saturation to occur. The model that was produced was rich and contained a large number of diverse themes. However, the conceptual depth of some of these themes was not great and certainly not saturated. Further recruitment of participants with the aim of expanding on the present themes would ideally have taken place.

The richness and breadth of the model was to some extent due to the incorporation of deviant or negative cases. The technique of identifying negative cases in order to expand upon theory was referred to in the method section. Within this study, negative cases were fully integrated into the model and conceptualisation of the categories. This allowed the model to demonstrate diversity, which actually became one of the most important themes and conclusions of this research.

Finally, the issue of whether this research is transferable needs to be addressed. As has been stated, the findings articulated within this research need to be understood as localised and provisional, but they were also aiming to inform therapeutic practice. To some extent, the transferability of these findings cannot be fully appreciated until further studies expanding upon this one have taken place. However, within the discussion section, the findings from a study by Marshall and Yazdani (1999) were compared with some of the findings in this study and were understood as complimenting each other. This does not mean that the present findings are generalisable, but it does allow for the idea that they may be transferable, and can go some way to building theory, despite the clear limitations of the model.

4.5 Reflexivity

The issue of reflexivity was considered in the method section. A large number of issues were considered reflexively including the difficulty and limitations of reflexivity itself. It is not possible to write about all the issues that were considered in this research; however, it is hoped that the transparency in the stance taken in this research and permeability of the methodology provided to the reader provides some sense of the functional reflexivity that informed this research. However, the issue of my being an outsider looking in was introduced in the method section and this is expanded upon here.

The issue of my being a white woman, investigating Asian women's experiences of therapy, was mentioned in the method section. However, in retrospect my position as an 'outsider' may have also been related to my position within the profession of clinical psychology and it is this that may have particularly impacted upon the accounts of therapy that I received. Within the results section, it was stated that the researcher was surprised at how positive these accounts of therapy were: very few difficulties in the experience of therapy were talked about with myself and explicit issues of racism were not illustrated. As has already been suggested, this may have been because these women were engaged in therapy (and they volunteered to take part in this study) and therefore did genuinely feel very positive about their experiences. However, the accounts may also have been impacted upon by my professional status and the possible assumption of these women that they were seeing therapists who were my colleagues (this would have been a correct assumption). A willingness to talk about difficulties in experiences of therapy may have been lessened in this situation. This potential limitation within my research highlights strength within the research of Aitken (1996,1998). Aitken's concentrated on the discourse of only one participant (a 'black' woman engaged in the experience of therapy); however, this participant was interviewed four times over an eleven-month period. The repeated process of interviewing may have enabled the participant to develop a greater trust of Aitken. Certainly Aitken's findings contain more issues relating to difficulties experienced in the therapeutic relationship with regard to the negotiation of difference and aspects of the experience of racism, (which were not talked about as being pertinent by the women in the present study, even when asked directly about it). The power differentials that exist between a white researcher aligned with the therapists being seen by 'black' participants are reflected upon by Aitken and Burman (1999) in relation to the impact they have on the processes and findings in such research. In their paper, Aitken highlights the benefits of interviewing participants over time which can enable the condition of trust to develop, thus allowing for the discussion of more difficult issues pertinent to the research, (Aitken gives the example of how she opened up a discussion about the participant's differential inclusion and exclusion of her as part of a white categorisation, and how this process may impact on their research relationship and the participant's relationship with her therapist.) Given the finding of a link between client trust of a therapist and subsequent disclosure in therapy, as generated in this study, it is not surprising to find that similar processes may also occur in the research process between researcher and participant. This issue of re-interviewing leads on to suggestions for further research to expand on the findings of this study.

4.6 Implications for Further Research

Models of research: The researcher believes that the findings of this study support the use of qualitative methodologies in exploring aspects of culture within experiences of therapy. The accounts generated by participants were both individual and diverse and it is, perhaps, a qualitative methodology that best allows for the exploration and identification of such diversity both within and across individual narratives. The production of such data, and an analysis leading to the generation of a model that can contain and link such diversity, highlights the strengths of qualitative methodologies. As personal constructs of culture - in relation to self-identity - remain under-researched, methodologies that allow for participant narratives to be 'expert' must also be encouraged. However, as Marshall and Woollett's (2000) study demonstrated, qualitative data does not need to be limited to narrative data. This study could have been meaningfully expanded through the use of the analysis of video recordings of actual therapy which, although ethically difficult, may provide important insights into the negotiations of culture within psychotherapy practice.

A broad approach to culture within psychological research (as introduced within the first chapter) which would include factors such as gender and socio-economic status appears to most meaningfully fit with the diverse and complex accounts of culture given by the women in this study. Such breadth in an approach to culture also reiterates the suggestion that findings should be understood within a socially constructed context.

Suggestions for further research: Ideas regarding further research include revisions and elaboration of the current study, and new investigations inspired by the research results.

The evaluation revealed some specific issues, which could aim to be addressed in further research. The involvement of a larger number of participants may be a way of enabling the saturation of categories, and the re-interviewing of participants could not only expand upon categories but may also allow participants to feel more able to talk about issues that they could not discuss with someone on a first meeting. With regard to south-Asian women in an UK context, further research should be carried out with the aim of developing more inclusive services and improving access to help. The present study informs models of practice but it remains only a starting point. As was stated earlier, further research should also include the narratives of

Asian women who have dropped out of psychotherapy services. Investigation into broader discourses with regard to therapy, which may exist within Asian communities, should also be explored (an example of one such study is Meldrum, 1998 who interviewed teenage Pakistani girls' constructions of help-seeking from mental health professionals). Interviewing Asian women, within the broader community, about their ideas of therapy may provide information that could further inform themes developed within this research (such as 'getting help from outsiders is shameful'). This, in turn, could allow services to consider ways of responding with the aim of providing more inclusive models of service provision.

This study began by outlining a literature suggesting reasons why people from ethnic minority groups may be under-represented in their use of psychotherapy services. With reference to Asian women, this study does not provide clear conclusions as to why there remains such low use of psychotherapy services. Current psychological practice, if reflective, was not indicated as being culturally incongruent and the complexities of individuals' cultural identities suggested that providing culturally sensitive practice is not about conforming to definitive therapy 'rules' but relates more readily to the processes within the relationship between the individual therapist and the individual client. However, this study does highlight values in the Asian community that may be contributing to under-representation. An example of this is the theme of psychological distress being, 'brushed under the carpet'. However, and as was indicated earlier, such themes understood as being associated with the Asian community, must also be understood in the context of the responses of mental-health services to those referrals of Asian women that they do receive; for example the redirecting of referrals of Asian women to specialist services which may serve to further silence the psychological distress of Asian women thus compounding the dismissal of psychological problems within their community. This remains a hypothesis and would require a study investigating accounts of service providers alongside the accounts of service users – of both specialist and non-specialist services. Nevertheless the findings from the present study go some way in challenging simplistic and generalised notions of culturally sensitive practice.

Perhaps the most pertinent issue for service providers, particularly therapists, is to be aware of the client's question: "Will he/she really be able to understand me?" The need for therapists to attend to this seemingly obvious question (so obvious, as to perhaps be overlooked) cannot be under-emphasised.

A number of the categories generated within this study could inform research in its own right. The ways in which people construct their culture and how this is understood to link with – or not – with constructs of psychological distress and/or experiences of psychological therapy would expand upon the findings of this study (Marshall and Yazdani's, 1999, study locating culture in accounts of self-harm is one such example).

The present study should also be expanded beyond the current sample frame; this would allow the place of culture within therapy to be more broadly investigated. Given the lack of knowledge that we have about how 'dominant' cultures are constructed as a part of self-identity, the accounts of 'white' women and men should be included alongside the accounts of 'black' and minority groups. Within psychotherapy research, locating culture of all clients of therapy may be important in the development of models of therapy, which provide ideas of context. Other groups within society who are also under-represented in their use of psychotherapy services should also be targeted in the exploration of experiences of therapy. Such studies should include, for example, men from lower socio-economic groupings, as themes of culture and difference may play important roles in blocking their access to, or desire to engage in, therapy.

These are only some examples of further research that could be conducted; however, the aims of such research should be to challenge and expand models of service provision rather than site pathology within socially constructed groups of people.

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Appendix 1: Interview Guide

Focus points for semi-structured interviews.

Initial ideas for topics to be covered in the semi-structured interviews:

These topics will be refined and made more accessible to the participants before the interviews begin. As the interviews progress, the topics will become focused by the results of the on-going analysis.

- How the individual's define their cultural background.
- Whether the individual's culture was overtly discussed as part of their assessment and therapy.
- Did they believe that their culture was relevant in any way to their experience of their psychological distress?
- Did they think that the psychologists' understanding of their problem matched their own?
- Did they perceive the psychologist's cultural/ethnic/religious background to be different to their own and did they think that this impacted on their work with the psychologist?
- Was the quality of care respectful and culturally competent?
- Perceived reasons for the success/failure of psychological intervention.
- What ideas do they have about why so few Asian women access psychology services.

These topics will be refined and made more accessible to the participants before the interviews begin. As the interviews progress, the topics will become focused by the results of the on-going analysis.

Appendices

Appendix 2: Letter of invitation

Letter of invitation to the participant

Dear [PARTICIPANT]

My name is Jo Scordellis, and I am currently carrying out some research as part of my training to become a Clinical Psychologist. I am interested in finding out about Asian women's experiences of seeing Clinical Psychologists.

This letter is to ask if you would be willing to take part in this research. Please would you read the enclosed information sheet, which explains more about the research and what you would be asked to do if you agreed to participate.

If you think you may like to take part in this study please fill out the attached form and return it in the stamped addressed envelope provided.

If you are interested in taking part in this study I have to inform your GP or your Consultant Psychiatrist (if you have one). They then have state if they have any objections to your inclusion in the study. No personal or confidential information is discussed. If you agree for me to contact them to let them know that you are interested in being interviewed by myself please tick box A. I will then contact you within four weeks.

If you are interested in taking part in the study but would like more information about why I need to contact your GP please fill out your contact details and tick box B. I will contact you within two weeks to discuss any questions you may have.

If you have any further questions about this study please contact me on the address below.

Thank you for your time.

Yours sincerely,

Jo Scordellis
Trainee Clinical Psychologist.

Department of Clinical Psychology,
Brandon Unit,
Leicester General Hospital,
Gwendolen Road
Leicester
LE5 62A

(0116) 258 4770

REPLY to Jo Scordellis.

Appendix 3: Information sheet

Participants' Information Leaflet

Study to explore UK Asian women's experience of seeing a clinical psychologist

I am approaching Asian women who have had a problem that led them to see a clinical psychologist. I'm interested in how you understood your problem and whether you felt that your psychologist was fully able to understand your experience. For some people their attitudes about seeing a clinical psychologist may have changed during the time that they saw them and this is also something that I am interested in considering.

This information is useful because to work successfully with clients, psychologists need to have a shared understanding of their problem with their client and there is research to suggest that this may be a problem when the client comes from an ethnic minority background. However very little research has been done in the UK with Asian women on this subject and in order to try and help services develop I am aiming to find out what (if any) issues arose from cultural factors in your work with your psychologist.

I would like you to help me in this research. If you agree to this I would come and visit you at home or another convenient place to interview you. The interview will last no more than one and a half hours. I would also like to audiotape this conversation, as this would allow me to get as full a picture as possible and not miss anything you might say.

I would make sure that anything you say would be completely confidential. No names, addresses or other information which would identify you will be held on computer or appear in any reports. The tape and transcripts will be held securely. The tapes will be destroyed once the study has been completed. The transcripts will be fully anonymised. There will be no contact with clinical psychologist whom you were seeing except in asking them to pass on this letter to you.

You do not have to help with this research if you do not want to. If after deciding to help with the research, you later change your mind, then it is okay to withdraw your consent. I am unable to offer you any personal benefit, such as payment, for taking part in this study. Whether you decide to help or not, this will not affect any care that you are receiving now, or may receive in the future.

Thank you for your time in reading this information.

Jo Scordellis
Trainee Clinical Psychologist

Date

Appendices

Appendix 4: Consent form

1

Consent Form

I have had the nature of the research explained to me.

I understand that any information I give will be anonymous. No names address or other information which identifies individuals will be held on a computer or included in any report of the research.

I have had the need for audiotaping of the interview explained to me and I give my consent to the recording of the interview. I understand that the audiotape will be stored securely and their contents remain confidential and used for this investigation only.

I understand that if I give my consent to participate, I can change my mind and withdraw my consent at any point in the future. My decision to participate or not will not affect any current or future treatment.

I give my consent to be interviewed and for the interview to be audio taped and transcribed.

Name (please print) _____

Name (please sign) _____ Date _____

Person Taking Consent

Name (please print) _____

Name (please sign) _____ Date _____

If you have any further questions I can be contacted at the following address and messages may be left by calling the telephone number.

Jo Scordellis
Department of Clinical Psychology,
Brandon Unit,
Leicester General Hospital,
Gwendolen Road
Leicester
LE5 62A

(0116) 258 4770


Appendices

Appendix 5: Letter of ethical approval

Melanie Sursham
Direct Dial 0116 258 8610

23 October 2000

Ms J Scordellis
Trainee Clinical Psychologist
Centre for Applied Psychology
University of Leicester
University Road
Leicester

**Health for
Leicestershire** 
LEICESTERSHIRE HEALTH
Gwendolen Road, Leicester LE5 4Q
Tel: (0116) 273 1173 Fax: (0116) 258 85
DX 709470 Leicester 12

Dear Ms Scordellis

Study to explore UK Asian Women's experience of seeking a clinical psychologist – our ref. No. 6040

Thank you for your letter dated 16 October and amended patient information sheet in response to points raised by the Leicestershire Research Ethics Committee in its letter dated 19 September 2000 in respect of the above study.

I have reviewed the information and documents provided and on behalf of the Leicestershire Research Ethics Committee, approve your application to undertake the above-mentioned research.

Your attention is drawn to the attached paper which reminds the researcher of information that needs to be observed when ethics committee approval is given.

Yours sincerely

M Sursham

Revd Philip Harbord pp.
Chairman
Leicestershire Research Ethics Committee
(signed under delegated authority)

(NB All communications relating to Leicestershire Ethics Committee must be sent to the Committee Secretariat at Leicestershire Health)

Appendix 1: Example of open coding

1 **Ayesha**

2 **Interviewer** As you've read in the information sheet, what I'm
3 really interested in is, I suppose, what your
4 experience of therapy has been like. Erm, as a
5 starting point I'm interested in how you define your
6 culture because I'm looking in particular at how
7 Asian women have experienced therapy but that is a
8 very broad group and I'm interested in how you
9 define your cultural identity?

10 **Interviewee** Erm in that do you mean what how I ... *Confusing question?*

11 **Interviewer** How do you see yourself? I mean I've come in and
12 somehow classed you as an Asian woman ...

13 **Interviewee** Yes.

14 **Interviewer** And I supposed if I was being classed I might be
15 classed as a white European or you know, whatever,
16 but actually the way I see my cultural identity is more
17 complex than that.

18 **Interviewee** I erm, I think it's like three different sections of defining
19 myself really because I was born in this country, I was

20 brought up in this country, erm defining myself in my
21 childhood years I was born in an Asian family with

22 parents that have Asian background but I have that

23 Western side of me as well which comes from my friends
24 and that because I was born and brought up in

25 Lancashire, Lancaster, it's a very English community

26 there were very few Asian families there at the time so

27 erm it's not like I was in a class full of Asian children, it
28 was English children with maybe one or two Asian

29 children in one class so I think there are two sections.

*Difficult
concept
to grasp
if going in
cold?*

Multiple parts

*use of researcher's
language
(memo)*

she separated

*family's
culture.
what is*

*Asian
culture,
what does
it mean
to be
Asian?*

*family
culture
relates
to parent
culture*

*V. Eng =
Western?*

*Wider
community*

*consequence of
where born &
brought up.*

Always Asian - Ascented to cultural. 'Western' more relational?

30 The Asian girl that was Western but at home I was the

31 Asian girl that was Asian because religiously I've had a

32 strict upbringing and I never had the chance to wear

33 Western clothing, except my school uniform I had to go

34 home and get changed into my Asian dress and it's

35 always been like that. But it was never a case of

36 because we were Muslim no you can't go on a school

37 outing or no you can't attend that class or no you can't do

38 this we did talk about it but we were allowed to do

39 everything we wanted to do. Then I started working and

40 that was all English friends but erm I could say to my

41 parents this is how things work out this is how it should

42 be done in England and they understood everything and

43 that was okay. It was once I got married that things

44 changed. I had to, it was very difficult and I had to put

45 that English side of me aside and I had to shut the book

46 on it and I couldn't. I found that very difficult plus my

47 home from being born to the age of twenty four I'd never

48 ever hear my Dad abuse my Mum, I'd never heard him. I

49 mean they could have an argument but it was an

50 argument and then it would blow over after half an hour it

51 would be okay again I've never heard my Dad swear at

52 my mum I've never hear him swear at any of us. But

53 once I got married it was just completely different and

54 culturally I was expected to put up with that it was just like

55 from my husband. I mean it wasn't an arranged

56 marriage, as such my father was completely against me

57 marrying this man. I'd met him when I went on holiday to

58 India when I left school, he's my cousin but obviously I

religious
a part of
Asian
culture

Poor
understanding
of wider
cultural
context

Marriage
led to
change.
Happy in
holding
multi-
cultural
I'd begin

Behaviour
of
husband
alien to
her

Male
behaviour
based
on
father-
role of
husband
as her
father

That
I
might
think that
because
she is
Asian?