CHINESE CULTURAL VALUES AND THERAPY:

PERSPECTIVES FROM CLIENTS AND THERAPISTS

JENNY JIM

JUNE 2003

UNIVERSITY COLLEGE LONDON

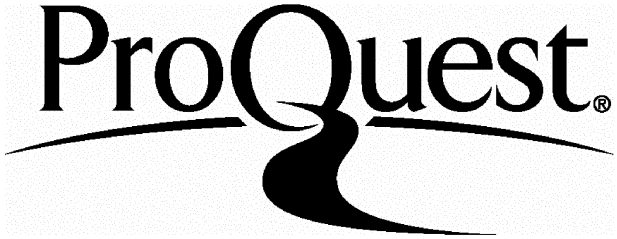
D.CLIN.PSY

ProQuest Number: U642519

All rights reserved

INFORMATION TO ALL USERS
The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript
and there are missing pages, these will be noted. Also, if material had to be removed,
a note will indicate the deletion.



ProQuest U642519

Published by ProQuest LLC(2015). Copyright of the Dissertation is held by the Author.

All rights reserved.
This work is protected against unauthorized copying under Title 17, United States Code.
Microform Edition © ProQuest LLC.

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

ACKNOWLEDGEMENTS

A very sincere and heartfelt 'thank-you' to:

Nancy Pistrang

For your unfailing support, guidance and enthusiasm

Chris Barker, Stephen Butler and Kerry Young

You have all given me the strength and support to grow

My family and friends

For believing in me,

You have all helped me much more than you know

CONTENTS

RESULTS continued

DISCUSSION continued

UCJTJJI

Title:	**Microsoft Word - Whole thesis.doc**
Submitted By:	**ucjtjji**
Submitted From:	**UCLUSERS-CTS4**
Printed By:	**ucl31ps**
Print Server:	**uclclust-lp4.uclclust.ucl.ac.uk**
Time Queued:	**10:01:25 Tuesday 30 September 2003**
Time Printed:	**10:01:25 Tuesday 30 September 2003**

Print Server News

```
Information Systems - Education & Information Support Division - UCL

Access to and use of this system are restricted to authorised individuals
and subject to UCL Computing Regulations.

All IS systems run unattended overnight and at weekends.
If they fail services may not be restored until the next working day.

IS Services:

IS Helpdesk opening hours:
Personal callers:     9.30am - 5.30pm
Phone calls:          9.30am - 5.30pm

For service news look on the Web at www.ucl.ac.uk/is/news

Central Unix service and Unix workstations:

All IS systems run unattended overnight and at weekends.
If they fail services may not be restored until the next working day.

PC DOS/Windows workstations:
**** The conversion of Windows 3.1 Managed PCs to the new WTS Only service is
     now well underway. If you have any queries or concerns about the
     conversion please email:
```

ABSTRACT

Chinese people are rarely seen in mainstream NHS mental health services and have been described as an 'invisible population' (DoH, 1994). Initial obstacles to accessing therapeutic services may be a result of a lack of awareness of services, language barriers, lack of availability of routine interpreting services, as well as perceptions of psychological help-seeking as a relatively modern and novel means of resolving mental health issues. There is evidence that those who do seek help, tend to disengage prematurely. Much has been written on the cultural differences between western and eastern values and belief systems but little exists on actually how these may affect the success or failure of the process of therapy. Furthermore, there is a dearth of literature on how to provide more 'culturally responsive' therapeutic treatments.

This study aimed to provide an exploration into the experiences of therapy or counselling of a small number of Chinese people living in London. It also tried to see what a small number of therapists experienced in working with this client group considered to be of importance in their clinical practice. Eight client participants and five therapists were interviewed. A semi-structured interview schedule was devised for each group. The client participants were asked about their process of help-seeking and their specific ideas of what was helpful or unhelpful about their therapy experience. The therapist participants were asked their views on what was important when working with Chinese clients. Responses for both groups were then organised into domains using themes derived from a process of qualitative thematic analysis.

Client participant accounts were marked by an open and curious approach to therapy, and a sense of ownership of both the problem and the outcome of therapy. There were also contradictory findings, with some client participants feeling that the success of therapy was inextricably linked to having seen a Chinese therapist; others conveyed a feeling of being 'freed' by seeing a non-Chinese therapist; and lastly, there were those who felt that whether their therapist was Chinese or not had no relevance to their experience at all. Client participant accounts also seemed to indicate a potential difference

between Chinese and non-Chinese clients in terms of the way that they viewed the role of the therapist.

Therapist participant accounts were marked by a sense of fulfilling multiple roles in helping Chinese clients. They were also largely unaware of how they implicitly and skilfully integrated their knowledge of Chinese values in their clinical work. The therapist participant accounts conveyed a tension between paying due attention to the importance of Chinese cultural values, whilst also needing to recognise diversity and individuality within Chinese clients.

Findings are discussed in terms of the implications for therapists working with Chinese clients and with regards to conceptual ideas relevant to service planning and delivery.

INTRODUCTION

Overview

Chinese people are rarely seen in mainstream NHS mental health services (NIMHE, 2003) and have been described by the NHS Executive Mental Health Task Force (DoH, 1994) as an 'invisible population'. Obstacles to engaging in services may be a result of language barriers, lack of awareness of services, as well as the perceptions of psychological help-seeking as a relatively modern and novel means of resolving mental health issues (P-L. Li & Logan, 2000; P-L. Li, Logan, Yee & Ng, 1999; Nagayama Hall, 2001). Those who do make contact tend to disengage prematurely (P-L. Li & Logan, 2000; P-L. Li et al., 1999; MacCarthy, 1988; Pedersen, Draguns, Lonner & Trimble, 2002; S. Sue & Morishima, 1982; Yee & Au, 1997).

There is a dearth of research on the ways to appropriately meet the mental health needs of minority ethnic groups. The National Institute for Mental Health in England (2003) has recently published a report based on the Mental Health National Service Framework (MHNSF, DoH, 2000a), titled 'Inside Outside: Improving mental health services for Black and minority ethnic communities'. It is aimed at reforming mental health services by promoting equality of service access and efficacy. The duty of public bodies to reduce inequality was first heralded by McPherson report (1999) and the Race Relation (amendment) Act (DoH, 2000b). Thus, there is widespread recognition of the present disparities existing in provision. It is likely that the differences in service use and treatment efficacy will be related to a complex interaction of many factors (i.e. socio-economic, political, cultural-psychological, and structural resources).

Much has been written on the cultural differences between western and eastern value systems but little exists on actually *how* these may affect the course of therapy (Kim, Atkinson & Yang, 1999). The low likelihood of utilisation of mental health services has been linked to cultural notions of stigma, shame and 'losing face' (Akutsu, Lin & Zane, 1990; Atkinson & Gim, 1989; DoH, 2002; S. Sue & Morishima,

1982; Uba, 1994). Once help is sought, however, less obvious cultural values may need to be considered in actual clinical practice. Implicit notions that relate to expectations of the purpose of therapy, the desired qualities of a 'good therapist', culturally-based differences which can affect the fundamental experience of 'self' and identity, as well as the impact of accepted ideas concerning social role hierarchy may play a role in the perceived appropriateness and thus usefulness of any therapy offered. The focus of the present study is to examine how Chinese cultural values may play a role in the experience of therapy.

Culture refers to the shared group beliefs, attitudes, values, behaviour patterns and modes of communicating that govern the way the environment is perceived and responded to (Berry, Poortinga, Segall & Dasen, 1992). Taking this into account, one may expect that cultural differences will globally affect personality, interpersonal dynamics and the meanings attributed to behaviours. Thus, it is important to study the role of culture in the development of psychological intervention for minority ethnic groups (S. Sue & Zane, 1987). This may involve developing psychotherapies and services for minority ethnic populations that are both empirically supported and culturally sensitive (Nagayama Hall, 2001). In addition, one must also examine in more detail, process-level issues regarding the factors that are of importance in engaging and maintaining a client of a different cultural background in the therapeutic process.

Cultural beliefs and practices enter into the psychotherapeutic process because they shape both the therapist's and client's definitions, understandings and perceived solutions to the problem. Assessing whether a behaviour is psychopathological, i.e., psychologically unhealthy, depends largely on the context in which that behaviour takes place. The majority of NHS psychotherapeutic work, therefore, takes on the context of being 'inter' cultural. The way in which these encounters are managed is likely to have a reflexive effect on subsequent future help-seeking.

Therefore, it follows that more in-depth information of *how* cultural values may affect therapeutic encounters is needed. The present study aims to provide a preliminary exploration of experiences of

Chinese clients who have received therapeutic support. Specifically, asking clients to expand on what factors enabled them to seek help and what they have considered to be helpful or unhelpful in their experiences, may offer useful insights to illuminate the 'missing therapeutic link' pertaining to the mechanism (i.e. the 'how' question) by which cultural values may have an effect.

This will provide a means to apply an existent knowledge base in a manner that extends understanding beyond the level of acknowledgement of explicitly manifest values such as stigma and its relation to underutilisation; to qualitative evidence that may point to more implicit and perhaps more subtle and harder to articulate interactions. Furthermore, the evidence will be derived from actual clinical experiences embedded within a context of contemporary Britain.

This chapter will present the background to the study. When appropriate, I will make reference to how the literature relates to the standards of care outlined in the MHNSF (DoH, 2000a). The structure of this chapter will be as follows: Firstly, the Chinese population in the UK will be placed within a socio-demographic context, followed by the major socio-economic and cultural-philosophical influences prevalent in Chinese societies. I will then present literature on the influence of culture on the expression of distress (concentrating on the issue of 'somatisation'), the process of help-seeking and therapy itself. I will specifically focus on evidence relating to Chinese and Asian American samples.

As a point of clarification, the vast majority of relevant research has been conducted in the United States. The term 'Asian American' originated in the 1960s in the context of the American civil rights movement as a means to avoid disparaging stereotypes associated with the label 'Oriental' (Uba, 1994). It is used in current literature to describe individuals from the continent of Asia (not individuals of Indian descent, as is commonly used in British and European classification systems). The research samples that are referred to as Asian American are typically formed by a majority of Chinese participants, with Japanese and Filipino participants included, but less represented (S. Sue, Nakamura, Chung & Yee-Bradbury, 1994). The rationale for grouping these populations relate to methodological concerns regarding sample sizes needed for statistical analyses, as well as reflecting an assumption

based on clinical and face validity of patterns of similarity between these groups based on history and culture (Uba, 1994). Several researchers (see D.W. Sue, 1981; S. Sue & Morishima, 1982) have reported shared cultural values and attitudes among Asian subgroups. Moves to establish empirical similarities are shown in recent development of scales of cultural values, such as the Asian Values Scale (Kim, Atkinson & Yang, 1999). Caveats to this approach will be considered in the section 'Methodological issues' of the discussion chapter.

Once the literature has been reviewed determining the major cultural factors salient in the help-seeking process and therapy itself, a summary will be given to clarify areas needing further research. Statutory, ethical and professional concerns will be presented and I will discuss some dilemmas that service planners and clinicians alike encounter when considering appropriate responses to increase equality in access and treatment outcomes. I will briefly address the ongoing debates regarding the utility of empirically supported therapies or culturally sensitive therapies, and the issues surrounding the provision of ethnic-specific mental health services.

As a result, assumptions that underlie the majority of psychological research used in developing theories tacitly considered to be generalisable cross-cultures will be highlighted. Epistemological concerns will be discussed in light of distinctions of theoretical positions delineated by the field of cross-cultural psychology. Finally, I will acknowledge the theoretical position that frames this thesis, present the rationale for this study and the research questions it aims to address.

The Chinese in Britain: A brief socio-demographic summary

National census figures for 2001 (National Statistics Bureau, 2003) indicate that there are now over 6 million people in England from black and minority ethnic groups, with approximately a quarter of a million Chinese people settled in the UK, accounting for 0.4% of the overall UK population. The Chinese population has increased by 50% since 1991. In terms of age distributions, 18% were under 16yrs, 76% were 16-64yrs and 6% were 65yrs and over. Geographically, most of the Chinese

population reside in England (89.2%) with markedly smaller populations in Scotland (6.6%), Wales (2.5%) and Northern Ireland (1.7%). Of those settled in England, 32% lived in London, 13% in the South East, 11% in the North West, with the rest of the population dispersed relatively equally (approximately 5% distributions) in the West Midlands, East Midlands, South West and Yorkshire and the Humber. The North East had the least number of Chinese at only 2%.

Chinese people in the UK show a high proportional employment in distribution or catering trades (71%) as compared to the overall UK population (18%). Average Chinese household size was 3, slightly higher then the national average of 2.3. The Chinese population were similar to the general population with regards to health as measured by risk ratios.

The Chinese community in Britain is a result of three phases of emigration. Initially, in the 1860s a small number of seamen and cooks employed on British merchant ships began to settle in major ports across the country (P-L. Li et al., 1999; Yee & Au, 1997). A more substantial population was established after the British Nationality Act (1948) enabled citizens of the New Commonwealth to live and work in Britain (P-L. Li et al., 1999). In parallel to this, Chinese living in rural areas of Hong Kong, i.e., the New Territories, were subject to land reforms and the collapse of the agricultural industry which provided further impetus for emigration from these particular regions.

The economic climate in Hong Kong led to between 30,000 and 50,000 Chinese, mainly Cantonese and Hakka-speaking men, settling in Britain in the 1950s (P-L. Li et al., 1999). Bolstered by the rise of the Chinese catering industry, the following decade saw these men reunited with their families who also left Hong Kong to work in Britain. This constituted the last major phase of emigration from Hong Kong; however, there has also been migration from Chinese settled in Vietnam and of Vietnamese refugees since 1975 as a consequence of the Chinese invasion (P-L. Li et al., 1999). This population present with high rates of unemployment due to professional and vocational qualifications not being recognised in Britain. There have also been increasing numbers of Chinese from the mainland seeking

asylum following the Tiannenman Square atrocity in 1989. This population is likely to include those more affected by political and cultural sanctions.

The Hong Kong Nationality Act (1990) has meant that 50,000 Chinese families (selected on age, occupation, professional qualifications and wealth) have been granted British citizenship. The arrival of these families, together with the impact of the handover of Hong Kong to China in 1997 is likely to constitute, perhaps, the fourth major phase of emigration of people of Chinese origin to Britain. It is expected that they will differ in their characteristics (such as educational background, occupation, age-range, socio-economic band, gender balance and cohort effects) from the existing resident population of Chinese (Race Relations Unit, Birmingham City Council, 1996).

Furthermore, there is the ongoing influence of second and third generation Chinese, the offspring of the previous phases of emigration. Individuals born in Britain will have also experienced the major societal-cultural influences on socialisation (such as education, exposure to media, and working practices) and are most likely to have value-bases that are a combination of traditional eastern and western values.

The socio-economic and cultural-philosophical context

Clearly when people migrate, they not only bring themselves but also the dominant cultural-philosophical context that exists in their country of origin. The extent to which these are influential, manifestly or latently, within an individual will obviously vary.

There are comparative differences between Chinese or Asian values and European or Western values. Both Eastern and Western cultural values are strongly influenced by the socio-economic structure of society. Whereas Eastern cultures are based on agricultural origins, modern Western culture is largely derived from the Industrial Revolution (E. Lee, 1997). The following general distinctions have been suggested (E. Lee, 1997).

Eastern (agricultural) cultures tend to be family/group oriented, have an emphasis on extended family and multiple parenting, with the primary relationship more associated with the parent-child bond. There is an emphasis on interpersonal relationships with both status and style of relationships determined by age and role in the family. Family members' roles tend to be well-defined, showing favouritism toward males and operating under more of an authoritarian organisational style. Eastern cultures tend to value the suppression of emotions, living in harmony with nature and a co-operative orientation. Spiritualism tends to be strong with fatalistic/karmic attitudes prevalent. Congruent with this, ways of thinking about the world tend to encompass an emphasis on the past, as well as present and future.

Western (industrial) cultures tend to be individual-oriented, have an emphasis on the nuclear family and couple parenting, with the primary relationship more associated with the marital bond. There is an emphasis on status achieved by individual efforts with value placed on self-fulfilment. Family members' roles tend to be flexible, with increasing opportunities for females, and operate under more of a democratic organisational style. Western cultures tend to encourage the expression of emotions, personal control over the environment, mastery over nature and have a competitive orientation. Materialism and consumerism tend to be major influences, reflected in ways of thinking about the world with a focus on the present and future.

As well as the socio-economic influence on Eastern societies, there is also the presence of cultural-philosophical influences that are more specific to Chinese and Asian societies. Although they have been guided by many philosophies (Carter, 1995), two of the most influential were the ideas of Confucius and Buddha (Shon & Ja, 1982), which appear to both enhance and extend many aspects of the effect of the socio-economic context as described above. Values that appear to be common to many Asian cultures are those of harmony, humility, and respect for the family, authority and tradition (W.M.L. Lee, 1999; D.W. Sue & D. Sue, 1990). Harmony is relevant to the maintenance of interpersonal relations and intra-personal emotional restraint. It can be linked to the Buddhist notion of moderation, with humility being valued over competitive pride. To maintain interpersonal harmony,

Chinese people may refrain from pushing to gain victory; intrapersonally, restraint or moderation may operate through maintaining an emotional balance by the suppressing of expression of extreme emotion.

The Confucian notion of filial piety teaches respect and obedience to authority figures beginning with the males in the family (W.M.L. Lee, 1999). This value therefore reinforces social role hierarchies, authoritarian orientation, importance of the extended family and precedence of the needs of the group rather than the individual. The influence of the historical meritocratic social structure (see Lau, 1997) may also underlie an emphasis placed on academic achievement, as may the potential benefits in directly increasing the status and wealth of the family (Uba, 1994). Failure to achieve academic or occupational success is congruently seen to bring shame on the whole family (E. Lee, 1997).

Co-operative orientation is also reinforced through an encouragement of dependency and respect for authority. Internal means of control such as guilt, shame, obligation, and duty, rather then individual freedom of choice and expression, are promoted in Chinese and Asian societies (Lin, Tseng & Yeh, 1995; Shon & Ja, 1982).

With this context in mind, it must also be recognised that Chinese and Asian societies have changed rapidly in many ways because of the forces of modernisation, urbanisation and industrialisation (E. Lee, 1997). Socio-economically, this has meant a shift from production to consumption. It has also led to widespread migration, particularly of younger generations from villages to urban centres. These factors are likely to impact on prevailing cultural values and traditional supportive networks, which would have typically centred around the extended family. The changes are more pronounced in modern industrialised Asian countries such as Taiwan, Japan, Hong Kong, Singapore and Korea. It is important, thus, for clinicians to remember that an Asian country, as it evolves from these recent socio-economic forces, may take on dramatically different characteristics, which will affect attitudes and values held by their population.

The research into differences in cultural values suffers from the deficit that it does not explicitly address differences between Chinese living in Britain and Chinese from China or Hong Kong. Nor does it give an acceptable temporal context to what may be termed 'traditional' values. There has not been any systematic empirical evidence to explore both these issues. Subsequently, Chinese values (or Asian values) can only refer to those values, beliefs and attitudes that have been reported in psychological research as being traditionally promoted – or dominant – in Chinese living in Britain (or Asian American communities).

In an attempt to clarify which cultural values may be important in a more contemporary context, Matsushima & Tashima, 1982 (cited in Uba, 1994) asked Asian American therapists working with Asian American clients what they felt were the most prevalent cultural values to be aware of when working with these clients. The list is strikingly similar to the aforementioned socio-economic and cultural-philosophical influences, therefore suggesting that these values have an ongoing significance and relevance to Chinese and Asian clients. The therapists listed the following: the importance of the family, the role of shame and guilt, respect for others based on their role and status, interpersonal styles of behaviour, the stigma of mental illness, restraint of self-expression, group orientation, achievement, sense of duty and obligation, and role expectations.

Cultural differences in expression of distress: The issue of 'somatisation'

The literature regarding the effect of culture on expression of psychological distress is dominated by the concept of somatisation (Cheung, 1995; see Kleinman, 1977; Lewis-Fernandez & Kleinman, 1994). This is especially so for Chinese societies, to the extent that somatisation was assumed to be a cultural trait (Cheung, 1995). Although there are many definitions of somatisation, it is generally accepted as referring to the experience and communication of psychological distress in the form of physical symptoms (Lipowski, 1987). Most explanations put forward to understand the high incidence of reporting of somatic symptoms in minority ethnic populations are based on a deficit model. For instance, psychoanalytic accounts refer to a pathological conversion of psychological symptoms into

physical complaints, which is hypothesised to enable the individual to avoid the stigma of mental illness (see Barsky & Klerman, 1983; Fry, 1993); a lack of vocabulary or semantic network (also termed 'alexithymia' (Kleinman, 1977); and the labelling of non-Western cultures as being 'primitive' and in the early stages in ontogenetic development, in which emotions are expressed in simple, undifferentiated, and concrete terms (Cheung, 1995). The latter is based on the idea that there is a lack of differentiation between mind and body, whilst assuming that the ability to separate the two is a 'true' indicator of ontological development.

Whilst most modern researchers eschew such judgemental ideas, which ultimately point to a form of psychopathology resulting from cultural weakness, it must also be said that there has been very little adequate research to illuminate thought in this area. Certainly, Chinese populations are likely to be greatly affected by stigma (P-L. Li & Logan, 2000; P-L. Li et al., 1999; Uba, 1994); however, *how* this contributes to expressions of distress is not necessarily clear. Krause, 1994 (cited in Patel et al., 2000) describes the Bedford Study that found an equal likelihood of somatisation in White British population as compared to a population from the Punjab. However, in terms of Chinese populations, differing definitions and inadequate methodology employed in research studies have precluded substantive conclusions regarding the validity of this concept and also the refutation of hypothesised psychopathological assertions concerning its underlying basis (Cheung, 1995). It may be the case that the tendency to express bodily symptoms may reflect different conceptualisations of distress, so that Chinese societies may simply not view psychological therapies as a credible source of help (Atkinson & Gim, 1989).

Models of distress are likely to impact on standard two of the MHNSF (DoH, 2000a), concerning primary care level identification of common mental health problems. Identification and appropriate referral by workers may be more challenging when implicit cultural models of understanding and expressing distress show disjuncture. This may further be compounded by the reported lack of Chinese language interpreters (P-L. Li & Logan, 2000; P-L. Li et al., 1999; Yee & Au, 1997). The role of English language proficiency and psychological distress has been demonstrated by Wong and

Cochrane (1989) and Furnham and Y.H. Li (1993), who investigated predictors of psychological adjustment and mental well-being in first and second generation Chinese in Britain. Wong and Cochrane (1989) demonstrated that proficiency in English was related to depression in first but not second generation samples. Furnham and Li (1993) found generally a higher level of psychological problems in the first generation. Psychological symptoms and depression were correlated with proficiency in English for both generations. This result, which appears contrary to the previous study's finding, may be explained through the inclusion of the category of 'psychological symptoms' in addition to depression in the correlation. Furnham and Li (1993) did, however, find a high prevalence of depression in first generation Chinese; the reasons for this are unclear although are likely include stress related to migration, loss and acculturative stress. Both studies highlight the important role of language, which is likely to affect ability to access and use informal and formal sources of help, as well as make adjustment to life in a new country difficult.

The influence of culture on help-seeking

People from many minority ethnic groups do not seek out psychological help through mainstream services (NIMHE, 2003). Researchers in the field (see MacCarthy, 1988; Lau & Takeuchi, 2001; Patel et al., 2000; S. Sue et al., 1991) have long acknowledged under-utilisation (based on expected usage given size of population) of mental health services by minority ethnic groups. Furthermore, under-utilisation may be seen as more striking given the level of adverse socio-economic factors that minority groups encounter (Fernando, 1989; NIMHE, 2003). These may not only have a primary pathogenic influence on mental health problems (NIMHE, 2003), but may also be a cause of discrimination and social exclusion. It is likely, however, that these factors do not have a linear relationship but show circularity in their impact on each other. Erens, Primatesta and Prior (2001) found that relative to the White majority, minority groups in England reported significantly higher scores of psychological distress and a severe lack of social support. This indicates that there is certainly a need for mental health services that are able to appropriately meet the needs of people from minority ethnic groups.

Standards one and three of the MHNSF address non-discriminatory mental health promotion and 'round-the-clock' access to appropriate local services, respectively. However, there is much literature to suggest a lack of equity in service utilisation with significant barriers to help-seeking for minority groups and, additionally, dissatisfaction with services received (see Callan & Littlewood, 1998; Commander, Cochrane, Sashidharan, Akilu & Wildsmith, 1999; Littlewood & Lipsedge, 1982; Parkman, Davies, Leese, Phelan, & Thornicroft, 1997). Furthermore, minority groups are more likely than the White majority to have aversive pathways into specialist mental health care (Sainsbury Centre for Mental Health, 2002).

Chinese cultural values concerning mental health have been shown to contribute to low rates of help-seeking from traditional mental health services (Lau & Takeuchi, 2000; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Li et al. (1999) conducted research focusing on the Chinese population in England, attempting to identify the barriers encountered by Chinese people with mental health needs in accessing appropriate NHS support. The participant sample was gained by targeting Chinese community centres in health authority districts with a resident Chinese population in excess of 2000. The initial stage of the study involved inviting attendees to complete a 12-point screening questionnaire (Chinese Health Questionnaire; T.A. Cheng & Williams, 1986; cited in P-L. Li et al. 1999). They received a total of 401 complete questionnaires. The researchers report that a score of 2 or above indicates 'a high probability of a mental health problem'; using this criteria, the attendees who fell into this bracket (21% of total respondents, equivalent to 86 people) were then invited to take part in a semi-structured interview. Of these, 83% agreed to be interviewed, giving a complete sample of 71 participants.

P-L. Li et al. (1999) reported only 39% of the sample went straight to their GP when first noticing their need for help (they do not include a comparative statistic for other populations using their GP as 'first port of call'), with others using accident and emergency departments, family, friends, Chinese community workers or Chinese doctors. Accessing help was reported to be delayed due to a lack of knowledge regarding statutory services, as well as participants' perception of their symptoms as

somatic. This finding fits with the previous research suggesting an increased likelihood of reporting somatic symptoms. Of the sample, 52% expressed difficulties when they sought professional help, the main barriers being language and lack of access to bilingual health professionals. Other reported barriers were a lack of knowledge about mental disorders, stigma associated with mental disorder, a belief in self-help, a belief in traditional Chinese medicine and also refusal of the usage of interpreting services for reasons of confidentiality. Strikingly, of the participants that the authors considered as providing reliable data (50 participants, i.e., 70%) and that had received a diagnosis (38 participants, i.e., 76%) none received counselling or psychotherapy.

Interestingly, participants' fears regarding the effect of stigma associated with mental disorder appeared to be well-founded with 56% of the sample finding their family unsupportive. Families were reported to view mental illness as "embarrassing and frightening" (P-L. Li et al., 1999, p.78); subsequently, many participants had made great efforts to conceal their illness. This finding, although congruent with research emphasising the role of stigma about mental illness in Chinese and other minority ethnic societies (Akutsu, Lin & Zane, 1990; Atkinson & Gim, 1989; NIMHE, 2003; S. Sue & Morishima, 1982; Lin et al., 1995; Uba, 1994), is incongruent to the research regarding the close and supportive nature of the family structure in Chinese communities (E. Lee, 1997; Lin et al., 1995; Uba, 1994). The authors conclude that their findings "do not support the stereotypical images of extended families supporting and caring for one another" (P-L. Li et al., 1999, p.79). The fact that of those that received a diagnosis did not receive any form of psychological therapy leads to the question of where exactly this population is able to get support.

This research is the only published systematic survey of Chinese people with mental health needs living in England. There were several methodological limitations to this study, some of which were acknowledged by the authors. These include the type of sample (lack of representativeness, non-English speaking only, able to attend in the day, over-representation of clients with severe mental health problems), the validity of data (self-reported diagnoses, unreported reliability and validity statistics for the CHQ, unreported interview schedule, unreported method of qualitative analyses of

interview data), and a general lack of comparison to expected statistics in the general population. Despite these limitations, it does provide a useful starting point from which to examine in greater depth the issues that this community faces.

Firstly, it highlights that there is a widespread perception of mental health services not adequately meeting the needs of the Chinese community and that stigma connected to mental illness remains prevalent, possibly superceding the strong family allegiances that are usually thought to be central to Chinese communities. The conspicuous finding that none of those participants who were considered reliable in reporting their diagnosis, actually received psychological therapy also mirrors deficiencies in providing effective service for minority groups members with more severe mental illness (Standards four and five of the MHNSF). Littlewood and Lipsedge (1982) and Fernando (1989) state that people from minority groups are less likely to be seen for psychological therapies, more likely to be prescribed drugs or ECT and more likely to be misdiagnosed. Furthermore, Bhui (2002); Commander, Odell, Sashidharan and Surtees (1997), and the Sainsbury Centre for Mental Health (2002) have shown that although minority groups have longer than average length of stay in hospital, they are in fact less likely to have their psychological needs (and social care needs) addressed in the care planning process. Readmission rates are also higher in minority groups (NIMHE, 2003).

Li et al.'s (1999) survey also showed that due to stigma, many Chinese people would delay help-seeking, only doing so when their difficulties had become unmanageable, which is consistent with the finding that consultation rate for mental illness, especially anxiety and depression, are reduced in the Chinese population in England (NIMHE, 2003). It also mirrors available literature on this subject in other Chinese or Asian American societies (see Lin et al., 1995; E. Lee, 1997; Uba, 1994). Exacerbating the effect of stigma as a barrier to accessing appropriate care may be an expectation, confirmed by literature that GPs are less likely to recognise mental illness in minority groups than non-minority populations (Shaw, Creed, Tomenson, Riste & Cruickshank, 1999). Thus, it seems that the rates of observed help-seeking are likely to be a result of an interplay of cultural ideas and values, as well as certain service provision realities regarding diagnosis and treatment.

Stigma has been widely acknowledged and researched as an important cultural barrier to accessing help for psychological problems in this population (see Akutsu et al., 1990; Atkinson & Gim, 1989; DoH, 2002; Kwok, 2000; Lee, Rodin, Devins & Weiss, 2001; Lin, Inui, Kleinman, & Womack, 1982; Parker, Gladstone & Tsee-Chee, 2001; S. Sue & Morishima, 1982; Tseng, Qiu-Yun, & Yin, 1995; Uba, 1994; Yee & Au, 1997). Investigations highlight that perceived stigma is not only felt on an individual level but also that Chinese people were often troubled by the social effects of stigma on their families. Consequently, they relied mainly on self-help (Lee et al., 2001).

Lin et al. (1995) state that in mainland China, the dominant political ideology during the Cultural Revolution led to strong opposition to and suppression of the practice of individual psychotherapy . As a result, knowledge of psychotherapy is either outdated or ignored by most practicing psychiatrists in China. Psychotherapy clinics are not provided for patients at most psychiatric facilities. Thus, not only do cultural values exist that can mediate against help-seeking but these have also been reinforced by political means. Thus, it is likely that widespread levels of knowledge about psychological therapies are low in many migrants' country of origin.

Relationships have been found between levels of acculturation, stigma and attitudes to psychological help seeking in Asian-American populations (Leong, Wagner & Tata, 1995; Tata & Leong, 1994). These studies have shown that more acculturated individuals have less negative attitudes to help-seeking and perceptions of stigma. Further, Atkinson and Gim (1989) found that the most acculturated Asian American students were most likely to recognise personal need for psychological help, most tolerant of stigma associated with help-seeking and most open to discussing their problems with a psychologist.

The notion of stigma on help-seeking behaviour is related to other cultural differences that have been observed in Chinese populations, such as the need to maintain 'face' and the emphasis on emotional restraint in Chinese communities. 'Face' is "an embodiment of social power that represents one's moral capital and one's prestige in the interpersonal field...to lose face is to lose one's ability to

engage in reciprocal affective relationships...it is to be demoralised...unable to face others" (Lewis-Fernandez & Kleinman, 1994, p.68). The need to preserve 'face', both at an individual and familial level is a major motivating social factor in Chinese societies (Lin et al., 1995), which as mentioned previously, emphasise internal means of control, such as guilt, shame, honour, duty and obligation (W.M.L. Lee, 1999). Socialisation in Asian American families often employs shame and guilt to reinforce obligations and social role hierarchy expectations (Shon & Ja, 1982). By doing so, this enables the maintenance of harmonious interpersonal relationships. Contravening the highly esteemed cultural value of emotional restraint can result in losing 'face' and therefore bringing shame onto oneself and to one's family. Interestingly, there is evidence that Chinese students, in particular, associate an ability to control their emotions with a higher degree of mental health than other Asian samples (Japanese and Korean students; Atkinson & Gim, 1989). However, the relationship between emotional expression and stigma is not confined to Chinese or Asian societies. Komiya, Good and Sherrod (2000) showed that in White American students, emotional openness and fear of emotions were predictive of perception of stigma and negative attitudes to help-seeking. These studies suggest that one of the moderating variables behind stigma in help-seeking for all populations may be the way emotions are either embraced or feared. The particular salience to Chinese and Asian societies, however, may lie in the fact that emotional restraint is an explicitly desired and socially reinforced value governing interpersonal and intrapersonal life.

These findings relating to the impact of Chinese cultural values on help-seeking also appear to indicate a potential difference in the importance of familial identity and the preservation of favourable social perception. Connected to this, are more fundamental notions regarding the socio-cultural organisational principles that underpin cultures in general. Chinese populations have been categorised as having a collectivist orientation, whereby there is an emphasis on the subordination of personal goals to those of the in-group (Hofstede, 1980). The in-group is defined as being comprised of members who share many common interests and concern for each other's welfare (Triandis, Leung, Villareal & Clack, 1988). Collectivism has been demonstrated as a dominant cultural influence in

cultures in Asia, Africa, South America and Pacific Island regions. Individualism, which conversely emphasises the fulfilment of individual goals over those of the in-group, is associated with most North and West regions of Europe, North America (especially USA) and Australia.

In collectivist cultures, the prevalent norms are interdependency, extended families, 'we' consciousness and socially-based identity. In individualist cultures, the prevalent norms are independence, 'I' consciousness and individual based identity (Hui, Triandis & Yee, 1991). These norms are suggested to influence the development of self-construal on an individual-level. Self-construal can be conceptualised as a constellation of thoughts, feelings and actions concerning one's relationship to others and the self as distinct from others (Singelis, 1994). Markus and Kitayama (1991) suggest that those individuals from cultures that emphasise connectedness and social relationships are likely to encourage interdependent self-construal, whereby they are most likely to derive self-esteem on ability to adjust and restrain oneself in order to maintain harmony in social contexts. Therefore, it is hypothesised that the closer an individual identifies with a collectivist society and construing self as interdependent; the more likely they are to experience the social pressures of stigma when encountering a psychological problem. Furthermore, the importance of favourable social perception appears to have serious repercussions in ability to maintain familial- and self-esteem. These cultural-psychological factors, combined with the possibility of different conceptualisations of distress may all contribute to a reluctance to seek help when experiencing difficulties in psychological well-being.

The influence of culture on therapy

Once help has been accessed, different cultural variables may be important in playing a role in aspects of the therapy itself. These variables can be broadly separated in terms of those relating to the client-therapist match, and those that are more pertinent to the process of therapy, i.e., preferences for different therapeutic styles (S. Sue, 1990; Akutsu et al., 1990), differences in communication styles (Hall, 1976) and 'gift giving' (S. Sue & Zane, 1987). Client-therapist matching variables that have been

researched with Chinese or Asian American populations and other minority ethnic groups include language (Flaskerud & Liu, 1990; Takeuchi, S. Sue, & Yeh, 1995), gender (Flaskerud, 1990) and ethnicity (Atkinson & Matsushita, 1991; Flaskerud & Liu, 1990; S. Sue et al., 1991).

The literature does not reflect general agreement on the effect of these variables (Pedersen, Draguns, Lonner & Trimble, 2002). A review of research did not show support concerning matching client and therapist on ethnicity, language or gender (Flaskerud, 1990). However, this is contrary to a large-scale study of ethnic match based on thousands of African American, Mexican American, and White American clients seen in the Los Angeles County mental health system (S. Sue et al., 1991). The researchers found that matching ethnicity and/or language resulted in more sessions attended, less attrition and better treatment outcomes for Asian Americans. This pattern of effects was also shown in the Mexican Americans, though less markedly. Gender match was associated with less attrition in Asian American and White Americans. Differential effects were found of ethnic matching on premature termination in African Americans and White Americans, although matching did result in more sessions attended for both groups. Interestingly, treatment outcomes for these two groups were not related to ethnic match. A lack of consensus in research on matching may result from a lack of uniformity in methodology and outcome criteria. S. Sue (1998) also offers the idea that some studies may not give due attention to the matching of acculturation level.

How 'credible' a therapist is perceived to be has been demonstrated as a strong predictor of utilisation intent for Chinese American and White American students, although it does seem to be particularly salient to Chinese Americans. Akutsu et al. (1990) showed participants transcript presentations of interview sessions of three therapeutic approaches (Shostrom, 1966; cited in Akutsu et al. 1990) and asked them to rate credibility and utilisation intent using the Counselor Effectiveness Rating Scale (CERS; Atkinson & Wampold, 1982; cited in Akutsu et al. 1990). They also measured perception of counsellor behaviour using a specially devised 14-item questionnaire, comprised of two dimensions, empathic involvement and directive counselling style. They found that empathic involvement was the sole predictor of perceived credibility in both samples. Credibility perception was found to be a stronger

predictor of utilisation intent in the Chinese Americans than White Americans. As 'expertness' was one of the five dimensions that was measured by the CERS, this finding may relate to an expectation of Chinese people for a therapist to be an expert. Lin et al. (1995) state that, "Since the patients expect the therapist to be authoritative, wise, knowledgeable, and experienced, it is important to maintain this posture in order for the therapeutic work to be effective" (p.286). S. Sue (1990) supports the view that authoritative as opposed to egalitarian behavioural styles appear to be more effective in therapy with Asian American clients.

Slightly counter to this assertion, however, was Akutsu et al.'s (1990) other finding that directive counselling style was not a significant predictor of counsellor credibility or utilisation intent. The authors suggest that it may be that there are different features within styles that may be termed 'directive' and that the directive style composite derived from factor analysis in their study contained several items that could have been perceived as confrontative. These elements are not present in styles termed as 'directive' in other studies and may have been crucial in influencing the perception of credibility in the Chinese Americans due to cultural values emphasising interpersonal harmony, emotional reservation and avoidance of conflict (Akutsu et al. 1990).

It may be that although Chinese people are more likely to respect social hierarchy, with a certain amount of credibility ascribed to others seen to be in a higher social position (Sue & Zane, 1987), the forming of harmonious relations also plays an essential role in perceiving a person as credible. The idea that confrontative aspects of the directive behavioural style may have a crucial role in their negative effect on credibility may also be related to differences in communication styles found between Chinese societies and Western societies. Broad differences between cultures have been found in relation to the communication process (Hall, 1976; cited in Robinson, 1998). In counselling sessions, Asian American clients often appear to be rather passive and formal, making great efforts to avoid confrontation and causing offence (E. Lee, 1997). Furthermore, making eye contact can be seen as disrespectful, especially when addressing elders or those perceived to be authority figures (E. Lee, 1997). Chinese and Asian American societies may be categorised as high context cultures (Hall, 1976;

cited in Robinson, 1998). High context communication relies heavily on non-verbal aspects, with phrasing, tone, gestures, posture, social status and social setting being essential to the meaning given to the message. Low context communication is more explicit and verbally-reliant.

Another factor that has been suggested in relation to perceived credibility is the concept of 'gift-giving' (S. Sue & Zane, 1987) in therapy. This is a metaphorical therapeutic mirroring of the long-standing Chinese traditional ritual of giving gifts in interpersonal interaction. Sue and Zane (1987) say that "Almost immediately, [Asian American] clients need to feel a direct benefit from treatment" (p. 42); they term this benefit a "gift" (p.42). 'Gifts' therefore embody the client's perception that something meaningful was received from the therapeutic encounter. In this way, 'gifts' may encompass a range of different benefits, such as alleviation of symptoms, introduction of clarity, and normalisation (S. Sue & Zane, 1987). The authors contend that initial sessions with Asian American clients (who are often unfamiliar with the process of therapy), should focus on education and 'gift-giving' to enhance credibility, likelihood of return and treatment efficacy.

Summary of current research addressing the influence of culture on the therapeutic process

The majority of research on the influence of culture on the therapeutic process has focused on the factors that affect access, concluding consistently the centrality of the role of stigma, shame and 'face' in deterring minority ethnic communities and those of Chinese and Asian American backgrounds to access mainstream services. These are additional to the structural barriers of lack of bilingual/bicultural workers. There have also been studies of particular variables that may be important once clients have accessed help. In terms of client-therapist matching, there is a lack of consensus on how culture affects the likelihood of successful outcomes in therapy with minority ethnic clients. However, empirical evidence suggests potential benefits of matching for Asian Americans, which is reflected in clinical evidence from Chinese clients in Britain, which indicates that more Chinese clients would seek help if Chinese workers were available (P-L. Li & Logan, 2000; P-L. Li et al., 1999; Yee & Au, 1997).

Regarding aspects more relevant to the process of therapy, researchers have alerted clinicians to important differences in the perception of therapist credibility and communication styles observed in therapeutic sessions with Chinese and Asian American clients. The differences found appear to be related to socio-economic and cultural-philosophical values dominant in Chinese and Asian American societies. These include, the predominance of an agricultural economic background, Confucian and Buddhist philosophy, political control, and a collectivist value orientation influencing the development of an interdependent type of self-construal.

Whilst acknowledging the gains researchers have made in the last two decades, there is inevitability the need for more studies in this under-researched area (Iwamasa, Sorocco, & Koonce, 2002). Particularly, there is a dearth of research on how to be 'culturally responsive' in clinical practice. Beyond the ideas that have been presented, very little research has been conducted on what a 'culturally effective treatment' actually means.

Obligations and dilemmas facing service providers responding to minority ethnic groups' needs

As mentioned previously, 'Inside Outside: Improving mental health services for black and minority ethnic communities in England' (NIMHE, 2003) is intended to support reform of mental health services for minority groups. Published in the wake of the McPherson report (1999) and the Race Relation (amendment) Act (DoH, 2000b), it acknowledges inequality in the existing provision of mental health services and a lack of appropriate services. It sets out the following three key objectives for change; firstly, "to reduce and eliminate ethnic inequalities in mental health service experience and outcome, secondly, to develop the cultural capability of mental health services and thirdly, to engage the community and build capacity through community development workers" (p. 19). The report refers to "significant and sustained differences between the White majority and minority ethnic groups in experience of mental health services and the outcome of such service interventions" (p.10).

The importance of appreciating and recognising diverse cultural groups and the ability to work effectively with them by clinical psychologists has been argued from an ethical perspective (S. Sue, 1999). The British Psychological Society's Committee for Training in Clinical Psychology (BPS; CTCP, 1991) and the BPS Equal Opportunities Statement have confirmed the duty of postgraduate training courses and qualified clinicians to appropriately meet the needs of all clients. Furthermore, the report 'Health of the Nation: Ethnicity and Health' (DoH, 1993) states that service provision should be 'tailored' to meet the specific needs of individual groups of people. With reference to the Patient's Charter (DoH, 1995a), it is clearly stated that clients should expect the NHS to respect and address their religious and cultural beliefs. The inability to work effectively with diverse backgrounds has been characterised as 'cultural malpractice' (Hall, 1997).

Responding to black and minority ethnic issues relating to mental health service provision, however, continues to provide planners with difficult dilemmas. There is a dearth of research on the most effective means to meet the psychological needs of minority ethnic communities in the UK (NIMHE, 2003; Patel et al., 2000; Robinson, 1998) and in America (Iwamasa et al., 2002). This is particularly true of the Chinese UK population, where only a handful of publications exist (Furnham & Y.H. Li, 1993; Wong & Cochrane, 1989; P-L. Li & Logan, 2000; P-L. Li et al., 1999; Yee & Au, 1997). Wright, Bindman, Thornicroft and Butcher (2000) reviewed NHS R&D funded research regarding minorities and the MHNSF, confirming an almost complete lack of output and poverty in commissioning of such research.

Thus, there is agreement about the inadequacy of and need for more equality in present mental health services. Providing 'culturally capable services', attractive in itself as an ideal, is unfortunately in reality rather nebulous. Operationalising 'cultural competency' or 'cultural responsivity' returns us once again to the issue of how? This dilemma began to be addressed in American research in the 1970s and 1980s, with researchers acknowledging that the single most important explanation for problems in service delivery to minority ethnic groups involves the "inability of therapists to provide culturally

responsive forms of treatment...therapists are often unable to devise culturally appropriate forms of treatment and ethnic-minority clients frequently find mental health service strange, foreign, or unhelpful" (S. Sue & Zane, 1987, p. 37).

The debate continues and one option under discussion concerns the idea of whether separate therapies need to be developed for minority ethnic groups by critically examining the epistemological bases of the therapies that clinicians routinely use and apply across cultures.

Empirically supported therapies vs. culturally sensitive therapies

Recently research has focused on the distinction between empirically supported therapies (ESTs) and culturally sensitive therapies (CSTs) (Nagayama Hall, 2001). ESTs are treatments that have been demonstrated to be superior in efficacy to a placebo, other treatments or the passage of time (Borkovec & Castonguay, 1998). CSTs involve the tailoring of psychotherapy to specific cultural contexts, with the underlying notion that a client of a different culture may require a different form of psychotherapy. It is thus recognised that nearly, if not all therapies that clinicians use (and tacitly accept) as ESTs have been developed by and tested on predominately White, middle class, European and North American populations (Willig, 2001). Doubt has thus been expressed on the 'exporting' of ESTs to different cultural populations from which they were developed, measured and validated (Matt & Navarro, 1997; S. Sue, 1999).

Presently, however, there is also no more empirical support for the efficacy of CSTs as compared with ESTs with minority ethnic populations (Nagayama Hall, 2001). This finding may have several possible explanations. Firstly, it may merely reflect the infancy of the evidence base concerning minority groups and the difficulties in recruitment of representative samples to test the treatments. Secondly, S. Sue (1998) points out that the selective enforcement of the scientific principle of internal validity often acts as an inhibitive force from researching minority groups. The evidence base for minorities is not substantive enough on which to demonstrate internal validity and much effort must be spent on showing basic relationship between variables. This discourages researchers to conduct studies on

minority groups and this further weakens the evidence base relative to the growth and expansion of that for the non-minority population. Thirdly, it may also be the case that those therapies that are used as ESTs are, in fact, as valid as CSTs with each appealing to different portions of each population. It is unclear which of these explanations is most appropriate and it is likely that they may all have utility in furthering the understanding of the dilemma encompassing culturally effective treatments.

Ethnic-specific mental health services: A way forward or backward?

Dilemmas about the development of separate therapies for different cultures lead on to ideas of whether minority ethnic groups would be better served by ethnic-specific mental health services. These may have the benefits of encouraging access through employment of bilingual or bicultural workers, provide a means to 'pool' cultural expertise and also provide a more unified basis on which to conduct studies on culturally appropriate therapies and lobby for ethnic-specific issues. Disadvantages may be that minority needs are 'ghettoised' when they should be integrated into mainstream agendas (MacCarthy, 1988; Nadirshaw, 1999; Fernando, 1989). Creating separate services may discourage some clinical psychologists from fulfilling statutory, ethical and professional obligations to provide culturally competent services, thereby promoting a reduction in the overall skill-base of the profession. Furthermore, separation may mask the degree of transferability in skills helpful in clinical work with minorities, to the general population. Presently, the issues of ethnic-specific mental health services in the UK can only be addressed using anecdotal clinical testimonies, of which concerns of validity, reliability and representativeness of contributors cannot be ignored. No research exists to demonstrate a supportable conclusion on these ideas. Testimonies of Chinese clinical samples indicate a need for more culturally aware and responsive services (P-L. Li & Logan, 2000; P-L. Li et al., 1999; Yee & Au, 1997).

S. Sue (1977) was one of the first researchers to address this issue in America, suggesting that existing services could usefully be improved by provision of parallel services (which have large numbers of minority staff and clients, providing separate but equal services and form part of existing services), and new non-parallel services (which would provide new therapies, constitute a new service

and institution). More recently, Zane, Hatanaka, Park and Akutsu (1994) have evaluated an ethnic-specific mental health service using a parallel approach for Asian Americans, which supported a conclusion that ethnic-specific services could reduce or eliminate service inequities (e.g., differential premature termination rates) for Asian Americans while at the same time not creating any for White clients. Additionally, enhancement of utilisation of community mental health services by minority ethnic populations has been shown to result from increasing the capacity for bilingual/bicultural service (Flaskerud, 1986).

Zane et al.'s (1994) findings are impressive in supporting innovation in service provision. However, it does not address *what* it was about the service that the bicultural and bilingual staff provided, that made treatment outcomes efficacious when the psychological treatment models they employed were those commonly used in most services (brief psychodynamic and cognitive-behaviour therapy). It appears to point to the applicability of using established therapies with Asian American populations although it still does not answer whether different sections of the population, i.e., the more acculturated, are more likely to find these means more acceptable. Equivalent research investigating new non-parallel services or ways of improving existing services is not yet available. In conclusion, the existing literature still leaves us with the question of what being culturally responsive in therapy really means and how is it achieved?

Epistemological issues and cross-cultural psychology

Perhaps the most important purpose of these debates is that they lead clinicians into examining the epistemological underpinnings of the approaches that are commonly used. Discussion about whether psychological approaches need modification or complete re-development is influenced by concerns of interested parties about the very nature of what can be deemed as true and genuine 'knowledge'. The theory of knowledge, i.e., epistemology, "involves thinking about the nature of knowledge itself, about its scope and about the validity and reliability of claims of knowledge" (Willig, 2001, p. 2). In the same way that feminist authors have critiqued established research methodologies, those with an interest in

cross-cultural psychology have highlighted the biases in the evidence base upon which western psychology tends to be founded. These biases focus on implicit assumptions about what constitutes 'the norm' and the purported 'objective' nature of the scientific research.

Cross-cultural psychologists emphasise the historical lack of research with culturally diverse populations, asserting that the evidence base may only be applicable to western, white, middle class people. This in itself does not amount to a claim that the evidence base should be ignored or deemed useless, but instead encourages researchers to re-consider the origins of what has been tacitly accepted as knowledge applicable to all and to see its inherent sampling-related limitations. It certainly does not preclude the possibility that when other populations are researched, psychological concepts may be supported as generalisable; the salient point is not to assume that what has been shown in one discrete population should automatically be accepted as applicable across cultures.

The presence of ethnocentrism (Sumner, 1906; cited in Berry et al., 1992), i.e., "the strong tendency to use one's own group's standards as the standard when viewing other groups" (Berry et al., p.8) in the development of psychology, is often used as a point of criticism. However, it must also be recognised that the propensity of members of groups to utilise an implicit hierarchy may even be a universal feature of cultural group relations (LeVine & Campbell, 1972).

Cultural encapsulation

Cross-cultural psychologists suggest that true objectivity cannot be achieved and the claim of research data being objective "serves to obscure the fact that the researcher's identity and standpoint do fundamentally shape the research process and findings" (Willig, 2002, p.7). These researchers accept that the theories an individual holds shapes their understanding and interpretation of the world. More practically, these theories determine research agendas, study designs, data interpretation and clinical practice. Wrenn, 1962 (cited in Pedersen et al., 2002) referred to the 'culturally encapsulated counsellor', signalling an acceptance that therapists may at times be unaware of the way their own culture defines the way they interpret, interact and ultimately, judge, what their clients bring to therapy.

It refers to the idea that views on reality are based on cultural assumptions, leading to insensitivity to cultural variation in others. This may encourage a bias in assuming our own views are right despite this not being based on all the available evidence and thus, a lack of rational proof. The concept of 'cultural encapsulation' appears to be a more benignly connoted version of ethnocentrism, with less of an emphasis on an inherent malevolent intentionality. It also can be used equally to describe any person or clinician, whereas the 'indictment' of 'ethnocentricity' is without exception, an accusation levelled only at White researchers or clinicians.

It is not possible for any research or work to be totally free of the influence of authors' multiple backgrounds, rather it is important that it is recognised and considered in its correct context. Difficulties arise when this is not acknowledged and the dominant discourse then becomes the privileged and more valued narrative. This is a point made by Patel et al. (2000) who state:

> "The dominant political and economic position of this White Western culture means that its world views, including psychological theories, hold the privileged discourse. Thus, the psychological, behavioural and social processes it describes and attempts to explain have come to represent the norm against which other types can be measured and, often be found to be deficient" (p.36).

Consumers of research are encouraged to show reflexivity in evaluating evidence due to the dominance of largely white western cultures in its foundation; inevitably resulting in the majority of what was considered psychology applicable to all cultures, to be instead, psychology that one must be aware stems from a particular frame of reference and world view.

Generating research with cross-cultural validity

The field of cross-cultural psychology is dedicated to "generating a more nearly universal psychology...that will be valid for a broader range of cultures" (Berry et al., 1992, p.3). These authors argue that for any particular principles to be considered valid for all cultures then they must be tested cross-culturally. They suggest that in order for this to be achieved, the process must comprise of two goals. Firstly, what is termed the "transport and test" goal (Berry et al., 1992, p.3), where ideas and

hypotheses developed from a particular culture are tested in their applicability to others. This is useful in initially gaining an understanding of gross differences between cultures, but is at risk of deriving ethnocentric conclusions if used as the sole research methodology. Specifically, this may be prone to cultural biases as formulation of questions in this way may limit discovery of psychological phenomena, which are important in another culture. Subsequently, there is also the second goal of exploring other *cultures in order to* discover *psychological variations* that are not present in one's own limited cultural experience.

This second goal liberates psychologists to be open to novel aspects of behaviour and to look at phenomena within a context. For example, stigma is clearly not a concept applicable only to Chinese populations (Komiya et al., 2000) but its impact on help-seeking and experience of help is likely to be influenced by a number of factors relating to its specific contextual meaning. For instance, cultural acceptability thresholds (what behaviours are considered stigmatising), its meaning (for self, others and the community at large), and its social consequences (extent of withdraw or ostracisation) could be hypothesised to have a potentially different type of impact on the therapeutic process experience for Chinese and White clients.

Positions in cross-cultural work: Relativism, absolutism and universalism.

The issue of the development of culturally appropriate practices is contained within a wider ideological framework. This relates to the adoption of either relativist, absolutist or universalist positions in understanding the aetiology of variation and consequently, appropriate methodology to study cross-cultural differences. These positions are broadly separated by their emphasis on 'etic' or 'emic' stances. An 'etic' stance is based on an assumed cross-cultural applicability of concepts derived in one culture (which has typically been that of Western societies). An 'emic' stance is based on an assumed cultural uniqueness (A.T.A. Cheng, 2001).

The relativist position has foundations in the ethnographical-anthropological ideas of Frank Boaz, 1911 (cited in Berry et al., 1992), who sought to understand other people on their own terms; avoiding ethnocentrism through reliance on emically derived information without imposing any *a priori*

judgements of any kind. This position seeks to avoid an evaluating-comparative stance, i.e., describing and categorising others from an external cultural view. Thus, the contribution of culture in behaviour is seen as substantial. Theoretically and methodologically, context-free definitions of concepts and their subsequent measurement are considered impossible and local instruments are used in assessment procedures. The derivation of similarities is not the aim of this approach, with comparisons between cultures usually avoided.

Diametrically opposed to this position is that of the absolutist, which focuses more on the homogeneity of psychological phenomena across cultures and "the possibility is ignored that the researchers' knowledge is rooted in their own cultural conceptions of these phenomena" (Berry et al., 1992, p.258). Factors underlying behaviour are seen mainly to be biological, with culture exerting a limited influence. Theoretically, similarities are seen to be due to species-wide basic processes with differences mainly due to non-cultural factors. Research is derived from a stance of imposed etic, and context-free definition of concepts and their measurement are seen as available and usually possible. Therefore, standard instruments are used in assessment and frequent evaluative comparisons are made. Biases are seen to be more prevalent in this approach as concepts and procedures are standardised and merely translated to be applied in another culture.

The universalist position is one that accommodates elements of relativism and absolutism. It accepts that while basic psychological processes are likely to be common, their manifestations are likely to be influenced by culture. Factors underlying behaviour are therefore seen as biological and cultural, with culture having a substantial influence and differences seen as a product of culture-organism interactions. Information is gleaned through a derived etic stance; namely that "universally applicable concepts will have to come about by reformulation of existing concepts" (Berry et al., 1992, p.258). Context-free concepts are seen as difficult to achieve and often impossible to measure. Thus, adapted instruments are used to assess and comparisons are made but from a non-evaluative stance.

In the relativist position, differences are typically interpreted qualitatively, i.e., people differ in their form or style of intelligence rather than in intellectual competencies. In contrast, the absolutist position assumes similarity and where differences do occur, they are quantitative differences on the assumed underlying common construct; different people are just 'less or more intelligent' (Berry et al., 1992). The major aim in the universalist position is to understand the extent and ways in which cultural variables influence behaviour. Quantitative comparisons can be made between cultures that share the same conception and expression of a particular phenomenon. "Differences that are of a qualitative nature require theoretical analysis to define a common dimension on which they can be captured as quantitative differences before a comparison can be made" (Poortinga, 1971; cited in Berry et al., p.258).

Universalism and this thesis

This thesis adopts a universalist theoretical methodological approach and takes an exploratory, curious stance for exploring the way Chinese cultural values may influence the experience and process of therapy. I acknowledge and accept the current epistemological limitations to the existing evidence base, yet also appreciate its benefits in generating ideas, skills, theories and therapies that have been crucial in the advancement of therapeutic services to other populations. In doing so, I attempt to justify my universalist position by stating that I do believe that inherently there will be some aspects of what is known that is likely to be widely applicable but that there must also be aspects that may require modification or in some cases complete reformulation.

Rationale for the present study

Minority ethnic groups underutilise mainstream NHS mental health services with Chinese communities, in particular, under-represented. Although research has delineated broad value differences between eastern and western societies, it is unclear as to how these may affect the therapeutic process. There have been numerous calls for changes in practice so as to reduce differential service use. The investigation of the way culture affects psychological phenomena and therapy is a relatively new

direction for the field of clinical psychology. It evolved out of epistemological concerns that have framed issues of the limitations in generalisability of current psychological theories and models. Cross-cultural psychology offers different theoretical positions from which new theories may be generated. Existing literature certainly shows potential differences in the conceptualisation of distress, help-seeking behaviour and elements of the therapy itself, but the whole area governing the interaction of culture and therapy remains under-researched with much still to be learned.

The lack of research relating to Chinese mental health issues in Britain has been acknowledged by Stanley Sue, the leading researcher in Asian American mental health issues (personal communication, January 22, 2003). There have been no studies expressly focusing on the experience of therapy by Chinese clients or views of the therapists that work with Chinese clients in Britain. Given the relatively advanced state of the evidence base in America, there is a corresponding lack of studies sampling actual clients as opposed to students or members of the general Asian American population (Kim & Atkinson, 2002). It is hoped that this study will allow greater insight into *how* and *why* Chinese cultural values may affect therapy, an area that is sorely neglected in existing research. I will be using the terms 'therapy' and 'counselling' interchangeably to mean broadly any therapeutic intervention.

This study is partly phenomenological in its approach as it is interested in gaining a detailed picture of participants' experiences, but it is also guided by theoretical concepts such as stigma and 'face'. An exploratory qualitative approach is being used given the lack of research in this area.

The research questions

This study will be based on detailed accounts on a small number of Chinese clients who have experience of therapy as well as a small number of Chinese therapists that have worked with Chinese clients. The research questions that this study aims to explore are: 'What enabled clients to seek help?', 'What enabled clients to stay in therapy?' and 'How do Chinese cultural values play a role in the therapeutic process?'. Ultimately, the aim is that answers to these broad questions will allow for some tentative directions for how therapists can approach working with culture in therapy.

METHOD

Overview

In this qualitative study, eight Chinese individuals who had experience of undergoing therapy and five Chinese therapists, all of whom were experienced in working therapeutically with Chinese clients, were interviewed about their experiences of therapy. A semi-structured interview schedule was designed for this purpose. Thematic analysis (Boyatzis, 1998; Joffe & Yardley, 2003) was used to analyse the data.

Ethical approval

This study was approved by the Joint UCL/UCLH Committees on the Ethics of Human Research. A copy of the letter of approval can be found in appendix 1.

Participants

Participants were English-speaking Chinese individuals who had or were having therapy or counselling ('client participants') and English-speaking Chinese individuals who had experience of providing therapeutic help for Chinese people ('therapist participants').

Client participants

Several lines of inquiry were made to NHS psychology departments and CMHTs serving boroughs known to have large Chinese populations. Staff members in these settings noted an obvious under-representation of Chinese people accessing psychological services with those that had, being clearly acutely unwell or feeling heavily stigmatised by having to access mental health services. The decision was made to use alternative recruitment strategies as staff members from these teams predicted that recruitment would likely be unsuccessful given the small actual numbers of Chinese people being served and difficulties engaging them with psychological services as a whole. Subsequently, no

participants were recruited through this strategy. Voluntary organisations that provided services specially for Chinese were then contacted (Chinese National Healthy Living Centre (CNHLC), Chinese Mental Health Association, Lambeth Chinese Mental Health Association, Vietnamese Mental Health Association, London Chinese Community Network). The recruitment strategy was further broadened as staff members in these organisations anticipated recruitment difficulties due to the stigmatised nature of mental illness in the Chinese community. Moreover, many of their clients did not show proficiency in or confidence with the English language as a means to authentically express their opinions. It was decided that a parallel strategy to minimise language-based recruitment limitations would be to place advertisements (appendix 2) in the Student's Union of the School of Oriental and African Studies, University of London; the University College London Psychology department; the Chinese National Healthy Living Centre website; and the London Chinese Community Network website. Through contacts made via these advertisements, I was also informed of an internet group set-up especially for Chinese students studying at University College London and consequently sent monthly emails to this group requesting volunteers. The email contained identical text to the paper advertisements.

Inclusion and exclusion criteria

Inclusion criteria were as follows: a) to be able to converse comfortably and fluently using English; b) to be aged between 18-65 years; c) to be currently in therapy or counselling, or to have done so in the last 12 months; and d) to have sought therapy or counselling for emotional or psychological difficulties such as anxiety and depression, as opposed to, e.g. career advice or financial problems. People were also excluded if they had sought help primarily for dependency problems (principally drug and alcohol abuse or gambling addiction) or for severe mental health problems (e.g. psychosis).

Initial telephone contact with respondents included a brief set of screening questions covering the above areas to establish agreement with inclusion criteria.

Characteristics of client participants

A total of twelve people expressed interest in participation and were screened on the telephone. Four people were found to be unsuitable for the following reasons: having a diagnosis of psychosis, having had only one session of therapy two years prior, self-reported lack of proficiency in the English language and one person changed their mind and withdrew without giving a reason. Eight client participants were found to be suitable after the initial telephone screening and were subsequently recruited to the study.

Three participants who were chosen by one therapist were recruited from the Chinese National Healthy Living Centre (a non-NHS charity organisation for Chinese people (Chinese and English-speaking) covering all aspects of health. This was the only voluntary organisation with an established therapeutic service to the Chinese community. Three participants were recruited through advertisements placed in SOAS and a further two were recruited from the advertisements emailed to the internet group for Chinese students studying at University College London. All client participants received therapy from non-mainstream services.

This sample comprised four women and four men. Their ages ranged from 19 to 37 years, with an average age of 27 years. Two client participants described their ethnicity as Hong Kong Chinese, one as Mainland Chinese, one as Taiwanese, one as Malay Chinese and the remaining three simply as 'Chinese'. Six were first generation Chinese, one second generation and one third generation Chinese.

Three of the client participants had expressly sought and were seen by Chinese therapists and the remaining five saw non-Chinese therapists. Four client participants were no longer in therapy; the average length of time since finishing therapy was eighteen weeks. Of the remaining four, one client participant was still in therapy, another was having a 'therapeutic break' and two others had infrequent telephone contact with their therapists. The average number of sessions attended by the group as a whole was nineteen.

Table 1 shows the socio-demographic details of each of the client participants, as well as the problems they had sought help for. Their scores on the Asian Values Scale (AVS; Kim, Atkinson & Yang, 1999), a measure of Asian cultural values, are also presented (this measure is describe fully later in this chapter). The mean score for the whole client participant sample on the AVS was 3.72, which is within one standard deviation of the mean score for first generation Asian samples of 4.28 (SD 0.56) reported by Kim et al. (1999).

Therapist participants

At the same time that enquiries were made to NHS Psychology departments and CMHTs regarding recruitment of client participants, staff members were also invited to volunteer as therapist participants. Staff members expressed a self-perceived lack of experience in working with Chinese clients and did not consider themselves suitable for the study. In fact, most acknowledged a need for training in this area of their clinical practice. It was expected that therapist participants would include both Chinese and non-Chinese participants; however, none of the non-Chinese therapists contacted in this way felt that they had sufficient clinical experience to participate. These non-Chinese therapists suggested that I contact specialist Chinese organisations that they often liaised with regarding the management of Chinese clients on their caseloads.

The recruitment strategy thus, changed from focusing on local NHS services to specialist Chinese community organisations. This resulted in sampling only therapists whom were ethnically Chinese, purely due to the lack of non-Chinese therapists engaged in working with this group. Chinese therapist participants were then recruited through 'networking' or 'snowballing' sampling method (Patton, 1990; Rossi & Freeman, 1993; both cited in Barker et al., 1994). The initial contact was the therapist providing services to the Chinese National Healthy Living Centre. Names of therapists were suggested, as well as other Chinese community oriented organisations. Therapists and organisations were telephoned and individuals were invited to be take part in the study. Via these contacts, further names were passed on as potential participants and telephoned.

Table 1. Client participants: socio-demographic characteristics and AVS scores

Client participant number	Gender	Age	Generation	Educational attainment level	Occupation	Presenting problem	AVS score	Recruitment source	Background of therapist/s seen
1	F	26	First	A-Level	Not working	Depression/ anxiety	5.03	CNHLC	Chinese and Non-Chinese
2	F	19	Second	A-Level	Student	Cultural difficulties	3.67	CNHLC	Chinese
3	F	35	Third	MA	Student	Relationship problems	2.75	SOAS	Non-Chinese
4	F	26	First	BA	Student	Studying and relationship problems	4.56	SOAS	Non-Chinese
5	M	27	First	Post-graduate diploma	Interpreter	Emotional problems	3.53	CNHLC	Chinese
6	M	22	First	A-Level	Student	Perfectionism and studying habits	3.11	Internet group	Non-Chinese
7	M	37	First	Doctorate	Professor	Emotional pressures	4.81	Internet group	Non-Chinese
8	M	35	First	MA	Teacher	Relationship problems	2.33	SOAS	Non-Chinese

Note- The AVS uses a 7-point Likert scale (1= strongly disagree, 7 = strongly agree). Totals are averaged to give the overall AVS value, with higher scores indicating greater adherence to Asian cultural values.

Inclusion and exclusion criteria for therapist participants

Therapists were included on the basis of having a qualification in therapy or counselling, having a 'reasonable' length of time in clinical practice with Chinese individuals (one therapist was excluded due to having seen just one Chinese client), and being experienced in dealing with mental health difficulties such as anxiety and depression.

Initial telephone contact with therapists expressing interest to participate in the study included a brief set of screening questions covering the above areas to establish agreement with inclusion criteria.

Characteristics of the therapist participant sample

A total of ten names were suggested for participation and these people were telephoned and invited to take part in the study. Those that expressed interest in participation were then asked the brief list of screening questions. Two people were found to be unsuitable: one had no experience working as a therapist, and the other had no therapy/counselling related qualification. Two therapists said they were too busy to participate. This gave a total of six therapists. I was unable to screen one therapist participant (TP4) due to the constraints of the organisation for which they were working. I thus relied on information gleaned from a manager. During the course of the interview, it emerged that the therapist did not have sufficient experience working with Chinese people or mental health difficulties in general. The data from this interview was excluded from the study. The remaining five interviews thus comprised the data used for analysis of therapist participants accounts.

The final sample of five therapist participants consisted of four women and one man. Their ages ranged from 30 to 62 years, with an average of 44 years. Two described their ethnicity as Hong Kong Chinese, one as Taiwanese, one as mixed (Chinese-European) and one simply as 'Chinese'. All therapist participants were first generation Chinese. The average score on the Asian Values Scale was 3.66, which is within two standard deviations of the mean score for first generation Asian samples (4.28, SD 0.56). This suggested that the therapist participant sample showed less adherence to Asian cultural values than the client participant samples. Four therapists had experienced working in both

NHS and non-NHS settings. The number of years working as a therapist ranged from two to more than 30, with an average of ten years. Two therapist participants were not currently working as therapists but had done so within the last 6 months. The problems that the therapist participants commonly dealt with were reported as: 'emotional'; 'depression and schizophrenia'; 'family'; 'relationships, mental illness and behavioural problems of children'; and 'depression, anxiety and phobia'. Table 2 shows the socio-demographic details of each of the therapist participants, their theoretical orientations, number of years working as a therapist and scores on the Asian Values Scale.

Procedure

Client participants who met inclusion criteria and agreed to participate in the study were sent a covering letter (appendix 3) and information sheet (appendix 4 for client participants & appendix 5 for therapist participants) outlining the overall aims of the study and what exactly participation involved. This was followed up by a telephone call to answer any questions the participants may have had.

The majority of the interviews took place at University College London, sub-department of clinical health psychology. Two took place at the Chinese National Healthy Living Centre in Birmingham (one client participant had recently moved from London to Birmingham and one therapist was mainly based in Birmingham); one took place at a client participant's university and two at therapist participants' places of work. Convenience was the only reason for the use of these different locations.

On arrival, client participants were reminded of the study's focus on respondent's thoughts and feelings about their experience of therapy or counselling and that the interview was semi-structured. They were told what would happen during their visit, assured of the confidentially of their data and asked to sign a consent form (appendix 6). Participants were told that if they decided to take part in the study they did not have to answer all the questions and that they could withdraw at any time.

The procedure started with the participants providing written demographic information (appendix 7, for client participants and appendix 8 for therapist participants) and the Asian Values Scale (described

Table 2. Therapist participants: socio-demographic characteristics, theoretical orientation, number of years working as a therapist and AVS scores

Therapist participant number	Gender	Age	Generation	Educational attainment level	Current occupation	Theoretical orientation	Number of years working as a therapist	AVS score
1	M	62	First	Degree	Therapist/manager	Problem-focused therapy	>30	3.67
2	F	37	First	A-Level	Manager	Person-centred therapy	2	3.36
3	F	30	First	Post-graduate diploma	Student	Person-centred therapy	5	5.22
5	F	45	First	MA	Family clinician	Family therapy	9	2.69
6	F	44	First	MSc	Nurse lecturer/ Psychotherapist	Cognitive-Behaviour therapy	5	3.36

Note- The AVS uses a 7-point Likert scale (1= strongly disagree, 7 = strongly agree).Totals are averaged to give the overall AVS value, with higher scores indicating greater adherence to Asian cultural values.
The data from therapist participant 4 (TP4) was excluded from the study.

below). This measure was given prior to the interview in order to avoid participants' responses being influenced by the material arising from their interviews. Participants then took part in a semi-structured interview (described below).

Following the interview, time was left for the participant to ask any questions, and to comment or give feedback on any aspect of the study. The participants were given a debriefing reiterating the aims of the study and I stated that should the interview have brought up an unwanted issues, that I suggested they re-engage with their therapist. No participants reported having experienced the procedure as unpleasant in any way; the majority reported it as having a positive effect on their mood. Several showed interest in being informed of the outcome of the study. A payment of £7.50 was made to all participants.

Asian Values Scale, Kim, Atkinson and Yang (AVS; 1999)

Overview

The Asian Values Scale (appendix 9) is a self-report questionnaire measuring Asian cultural values. It consists of 36 items, and uses a 7-point Likert scale (where 1=strongly disagree and 7=strongly agree).

Its development involved several stages. Firstly, the authors generated a list of Asian cultural values via methods recommended by Crocker and Algina (1986). This involved reviewing the literature, conducting a nationwide survey of Asian American psychologists, and arranging three focus group discussions. To identify the most culturally-representative statements the authors then compared the responses of 303 first generation Asian Americans and 63 European Americans (all students recruited from two large universities). Consequently, the items that differentiated between these two groups were retained. Factor analysis yielded six factors: conformity to norms, family recognition through achievement, emotional self-control, collectivism, humility and filial piety. The internal consistencies were then calculated for the entire scale and for each of these six sub-scales, yielding co-efficient alphas of 0.81 and 0.77, 0.72, 0.52, 0.56, 0.55 and 0.44, respectively.

The scale received confirmation of internal consistency from a following study using 399 Asian American college students (from two universities). A confirmatory factor analysis indicated that the scale was a good representation of the two-dimensional construct of acculturation (values and behavioural) and provided concurrent validity for the AVS (via comparison with items from the Individualism-Collectivism Scale, (INDCOL; Triandis, 1995) and the Suinn-Lew Asian Self-Identity Acculturation Scale, (SL-ASIA; Suinn, Rickard-Figueroa, Lew & Vigil, 1987; cited in Akutsu et al., 1990). The low correlation of 0.15 between values and behavioural acculturation also provided evidence of discriminant validity for the AVS.

Scoring

The AVS is scored by totalling the responses and calculating an average. Half the statements are worded positively, i.e., high scores indicates greater adherence. Half the statements are worded negatively to avoid an acquiescent response set, i.e., high scores indicate lower adherence. Possible scores range from 1 to 7 with largest scores indicating greatest adherence to Asian cultural values. Half of the statements are reversed in their direction to reduce acquiescence. The only available norms for the AVS are as follows (Kim et al., 1999): first generation (n=155), mean of 4.28 (SD 0.56); second generation (n=118), mean of 4.30, (SD 0.62); and third generation or higher: (n=18), mean of 4.15, (SD 0.71).

Rationale for use

The AVS was used as a means to describe the sample of participants along a cultural value dimension. This was done in order to provide a means of comparison to other samples and help the reader situate the sample. This scale was judged to be the most contemporary and most rigorously tested scale available for the purposes of this study. The only other potential scale was the Chinese Values Scale (CVS; Chinese Culture Connection, 1987) which lacked non-subjective definition of the concepts of study and was based mainly on the views of four Chinese social scientists. Moreover, the student sample that the AVS was validated on also showed similarities to the anticipated client sample

likely to volunteer for this study, whereas those that the CVS used would be more likely to correspond to an older generation cohort.

The interview schedules

Two semi-structured interview schedules were designed, one for the client participants (appendix 10) and one for the therapist participants (appendix 11). I developed both schedules drawing on published guidelines for semi-structured interview schedules (e.g. Smith, 1995) and in consultation with another researcher with extensive experience in qualitative research. The schedules served as guides and were flexible enough to allow the exploration of novel areas arising during the course of the interviews. The vast majority of the questions were 'open', with 'closed' questions and reflections being used to clarify responses from participants. The interviews lasted approximately one hour and were audiotaped.

The interview schedules were modified at several points during the research process in response to observations. Interviewees found some questions very difficult to respond to without resorting to more abstract, prototypical responding and as such seemed to give answers that were too removed from their actual experiences. Typically, the questions that fell into this category were ones that explicitly canvassed opinion on what or how Chinese values affected therapy. Often interviewees would find it difficult to express this explicitly and then tended to then give their best guess without being able to substantiate their response with examples. A decision was made to focus more on interviewees giving examples and elaborating in depth about the helpful or unhelpful aspects of therapy, which they had experienced, and I would then speculate on the cultural values that seemed to be evidenced in those scenarios. Each interview had several sections, which are described below.

The client participant interview schedule (appendix 10)

The main aim of this interview was to obtain a detailed picture of how the client participant had experienced therapy. Their thoughts and feelings pre-, during and post therapy were explored. The interview schedule contained four sections:

History of contact: This initial section had the dual purpose of establishing a rapport with the client and elicited information regarding the enabling process that occurred which allowed the client participants to seek help.

Relationship with therapist: The aim of this section was to find clues as to what factors enabled the clients to build helpful therapeutic relationships and stay in therapy. Particularly, those relating to any potential differences as compared to conventional notions about robust therapeutic alliances, i.e., Bordin (1976).

What has been un/helpful in therapy: The aim of this section was to elicit ideas around potential factors that may increase or decrease the likelihood of drop out and to establish whether these could have any connections to Chinese cultural values.

General cultural issues: This section was included to seek opinion on salient cultural concepts that may not have been spontaneously mentioned by the client themselves but may have been pertinent to their experience of therapy. It was felt that because the interviews relied on a reconstructed memory of their experiences that participants could not be expected to spontaneously recall all concepts that were potentially salient in their experiences. This section was intended to provide prompts to cue recall and care was taken to offer concepts in a way as not to lead participants into a perceived 'right' way of responding.

The therapist participant interview schedule (appendix 11)

The aim of this interview was to obtain a detailed picture of therapists' experiences when working with Chinese clients. This schedule contained four sections:

Therapist background: This section aimed to establish rapport with the therapist and get an idea of the context from which they approached their work.

What is helpful in therapy: It was hoped that this section would gently guide the therapist to talk about anything, which they felt may impact on building a relationship and maintaining a client in

therapy. Particularly, care was taken to probe into ways the therapists implicitly conceptualised what an effective alliance would need to include and to see if they considered there to be pertinent differences in this compared to non-Chinese clients that they work with.

What is important to know when helping Chinese clients: The aim of this section was to allow the therapist to focus solely on the possible differentiating factors in their work with Chinese and non-Chinese clients. This section was kept deliberately broad as to enable concepts or ideas novel to the researcher to emerge.

General cultural issues: The aims of this section were the same as that for the client participants.

Qualitative thematic analysis

The interviews were transcribed and then analysed using procedures of thematic analysis (Boyatzis, 1998; Joffe & Yardley, 2003). This process involves identifying patterns or themes in data in a systematic and rigorous way. These themes are analysed and their meaning related to the context from which they arose. The themes may refer to the manifest content of the data or they may be latent, with their presence implied rather than directly observable.

There is a distinction between deductive and inductive coding. In the former, the researcher draws from existing theoretical concepts and in the latter the themes are derived completely from the data itself. Although this separation exists, it is acknowledged that no theme can be purely deductive or inductive (Joffe & Yardley, 2003). The analysis I employed included elements of a deductive, as well as inductive approach. Specifically, the researcher was aware of the major cultural values and concepts that could potentially impact on the participants' experiences and very often these would be values that the participants themselves would relate to existing concepts. More often, however, I classified themes as they emerged from the participants' accounts. All themes were then clustered into higher order domains.

Analysing the data using both deductive and inductive coding methods was beneficial in different ways. Deductive coding allowed the researcher to compare the experiences of participants with existing literature, i.e., looking at how participants understood and experienced identified concepts had the potential to add or refute their bases, e.g., stigma and its effects. Inductive coding allowed novel and unexpected links to research, i.e., often when participants elaborated on their experiences unexpected connections were made (explicitly and latently) linking concepts of interest, e.g., stigma and the importance of language; additionally it was also the case that totally novel and unprecedented concepts emerged from the data which I then labelled.

The thematic analytic process involved the following steps:

1. **Generating a 'gestalt':** A very brief two-four sentence summary impression was written after each interview in order to help recollection (see appendix 12 for an example).
2. **Transcription:** All the audiotapes were transcribed by the researcher as a means to increase familiarity with the data (see appendix 13 for an extract of an interview).
3. **Re-reading of transcripts:** The transcripts were read over several times to further increase familiarity with the data.
4. **Deciding on a codable 'unit':** Boyatzis (1998) and Joffe and Yardley (2003) both state that a codable 'unit' is not prescribed, rather it is decided by the researcher on the basis of best fit with the data and its ability to capture the richness of the phenomenon. Based upon this idea, I decided that a codable 'unit' would not be based upon physical criteria e.g., each line of text or sentence, but would instead constitute data (of varying length) that conveyed a particular meaning or concept.
5. **First order themes for each interview identified:** First order themes for each interview were identified through making notes on the right hand margin of the transcript. Excerpts of interest were then pasted onto a table and assigned a theme label. Tentative connections of the themes to Chinese cultural values were also noted. These connections were not necessarily all affirming a consistency with available literature; in fact, often an excerpt could be

consistent and inconsistent with different Chinese cultural values (see appendix 14 for an example)

6. **Clustering the first order themes for each interview:** Once all excerpts had extracted, labelled, with tentative connections noted, all the emerging first order themes were then clustered into second order themes. Specifically, the themes were written on a piece of paper and I made decisions as to which themes seem to correspond closely with each other (i.e. expressing similar ideas or concepts) and then decided on a second order theme label that best captured the essence of the meaning conveyed by those themes (see appendix 15 for an example).
7. **Generating a visual representation of the second order themes:** A visual representation was made of the second order groupings as to illustrate perceived relationships between them (see appendix for 16 an example).
8. **Looking for commonalities across all interviews:** The visual representations were used as a useful shortcut summary of the analysis of each interview to look at similarities across participants. Additionally, this stage also provided an opportunity to check whether first order themes and second order themes given the same labels were consistent with each other in content, in different interviews.
9. **Looking for differences across interviews:** Second order themes that were less represented across interviews were identified. A decision on whether to include these categories in the final domain-classification was based on their importance in adding additional significance to the research questions.
10. **Summarising the data using domains:** Broad domains that accommodated and organised the categories were generated as an overarching clarifying framework. These domains and their themes were then tabulated and used as a means to summarise the analysis (see Results chapter).

Throughout the thematic analytic process credibility checks were employed to ensure as much as possible, that the analysis was coherent and reliable. Firstly, as a form of test-retest reliability, I

identified themes in one interview and then repeated this process on the same interview, one week later. This process does not of course ensure the 'objectivity' of the themes identified, merely it gave a benchmark as to whether theme distinctions were clear in my mind (Joffe & Yardley, 2003). It was found that themes were consistently identified. Secondly, the process was made transparent to other people, namely a researcher with experience of qualitative methods and another trainee clinical psychologist. Rationales for first and second order theme labels were discussed and some modified as an outcome of discussions. Finally, the domains were developed together with the aforementioned researcher.

Researcher's perspective

I am a 26 year old, second generation British-born Chinese woman raised and schooled in London, England. I come from a Hakka Chinese-speaking family from Hong Kong. I am not fluent in any Chinese dialect. My parents migrated to England in the 1970s and have worked mainly in the Chinese catering trade. I attended mainstream schools and for a brief time also attended Cantonese Chinese school. I have been influenced by topics covered by my undergraduate degree program such as cross-cultural psychology, anthropology and archaeology.

I have a long-standing interest in the influence of culture on experience. I describe my theoretical orientation as primarily influenced by systemic and cognitive-behavioural therapies, with an additional, less significant influence of psychodynamic thought.

I was not previously familiar to the research sample although had personal experience of issues relating to identity that some client participants' spoke about. I expected that recruitment would be difficult due to knowledge of the pronounced influence of stigma about mental illness in this community but my ethnicity would serve as a factor increasing the likelihood of volunteering. I anticipated that the research would provide a way of connecting cultural theory and therapeutic practice.

Other pre-conceived ideas regarding the study and its potential findings were that I expected that interviews would be difficult to conduct and that interviewees would need a lot of prompting to engage in talking about their therapeutic experiences. I expected to find in the client accounts many references to a sense of personal and familial shame. I also expected that client participants would report feeling confused by the format of western psychotherapy. From therapist participants I expected numerous references to expectations of expertness, directiveness and the necessity for the therapist to convey a sense of certainty in advice and suggestions given to clients. I also expected therapist participants to represent themselves as quasi-parental figures.

RESULTS

This chapter will present the results of the thematic analysis. Firstly, I will address the themes in the client participant accounts, which were clustered into the domains of 'What attitudes do I bring to therapy?', 'What is the purpose of therapy?', 'Does culture matter?', 'What is the role of the therapist?', and 'What did I get out of therapy?'. I will then present the themes in the therapist participant accounts, which were clustered into the domains of 'What attitudes do I as a therapist bring to therapy?', 'What do I do as a therapist?', and 'What is most important in helping Chinese clients?'.

Client Participant Accounts

Analysis of the transcripts of the client participants' accounts yielded 12 themes (see Table 3). These were clustered into five domains, which were largely determined by the topics covered in the interview. The themes are not intended to be mutually exclusive: some overlap exists between themes.

This section presents each of the themes in turn, illustrated by excerpts from the interviews. Where editing has occurred, three dots "..." represents this. Long pauses are represented by five dots ".....". Words that were spoken with special emphasis by the participants are italicised. Linguistic or grammatical errors that occurred naturally in the speech of the participants were not edited. Where dialogue is presented, "I" refers to interviewer and "CP" to (client) participant. The source of each quotation is indicated by the participant's research identification number.

Table 3: Client participant accounts: Domains and themes

Domains	Themes
1. What attitudes do I bring to therapy?	A spirit of inquiry: Curiosity and openness
	'I know there's a stigma but I want to try it anyway'
	Ownership of the problem
	Ownership of the outcome of therapy
2. What is the purpose of therapy?	A journey of discovery
	Fitting the jigsaw together: Finding coherence
	A safe place to 'purge'
3. Does culture matter?	Cultural encapsulation vs. cultural containment
	Cultural liberation
	'What's culture got to do with it?': Culture has no role
4. What is the role of the therapist?	The universal therapist
	Therapist as a friend
	Therapist as teacher
5. What did I get out of therapy?	'I found me': A discovery of identity

What attitudes do I bring to therapy?

Participants' attitudes towards therapy were characterised, quite strikingly, by an overriding 'spirit of inquiry': they seemed to approach therapy with curiosity and openness. This theme was strong despite the majority reporting varying degrees of the impact of stigmatised views on seeking help for their problems. Having a belief in emotions as universal and natural seemed to be a major factor in reducing the potentially obstructive influence of stigma. Another distinct characteristic of the accounts was the idea of ownership. This not only applied to an explicit ownership of the problem but also of the outcome of therapy. All of the participants displayed a strong internal locus of control and a sense of obligation to the process of helping themselves.

A spirit of inquiry: Curiosity and openness

All participants described viewing therapy in a curious and interested manner. They appeared to approach the process with open minds.

> "I never see therapy, counsellor before. Because I was very depressed and stressed I think I should speak to counsellor to *try* to see how it's going...it would be a bit *interesting* to speak to counsellor...I just *talk* to somebody understanding." (CP1)

> "I just wanted to have a *try* for whether to see whether I could get help there, and give me some advice or help.....solutions...I feel it's a little *interesting.*" (CP4)

> "I don't know whether they can help me, I just wanted to go and see anyway, just to have a try...I want to show my *curiosity.*" (CP4)

The sense of openness to therapy was also seen in participants' candidness in disclosing their feelings to their therapist. As one participant said, "I told her about what is happening, what I *feel*, what I hope

in the end. I told her.....I say *everything,"* (CP1), with another saying "I kind of gave myself in really," (CP8).

Many participants conveyed a lack of expectations of therapy: "I don't have preconcept or how or what the counselling will be or the quality whether it be high or low, no idea" (CP7) and "I didn't have any expectations of how the counselling sessions would turn out, I just went" (CP6).

'I know there's a stigma but I want to try it anyway'

All participants expressed an awareness of stigma. Commonly, they explicitly located the origin of the stigma in culturally-based notions that tended to link help-seeking to ideas of personal, familial and ancestral weakness. The nuances of this impacted on each participant in varying degrees. All seemed able, however, to view stigma as a flawed belief; this conclusion appeared to originate, in part, from believing that emotions were natural and the need to express them as universal.

The personal impact of stigma. Several participants spoke about how they felt help-seeking was likely to reflect negatively on them personally. At times, participants expressed their own ideas about the views of Chinese culture through third person terms such as 'others' or 'they'. This seemed to have the dual purpose of brevity and of providing distance in speech, that also mirrored a kind of psychological dichotomy (or schism) existing within the participants themselves:

> "You shouldn't talk to anyone else, otherwise they will think differently about you or they might put you down or something...they feel that you see a counsellor, you don't have a sense of understanding or controlling your emotions...it means that they are not a very strong person and are actually extremely weak." (CP2)

> "If I tell them that I go to a counsellor...I think maybe others will think I'm not so capable, I can't deal with my own feelings and life. I think I don't want others to know...I think I still have

the common.....common sense of Chinese people.....so we, yes.....that I feel a little strange if I told my Chinese friends." (CP4)

One participant also spoke of having to conceal the fact that she was seeking help from her parents:

"...because my parents disagree with seeing counsellors because they find it.....someone with *'mental problems'*, so if they found out then I wouldn't be able to see a counsellor, so I had to go counselling secretly." (CP2)

Another also spoke of the outright rejection he experienced when confiding in his parents that he was seeking a therapist:

"When I sought help inside the family, a very innocent and *stupid* thing to do...I said to them I'm so depressed, I don't know what to do and that upset my father a *great* deal...he shouted 'you think you have problems, you have *none!*'...that's how he sees the world, we are all robots, we don't have any emotions." (CP8)

Having to seek help seemed to be connected to a sense of being personally bereft, a loss of self-efficacy and purpose:

"...you have no control, you don't know anything...you're just this person who is there but empty...who can't make decisions...people look down on them in a way that they are not good enough to be in the society to be *useful*." (CP2)

Furthermore, some also emphasised the enduring nature of being labelled as 'mad' or 'mentally ill':

"...they would be like you know *'oh you mad person'*, as in completely *'looney toon'*...they don't see a therapist as somebody who can actually help resolve your problems, it's more like

you've got mental health problems as in you're *mad*.....ummm that is why you see a therapist." (CP3)

"...being *'mentally ill'* it's for life that's it, it stays with you." (CP2)

The behavioural consequences of the stigma, through labelling, were described mainly in terms of social isolation:

"Chinese people would treat them more differently...they stay away from you...emotionally they keep a distance from you.....they would set you aside." (CP5)

Although all spoke freely about their explicit ideas about stigma, it was also the case that many showed evidence of the latent effects of stigma. For instance, some talked of taking a long time to seek help, being embarrassed about seeking help and not disclosing this fact even to close friends:

"Actually when I went to him for that kind of help, I did it in a roundabout kind of way.....not straight away yeah.....gradually.....yes it was a gradual process (laughs)." (CP7)

"...nobody knows that.....uhmm.....I don't want them to know...I think I feel a little embarrassed, if somebody or maybe some friends.....ummm.....know that I seek help from counsellor." (CP4)

The familial and ancestral connotations of stigma. When participants talked about the familial or ancestral connotations of stigma, they all indicated an idea of 'karma': a feeling that others perceived them as paying for wrong doings or deficiencies of their family members (alive or deceased). Connected with this appeared to be superstitious lay ideas relating to spirits, gods and luck.

"...they label a person with mental illness 'it must be a bad guy...must've done bad things'."(5)

"...its family loss of face...that they weren't there when they were really needed really." (3)

"...It's a curse in Chinese culture (mental illness).....or it's shameful...they believe anything that can bring them luck, they believe in a lot of different gods...they go to the temple and pray...they believe in devil as well...they believe there is a price to pay." (5)

Stigma as a 'flawed' belief: Emotions are natural and need to be expressed. All participants, either explicitly or implicitly expressed the view that cultural views on controlling emotions as a sign of personal strength, did not feel right to them. They often spoke of being taught not to express any emotions and feeling suppressed by this. None of them voiced opinions that to actually have emotional responses was in any way wrong; rather they felt that their inherent need to do this had been curtailed. Many participants saw early learning experiences as having fundamentally impaired their ability to recognise and articulate their emotions.

Talking about and expressing emotions was accepted by the participants as 'normal' and useful in relieving their distress: "...I just want to expression to somebody...I think it is important to talk about my feelings." (CP1) and "Chances to talk to people became less and less. That is when the psychological burden became heavier and heavier." (CP7)

Some conveyed having fought against cultural taboos to be able to express their 'right' to talk about their emotions:

"My parents...they actually don't allow any kind of talk about emotions in the household not even happiness...they just didn't approve of any kind of emotions...you are supposed to live

like a robot...human beings are emotional creatures after all so that's how I started therapy." (CP8)

"There is certainly emotional suppression and it's something I've experienced and seen in a lot of people around me." (CP6)

"...that is one side of the Chinese culture I really hate, the denying human feeling." (CP8)

"Its discrimination against people who have mental issue to deal with and let's face it everyone has mental issues but we are just not encouraged to deal with them." (CP6)

"I have a better emotional vocabulary in English because Chinese culture doesn't encourage emotional openness certainly not among men...we are expected to be strong, to be cold." (CP6)

As well as those who had found it somewhat of a struggle to break free from unwanted social expectations, there were also those who seemed to discard them with apparent ease and conviction:

"I think it [stigma] is wrong because you have problems that is why you go and see a therapy. If you don't have any problems, you don't need to go and see a therapy. You see, you know? What do you care about? The therapy they are working for that." (CP1)

"I don't think it would be a kind of face problem to ask someone for help. I don't think that there is a close relationship between face problem and asking for help." (CP7)

Ownership of the problem

Regardless of each participant's view of whether their therapy had been successful, all accounts were notable by the way participants 'owned' their problem. They displayed a strong internal locus of control

in dealing with their problem, even in cases where there was clearly an external trigger or cause of their distress:

> "I know she just going to listen, the matter is *me*, *I* am going to sort out...I think she might be give me some ideas, some advice. That's all." (CP1)

> "...by then I had stopped thinking it was all the other person's fault...I didn't think that way anymore so that is why I wanted individual therapy." (CP8)

> "I think.....ummm.....the problem.....is my *own* problem." (CP4)

This view of owning the problem seemed to be positive, engendering an ability to help themselves. This was contrasted with the social expectation of being able to resolve psychological issues on their own, which participants seemed to perceive as oppressive and disempowering:

> "Basically if there's a problem then it *should* be solved by yourself and *not* anyone else you shouldn't talk to anyone else." (CP2)

Ownership of the outcome of therapy

Having a clear idea of ownership of the problem seemed to lead naturally to an ownership of the outcome of therapy. Many assumed responsibility for ruptures in the therapeutic process whilst others were happy to talk of whether 'the therapy' worked or not. Even if therapy had been perceived as unhelpful, none of the participants blamed the skill of the therapist. This attitude also applied to those who were still seeing their therapist.

Ownership of the outcome appeared often to be linked to a sense of obligation, on the part of the participants to their role in the client-therapist dyad and to the process of therapy itself. As one participant said, "I used that 50 minutes a week as my chance to explore safely..." (CP8). Another

commented, "If I couldn't overcome then that would be a failure of the whole therapy I think, right?" (CP7).

Participants who conveyed dissatisfaction or disappointment with aspects of their therapy were keen to assume responsibility for this:

> "I think it was my expectations." (CP3)

> "...because I wasn't prepared to go the next step." (CP2)

> "There are different types of psychologist I think, even psychologists, they are people themselves...there are some different types of psychologists for some types of people. I think maybe, maybe she's not my type – I don't know." (CP4)

Assuming responsibility appeared to be linked to a sense of obligation, of being a 'good' client and fulfilling the expectations of the client role. One participant described what he understood to be the reasons for not continuing therapy, in the context of the therapist showing a lack of empathy:

> "...my feet became very heavy (laughs) and that's a bad faith...that's one of my failures...I always start something then give up half way...maybe it's a kind of fear of freedom, when you want to do something but don't want to work hard...I had bad faith you know, more to do with me, nothing to do with [name of counsellor]." (CP5)

What is the purpose of therapy?

Many participants could not state explicitly what they expected of therapy. However, three major functions of therapy were identified by participants. Some spoke of a 'journey of discovery' typified by gaining learning and insight. 'Discovery' appeared very much linked to understanding themselves and

becoming better at articulating their inner emotional world. Closely related to this was the theme of finding coherence in their narratives, an idea of 'fitting the jigsaw together'; perhaps what clinicians would recognise as a formulation. They all spoke about the way therapeutic space gave them time to 'purge' their inner worlds in an environment of safety and respect. For one, this was the sole purpose of their therapy. Within this domain, the emergent themes showed a high degree of overlap.

A journey of discovery

Several participants expressed very strong views about therapy allowing deeper understanding of themselves and their emotions:

> "It [the therapy] was really opening new ways for me to see my life. I could talk about my emotions and thoughts all the time and all the time I was developing a better understanding of myself which was very useful." (CP6)

> "He would recognise my emotions...resurrecting I would say [emotions]...I think there was always an emotional side to me but it had been submerged for some reasons, for some time...my emotional world was re-awakened." (CP6)

Fitting the jigsaw together: Finding coherence

Clearly, therapy seemed to have allowed a synthesis of participants' current feelings into a wider context, allowing a sense of coherence to emerge from their narratives. Participants were able to develop formulations of their problems:

> "Now I *understand* why my parents do these things and why I can now not feel guilty about feeling very angry at them." (CP2)

"I think he was just showing me the bigger picture...because as I spent time unravelling the whole problem with my counsellor, I had a better understanding of myself, my character, my principles and beliefs and also of my, how my past has shaped me." (CP6)

"She talks about an *overall picture* of my fuck-ups." (CP8)

"I would say that talking is a process when you are re-arranging your thoughts, you just like, how you say.....just like a fragmentation, defragmentation, I mean of your brain you know if you compare it with your computer system." (CP5)

These formulations allowed participants to generate ways of coping with their situations differently:

"Now when I have 'the rage', I *know* its to do with *the past.* The rage comes from the toxic behaviour of my parents...*not* this specific person or time so that understanding *helps me control* the rage better." (CP8)

"...having more understanding about solving my problems than just being totally angry and not understanding and feeling really really depressed and feeling guilty." (CP2)

A safe place to 'purge'

All participants valued the chance to 'purge' their feelings:

"I could go and pour out the contents of my heart each week and I could go to him without the fear and in the secure knowledge that he would respect and appreciate my feelings." (CP6)

"I have way too much shit to have to let out for just my friends to cope with and yet I have to let it out...all of a sudden there is so much shit that I just go 'get it out get it out'." (CP8)

For some participants, 'purging' represented the sole restorative function of therapy:

> "You needed to speak to somebody, even just...I just want to expression to somebody" (CP1)

> "My main purpose was to talk and I find talk was a very good way to release...the more I talk to him the more relief or release I had, so I think that is good." (CP7)

Conversely, another participant expressed latent frustration that therapy had not moved on from simply letting her feelings out or led to useful insights in managing her difficulties:

> "It is good to 'air' [your problems]...you know you need *friends* to 'air' things.....she didn't really suggest that much so I don't really have much to go on.....I did more of the talking.....I wouldn't say there was anything else." (CP3)

Does culture matter?

This domain was in many ways the crux of the study. Three main themes emerged. For some participants, their experience of therapy had clearly been hampered by a lack of cultural knowledge and empathy from their therapist. This seemed to be very similar to the idea of 'cultural encapsulation' presented in the introduction chapter. Congruently, there were those who reported great benefits from seeing a therapist from their own cultural background. Another distinct theme was related to a sense of 'cultural liberation' made possible from being able to engage and talk to a non-Chinese therapist about their difficulties. The final theme that emerged in some participants' accounts was cultural values having no relevance on the therapeutic experience. They were also those who had used therapy solely for its 'purging' function.

'Cultural encapsulation' vs. cultural containment

Some participant accounts made explicit reference to the therapist having not understood the impact of their worries and they related this clearly to the 'cultural encapsulation' of their therapist (therapists they referred to were all non-Chinese). One participant described being caught in a dilemma between balancing a new relationship with her studies, a difficult position possibly due to the presence of two competing highly prized values in Chinese culture: that of obligation to relationship roles and academic achievement. She referred to the therapist as being unable to fundamentally grasp her context and the cultural inflections of the problem she went for help with:

> "I think understanding, at first that is the most important thing...the reason why I stopped...I think gradually, that she couldn't, she can't understand me...it seems she couldn't understand what I was saying...I tell her every , *every* aspect about the difficulties I confront, the *pressure* I endure and what I was worried so much...I think even my culture or myself, she didn't understand any of them." (CP4)

This participant went on to explain:

> "...because she was born here...if a counsellor wants to help a foreign student, at least she should have some experience about...have some *knowledge* about China, about their culture...I think about my counsellor she maybe she knows *nothing* about China...she should have some understanding about Asian culture, about their values, their tradition I think it is necessary...how the people there live and get along with each other...if [s]he is interested in helping Chinese people...I think she didn't understand *anything* about Chinese culture." (CP4)

It seemed that, having disclosed fully about her difficulties without their being met with understanding, she had concluded that the counsellor simply could not help due to an inability to remove herself from her own frame of reference:

> "I didn't say 'I couldn't find any help here' because I think, even if I tell her, I don't think she *could* help me." (CP4)

These excerpts demonstrate how the therapist seemed unsuccessful in taking a meta-position on her own values, which consequently affected the appraisal of the participant's inner world. Inappropriate suggestions from the therapist of "don't worry too much about study" (CP4) conveying a sense of "there are more funs, I should be enjoying myself"(CP4) had a negative effect on the participant's experience of feeling understood, "You can't describe it, but you can *feel* it if somebody can't understand then you feel, feel a little annoyed." (CP4).This unexamined advice rather than empathising and exploring her dilemma served to actually *break* a therapeutic alliance that previously appeared to show a very strong emotional bond:

> "...even she couldn't understand me, but, she did hear with all her *attention*, with her *heart*, I can see that...she wanted to help me. I think it's a kind of warmth." (CP4)

In another account, dissatisfaction was shown latently, with the participant unable to explicitly link her disappointment with the therapist's lack of understanding of culture. In this account, she described how the therapist had recommended a particular course of action to "take control back off your mother" (CP3), which in the context of Chinese cultural values was very difficult to undertake. The participant reported the therapist as having not understood her: "...these are the things why I am coming to therapy...because I can't talk to her [her mother] about it...I didn't actually think that she understood why I *couldn't* approach my mother about things like that." (CP3). However, she did not link this to a possible internalised value of filial piety and subordination to parental figures, which may have been a helpful connection to consider. This may have been due to by the fact that the participant felt she was not particularly traditional in her perspective.

An important point that arises from these two participant accounts is that both found it very hard to verbalise implicit internalised values. The first participant (CP4) had an awareness that the therapist

had transgressed elements of her value system, whereas the second participant (CP3) had no explicit association at all to any possible internalised values. These excerpts, thus, not only emphasise the cultural encapsulation of the therapist but *also* of the participants. It also highlighted the interviewer's naiveté in assuming that participants would be able to 'magically' take a meta-position on their value system to verbalise tacit assumptions.

On the other end of the scale, there were participants who were able to use their therapist as a means of 'cultural containment': the therapist seemed to have acted as a recogniser and digester of the effect of cultural values on their clients' presenting problems. This facet of the therapist as a 'cultural formulator' was felt to be extremely beneficial, especially in aiding a deeper understanding of distress that appeared to originate in times when value systems were in conflict. In the excerpt below, the therapist was able to expand and normalise some of the participant's dilemmas, as well as make explicit some latent values that added to a feeling of coherence. This led to the participant increasing her ability to take a meta-position on her situations and to externalise the role of 'values', reducing a sense of blame:

> " [The therapist] basically helped me understand my culture more...the depression I was in because of my actual cultural situation... before I felt guilty about going against them [her parents]...I should actually try and live out their dreams and expectations...now I understand *why* my parents do these things and why I can now not feel guilty about feeling angry at them...they [friends and other non-Chinese therapists] can only see it from a very British background and give me their points which is more like 'this is wrong' and then I would feel even more angry at my parents but seeing [name of counsellor] helped me as she wasn't actually shocked, so that made me more understanding than angry about it." (CP2)

This participant experienced advice from non-Chinese sources as having a kind of 'negative reframing' effect: their reactions and advice served only to appear to pathologise her situation and increase the intensity of the anger she was feeling. This left her less able to understand and contain her distress.

This example demonstrates the indispensability of using the therapist's knowledge of Chinese cultural values, a sense of "she knows and can pass on knowledge as well...instead of just sitting there and listening,"(CP2).

Additionally, within the interview it was also clear that the therapist had a good grasp of British cultural values. The participant talked of the vital role of the therapist being able to *integrate* knowledge of both cultures as her distress stemmed from clashes of cultural values relating to a transition to more of an adult role in her life. This idea of being "caught between two worlds" (CP2) was common to other accounts, displaying in a sense, an *intra*personal and *inter*personal cultural conflict existing through differences in internalised belief systems.

Interestingly, one participant made extensive references to how knowledge of cultural values was extremely important. When describing why he chose to end therapy prematurely, the disappointment he felt was closely linked to a failure in the therapeutic alliance. He referred to a time when he had felt that his therapist had acted dismissively towards him, "...not hurt but a bit angry, I come to you...you supposed to listen to me, show your empathy..." (CP5). This participant's experience serves to show that caution must be taken against a tacit acceptance that matching clients based on cultural needs will necessarily bypass the need to negotiate a sound therapeutic alliance.

Cultural liberation

A sense of being freed from the constraints of culture was an interesting and unexpected theme. This sense of freedom appeared to encourage a context whereby emotions and problems could be addressed more openly. This further reinforced the spirit of inquiry and increased a sense of discovery, coherence and safety.

> "I actually prefer that she is not Chinese because I feel that in Chinese families that there is always this taboo view- you don't really discuss your feelings and after all the study of the mind came from the West and I think it is for the best for my therapist being a westerner, well

she is like a white sheet of paper that I feel comfortable starting with...If it's a Chinese...I would actually feel uncomfortable because I then I know for sure they are thinking that to obey your parents no matter what...then that's *good* behaviour for Chinese people, then I would feel uncomfortable to talk about my parents and myself with such therapists...the benefit is that I feel open, well 'let's explore', I don't hold back any secrets really...but somehow if it's a Chinese I will feel 'oh my gosh shall I tell him this, shall I tell her that'." (CP8)

Another participant talked about the stigmatised nature of talking about emotions but extended this to the inflections attached to the vocabulary of emotional experience itself:

"It was actually good that I had counselling sessions in English...and this is something I would like to highlight 'cause I feel I have a better emotional vocabulary in English, because Chinese culture doesn't encourage emotional openness certainly not among men...it was much easier for me to talk about emotions in English. English is just a *friendlier* language for me to be expressive." (CP6)

The idea that "if you talk about emotions in Chinese, people will think you are being very serious and seriously it is very rare to hear people express their emotions," (CP6) thus seemed to permeate the intrinsic value of the language itself. This participant appeared to be conveying that he refrained from talking about emotions in Chinese as the vocabulary itself (as apart from predicted social effects: "I don't think people will know how to react,") had a pathologising effect on his own and others' perception of the gravity of his problems. This may constitute another example of 'negative reframing' with this instance based on the value of the language rather than other people's reactions.

This same participant also described a splitting off of emotions interpersonally as well as intrapersonally:

CP6: "There is the vocabulary but I would say that a lot of people don't say that sort of vocabulary as we are just not encouraged to talk about our emotions..."

I: "Do you mean that people don't ask how you are feeling?"

CP6: "And we don't ask our selves how we are feeling too"

This suggests that societal attitudes of emotional suppression encouraged him to not think about his own emotional world. In effect, it seems to constitute a 'foreign land' to him. His unfamiliarity to this part of himself was reflected in being unable to recognise or label his emotions, consequently impairing his ability to process the distress he was in. This was also expressed by another participant, who talked very much of a type of 'emotional disability' resulting from Chinese culture valuing the ability to suppress and disown emotions:

> "When I first learnt to name the feelings I had with my therapist she said 'wow you are learning' and I actually felt good that I was able to say it...it really disables you if you are born in that part of the world, as a Chinese." (CP8)

He went on to say:

> "It disables you in terms of communication because, from a very young age you are taught to read adult signals, their facial expressions, their body language to guess what they are trying to tell you and that is bad, that was the same when I started therapy. I just didn't know how to say what I wanted to say.....I would get really frustrated because I would hate the therapist for not being able to read my mind. But then she told me that 'nobody can read anybody's mind- you have to express it'..." (CP8)

This excerpt demonstrates the valued ability to second guess another's emotional state without being told and conversely expecting others to be able to do the same in return. Having not practiced the ability to express his own emotions and intentions had led to his being unable to express his needs.

What's culture got to do with it?: Culture has no role

Some participants felt that cultural values did not have any relevance to their experience of therapy. The accounts of these participants often emphasised the universal qualities of therapy as a place to be heard and understood, highlighting much more the centrality of being able to use language effectively to express themselves. Indeed, one participant was quite surprised at being asked about his thoughts regarding whether cultural values had played any part in his decision-making process in seeking help:

> "Well I don't think it is very important, just as long as I can communicate with them, that is the most important. If I cannot express myself clearly then I have to find Chinese counsellor to help me but that isn't necessarily important, right?" (CP7)

Another participant also emphasised the principal concern of being able to communicate in a common language, "Because my English is not very good I asked her [keyworker] to find a Chinese counsellor for me." (CP1) When this participant was asked if she felt she could equally be helped by a Westerner with a firm grasp of the Chinese language, she replied: "That's fine if this person can speaking Chinese, that's fine." (CP1)

What is the role of the therapist?

Participants spoke of the different roles or characteristics that their therapist fulfilled. All spoke of qualities congruent with those expected of a universal therapist. Some participants emphasised the benefits of feeling that they knew their therapist personally and therefore relating to them as a skilled friend. The theme of therapist as a teacher also emerged powerfully among many participant accounts.

The universal therapist

The participants expressed views on what they perceived to be useful characteristics in their therapist, with all commenting on universal, core qualities. These included, being a good listener, respecting their perspective, being non-judgemental and having a good understanding of their internal world:

> "My counsellor was all along treating my emotions and thoughts on their own terms...being non-judgmental and that's very important...I was going through a really emotionally tumultuous time." (CP6)

Another universal quality was the ability to form a sound therapeutic alliance. This was shown by the three elements of the alliance having been commented on by participants (either spontaneously or after questioning from the interviewer).

> "She told me to go home with some aims and goals and I would write a list and she would go through it with me on how to achieve them." (CP2)

As mentioned previously, disappointment with therapy related to ideas of cultural encapsulation on the part of the therapist and participant, but also to a failure in the alliance. For instance, one participant felt her therapist could not empathise enough to agree on the overall goal of therapy: "I didn't actually feel she understood where I was coming from or what I wanted to achieve." (CP3)

Therapist as a friend

Perceiving the therapist as a friend was also expressed frequently:

> "I felt like I had known her for years and can actually talk to her more than anyone I can think of...just talking to me like a friend would instead of like a counsellor." (CP2)

Knowing something about their therapist in a less formal, more person-focused way seemed especially important to some. Many participants referred to formality (interpersonal and structural) as something that would deter them from opening up. Perceptions of helpful qualities seemed to focus on being able to have an idea of the 'personhood' of the therapist:

> "She talked about where's she's from, what she's doing and how's she's become a counsellor and where she studied." (CP2)

One participant felt unable to make a therapeutic bond with her therapist, whom she perceived as rather unnecessarily austere and formal:

> "I thought she was very professional in the sense that I know *nothing* about her...I like to know a little bit about them [professional helpers] so in a sense I felt that she quite *isolated* herself...getting to know your counsellor on a sort of more personal basis I think that's quite important, for *me*...I think I would have felt warmer towards her...I found it very cold, which is probably why I backed out of it." (CP3)

Therapist as teacher

Interestingly a final theme of 'therapist as teacher' emerged very strongly. This type of relationship role did not seem to jar with a preference for informality. This may have been due to all participants having strong academic backgrounds and thus a familiarity with this type of relationship. It may also represent a comfortableness with interactions embedded within a hierarchical structure. Participants often referred to therapy as a learning experience, of feeling guided through by a knowledgeable and respected professional. Seeing therapy as a learning process appeared to counteract the stigma attached to seeking help:

> "Why I share the news? [disclosing to others about seeking help] I didn't feel that I couldn't dare to *learn* something...it's like a maturation process." (CP5)

The therapist was often perceived as an authoritative guide:

> "I found he could give me right indication and use me to 'speak me out'...command, control and understanding the whole psychological problem so he could tell me what I could or should do" (CP7)

> "She would guide me to think in a way, from a more objective perspective...she not only spontaneously guides me to the right path but...a strategy, mechanism to cope with life....a couple of suggestions that you can actually do." (CP8)

This type of role relationship seemed to be described by participants who expressed obligation or deference to their therapist, in a sense being a good 'student'.

> "I posed an attitude to see her as a teacher more than a therapist and I learn something." (CP5)

> "I feel it's like doing a degree really, in psychotherapy, you are doing a degree on your own psychology and she is the teacher who guides you and you are the student who learns." (CP8)

The result of having this type of attitude to the therapist seemed to have a positive effect on the therapeutic relationship. Indicators pointed to it as increasing the likelihood of therapeutic tasks and suggestions being acted upon. This is an interesting point to consider in light of the strong themes of ownership of the problem and outcome of therapy, which at first glance would not seem to fit comfortably together.

What did I get out of therapy?

'I found me:' A discovery of identity

The theme of 'I found me' was expressed explicitly by some participants but more often seemed to permeate accounts of those who had found therapy successful. This was displayed by those participants expressing the value of a greater insight into themselves and the coherence of how their life experiences had shaped them. For some participants, therapy had the effect of reinforcing and deepening the 'personhood' of the participant. Having the therapist appreciate them as an individual was very striking in participant accounts. This was opposed to either constantly perceiving them through a cultural lens or indeed dismissing their cultural backgrounds.

> "I had not been fully appreciated for what *I* was pursuing...what I...what *my* interests are by people who are really close to me, i.e., my immediate family, but my counsellor, he treated me as an individual..." (CP6)

> "It helped me understand that I could be my own person..." (CP2)

The therapist was also perceived to have had an active part in the journey to self-discovery, as displayed by this next excerpt in which the participant talks about the helpful therapists he has seen:

> "They really listened, they ask questions about what I said, they wanted to clarify things and they ask you very provocative questions that make you reflect...I had a better understanding of myself, my character, my principles and beliefs and also of how my past has shaped me." (CP6)

A sense of being 'seen' without the filter of cultural expectations and of, in particular, academic achievements was very important:

"...helping me understand why my parents...have such high expectations and why they can't recognise me for my other achievements, other than academic..." (CP2)

This participant had experience of seeking help with other therapists whom she had found over-focused on differences in culture to the expense of seeing her personhood, leading to a feeling of being a 'specimen':

"I thought she was not listening to me and more like researching me, I'm a piece of object being researched." (CP2)

It seemed that what was most effective was the therapist's ability to make individualised formulations that managed the tension between culture, personality and its integration to form 'an identity'. In a sense, enabling the client to 'de-encapsulate', to take a meta-position on their own situation whilst simultaneously understanding their problems in context.

Summary of client participant accounts

Participants expressed a range of shared and divergent views on their experiences of therapy. Common to all participants were the attitudes they displayed about therapy. Having a curious and open stance together with strong ideas of ownership appeared to characterise the group as a whole. The purpose of therapy showed differences between those who found cathartic release to be sufficient and those who desired more insight-oriented change.

Within the domain of 'Does culture matter?', a range of very interesting and at times completely conflicting views were expressed. For some participants, cultural values had been unacknowledged in therapy, resulting in a failure of empathy; for others, cultural values were of little relevance. Importantly, the ideas of 'cultural encapsulation' (both of the therapist and the client participants themselves),

cultural containment and cultural liberation emerged within participants' accounts. The divergence of views was at times surprising but refreshing, reinforcing the different roles culture may have in therapeutic encounters.

All participants appeared to value the universal qualities of therapists and their ability to form sound therapeutic alliances. They all also viewed their therapist as a helpful amalgamation between a friend and teacher.

A sense of participants having been able to use therapy as a way of forging and validating a sense of identity came through strongly in the accounts of those who felt they had benefited from their therapy. Particularly important to this was the way the process of therapy and the skill of the therapist themselves enabled the participant to manage the tension between their cultural backgrounds and personality to form a coherent sense of their own identity.

Therapist Participant Accounts

Analysis of the therapists' accounts yielded six themes (see Table 4). These were clustered into three domains largely determined by the topics covered in the interview. The themes showed similarity to those derived from client participants' accounts. This section presents each of the themes in turn, illustrated by excerpts from the interview. Once again, the themes are not intended to be mutually exclusive: some overlap exists between the themes. The source of each quotation is indicated by the (therapist) participant's research identification number.

Table 4: Therapist participant accounts: Domains and themes

Domains	Themes
1.What attitudes do I as a therapist bring to therapy?	Tension between 'absolutist' vs. 'relativist' stance
	Recognition of diversity
2.What do I do as a therapist?	Implicit and explicit acknowledgement of the impact of Chinese values: 'Natural cultural empathy
	'Beyond the call of duty': The multi-roled therapist
3. What is most important in helping Chinese clients?	Therapists' helpful knowledge
	Recognising the belief in mind-body unity
	'Finding a balance'

What attitudes do I as a therapist bring to therapy?

Therapist participants' attitudes towards therapy were largely characterised by a tension between adopting 'absolutist' and 'relativist' ideology. Therapists were also keen to highlight that the diversity amongst Chinese people must be acknowledged.

Tension between 'absolutist' vs. 'relativist' stance

The tension between ideological positions was not displayed explicitly, but seemed to be expressed latently through slightly contradictory comments emphasising the universals of therapy and the differences between Chinese and non-Chinese values. There was a sense that therapists were unclear as to whether similarity or difference was the preferred position to adopt when taking an ideological stance. For instance, one therapist emphasised the paramount role of listening to clients and building a good bond, saying:

> "If they don't trust you then you've had it. Well, not just Chinese clients, all nationalities I find that over the years, it is the bond between you and the clients [that is paramount in successful therapy]...I think it is really the same [making a bond with a Chinese and non-Chinese];" (TP1)

This therapist also expressed: "...an English therapist and a Chinese person, yes, I think it would damage [the bond] because the, I think cultural thinking do influence a little bit of the mental health problem".

There were also therapists who very clearly and explicitly expressed a stance embedded in an emphasis on similarity across cultures. In fact, the continual focus on inquiring about differences from the interviewer perplexed one therapist participant. This is displayed in the following dialogue:

I: "Do you think there are any differences.....in the process of developing a relationship...with your Chinese clients?"

TP3: ".....I just try to be with them in the session and they [the client] will be central...the method I use are quite similar it really depends on different clients." (looking slightly puzzled)

I: "I know I am asking difficult questions."

TP3: "The point is you try to be to see the differences, but my point it that they are quite similar so it becomes quite difficult to get my head." (laughs)

The majority of therapist participants latently appeared to be more closely aligned to a universalist approach, accepting that core processes (forming sound alliances) would be the same across Chinese and non-Chinese cultures. Most therapists were simultaneously keen to emphasise specific differences. These differences echoed those that featured strongly in the client participant accounts, which were the impact of stigma and issues concerning the taboo nature of emotional expression in Chinese culture.

Recognition of diversity

Diversity amongst Chinese was a point that most therapists expressed. They advocated working with the individuality of each client, which was very similar to the idea of the personhood highlighted in the client participants' accounts. For instance, one therapist said: "It is a very broad area [Chinese culture], you must have an open mind, even though we are all Chinese by birth" (TP2). Whilst talking about the need to recognise the 'within cultural' differences, one therapist extended this to include intra-racial conflicts within the Chinese population and said:

> "I am aware that among the Chinese they do discriminate other Chinese...people from mainland China and people from Hong Kong or Vietnamese people, these are the main conflicts...so I was struggling with language and with prejudice...they would say 'what would you understand? You people from Hong Kong you are so well off, you won't understand!' they think you are not committed." (TP2)

What do I do as a therapist?

Congruent with the previous domain, where therapist participants displayed a tension between ideological positions, their accounts of what they actually did in therapy reflected a similar kind of dilemma. Whilst several therapists explicitly expressed the notion of people across cultures having similar needs of therapy, i.e., that there was little or no difference to the way they approached Chinese and non-Chinese clients, it was latently clear that they flexibly modified their clinical practice to take into account Chinese values. As well as this empathic ability, therapists' accounts were very much characterised by the multitude of roles they fulfilled when ostensibly working purely in a therapeutic or counselling role.

Implicit and explicit acknowledgement of the impact of Chinese values: 'Natural' cultural empathy

Often therapists themselves did not seem to realise the extent to which they were able to convey cultural empathy until they were prompted to talk about their practice in more depth. As all the therapists participants were Chinese, it seemed that their encapsulation and ability to observe British cultural values was helpful in understanding their clients' problems. This seemed especially important when their clients presented with difficulties due to conflicts of cultural values. Their ability to show cultural empathy appeared natural and at times entirely implicit.

One therapist talked of the way her first hand knowledge of Chinese culture affected her clinical practice, referring to a greater ability to formulate her clients' problems without the need to change the actual model of intervention:

> "I think I'm more empathetic about their dilemma. I think that's all I can be, I have a better understanding...because of the values we share and being able to sympathise or empathise and help the person to look at ways to deal with it...in terms of the intervention, about helping people look at things from different perspectives then it is very much similar." (TP6)

This therapist, later on in the interview, seem to display a more consolidated view of her input. The following summary demonstrates not only how the interview itself seem to prompt novel self-reflection but also adds to a more detailed understanding of the impact of culture:

> "I think an understanding of the Chinese culture enabled me to understand the shared values, enabling me to understand the problem and once I understand the problem, I can relate the problem to a CBT framework and that enabled me to tackle the problem easier. So maybe this understanding of the problem would be the key to facilitate a therapeutic change." (TP6)

Quite clearly, this therapist displays a universalist approach to her work, as she said:

> "They do respond in a similar way...the way I use the cognitive behavioural model is very similar, so I haven't actually picked up anything different in their *process* of thinking...one thing perhaps I be more sensitive about the value system and how they see certain things through the own lens of their values." (TP6)

Another therapist was able to talk extensively about the impact of Chinese values on the therapeutic process (e.g., engaging Chinese clients in an informal manner, taking account of lay beliefs and models of mental illness, the importance of relationships, the nature of intergenerational conflict and the role of shame through mental illness' stigmatising effect), whilst explicitly expressing a slightly contradictory view of language being the most important factor in working with Chinese clients. This therapist participant said:

> "I think that it takes a lot of effort and patience for a non-Chinese therapist to work with Chinese clients who don't speak English, I think language is the main issue. I think culture you can learn through books or seminars but language is really really hard." (TP5)

It seems possible that this therapist was unaware of the cultural expertise that she naturally applied in her clinical practice, or, that indeed does believe that the cultural knowledge that she applied could be easily learnt through books.

In contrast to this therapist (TP5), who showed a slight disjuncture between implicit and explicit ideas regarding the impact of Chinese values, another therapist demonstrated a compatibility between her notions of the role of culture in her practice. She emphasised the recognition of personhood and the similar means of meeting the needs of clients (e.g. using an individualised formulation to the client, expressing empathy through: "putting myself in their shoes," and helping clients get insight into their problems) by forming sound alliances:

> "I think people are quite the same...if they feel they can trust, they feel that you are really concerned about them, that you are really care about them, then they will just open their mind, I just found it's like that." (TP3)

Furthermore, as she felt that being able to empathise with a client's situation in order to convey concern was of most importance, she expressed that cohort and gender differences posed more of a challenge than cultural differences. In line with this position, she went onto to talk of the personal frustration that she had felt when others (non-Chinese supervisors and colleagues) persistently interpreted her thoughts and actions "in the oriental way". For instance, due to language difficulties she had experienced difficulty in expressing her deep emotional feelings. Instead of her supervisors recognising this, they 'over-applied' ideas they had learnt from books of Chinese people, choosing to interpret her behaviour as an example of cultural taboos about expressing emotion.

She referred to a sense of oppressiveness and suffocation resulting from a superficial application of cultural knowledge:

"...because the knowledge they got for Chinese people, it's just a *knowledge*, they don't really *understand* Chinese people...they read some Chinese traditional cultural thing and they got some ideas that the family is very important for Chinese people, they always remember that...then next time they will see me he will give me the stereotype, 'the family, the family is really important for this girl', may be *not so*." (TP3)

Thus, she warned against the temptation to apply cultural knowledge in a blanket way, which may lead to stereotyping and losing the personhood of the client. This is displayed in the following dialogue:

I: "They can't see the person behind it and can't see how strongly you hold those values or not."

TP3: "Exactly."

I: "Right."

TP3: "Yeah, sometimes it can be a barrier to them understanding as they trying to put me in this frame."

'Beyond the call of duty': The multi-roled therapist

A strike theme that arose when therapist participants talked about their clinical practice was the way they engaged simultaneously in fulfilling several roles in their client work. Some of these roles were common to the client participant accounts i.e., the Universal therapist, the Teacher and the Friend, but others emerged, such as: the Normaliser, the Emotions Detective and the Practical therapist. Therapist participants also seemed to display multi-roles within their services, which gave rise to other sub-themes of the Crusading Pioneer and the Infiltrator.

The Normaliser. This role overlapped a great deal with the role of therapist as Teacher and Friend. However, it differed in its explicit application in normalising and de-stigmatising mental health problems and help-seeking. In a sense, it represented another application of the friendly, educative role that client participants had reported beneficial in understanding their emotional worlds.

One therapist participant talked of the importance of normalising in the initial engagement of the client (who often self-referred through a telephone call):

> "I would approach it in a very friendly way, I would give them at least this message: 'It is very good that you...are thinking about talking about the problem...it is very brave...you are having problems and it is very common', just to help them think that coming to a service like this is not shameful, it's not a sign of their deficiency...just make them feel it's OK to have problems, it's no big deal." (TP5)

Another therapist participant connected the idea of 'saving face' to the role of normalising mental illness, saying:

> "...saving face, just tell them: 'everyone will get ill, what's the big deal? You know, it's no big deal, you can't help it'." (TP2)

The Emotions Detective. This role related to the techniques that therapists used to enable their clients and themselves to gain a better understanding of their emotions. As such, it shows considerable commonality to client participant accounts relating to therapy as a learning process. Many therapist participants seemed to implicitly accept that their clients might may have difficulty recognising and identifying their emotions and so had developed ways of questioning to be able to gain insight. For instance one therapist said:

> "I noticed some can not actually describe how they feel...and it is quite frustrating for someone who wants to tell you about it...so what I say is 'when you are feeling like that what do you tend to think? ...or what would you likely to do?'...their behaviour would give me a clue as to their emotion, the intensity of their emotion and then I try to feed that back to the person

to check...so I try to get them to associate their feelings with the thinking and doing level." (TP6)

The Practical Therapist: integrating roles. As well as their role as a therapist, many also engaged in more 'practical' tasks traditionally outside this occupational remit. Several therapist participants spoke of being mental health advocates and promoters, benefits advisers, acting as impromptu interpreters and informal social network developers. This gave the general sense that they tended to be responsible in overseeing most of their clients' psychosocial needs.

As one therapist participant said:

> "In the process of trying to tackle the main problem, you are also trying to help in their practical issues, which are important for their well being as well...I go to schools to be interpreter for them sometimes when the school ring me and say that we are not going to provide any interpreter, then you have no choice." (TP5)

This highlights a general lack of resources and the subsequent duties that fall onto some therapists working with Chinese clients.

There were also those therapists who were able to meld their therapeutic and practical role. The following excerpt demonstrates how this therapist participant dealt with a client's relationship worries (when having to stay on a hospital ward) through using a formulation followed by practical help:

> "I explain to him why there was arguments, lots of different opinions but they do eventually get on...I get the social services to give him some cash so he can buy phone card and call home, so that helps." (TP2)

Therapist participants also seemed to display multi-faceted existence within their services, which gave rise to other roles such as the Infiltrator and the Crusading Pioneer. Common to all of these was very much a sense that they were obliged to 'fly the flag' for all issues relating to the welfare of their Chinese clients. Akin to a 'spirit of inquiry', there was an analogous sense of a journey to the undiscovered, to be proactive in mapping-out the uncharted and to set precedents. This feeling emphasised the novelty of thinking and the infancy of developing mental health services to meet the needs of the Chinese population.

One therapist participant spoke of having to be exceptionally proactive to gain access to work with Chinese clients:

> "I joined them [locality mental health team] for team meetings and give them my leaflets, my cards, not once or twice, but you must do it on a continual basis as people lose your card. You need something big to stick on the board and to give the administrator to put in file and a small leaflet for workers to carry with them...lots of promotion combined with casework, but once you have got one or two clients in the area and if you can deliver, then believe me then you get phone calls from people who don't even in this borough..." (TP2)

Another therapist also showed a very personal commitment to improving mental health services for the Chinese population:

> "My telephone number is advertised in one of the Chinese magazines, so I receive a lot of calls...it is the only Chinese hotline in the UK, but I am a one man service and only answer the telephone when I am in the office...I want to promote raising awareness, I want the people who are so called suffers to come [referring to a conference he was organising for Chinese mental health clients], I want the carers to come I want the professionals to come...this year we did the first ever national carers award in Sheffield, the first one." (TP1)

What is most important in helping Chinese clients?

One central theme in the therapist participants' accounts was the clinical knowledge that they applied in their practice. Therapist participants talked of the prominent role of education in their work with Chinese clients (more so than non-Chinese clients). They associated the need for education as a means of counterbalancing the stigma surrounding mental illness and help-seeking. Furthermore, they also talked of the need to educate themselves about different Chinese populations. Knowledge of a more psychological nature concerned being aware of the tendency to use intellectualisation when facing emotional situations and being able to see 'face' as a defence.

Another prevailing theme that was present in all the therapist participants' accounts was the need to find a balance when managing the tension between culture, personality and identity (or culture, identity and personhood). There was more of a sense of an acknowledgement of the dynamic nature of 'culture' by the therapist participants, whereas client participants talked about the clash of Chinese and British cultures, thereby seeing them more as separate and unchanging entities.

Therapists' helpful knowledge

Therapist participants emphasised the benefits of explicitly educating their Chinese clients regarding the nature of mental illness to help allay the stigma that they often felt. This often happened in the context of normalising. Some therapists also recommended specific psychoeducation about 'therapy' and in particular, its collaborative nature. As one therapist participant said:

> "I think the concept of 'therapy' needs a lot of clarifying...the concept of 'therapy is about partnership work'...I think perhaps they [Chinese clients] need some more education, some more understanding at the start of therapy ...when I ask them to put the problems in order of priority...they tend to say, 'you're the expert, you can tell me which one should go first',...so I think the concept of therapy needs a lot of clarifying." (TP6)

The role of education also encompassed the therapist themselves taking on the responsibility of accruing knowledge about socioeconomic and political contexts that their clients are embedded. For instance:

> "I think not just Chinese but other ethnic minorities, I think it will be helpful to have an understanding of their cultural background and their society background...we've got Chinese from the mainland, Chinese from Hong Kong and Chinese born here...their [mainland Chinese] journey...it is terrible, terrifying...if you don't have that empathy and understanding of their society background, their oppression, politically and economically, you will never understand [or] imagine what it is like." (TP2)

This therapist relayed the suspicion she was often met with by clients from mainland China (who were seeking asylum) and the constant need to assure them that she was not from 'the authorities'. Approaching these clients persistently in a friendly and informal manner whilst clarifying her role enabled her to build trusting therapeutic relationships.

Knowledge of a more psychological nature involved having an awareness of a tendency of Chinese clients to intellectualise emotional situations. This was framed as a separate cultural influence to that of emotional expression being seen as taboo and related more to the emphasis of Chinese culture on intellectual development. As one therapist participant said:

> "The Chinese culture and the way in the early socialisation, they tend to internalise things by the way they think. So they are less emotive, they learn by adapting their thinking and intellectual functioning should come *first*. For example, if you lost someone you love you might say 'life moves on you can't stay here and grieve for the rest of your life', and people tend to get up and move on...the way Chinese people are brought up, they very much look at

> the thinking, the cognition as the first focus of development...any distress, they will use their thinking to rationalise and to help the person stay rational." (TP6)

Several therapist participants also spoke of viewing 'face' as a defence and seeing it as an obstruction to therapeutic work. Whilst acknowledging it as an important although declining concept akin to social reputation, therapists simultaneously emphasised the need to eliminate it in order to progress therapy. As one therapist participant said:

> "I think that is big issue, they have to preserve face...I think that if in therapy, that they still have to wear the 'face' then it won't be any helpful...after the client trust the therapist...I think finally they have to get rid of the 'face'...because the 'face' is just a big defence, they have to protect their weakness...I think maybe at first we have to saving their face then finally you have to get rid of that 'face'...otherwise they can not face themselves." (TP3)

Recognising the belief of mind-body unity

This theme was arose latently, with therapists referring to a non-dualistic way of viewing distress. Whilst some therapists talked of some clients relying purely on treating physical signs, others referred to this method in the context of approaching the treatment of the whole individual. One therapist participant talked of the way Chinese clients often expected medicine to relieve their distress, "If I say...talk to somebody, getting someone to feel better, most Chinese would not believe in that. I think that they would believe in an injection to get them better," (TP1) and another therapist participant explained:

> "...those from a traditional culture they still obviously believe in treating the body...if they see someone is very angry, they think it is the 'hot'. The yin and yang, the 'hot' bit so they bring the person along and suggest that certain types of remedy, such as having more soup – remedies to 'cool off' the system will get rid of the anger..." (TP6)

One client participant also expressed quite strikingly, a congruent view when encouraging people with mental health difficulties to engage in services, "...you are not alone, there are always people who can help, don't die in your thoughts," (CP5).

'*Finding a balance*'

A prevailing theme in the therapist participant accounts was the need to manage the, at times, competing elements of culture, personality and identity. All participants highlighted (one explicitly, but others latently) the need to be flexible in the application of cultural knowledge whilst respecting the personhood and identity of their client. This final theme corresponded very well to that of 'I found me': reinforcing personhood that also emerged in client participant accounts. As one therapist said:

> "I think there has been arguments about whether having a Chinese counsellor would provide a linguistic and culturally appropriate care or intervention. I think that there is some truth to it, but at the same time I think the counsellor needs to be mindful of the balance of the two: not making a sweeping statements about certain things that happen in Chinese culture and 'that is a cultural issue for them', but I think that it is that interpretation of that culture may be shared across other cultures as well." (TP6)

Therapist participants also emphasised the need to reconcile the differences that value conflicts generated, for those experiencing intergeneration conflict and for the many first generation Chinese who are living in a British culture. An important idea that emerged seemed to be the acknowledgement of the dynamically evolving nature of culture. For instance, as this therapist participant said:

> "I just feel people tend to be not so 'traditional' anymore...such traditional views still exist but they have some influence with the western culture then some of them can be very individual." (TP3)

The impact of having a more dynamic view of culture appeared to be that some therapists were focused more on *integrating* all the elements of their clients' identity (be it those values classed as British or Chinese) rather than merely separating them out for scrutiny and discarding some as problematic or dysfunctional. The next excerpt demonstrates the role of the therapist in recognising and reconciling differences within an individual:

> "...maybe the cultural conflicts will cause the problem, the psychological distress. But the psychological distress is something about the *individual* how they formulate their thinking and respond and we need to address the balance...the child is growing and is actually assimilating other western culture in her own life...experiencing the dilemma of how to reconcile you know the differences...so that's the thing I find is important working as a therapist with Chinese culture. To make sure we have the *balance*." (TP6)

A way in which one therapist participant used her clinical skills to increase understanding and integration of values was to enable her client to take a meta-position: tracing the formations and development of parental beliefs:

> "I open up the discussion...I don't say my opinion, I just try to ask questions as to why her Mum has such sorts of expectations and what sort of environment she was being brought up in at the time and she would [then] reflect on her own [expectations and environment]." (TP5)

Related to this point and echoing once again themes seen in client participant accounts, therapist participants also emphasised the benefits of de-encapsulating to maintain a non-judgemental stance throughout the therapeutic process:

> "...it is difficult sometimes but we must try our best...if you can step out of that [our own] frame, that would be very very good and that will be very very beneficial to the client." (TP2)

Therapist participants made the point sometimes explicitly, but more commonly, latently, that on a wider level therapists should be aware of the overriding *similarities* in the way we all respond to therapy. Subsequently, therapists should perhaps resist the temptation to place 'culture' *necessarily* in the foreground of the treatment of an individual perceived to be 'different':

> "Instead of treating them [people of ethnic groups other than British] differently, we should look to the *similarities* to the way that they respond. The 'culture issue' may become a content of the discussion but the pattern, the way that they think are the key as therapist we need to tackle, rather than being driven to look at the 'cultural needs'." (TP6)

Summary of therapist participant accounts

Overall therapist participants expressed many shared views about their experiences of working with Chinese clients. The majority also expressed a tension in the attitudes they brought to therapy, regarding whether to adopt a basic position of cross-cultural similarity or difference. Despite this the majority did appear to condone a largely 'universalist' stance to working. Certainly all therapist participants recognised the diversity amongst the clients they had seen and were keen, it seemed to prevent a particular stereotyped perception of a 'Chinese client'.

In terms of what therapists said they did in therapy, there seemed a disconnection of the latent and the explicit that had also been a feature of client participant accounts. Just as some client participants had found it very difficult to verbalise at times the impact of cultural values on their experience of therapy, so too did therapist participants in relation to their work. This led to the idea of therapist participants having a 'natural cultural empathy', that seemed to be potentially helpful in amplifying their understanding of their clients' problems and subsequently deriving formulations that were congruent (at times implicitly) with the clients' understanding of their problems. Therapist participants were also striking in the way they seemed to fulfil a multitude of roles with their clients and within their wider

service context. This sense of 'forging a path' was reminiscent of the sense of discovery that client participants expressed of their attitude toward therapy.

In terms of what therapist participants felt was most important in working with Chinese clients, all therapists emphasised the need for relevant knowledge, the recognition of the belief in mind-body unity, and perhaps most pertinently, being able to find a dynamic balance between culture and identity. This in many ways closely mirrored the final theme derived from client participant interviews of 'I found me: A discovery of identity'.

DISCUSSION

This qualitative study aimed to explore into the experiences of therapy of a small number of Chinese people living in London. It also aimed to get an idea of what therapists working with this client group considered to be of importance in their clinical practice. Eight client participants and five therapist participants were interviewed using a semi-structured schedule specially devised for each group. The schedules were based loosely on values or concepts shown in the literature to be of importance in this client group, but were hoped to be open enough to allow unexpected themes to emerge. A number of themes were identified in client and therapist participant accounts and organised into domains.

This chapter will discuss the results in the context of the original research questions of 'What enabled clients to seek help and stay in therapy?' and 'Ho do Chinese cultural values play a role in the therapeutic process?'. The findings will be considered in light of current literature and I will be speculating on their application to clinical practice throughout the course of the discussion. The methodological issues and future research directions will be outlined. I will then integrate findings into a section addressing 'How can therapists approach working with 'Culture' in clinical practice?'. The wider service relevance of the findings will then be presented. This chapter will end with a summary and the conclusions of this study.

Research Questions

What enabled these clients to seek help and to stay in therapy?

The client participants were notable in the way themes relating to openness and curiosity pervaded all the accounts. They were all very candid about their experiences, presenting a somewhat unexpected picture in light of the substantial literature on taboos regarding help-seeking and emotional expression

(Akutsu, Lin & Zane, 1990; Atkinson & Gim, 1989; NIMHE, 2003; E. Lee, 1997, W.M.L. Lee, 1999; S. Sue & Morishima, 1982; Uba, 1994). It appeared that what predominantly enabled the client participants to seek help was a combination of an overriding attitude of inquiry, an acceptance of emotions as natural and universal, seeing stigma as a flawed belief and viewing therapy as a learning process.

All the client participants were aware of the traditional cultural restraints that serve to limit the expression of emotions, associating emotion with indiscretion and attributing a weakness of character especially to the voicing of very strong emotion (Uba, 1994). However, they were able to actively challenge this emotional double-bind as none believed that they should have to endure their distress silently. This finding is consistent with emotional openness and fear of emotions as being predictive perceptions of stigma and negative attitudes to help-seeking (Komiya et al., 2000).

Thus, client participants appeared to be able to take a meta-perspective on cultural taboos that could have had a potentially obstructive influence on not only the process of seeking help in the first instance, but also probably would have discouraged them from discussing their problems openly *in vivo* in therapy. Furthermore, framing therapy as a learning process aligned it with a highly prized and much encouraged value relating to academic achievement and continual self-reflection. This may have enabled the client participants to be receptive to the idea of therapy and also to be open in the therapy itself. These attitudes show coherence with the continuing influence of meritocratic ideas and the esteemed nature of educational attainment in Chinese and Asian societies (Lau, 1997).

Connected with this point are the themes of viewing the therapist as a benign combination of a universal helper, teacher and a friend. These perceptions of are very similar to the ideas of therapists working with Chinese clients needing to show authority (Lin et al., 1995; S. Sue, 1990) but also balancing this with being a "personal friend" (Lin et al., p.258). Viewing the therapist in this way reinforced the idea of therapy as a 'normal' experience and opportunity to learn. It also embedded the interaction within a social role hierarchy, which most were familiar and it is assumed probably quite

comfortable with, given the high level of educational attainment in this group. Assigning oneself the 'student' role also appeared to influence the degree to which client participants valued and followed the advice of their therapist.

Client participant accounts displayed themes of a sense of obligation to the therapist and ownership of the outcome of therapy. These show parallels to common beliefs concerning scholarly achievement, i.e., that a student is responsible for their own learning and chooses amongst different study techniques those that fit with them. Ultimately, the responsibility always falls to the student and their own creativity. Another way in which, this finding may be connected to the literature on relevant cultural values is by linking it to the preponderance of more internal means of social control, i.e., through mechanisms of guilt, shame and obligation (W.M.L. Lee, 1999). This may further encourage an internal sense of responsibility to the therapist and outcome of therapy.

Relevant to this enabling process were the ways in which the therapist participants talked about what they regarded as helpful ideas in their work with Chinese clients. Congruently, therapist participant accounts were abundant with references to the need to explicitly educate their clients about the concept of therapy itself, in order to normalise and de-stigmatise the process. It is possible that this encourages the client to relate to the therapist as both a teacher and a friend, and thus both sides of the dyad are maintaining a relationship with which they are familiar and comfortable. This relationship may further be reinforced by the therapist participants' view of themselves as 'normalisers' and 'emotions detectives'. Additionally, therapists behaving in this way may also have been inadvertently fulfilling the obligation of 'gift giving' in the early stages of therapy and thus enhancing perception of therapist credibility (S. Sue & Zane, 1987).

Thus, the dominance of one prized cultural value of academic and scholarly pursuit served usefully to counteract both stigma pre and *during* therapy. The teacher-student dyad also seemed to have benefits during therapy by encouraging an internal locus of control. This seems a counter-intuitive outcome, as one may have expected that the deference to this perceived hierarchy from client

participants may have interfered with their abilities to be 'the master' of their own therapy. It seems that the client participants were comfortable with receiving a slightly more 'expert-like' approach to their therapy, whilst importantly, also retaining an internalised sense of ownership to outcome. It is suggested that this way of experiencing the therapeutic relationship was not only linked to this particular group's familiarity with the educational system but also to specific cultural values that influence the tendency for this kind of therapist-client relationship to develop and be maintained. This finding is consistent with Lin et al.'s (1995) view that for Chinese people it is especially important that the therapist is seen as an expert *and* as a personal friend. They go as far as saying "...in contrast to the concept that the therapist should adopt a 'professional', 'neutral', and 'distant' therapeutic relationship with a patient as emphasised in traditional psychoanalytic therapy, the therapist working with Chinese patients should not hesitate to establish a 'pseudo-kin' of 'own friend' relationship to facilitate the therapeutic work, particularly in the initial stages of therapy" (p. 285-286).

The psychological position expressed by this group of clients and those written about by Lin et al. (1995) may be closely linked to Chinese philosophical traditions in Confucianism and Buddhism. Many Chinese societies subscribe to the Confucian view of filial piety, which values unquestioning obedience to parents and those in authority positions, which may lead to an expectation of the therapeutic relationship to be hierarchical (Lau Chin, Huser Liem, Domokos-Cheng Ham & Hong, 1993). Buddhist philosophy concomitantly emphasises the study and awakening of oneself through a process of enlightenment, whereby: "...knowledge is not handed down like an antique. One teacher experiences the truth and hands it down as an *inspiration* to his [or her] students. That inspiration wakens the student who passes it on further. The teachings are seen as always up to date, they are not thought of as 'ancient wisdom'." (Hope & Van Loon, 1998, p.5).

By considering these traditions together, one can perhaps understand how a compatible combination of respecting a figure perceived as learned and "experiencing the truth for oneself" (Hope & Van Loon, 1998, p.7) may influence how Chinese people may relate to each other in every day life and may also be demonstrated in the therapeutic situation. An additional point in understanding the cultural normality

of this type of relationship may be that the teacher-student dyad appears to pervade the life span. Traditionally, in Western cultures this relationship is expected to end when formal schooling finishes. However, this assumption may be less typical in Chinese/Asian societies. The passing down of knowledge and wisdom, although at times used as a negative stereotype, is still very much reflected in modern Chinese/Asian cultures. For instance, respecting elders and the views of those older or perceived as more knowledgeable, is very much part of the cultural experience (Kim, Atkinson & Yang, 1999). In this way, adults as well as children are familiar with this style of relationship.

Mordkowitz and Ginsburg, 1986 (cited in W.M.L. Lee, 1999) place this type of thinking in a contemporary context with the Asian American population. They address the academic success of this population by linking it with a process of 'academic socialisation' which results from "a combination of authoritative families, high expectations, emphasis on effort, supervision of children's time, allocation of resources for educational purposes, and reinforcement of beliefs and behaviours conducive to learning." (p. 110). This socialisation process has also been observed clinically in Chinese living in Britain (Lau, 1997).

The findings of the present study suggest that there is a potential difference between Chinese and non-Chinese clients regarding the containing influence of a more teacher-type of role, which may jar with specific types of therapeutic styles and approaches that emphasise a lack of structure and minimal feedback in therapy. This may inadvertently suggest to the client that the therapist does not know what they are doing or worse, may be withholding information from the client on ideas of how to relieve their situation. Thus, the client may perceive the therapist not only as lacking in credibility but also rather punitive and stigmatising. This point was made by one client participant, who experienced less structured approaches as being made to feel as a "specimen...an object to be studied" (CP2).

The themes discussed so far have several clinical implications. Firstly, given that what facilitated help-seeking in this group was to take a meta-perspective on their beliefs, then fostering this kind of self-reflection may allow others to evaluate how useful or relevant certain beliefs are to the maintenance or

relief of distress. This way of thinking is consistent with Boscolo and Cecchin's (cited in Carr, 2001) social constructionist influenced systemic thought.

Raising awareness through mental health promotion, of the ideas of stigma and emotional suppression as 'beliefs' could help open up new ways of viewing their situation and create psychological space to allow different ways of coping other than the traditionally accepted ways of not seeking help from outside the family and having to endure distress until a crisis point is reached (Pedersen et al., 2002). Once beliefs are framed in this way and placed in a cultural-philosophical context, it may allow individuals to observe them as *concepts* and judge their relevance.

Furthermore, framing therapy in a culturally familiar context of learning and self-enlightenment could help individuals to engage with these highly prized beliefs regarding the importance of continual learning. This approach avoids rejecting or relating to cultural-philosophical influences as negative, rather it opens up possibilities of looking to other aspects of the culture to encourage engagement in therapy. Acknowledging the past and present meritocratic influences on the individual could therefore provide an explicit way to de-stigmatise help-seeking behaviour *pre* and *during* contact. For instance, one may help a person ask questions such as: "What do I hope therapy will teach me?", "How can I match up what I want out of therapy with a therapeutic style/model?", "What therapeutic approach best suits my learning style?", "What have I learnt so far?" and "How can I evaluate and apply these ideas to my situation?".

Another theoretical reflection on the teacher-student relationship concerns its potential impact on a psychodynamic model. Considering the central role of transference, i.e., the client's reactions to the therapist as they are determined by fantasy and unconscious factors, Lau Chin et al. (1993) discuss the idea of an increased likelihood of a hierarchical transference relationship and its implications. They suggest that Asian clients will more often view the therapist as an "all-knowing advice giver or as a wise and caring authority figure whose recommendations are to be followed," (p.21). They also state

that the authority figure is somewhat idealised as benevolent, an observation clearly reflected in the client participants experiencing their therapists as a teacher and a friend.

Lau Chin et al. (1993) suggest that the key to the impact of this hierarchical rapport on the therapeutic relationship is the way individual dynamics brought by the clients interact with how the therapist uses the transference. For instance, depending on whether the clients had parenting styles such as dominant and intrusive parenting or authoritative and supportive, the hierarchical transference may be experienced as negative or positive, respectively. In the former, this negative hierarchical transference may benefit from therapeutic analysis whereas in the latter the transference may serve to be positive and facilitative in forming an alliance.

How do Chinese cultural values play a role in the therapeutic process?

This question relates to the 'etic' vs. 'emic' debate presented in the introduction chapter. There were specific themes that clearly demonstrated that the influence of culture was not significant, i.e., themes that showed cross-cultural similarity (and therefore etic value), and also specific themes that showed culture to be an important variable, i.e., a major interaction of culture on the therapeutic process (and therefore emic value). Both findings can be reconciled when considering that therapy itself is composed of different aspects or elements. The elements that appeared not to be influenced by cultural values were those relating to helpful therapist qualities and the perception of the purpose of therapy. However, cultural values seemed to come more into play when examining the nuances of the therapeutic process in more detail. I will firstly discuss the aspects of therapy that appeared to show cross-cultural similarity and then move onto the evidence of the involvement of culture in therapy.

Evidence of cross-cultural similarity: The case for an etic approach to some aspects of therapy

Evidence of cross-cultural similarities was shown with regard to client and therapist participants' accounts of helpful therapist qualities and the perceived purpose of therapy. The presence of these themes was helpful in understanding how certain aspects of the therapeutic process may not necessarily be culture-specific. This therefore relates to what we could term the 'etic' elements of therapy.

Therapist qualities

The theme of the 'The universal therapist' that arose in client participant accounts and was also reflected in therapist participant accounts, seemed to capture what most would regard as helpful qualities for a therapist to have regardless of cultural background. Qualities such as being a good listener, empathic, respectful, non-judgemental, having the ability to negotiate the goal/s of therapy and agree on tasks to achieve them were stated in both of the group's accounts. Many of these qualities related directly to the core counselling skills and traditional Rogerian principles of client-centred therapy, as well as the concept of the transtheoretical re-working of the therapeutic alliance (Bordin, 1979; cited in Safran & Muran, 2000), which has subsequently been shown by many researchers to be the most robust indicator of outcome across theoretical treatment modalities in Western populations (see Safran & Muran, 2000). These ideas are widely accepted as a basic foundation to clinical practice, however, it must also be said that these ideas have not been tested cross-culturally.

The purpose of therapy

Client participant themes of 'A journey of discovery', 'Fitting the jigsaw together: finding coherence' and 'A safe place to purge' were also mirrored in therapist participant accounts regarding what they saw as the purpose of therapy. These themes show similarity to the two distinctions of insight or non-insight oriented Western models of therapy, respectively (Uba, 1994). Insight-oriented therapy focuses on alleviation of symptoms through facilitating the client to gain awareness of underlying causes of their

problems. Non-insight therapies do not focus on understanding and would encompass more ideas of expressing emotions and behavioural coping strategies. Thus, the perceived function of entering therapy does seem to show similarity rather than difference.

Additionally, there were two client participants who both explicitly and latently expressed that cultural values did not play any discernible part in their own process of therapy. These participants reported (and demonstrated through the interview data) that the sole function of their therapy was catharsis and a chance to 'purge' and have emotional release. This suggests that there are clients who seek merely 'a listening ear', for whom in-depth analyses of the interaction of cultural factors on their distress would be of little appropriateness or meaning.

Clinically, this suggests that the basic skills that therapists are trained with in western therapeutic models and the broad conceptual ideas regarding what those models aim to achieve show a high degree of transferability. This may potentially enable therapists to start approaching working inter-culturally with some confidence and framework rather than on a footing of uncertainty that is commonly reported and observed in clinical practice (Aitken, 1998).

Evidence of the interaction of Chinese cultural values in therapy: The case for an emic approach to some aspects of therapy

The need to acknowledge the effects of cultural values was demonstrated by the themes arising in client and therapist participant accounts of 'Cultural encapsulation vs. cultural containment', 'Cultural liberation', 'Implicit and explicit acknowledgement of Chinese values: 'natural' cultural empathy' and 'Therapist's helpful knowledge'. For the purposes of brevity, I will concentrate on an in-depth discussion of the first three themes, which I consider to be central to understanding the way cultural values have interacted in the client participants' therapeutic process.

Cultural encapsulation

The notion of 'cultural encapsulation' was derived from Wrenn's, 1962 (cited in Pedersen et al., 2002) idea of the 'culturally encapsulated counselor' referred to in the introduction chapter. This term was first used to describe unwitting racism on the part of the therapist due to a submergence in the approaches and attitudes inherent in a Western training approach. This envelopment results in a complete lack of awareness that cultural differences may have a role in the therapeutic process. It can be seen as unwitting, as therapists that adopt this 'colour blind approach' are often well intentioned by applying the principle of equality, i.e., treating everyone the same. However, it is also the case that by not recognising and appreciating difference, these therapists are prone to inappropriate lines of formulation and treatment, as well as being perceived by clients as not respecting their cultural context.

W.M.L. Lee (1999) acknowledges this interpretation of the concept but also places it in a different and less positive light, using it to refer to an inability or unwillingness to modify practice in accordance with culture. W.M.L. Lee does not expand upon this idea and I feel it may be useful to speculate about the distinctions between therapists who could be described as 'well-intentioned' or 'unable' or 'unwilling', and the thinking styles characterising each of these. Distinguishing these different thinking-styles could potentially be very pertinent to several aspects of clinical practice, i.e., how a therapist approaches their practice, how a therapist understands ruptures in a therapeutic alliance (regarding formulation or treatment suggestions) and how a therapist frames the need (or not) for training to become more culturally competent. I will discuss each of these points in relation to these hypothetical therapist thinking-styles.

The 'well intentioned' therapist who bases their approach on equality and prides themselves in 'treating everyone the same' may approach therapy with a 'pseudo open mind'. By this I mean that, it is arguable that one can only be truly open to what one has at least a conception of. Trying to be open to difference is very difficult if one has no framework for helping to identify a 'difference'. Furthermore, when the therapist is able to identify 'difference', they are probably unlikely to consider its relation to the wider cultural context of which their client is a part. Instead, there will be a temptation to attribute

those differences to the internal pathology of the client. This was demonstrated latently in the account of one client participant (CP3), who it seemed, felt the therapist located her reluctance to "confront your [her] mother" in a personal deficiency rather than frame it within an understandable and more benign context of parental respect and filial piety. Ruptures in the therapeutic alliance may result therefore from a culturally devoid formulation leading to inappropriate treatment goals. This type of 'well intentioned' thinking-style may view training in cultural competency as favouritism or privileging one group's needs over another causing a rejection of a call for further learning as it would conflict with strongly held beliefs of equality.

The 'unable' therapist thinking-style (due to a lack of training or guidance) is perhaps paradoxically, potentially more open to flexibility in clinical practice. They may be aware of a need to modify their practice but obstructed by unclear messages about the role of 'cultural values' and caught between a tension of not knowing and wanting to know. This tension may exist because if the clinician does not feel they have the 'special skills' to cope with difference then they may feel uncomfortable in knowing about that difference. Thus, it may lead to less exploration of the cultural inflections that impinge on a person's experience of their mental health problems that could result in inappropriate formulation and treatment (the same outcome of the 'well intentioned' thinking-style). There may be a tendency to under- or over-attribute ambiguities in the therapeutic process to 'cultural differences'. Ruptures may be ignored or denied as they may reflect too much on the inadequacy that is felt (somewhat wrongly) personally by the therapist themselves. However, what may distinguish this 'unable' type of therapist thinking-style from the 'well intentioned' thinking-style is the degree to which they are enthusiastic and actively desiring to take up opportunities of further training to develop cultural competency.

The 'unwilling' therapist may have a thinking-style more aligned to what past and contemporary authors have referred to as ethnocentrically biased clinicians. The tendency for ethnocentricity may result in the idea that other cultures will have to 'like it or lump it' due to an inherent belief of a 'right' or 'truth' in psychological theory and practice. In this way their encapsulation is recognised as the 'best' way of understanding the world. They are likely to approach therapy with prescribed ideas and beliefs

that are rigidly held even in the face of evidence that suggests equally valid interpretations. There is perhaps a greater danger, as compared to the other thinking-styles, that this will result in particularly offensive or insulting interactions in therapy. Furthermore, this is likely to extend to the formulation and treatment plan for the client too. It may also be the case that ruptures in the alliance are more automatically attributed to 'cultural differences' and culture often seen as the sole source of *interference* from getting better. Those with an 'unwilling' thinking-style are not likely to see any benefit in training opportunities to become more culturally competent due to the implicit and explicit belief that cultural differences are a deviation from what 'should' be the case, thereby placing a value on what they believe to be healthier ways of expressing distress or understanding it.

I emphasise again the hypothetical nature of these distinctions, which are based more on a heuristic sense than empirical foundation. Bearing this limitation in mind, I would like to briefly explore and reflect upon their potential wider clinical implications. Firstly, I would like to illustrate their impact the understanding of cultural differences in the expression of distress, namely the issue of 'somatisation' presented in the introduction chapter; secondly, I would like to touch upon how as a profession psychology can benefit from keeping these ideas in mind when considering the changes required for a cultural shift in the thinking of service delivery.

In the client and therapist participant accounts, consistent with previous research findings (Lin et al., 1995), some intimated a connection between the psychological and physiological aspects of expressing distress. This arose spontaneously, as the interview was designed to focus more on therapeutic process issues rather than the specifics relating to the content of distress. Implicit in their accounts was a suggestion of an inherent connectedness of psychological and somatic experience. When encountering this clinical situation, the 'well-intentioned' therapist thinking-style may lead to a reluctance to acknowledge this type of expression and merely focus on those aspects that are shown across cultures, i.e., those relating more to psychological symptoms, therefore perhaps running the risk of leaving the client feeling unheard. The 'unable' thinking-style may lead to the therapist not knowing how to conceptualise the distress and inappropriately referring the client on to medical colleagues,

thereby pursuing a client-centred approach in a potentially fruitless way. The 'unwilling' thinking-style may lead to the client being deemed as a pathological 'somatiser' and pave the way to having all their symptoms devalued or even dismissed due to being negatively labelled as 'psychosomatic'.

This hypothetical situation demonstrates the variety of potentially inappropriate outcomes that can be reached from thinking-styles resulting from the cultural encapsulation of the therapist. This could be avoided if the therapist themselves were able to realise the underlying assumptions or beliefs that implicitly guided them to discount that a mind-body connectedness may actually be *another* way of experiencing distress and that this is 'normal' in other cultures. The valued judgements inherent in the use of the term 'somatisation' are an assumption of a split of the 'psyche' and the 'soma' and that somatisation occurs when there is a pathological conversion of psychological symptoms into somatic symptoms (Barsky & Klerman, 1983; Fry, 1993). This assumption often leads to ideas around 'helping' clients to 'accept' their psychological distress in order that they express it 'appropriately' instead of having to 'make them' into bodily symptoms. It also, unfortunately, often goes hand in hand with a denigrating sense that the client is functioning at a less sophisticated psychological level. Cheung (1995) and Barnes (1998) instead suggest that 'somatisation' can be seen as oppositionally equivalent to the bias in Western societies to 'psychologise' distress. Cheung (2002) has also recently demonstrated that Chinese mental health in-patients (n=3925) actually report significantly more psychological symptoms than psychophysiological, physiological and ambiguous symptoms (using the 22-item Langer scale). Cheung (2002) concludes by making the point that the reporting of both somatic and psychological symptoms are not mutually exclusive, and that professionals would benefit from learning more about the conceptualisation of mental illness among Chinese societies.

A discussion of the development of thinking leading to mind-body dualism (Descartes, 1596-1650; cited in Farthing, 1992) is beyond the scope of this study, it may be suffice to say that it is a traditional Western concept that is simply not endorsed in non-Western cultures who do not experience their world in such a dichotomised fashion (L.Y.C. Cheng, 1991; E. Lee, 1997; W.M.L. Lee, 1999; Uba, 1994). Shia (1997), states that the first textbook on Chinese medicine 'Yellow Emperor's Internal

Classic' was published around 700 BC, which laid down a holistic theory of body and mind. The theory proposed an interdependency of mind and body in maintenance of the wellbeing of an individual. This is reflected in the practice of Chinese medicine which uses ideas of excess or deficiency to identify 'syndromes' in the diagnosis of illness; because 'syndromes' are statements about the whole being, the same syndrome used to describe a mental problem may also describe a physical ailment (Shia, 1997).

To accept that mind-body interdependency may be an alternative and as valid phenomenological experience could add greater clinical coherence in formulation and treatment. It is perhaps surprising that the dualistic paradigm continues to exert so much implicit influence when contemporary formulation in clinical psychology continually emphasises the bio-psycho-social approach. There thus appears to be a disjuncture in truly integrating and holistically understanding an individual's distress.

How might these ideas help psychology as a profession to deal with cultural encapsulation in a positive way, to enable cultural shifts in thinking therapeutically? (I will re-visit this issue in the section titled 'Wider service relevance'). To recognise that there are different thinking-styles that lead to less culturally sensitive practice must be incorporated in the way the profession frames the rationale to change and develop practice. It is observed that many clinicians feel blamed or unfairly labelled as 'ethnocentric' or outright 'racist' when they are genuinely well intentioned and express under-confidence in dealing with cultural issues in practice. The way in which this issue is phrased in some publications seem often to overemphasise a blaming model, whilst not acknowledging the willingness that is present within the profession to learn to modify practice in order to be more culturally competent. It follows on to say that fostering different attitudes in this respect will enable change to be facilitated in a more supportive and open environment.

Cultural containment

A way in which culture positively interacted with the therapeutic process was demonstrated by the reported ability of therapists of the same culture to 'culturally contain' the dilemmas that often arose for

clients who were experiencing distress from cultural value clashes. Thus, these therapists were familiar with both Chinese and British values and were able to go beyond a level of acknowledgement to that of *incorporation.* For some client participants, an appreciation from their therapist of the impact of Chinese values was crucial in helping them come to terms with their presenting problems. In this way, the therapist functioned as a means to 'cultural containment' by acting as a 'cultural formulator'.

This kind of cultural containment relates, in principle to Bion's (1962, 1963; cited in Bateman & Holmes, 1999) ideas of the unconscious process underlying empathy, "...by which the mother contains projected painful and hostile feelings, 'detoxifies' them, and returns them to the infant in a more benign form at a phase-appropriate moment," (1962, p.86). Client participants spoke of their therapists (and therapist participants also expressed it themselves) referring latently and explicitly to the skill of 'digesting' distress by placing it in an understandable cultural framework, thereby enabling the client to gain a sense of being able to manage their feelings.

As mentioned, this skill seemed of particular relevance in helping clients presenting with difficulties reconciling values from their Chinese and British cultural backgrounds. This touches upon the dilemmas that may be a result of an individual having to evaluate and balance behaving as according to independent and interdependent self-construals (Markus & Kitayama, 1987), which may be *simultaneously* being encouraged by the dominant culture and their families, respectively. Clinical implications of this finding relate to the need for clinicians to be able to take a meta-perspective on their own values and that of other cultures that may be relevant to the client, as well as reflecting on the therapeutic challenges/dilemmas this may present to clinicians. I will now go on to discuss what I perceive to be some challenges that may arise related to working with clients experiencing a clash of cultural values.

It is perhaps interesting to contemplate the idea that there are both intra- and interpersonal elements of this clash. The internal value clash is concurrently present explicitly as an *inter*personal difference, i.e., between a parent and a child dyad; the implication of this maybe that therapists of family therapy

approaches (see Minuchin & Fishman, 1981; Palazzoli, Cecchin, Boscolo & Prata, 1978; Watzlawick, Weakland & Fisch, 1974) may be more *prone* to concentrate on 'repairing' a relationship *between* people rather than concentrate on the *intra*personal dilemma. Whilst advocating for the utility of these approaches, reflecting on existing research suggests that focusing on bringing family members to sessions may not be the easiest area for a clinician to target due several reasons.

Firstly, doing so will almost certainly contravene the value of filial piety; secondly, parental attitudes are more likely to be more traditional and they may still see engaging in mental health services as stigmatising; and thirdly, there may be an important motivation of the parents to hold almost an amplified version of traditional values as a connection to 'cultural identity'. This may be especially so for a family that has migrated and no longer has close links to their place of origin. Thus, the loss connected to missing a valued time and sense of place may be inadvertently compounded by a therapeutic agenda, which may perceived as (but not intended to be) a request that the parent/s disengage or relinquish some of their values. This may therefore make a therapeutic approach based on getting family members together extremely difficult.

However, the point must be also be emphasised that this does not mean this approach will be embraced in this way by all Chinese families and that family therapy has been shown to be useful in this population (E. Lee, 1997). Krause and Miller (1995), state that family therapists although showing great interest in 'belief systems' tended to "portray beliefs as straightforward non-contradictory bits of information which could be considered out of context and therefore easily changed" (p.149). However, development of the approaches, i.e., embracing of social constructionist ideas (see Burnham, 1986, 1992: Carr, 2001; White, 1991), the 'not knowing position' (Anderson & Goolishian, 1988), curiosity (Cecchin, 1987), multiple selves (White, 1991), and co-constructed narratives (White & Epston, 1990), position family therapists as ideal clinicians to address culture as a systemic influence.

The above discussion highlights the clinician's dilemma when trying to gain a position of cultural containment of whether to locate the clash between client and family or within the client themselves.

The benefits of an interpersonal focus (between) is obvious, there is potential to forge an 'ideal outcome' of repairing explicitly a relationship. However, the disadvantages of pursuing this stance are related to the limited likelihood of it being realised in vivo (due to the reasons discussed above) and a more worrying consequence may also be that it could have the undesired effect of increasing the parent/s' idea of pathology in the child due to them being seen as bringing shame onto the whole family.

Uba (1994) also suggests several other culturally relevant ideas to consider when addressing whether to focus on intra- or interpersonal avenues in therapy. For instance, a family approach would obviously necessitate the clients themselves disclosing to their family that they have shared concerns with a person outside of the family system, which is not seen as ideal. For several client participants this simply would not have been possible due to having attended counselling "secretly" (CP2), having the idea that they needed help rejected (CP8) or not wanting their family to feel stigmatised on their behalf (CP3) and thereby protecting the family's honour. These findings fit with research showing that Chinese students judged that their parents would have negative reactions to the news that they had sought help for psychological issues (Atkinson & Gim, 1989).

E. Lee (1982) also makes the point that the traditional hierarchical structure of the family is likely to result in a system whereby members are not familiar with sharing their feelings with each other. This may have undesirable consequences for both sides of the parent/s-child dyad: it may be particularly difficult for parents who subscribe to the traditional authoritative roles and it may also cause discomfort for the child to see their parent/s' vulnerability. It may also encourage a family to 'paper over the cracks' in order to prevent damaging the family 'face' or reputation. This may be a very hard dynamic to transcend as it touches on the very highly held belief of family representing the family name.

As well as these caveats, locating the clash externally, as an interpersonal problem may inadvertently lead to 'splitting off' the troublesome Chinese cultural value, which is jarring with their ability to fit in to British culture. Specifically, it may represent an easier route to relieving distress to simply locate all

those values in a physical entity, i.e., parent/s, and subsequently reject *them* as a means to get out of their psychological dilemma. This contrasts with an approach that concentrates intrapersonally (such as systemic working with individuals, see Walker, 1995/1996; or a psychoanalytic approach) where there may be more of a focus on reconciling *all* parts of the self inclusive of those labelled crudely as 'Chinese' or 'British'. The individual approach does avoid the *potential* difficulty of therapy being perceived as a direct confrontation of the parent/s and child, thereby preserving the value of interpersonal harmony and filial piety. Of course, there are differences within intrapersonal approaches, some of which may be just as prone to inadvertently label unfamiliar and antagonistic (to British culture) beliefs as unhelpful and in doing so also encourage unwittingly a sectioning off/disownment of Chinese values.

From the client participants' accounts it was notable how there was one individual who had been helped to integrate the dual aspects of 'Chineseness' and 'Britishness' that were initially in conflict, i.e., CP2, but also one (CP8) (although reporting therapy as having been successful) demonstrated what appeared to be a disownment of 'Chinese parts' of himself that through therapy had clearly been labelled (rightly or wrongly) as the source of his psychological problems. For this participant (CP8), who had seen a non-Chinese therapist, when talking about the "emotional disability" resulting from the cultural taboo surrounding emotional expression, went on to say "...oh dear, I hate being Chinese". Although this was said in a quasi-jocular manner, it was difficult not to wonder about the degree to which 'culturally uninsightful' therapy does indeed run the risk of pathologising 'the other' cultural background. For this client participant, it may well have been the case that cultural beliefs played a role in his distress; however, these may have been more positively or neutrally connoted or balanced with a more examined approach of the benefits of having a Chinese cultural heritage.

It is by no means inevitable when a Chinese client sees a non-Chinese therapist that undesirable or unhelpful outcomes will ensue. For instance, one client participant who had seen a non-Chinese therapist felt he had been guided to be made more aware of cultural values: "...as the counselling sessions progressed, I was able to see the *deficiencies of a sort* in Chinese culture" (CP6). Although

he used the term 'deficiency', the manner in which he expressed this was connoted in an attitude of curious discovery as opposed to the more condemning tone present in the previous account.

The clinical implications of this notion of cultural containment are thus potentially very far-reaching and may encourage the clinician to consider the short and long-term benefits of a particular line of treatment. It was clear that the client participant (CP8) who showed a rejecting attitude to his culture, found many short-term gains in the relief of his distress. However, it may be argued that a long-term reconciliation inclusive of all parts of his *whole identity* may well have been sacrificed.

Whilst bearing this belief in mind, I would strongly advocate that cultural containment can only be achieved through the clinician being aware that when a client expresses cultural value clash, that there are considerations of an internal and external locus of therapy. Both of which share similarity in giving attention to the impact of relationships on the individual, whether they are represented internally, e.g., akin to object-relations ideas or externally, e.g., real life people. What approach or combination of approaches that would be most beneficial will of course be influenced by the client themselves. Both have potential up and down sides. However, the clinician also must assume responsibility for considering the short and long-term impact of their therapeutic intervention on the whole identity of the client, whilst being mindful not to over value those beliefs and assumptions that show the highest degree of familiarity with their own background.

I will tentatively offer a very broad framework for achieving cultural containment. The clinician must assume responsibility for firstly, taking a meta-perspective on the values they hold in esteem (and continue to examine what beliefs they tend to be drawn toward or repelled) and secondly, having a useful knowledge base of the client's culture/s. These points are related to the themes in therapist participants' accounts of *'Implicit and explicit acknowledgement of the impact of Chinese values: 'natural' cultural empathy'* and more so to *'Therapists' helpful knowledge'.* This will enhance the clinicians ability to 'deconstruct' the psychological dilemma that results in distress. Lastly and most importantly, I have the view that the clinician must look toward a *psychological integration* whilst

always being mindful of the origin of the temptation of both the client and therapist to simply 'split off' and reject certain beliefs of the client.

There are potential pitfalls in ethnic matching of client and therapist, 'Natural' cultural empathy is clearly useful but potentially may also become a hindrance due to the therapist making false assumptions of similarity and therefore not 'checking out' the meaning of certain beliefs to the client. The therapist may also over-identify with the client in unhelpful ways (Patel et al., 2000).

Cultural liberation

Another way in which culture played a role in the therapeutic process was how some client participants felt that seeing a non-Chinese therapist 'freed' them from some constraints of their culture so as to enable them to feel less stigmatised about talking about their emotions. Several expressed views on the negative value present in the Chinese language. This may reflect a finding that Southeast Asian populations attitudes show no gradations of emotional difficulty, only insanity and normality (Kam, 1989). This was a thought-provoking theme in a somewhat unexpected way as it demonstrated the impact of cultural matching in a potentially inhibitive way on therapy. It seems directly connected with the idea expressed by one therapist participant of the 'double stigma' of having a mental health problem and then seeing a Chinese therapist. This theme is somewhat contradictory to the findings of studies suggesting that ethnic and/or linguistic-matching result in more sessions attended, less drop out and better treatment outcomes (S. Sue et al., 1991). However, S. Sue (1998) also discussed the idea that "the importance of ethnic matching may heavily depend on the acculturation level, ethnic-cultural identity, or ethnicity of the clients" (p.442). Those who were most unacculturated showed the most benefit from matching (S. Sue et al., 1991).

Clinically, this has the obvious implication that those new to Britain may benefit most from seeing a clinician familiar to their ethnic origin; however, it has the less obvious implication of reminding the clinician that ethnicity and culture may be very different. Thus, the more acculturated an individual becomes the less likely that an ethnic rather than cultural match is paramount. Reflecting upon this,

one must also be reminded of the meaning of the concept of 'acculturation'. Whilst a review of acculturation models is beyond the scope of this thesis, it is important to note a broad and clinically helpful distinction on the dual nature of 'acculturation'. Graves (1967) refers to acculturation as the adaptation of behaviours *and* values in accordance to that of the dominant society.

The importance of distinguishing behaviour and values is evident when one considers that these are likely to change or adapt at different rates. Behavioural acculturation is likely to occur faster than the acculturation of values (Szapocznik & Kurtines, 1980; cited in Kim et al., 1999) and indeed complete value acculturation may never occur. This is salient to clinicians as a reminder to be mindful that a client may still hold less acculturated views despite 'looking' fully acculturated and also emphasises that a cultural match is not necessarily that closely linked to an ethnic match. Cultural matching thus may have occurred in the client participants who reported a close therapeutic relationship. 'Liberation' may have resulted through those client participants identifying strongly with the therapist's culture, which may be more accurately termed an 'ethnic-cultural liberation' and thus a 'cultural match' with their therapist. Furthermore, the theme *'What's culture got to do with it?'* may more correctly be named as *'What's ethnicity got to do with it?'*.

Methodological Issues

This section will present issues regarding epistemological and personal reflexivity. In addressing epistemological reflexivity issues, I will discuss limitations relating to the research questions, sample and generalisability, method of data collection, and qualitative analysis. In addressing personal reflexivity issues, I will discuss the ways I have influenced study.

Epistemological reflexivity

The research questions

The research questions focused the study on Chinese participants only and it is impossible to gauge how the interview data would have differed had a non-Chinese sample also be included as a quasi-comparison group. This, thus precluded comparative 'conclusions' with other groups and did not 'safeguard' against the idea that some of the issues that were salient for the Chinese participants would also be so for other groups. Having said this, however, one must re-emphasise that it was not the intention of this study to isolate culture-specific conclusions. Rather, it was merely to get an idea of the experiences of Chinese people when they sought help and to make some tentative links with dominant cultural values.

The sample and generalisability

A major consideration when evaluating this research study is to emphasise the nature of the sample of participants. Although qualitative research often does not aim for broad generalisability this does not mean that one can ignore characteristics of the sample. The client sample may be considered unusual (as compared to the majority of Chinese living in London, although the AVS scores suggested the client sample to be comparable to Asian American samples) and not representative of a single, homogenous 'Chinese' population as all client were moderately to highly educated, middle class, able to converse in English, relatively young and were predominantly students. This would have likely affected the level and degree of articulation expressed in client participant accounts. The client sample was also not randomly selected with three being chosen by one therapist and five volunteering. There may have been many reasons as to why the therapist chose those clients, but, it may be fair to say that they perhaps would be more likely to reflect examples of clients able to 'use therapy' or those showing a favourable treatment outcome. This may have then affected the quality of the data through skewing it towards including more thoughtful or positive accounts. Reflecting on the data from these interviews, it was clear that the latter assertion was not supported. However, overall, the data is likely to portray a more circumscribed pictured than had all the clients seen different Chinese therapists.

Furthermore, the Chinese therapist participants interviewed were not selected randomly. It is hard to say how the group would have differed had this been the case. Speculating behind reasons given by those declining the offer to take part (i.e., inability to make mutually convenient appointment times), it may be the case that some therapists felt that cultural issues were not a major factor in their work or if they were, they felt unable to verbalise them, they may have been less fluent in the English language or may have been simply too busy to participate. Therapist participant accounts used may therefore be more likely to include those motivated by and articulate in cultural issues, perhaps showing a greater degree of acculturation and represent those not excessively pressured by time.

It was likely due to the manner client participants were advertised for, that these participants would share the researcher's agenda in trying to effect positive change in mental health services for the Chinese community. This self-selection bias may mean that the client participants that displayed willingness to volunteer could have been more likely to either have had very positive or negative experiences. It may also have implicitly affected the way all participants recalled their experiences. For instance, the benefits of ethnic matching may have been amplified or exaggerated by participants with negative experiences down-played. The participants may have felt pressurised to 'stand up' to voice opinions on a largely neglected area and may have consequently over or understated points, which they felt to be salient.

Reviewing the data overall, one may further speculate on the conclusions likely to be sample-specific and those that may show more general application. It may be that sample-specific conclusions would include those most likely to be associated with educational level, social class and severity of the mental health problem they sought help for (all had problems such as relationship difficulties, anxiety or depression, those with serious mental illness and addictions were not included in the sample). These factors may affect how stigmatising mental illness problems are perceived to be and pathway of care into mental health services. It is pertinent that none of the client sample experienced forced detention under the Mental Health Act (1983) or sought help in crisis, which has been a common

pathway into entering mental health care for other Chinese people in England (P-L. Li & Logan, 2000; P-L. Li et al., 1999). Furthermore, none actually received therapy from mainstream services, relying on private or charitable organisations, thus no conclusions can be made about provision existing in the NHS. It is a weakness of this study that I did not include items on the interview schedule to cover reasoning processes that led to the decisions not to seek help through mainstream services.

In terms of conclusions that may have more potential to be generally applicable, these may include, the idea of 'framing' the notion of therapy in more culturally acceptable ways, the potential etic and emic aspects of therapy, highlighting of benefits and pitfalls of matching or not matching ethnicity, specific skills that may be considered culturally competent, clinical errors that convey cultural incompetency, the pressure on Chinese therapists to be multi-roled and the emphasis on finding individuality within an 'ethnic label'.

Other limitations concern the nature of the literature used to inform the study. Specifically, I refer to the use of research conducted on Asian American samples and potential problems in its applicability to Chinese samples in Britain. Firstly, one must acknowledge that there is no single 'Asian American' culture (Uba, 1994), and thus the research conclusions using these samples are at best going to be very general. The inclusion of many different Asian groups in research may obscure important ethnic-specific differences which may refute more general findings from 'Asian' samples. This critique is being addressed by researchers in America who are attempting to delineate differences in values and treatment efficacy (Sue, Nakamura, Chung & Yee-Bradbury, 1994). It is not possible to say with certainty how applicable the findings from this heterogeneous group are on the Chinese population living in Britain. Another point is that Asian American samples, although increasingly including Vietnamese samples have more of a representation of Filipinos. As a gross indicator of sample equivalency, it can be seen that this does not reflect the fact that Britain has a significant number of Vietnamese Chinese.

Certainly one can say that these groups are likely to share influences such as historical agricultural socio-economic context (E. Lee, 1997), cultural-philosophical ideals, i.e., Confucian and Buddhist belief systems (Uba, 1994). However, one cannot dispute that migration experiences, political sanctions on those allowed to immigrate, existing economic climate, and perceptions of the minority endorsed by the 'host' culture may constitute sufficient distortive influences as to make the samples non-comparable. As far as I am aware, there is no research that addresses this issue and thus, I can only assure the reader that these factors have not been ignored, rather, that in the absence of any strong indications of irrelevance, that I have attempted to make best use of the evidence base that I have judged to be relevant.

Method of data collection and the interview

The research interview required responses based on the recall and therefore inevitably a 'reconstructive' process, cognitively and conceptually, occurred for the participants to be able to do this. Asking participants to speculate on the way cultural values could have affected their experience may also have unwittingly encouraged prototypical/intellectualised abstract thinking, rather than more 'genuine' responses based on their own experiences. This criticism is based on ideas that value usage in individuals can be context-dependent (E. Lee, 1997) the participants may have inadvertently taken a stance of becoming more or less 'Chinese'. Another retrospective recall bias may have been towards participants being more prone to recall only the aspects of therapy they felt had cultural significance, thereby presenting a narrowed view on their experiences. The data do not suggest that these were actually a major influence; however, to deny that they were likely to have some influence would be naïve.

The design of the study and analysis precluded those participants who did not have the ability to converse comfortably or fluently in English. This of course constitutes a sampling limitation, but one may also acknowledge that language itself has a profound effect in shaping and constructing experience (Fairclough, 1995; cited in Willig, 2001). The fact that language does not simply mirror reality is important to bear in mind together with the above point of the research focusing on a

reconstructive memory of an experience. A discussion on the constructive effects of language on personal realities is beyond the scope of this thesis but, nonetheless this notion is relevant to its evaluation.

Qualitative analysis

Efforts were made to address good practice guidelines for qualitative research and analysis, e.g., Elliot, Fischer and Rennie (1999) and Henwood and Pidgeon, (1992); and judging research quality (Salmon, 2003). The next section will include reflections regarding my role in the data analysis.

Personal reflexivity

Willig (2001) states that *"Personal reflexivity involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped research. It also involves thinking about how the research may have affected and possibly changed us, as people and as researchers"* (p.10). Inherent in this definition is the idea that the researcher is culturally encapsulated and cannot remain completely 'meta' to the research process. Indeed to do so may not be as potentially informative as a position whereby the researcher acknowledges their position and is curious to understand the interactive/iterative process of 'self' and the data. This is a conclusion that mirrors thought regarding therapist 'neutrality' in post-Milan systemic family therapy (Hayes, 1991) and Fredman's (1997) ideas around becoming an observer to our own beliefs and then treating them as a resource.

I will now consider the many ways I have influenced this research study. The nature of the questions that formed the basis of the study were very much influenced by my position that I consider as being on the 'fringes' of both mainstream Chinese and British culture. I feel very behaviourally acculturated to British culture whilst less so in terms of values. My experience as a developing therapist also provided a context in which I wanted to understand more fully the interface of therapy and culture. Having studied experimental, social, cross-cultural, biological and clinical psychology; as well as anthropology

and archaeology, it seems that what I have 'brought' to this study are influences from all these areas. I have selected and organised the data in a framework for meaning on this basis, in a background agenda of aiming to facilitate positive change in clinical practice.

When interviewing the participants I was aware of the dilemma, as a researcher who shared the cultural background of the interviewees, of managing both rapport and alienation. Having a shared context was useful for participants to feel a basic connection with me (a view reported by many participants) but I also noticed a implicit temptation within myself to 'collude' in a perceived similarity by not exploring as deeply as I could the idiosyncratic meanings behind cultural values expressed by participants interviewed in the early stages of data gathering. On reflection, I understood this to have originated from a desire not to alienate myself from the participants. I feared that the act of asking participants to explain exactly what they meant, could damage the basis upon which our initial rapport had been built.

When reviewing the transcripts with clinical psychologists experienced in qualitative methods, it was easier to identify the instances when this occurred and be mindful of it in future interviews. I felt that the temptation to overidentify my understandings with that of the participants was managed with more confidence as I became more familiar with the process of interviewing. I attempted to consciously 'keep curious' whilst trying to strengthen rapport through conveying to the participant that I could reflect accurately a portrayal of *their* individual ideas. Overall, the feedback that I received from participants very much indicated that being Chinese and British was a definite asset in being able to talk freely and openly about their experiences.

It was clear also that the Chinese organisations and clinicians I contacted displayed a sense of 'obligation' to me as a Chinese person trying to research issues of mental health. This seemed to have increased willingness to participate, openness during interview, as well as be connected with participants often initially refused payment or not expecting it. I understood this also in terms of the Chinese principle of 'guanxi', which refers to 'relationship' or 'connections' and a mutuality or reciprocal

obligation in *useful* social relationships (Lin et al., 1995). My opinion was that this sense of responsibility may not have been as strong towards a non-Chinese researcher.

One of the main conclusions of the study was the ongoing dilemma existent in managing the tension between culture and the therapeutic process in the context of an individual. This reflected an internal dilemma existing within myself of an ongoing effort to understand how both Chinese and British influences have or are affecting my experience and interaction with the 'world' or 'environment'. I have the perspective of seeing the similarities but also the important differences that exist in these two world-views. It was important therefore to spend time reviewing the data of the interviews and thinking of how my position affected the research process.

On reflection, it may have been the case that I implicitly focused more sharply on differences (although this did not clearly inhibit participants emphasising the similarities), as perhaps ambiguities in the data may have had more potential to evoke confusion in my own dilemma. My discussion of the role of cultural containment and the internal or external locus of therapy may also have been influenced by my belief that therapy should as much as possible foster an authentic and inclusive idea of the client's self. This may be related to my own internalised ideas influenced by humanistic-existential concepts, such as *self-actualisation* (Maslow, 1967, cited in Comer, 1995) and more philosophical notions of developing in one's own unique ways through one's actions (Binswanger, 1942; Sartre, 1895-1980, cited in Comer, 1995). This approach focuses on the broader dimensions of human existence which other clinicians or approaches may not place in as central a position as I.

Managing the interaction of my beliefs and the data was enhanced by initially considering carefully the position from which I posed the questions, and to think about the biases and agendas that may govern these. Secondly, when data collection was underway, I was careful to note and discuss with my supervisor, times in which I felt I could have followed up responses differently with participants. Thirdly, within the data analytic phase, I explained the ways I derived themes to my supervisor and two other trainee clinical psychologists in an effort to ensure coherence. Throughout the cycles of this research, I

was mindful to ask myself questions based on those suggested by Fredman (1997), such as: 'What are my beliefs about this issue?', 'How do they fit or not fit with the data and literature?', 'What aspects of my beliefs are helpful and which are not helpful?', 'Do the views expressed by the participant contradict or conflict with any of my ideas?'. Importantly, when at the final stages of research, when my ideas had consolidated more, I also considered at what *level* of context I was relating to in the data and subsequently, what *other* level could I move to. In this way, I was able to move from an ethnic to cultural and then to a holistic contextual dimension in understanding the applicability of the research.

Conducting this research was an exciting and personally enriching experience. I feel this enrichment was inevitability enhanced by my position as a British born Chinese, as well as my role as a developing therapist. Within both these contexts, I felt I was able to be both 'inside and outside', and to be continually reflexive upon my position on the study itself. I was able to gain insights into parts of my cultural context and challenge some personal assumptions and beliefs surrounding mental health and therapeutic work with the Chinese community. It also added another layer of understanding to the way I classify my own ethnicity as 'British Chinese' and made me curious as to why in many NHS and organisational ethnic monitoring forms, I am unable to be both British and Chinese. This highlighted to me that the many social identities/roles one possesses often are not 'allowed' to be simultaneously considered. This point, I feel, mirrors perfectly the theoretical and clinical dilemmas that this research originated from, described and generated.

Future research directions

Following on from the reflections, one can suggest ways that future research may address some of the issues raised. Firstly, in terms of the research questions, they could be broadened to include non-Chinese groups as quasi-comparison samples for interest and stimulation. Secondly, with regards to the sample and generalisability, future studies could include a wider range of participants (in terms of educational level, social class, severity of mental health problem, clients experiencing different and perhaps more aversive pathways into care), accommodate Chinese speaking-only participants,

participants who receive therapy in NHS settings, and lastly use a random sample of client and therapist participants (including non-Chinese therapists). Thirdly, with regards to data collection and the interview, the present study suffered from the fact that there were no questions on the interview schedule addressing why clients chose not to pursue NHS mental health services, thus futures studies could focus on this aspect of help-seeking in detail. The issue of minimising over-identification of the researcher with the interviewees could be reduced by having a non-Chinese researcher conduct the interview using the same schedules. However, the benefits of doing this will have to be carefully considered in light of the positive feedback expressed by the participants concerning the researcher being Chinese and British.

The study could have been conducted differently by focusing on the clinical process in vivo. Asking a client and therapist dyad to comment on a video recording of a session in their preferred language would lessen the degree that reconstructive and distortive influences may affect recall. Indeed comparing their impressions of therapy pre- and post-viewing recorded data may allow one to ascertain the likely discrepancies that may have influenced the present study. Furthermore, using a survey prior to the development of the interview schedule allowing canvassing of what values and concepts participants thought were of importance would almost certainly have improved the scope of the information gathered.

Another future research direction concerns standard six of the MHNSF, which addresses the need to 'care for carers'. This is an especially important point when considering the fact that if mainstream support is accessed, this is only after long delays with family providing the majority of care. Au and Au (1994), state that Chinese carers in England often felt neglected. The finding by Li et al. (1999) that 56% of the participants in reported their family as being unsupportive is ambiguous as it does not give an idea of if this was always the case, the direction of causality, the interaction of deterioration in mental state in experience reporting, or other stresses present in the family context. However, research with Chinese Americans indicates that family conflict predicts both mental health and medical service use, whereas family support was not predictive of help-seeking (Abe-Kim, Takeuchi & Hwang,

2002). This supports the idea that the cultural importance of the centrality of the family in supporting the person with mental health needs is delicately balanced with the resultant stress and pressure on the family.

One therapist participant (TP1) talked at length about the invisibility of the Chinese mental health population but also of their family members who care for them. Carer burden has been studied extensively in western mental health populations (see Pearlin, Mullan, Semple & Skaff, 1990) but this is rarely addressed in Chinese populations despite their implicit inclusion in the Carers (recognition and services) Act (DoH, 1995b). Cultural values may have a role in discouraging accessing help on many different levels. This study echoes a common finding that stigma can be a barrier to access, however, there may be ways in which beliefs about 'caring', 'illness' and 'roles' in families may also interact with early intervention. For instance, the concept of carer burden may be incongruous to the value of family obligation. Conversely, Yee (1997) talks of the role of racial stereotyping of preferring to care for their own without needing support from other sources. Clearly, there is the need to study the role of carers in light of cultural expectations and stereotypes, and their impact on stress and conflict in families who care for a person with mental illness.

A final future direction for research which arises from standard seven of the MHNSF (DoH, 2000a) rather than a direct connection to the aims of this study is the prevention of suicide. Whilst research shows this to be especially pertinent for Indian-born and East African-born women (NIMHE, 2003) rather than Chinese communities in Britain, its importance can not be ignored given the alarming and rising rates of suicide in young people in Chinese societies (E. Lee, 1997). Future research addressing the cultural values influencing such alarming trends may be usefully focused on the role of internal means of social control. The reliance on shame, guilt, obligation and honour, together with values emphasising educational and occupational attainment to maintain self- and familial esteem may be proving to be both the foundation of the success of these societies, but also major factors in creating unmanageable pressures. Socio-economic changes through industrialisation are likely to be encouraging culturally oppositional values which may be manifest in young people feeling unable to

reconcile both value bases that converge in creating exceptionally high expectations on achievement with equally high costs of failure.

How can a therapist approach working with 'Culture' in clinical practice?

This section integrates the findings of the study, drawing on the themes important to the research questions and including the theme in client participant accounts of *"I found me': reinforcing personhood'* and themes in therapist participant accounts of, *'Tension between absolutist Vs. relativist stance'*, *'Recognition of diversity'* and *'Finding a balance'*. As this final section relates to the meaning of the data as a whole, each theme will not be discussed in turn, rather an integration of salient ideas significant in these themes will be presented.

A central issue in working with different cultural groups is the management of the balance of the etic and emic aspects of therapy. The therapist participants' accounts revealed a tension between adopting a position of basic similarity, i.e., an absolutist approach, or, difference, i.e., a relativist approach whilst also very much trying to emphasise the cultural diversity within 'Chinese' societies. This is a debate mirroring that surrounding empirically supported therapies (ESTs) and the development of culturally-specific therapies (CSTs). There is far from a consensus on the validity of each approach in addressing the mental health needs of minority ethnic groups (Nagayama Hall, 2001).

Those that advocate an absolutist / EST approach assume the cross-cultural validity of their methods. There is no evidence that any EST is valid for minority ethnic groups (Matt & Navarro, 1997; S. Sue, 1998, 1999); although this does not necessarily mean that these approaches will not go on to be shown to be valid, one must be most wary of the cultural encapsulation that may permeate such approaches. The findings of this thesis suggests that there are some aspects of therapy that show potentially a high degree of transferability, but one must also be cautious about generalising beyond the data. It may be that this was shown to be the case for these client participants only, however, it

could equally represent the 'tip of the iceberg' on the aspects or indeed whole approaches that will show exportability across a range of cultures.

This position is somewhat supported by epidemiological and personality data which reveal very few differences in psychopathology across cultures (Nagayama Hall, Bansal & Lopez, 1999; Kessler, 1994). However, one cannot dismiss the cultural encapsulation of the context of which these studies were developed, in fact Nagayama Hall (2001) states: "...the measures were all developed within a European American context, which precluded the investigation of culture specific phenomena. Cultural differences are unlikely to be detected unless there is a conceptual rationale to expect such differences and measures to assess relevant culturally related constructs," (p.4). This critique therefore echoes the 'well intentioned' thinking-style presented, that *may* lead to an inadvertent neglect of the impact of culture by being biased toward the identification of similarities.

Those advocating for taking more of a relativist / CST approach conversely adopt a basic position of difference. Support for focusing more on culture-specific phenomena is available from the client and therapist participant accounts showing potential differences in the client-therapist relationship, i.e., a teacher-student dyad, inappropriate treatment suggestions due to a lack of understanding about cultural values, looking at the role of stigma, 'face', obligation and intellectualisation, the prevalence of a perspective of mind-body unity, stated benefits of seeing a therapist of the same ethnic match and appreciating the impact of the socio-political context. However, whether this evidence suggests that specific new forms of therapy should be developed for different minority ethnic groups is debatable. These forms are derived from or in conjunction with indigenous/traditional treatment methods. Developing CSTs therefore requires psychologists to study culture 'on its own terms' (Boaz, 1911; cited in Berry et al., 1992) requiring a paradigmatic crossover into the field of cultural anthropology.

This approach has the advantage of focusing centrally on different world views and thus may prove to be more ecologically valid, however it may also suffer from over use of generalisations and differences which may eventually obscure commonalities in human experience. This fear was echoed in one

therapist participant (TP3) who expressed frustration from always being interpreted by peers in "the oriental way" to the extent that it caused her to experience a sense of alienation "...it just made me feel more different". Paradoxically, this approach may suffer also from the converse problem of being so specific that they become obsolete. Boaz, 1911 (cited in Berry et al., 1992) eschewed ideas of theorising and use of any explanatory models before the collection of *all* facts at which point these facts should speak for themselves. This idea was taken to the extreme and anthropologists became fearful of theorising lest their prejudices and biases distort *the facts* (Parkes, Laungani & Young, 2000). This unfortunately led to anthropology becoming more of a descriptive discipline avoiding comparative analysis between cultures as this was perceived to be in conflict with the idea of true relativism (Parkes et al., 2000). This position shows parallels to that of the 'unable' thinking-style (described earlier), except that it is not the lack of cultural knowledge that is the disabling influence, rather it is the lack of an overarching theoretical framework in comparisons to other cultures that can serve to confuse and potentially leave the therapist feeling rather directionless and 'at sea'.

Reconciling etic and emic approaches: Removing the 'all or nothing' thinking error in approaching the question of culture in clinical psychology

Inherent in the views expressed by the client and therapist participants, as well as most research and literature addressing culture, is a struggle arising from an underlying assumption of a need to take an 'all or nothing' approach to addressing this dilemma. This kind of false dichotomy was mirrored in the contradictions in the latent and explicit views in the accounts of the client and therapist participants. This was at times quite marked, with participants from both groups overtly saying that either culture played little part or it played a crucial role in their experiences, whilst then conveying examples that appeared to be inconsistent with their explicit statement. This was embodied in the theme *'Implicit and explicit acknowledgment of the impact of Chinese values: 'natural cultural empathy'* and the observation that both client and therapist showed evidence of cultural encapsulation.

This etic vs. emic argument appears to show conceptual equivalency to the age old 'nature vs. nurture' debate which encompasses psychological inquiry on many different levels. What seems to distinguish

them, however is that there does appear to be a professional consensus on a explanatory 'middle ground' with regard to the latter debate. It is my opinion that this is simply not so in the research and literature regarding culture. By this I mean that the 'third position' of universalism is often ignored. This is not intended to be conveyed in a blaming sense, rather it is an observation that researchers and authors often do not take a standpoint of universalism or explicitly address the potential interface of absolutist and relativist views.

Closely related to this point are two particular themes in the data, *"I found me': reinforcing personhood'* and *'Finding a balance,'* arising in client and therapist participant accounts, respectively. These themes were both an articulation of the existing tension of balancing culture, identity and personhood, whilst simultaneously encouraging recognition of the *dynamic* nature of culture. They appeared to provide support for a universalist stance in relation to the overall conceptualisation of culture in therapy, but most importantly, they also indicated the need to address the client as a person embedded within a multi-layered context, *one* of which may be their ethnic-cultural heritage.

This point is of integral importance when examining the relevance of the findings of this study. As S. Sue (1998) states, "It is known that ethnic or language matches do not ensure cultural matches, which may be of major importance. That is, ethnicity is more of a demographic variable than a psychological variable. The psychological aspects (e.g. identity, attitudes, beliefs, and personality) may be of greater importance" (p.442). This re-engages clinicians to realise the 'fine line' separating cultural expertise and cultural stereotyping.

The notion that ethnicity be considered as more of a demographic vs. psychological variable is relevant when returning to the ideas of self-concept raised earlier in the introduction chapter. In attempting to understand how acculturation may affect identity or personhood one might agree that culture-level distinctions of individualist and collectivist values *may* broadly manifest as independent Vs interdependent selves (Markus and Kitayama, 1991). However, what has emerged from this study are the personal nuances that are beyond these types of labels and a 'fleshing out' of the many ways in

which cultural values (and perhaps *false* poles of the independent vs. interdependent personality continuum) can and do exist concurrently in a individual.

After all, what are traditional values? - for who sets the temporal limit whereby values are seen to be 'traditional' of that culture. The absurdity of a static view of culture is highlighted when one attempts to apply this principle to viewing an individual. Clearly, there is a core that remains 'the personhood' of an individual but within a life span of development there is the influence of many different values, beliefs, assumptions coming from the multiple contexts of age, gender, class, cohort and ethnicity.

Therefore the challenge of finding a balance, of managing the tension between the 'all or nothing' that the profession of clinical psychology embraces, mirrors that faced by cultural anthropologists which in turn reflects upon the internal dilemma that clients and therapists feel alike. To accommodate this challenge openly it may be useful to take a meta-perspective and therefore become knowledgeable on the many and often disguised false dichotomies that exist in the 'science of culture' and its relationship with clinical psychology. Indeed, this point extends to the degree one views the endeavour of clinical psychology as separate to other fields of human experience in the widest sense, e.g., philosophy, anthropology, biology, sociology

Looking towards a multicultural or multi-contextual competency model in clinical work may be an appropriate focus for clinicians. This removes the issue of a 'monopoly on culture' with which ethnic minority groups seemed to have been endowed (whether purposively or not) to thinking about how an individual, in light of the various influences that impinge upon them across the lifespan, may experience their distress and how as clinicians we show competency in dealing with this. This also shifts thinking away from minority groups 'looking after themselves', as in ethnic-specific mental health services and focuses on improving existing services structures. This is a viable way of addressing standard one of the MHNSF (DoH, 2000a) of health and social services promoting mental health for all individuals and communities. It also will have a crucial impact on standard two by enhancing appropriate assessment at the level of primary care. It is an approach that shows similarities to the

move towards developing core competencies in the doctoral training courses. Specifically, identifying what is common in therapeutic processes perceived or experienced as culturally competent is much the same as identifying the core skills that underlie a competent clinical psychologist.

Wider service relevance

Whilst one may advocate for a multi-context or multicultural competency in clinicians, one also has to address how this may be reflected within a service. Before I enter more of a conceptual discussion around how this might be achieved (i.e. micro-level aspects), I would first like to highlight some aspects of service delivery that relate more to structural/practical organisation (macro-level aspects) that were often highlighted by client and therapist participants. These covered basic level of education about mental health issues, use of translators and phone access. Both the macro- and micro-level points are potentially relevant to standards one, two, three, four and five. However, the structural, macro-level aspects are potentially more relevant to addressing standards one, two and three of the MHNSF (DoH, 2000a) which relate respectively, to mental health promotion for all communities, to enhancing primary care assessment and access to local services. The conceptual, micro-level aspects are more likely to show transferability, in principle, to standards four and five, which relate to effective service provision.

Many of the participants felt that wide-scale education was needed regarding the basic nature of mental illness and this has recently been echoed by Yeung (2003). There were concerns that unhelpful lay beliefs and models (see Furnham & Henley, 1988; Helman, 1994; Luk & Bond, 1992) were still very prevalent, serving to perpetuate stigmatised attitudes resulting in many not benefiting from support at early stages. A second point concerned the difficulties of finding good quality translators and thirdly, the marked benefits of providing access to services through telephone consultations directly with potential clients and referring professionals. This latter strategy served to bypass the stigma of help-seeking through anonymity (some researchers have extended this idea to offering therapeutic services on-line to Asian Americans, Chang, Yeh & Krumboltz, 2001) and provided a chance for an initial

helpful experience. It is likely that utilisation may be improved if these 'macro' level issues are addressed.

Moving on to more conceptual issues regarding the management of cultural encapsulation in clinical settings, clinical psychologists must encourage services to take a meta-perspective on the way questions of 'race' and culture are addressed in all aspects of provision, from the basic assumptions from which the service is based to the way services are delivered. As Nadirshaw (1999) has proposed, "the discipline of psychology does not operate in a social, political and historical vacuum; on the contrary, it is influenced by, and in turn influences, society in a reflexive way" (p. 156). The recognition of the role of the clinical psychologist as an 'agent of change' in the provision and delivery of services (Webster, 1997) will be a step forward to achieving cultural shifts within the NHS. Only in this way can services address how they, as well as the clinicians themselves, are culturally encapsulated. By learning and applying models of psychological change derived from individuals (see Prochaska, DiClemente and Norcross, 1992), they may anticipate and appropriately manage a similar turbulence whilst attempting to effect 'cultural shifts' in services. Applying another integrative pantheoretical model of psychotherapy, services may also benefit from 'remoralisation' as a precursor to 'remediation' and 'rehabilitation' (Howard, Orlinsky & Lueger, 1995). Enabling all levels of a service to gain a sense of hope in addressing 'yet more' recommendations may be a valuable first step in motivating and maintaining long-term shifts. This will be enhanced by services having clear non-blaming messages, emphasising the inevitability but potential undesirability of cultural encapsulation.

The responsibility lies with clinicians and services to provide culturally competent models of service delivery. Services must encourage and foster skills and attitudes in staff so that they feel well-equipped with managing culture in their clinical practice and clinicians must take personal responsibility in looking at areas of their work which may be supplemented usefully by gaining more cultural knowledge. The approach of dual responsibility on behalf of services and clinicians also has the benefit of relieving the client of the role of 'cultural expert', a position which may feel imposed and also as seen from this study, may not be the only or most beneficial way to understand how cultural values

may be affecting an individual's experience of therapy. This does not in any way mean that the phenomenological experience should be ignored, rather it suggests that the client themselves may not be able to voice implicitly held beliefs or make sense of their effect on their therapy.

Summary and conclusions

This study was conducted in the context of the underutilisation of mainstream NHS mental health services by the Chinese community in Britain, and the corresponding dearth of research addressing therapy with minority ethnic groups, particularly the Chinese population. It was hoped that the findings would contribute to meeting the objectives of the recent NIMHE (2003) report 'Inside Outside: Improving mental health services for Black and Minority Ethnic communities' through illuminating tentative links between Chinese cultural values and their influence on therapy. The study aimed to provide an exploration into the experiences of therapy for a small number of Chinese people living in London. It also tried to see what a small number of therapists experienced in working with this client group considered to be of importance in their clinical practice.

The findings were relevant in providing a basis for understanding the potential etic and emic aspects of therapy. For the sample of participants in this study, therapist qualities and the purpose of therapy appeared to show etic value. Emically important ideas were embodied in concepts of cultural encapsulation, cultural containment and cultural liberation. The findings are pertinent in debates regarding the applicability of psychological theory and the role of single ethnic mental health service provision. They also provide ideas for future directions in research and wider service relevance in the form of advocating the recognition of the need to develop 'multi-context' or 'multiculturally competent' clinicians and mainstream NHS mental health services.

REFERENCES

Abe-Kim, J., Takeuchi, D., & Hwang, W-C. (2002). Predictors of help-seeking for emotional distress among Chinese Americans: Family matters. *Journal of Consulting and Clinical Psychology, 70*, 1186-1190.

Aitken, G. (1998). Reflections working with and across differences: Race and professional differences in clinical psychology therapy encounters. *Clinical Psychology Forum, 118*, 11-18.

Akutsu, P.D., Lin, C.H., & Zane, N.W.S. (1990). Predictors of utilization intent of counseling among Chinese and White students: A test of the proximal-distal model. *Journal of Counseling Psychology, 37*, 445-452.

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*, 371-393.

Atkinson, D.R., & Gim, R.H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 36*, 209-212.

Atkinson , D.R., & Matsushita, Y. (1991). Japanese American acculturation, counseling style, counselor ethnicity and perceived counselor credibility. *Journal of Counseling Psychology, 36*, 209-212.

Atkinson, D.R., & Wampold, B.E. (1982). A comparison of the Counselor Rating Form and the Counselor Effectiveness Rating Scale. Counselor Education Supervision, 22, 25-36. In P.D. Akutsu, C.H. Lin, & N.W.S. Zane, (1990). Predictors of utilization intent of counseling among Chinese and White students: A test of the proximal-distal model. *Journal of Counseling Psychology*, 37 (4), 445-452).

Au, W.K., & Au, K. (1994). *Care in the Chinese community: The way ahead.* Merseyside Chinese Community Development Association.

Barker, C., Pistrang, N., & Elliott, R. (1999). *Research methods in clinical and counselling psychology.* Chichester: John Wiley and Sons Ltd.

Barnes, L.L. (1998). The psychologizing of Chinese healing practices in the United states. *Culture, Medicine and Psychiatry, 22*, 413-443.

Barsky, A.J., & Klerman, G.L. (1983). Overview: hypochondriasis, bodily complaints and somatic styles. *American Journal of Psychiatry, 140*, 273-283.

Bateman, A. & Holmes, J. (1995). *Introduction to psychoanalysis: Contemporary theory and practice.* London: Routledge.

Berry, J.W., Poortinga, Y.H., Segall, M.H., & Dasen, P.R. (1992). *Cross-cultural psychology: Research and applications.* Cambridge: Cambridge University Press.

Bhui, K., & Olajide, D. (1999) (Eds.), *Mental health provision for a multicultural society.* London: Saunders.

Binswanger, L. (1942). In R.J. Comer (1995). *Abnormal psychology (2nd Ed).* USA: W. H. Freeman & Company.

Bion, W.R. (1962). Learning from experience. London: Heinemann. In A. Bateman & J. Holmes (1995). *Introduction to psychoanalysis: Contemporary theory and practice.* London: Routledge.

Bion, W.R. (1963). Elements of psychoanalysis. London: Heinemann. In A. Bateman & J. Holmes (1995). *Introduction to psychoanalysis: Contemporary theory and practice.* London: Routledge.

Boaz, F. (1911). The mind of the primitive man. New York: Macmillan. In J.W. Berry, Y.H. Poortinga, M.H. Segall, & P.R. Dasen. (1992). *Cross-cultural psychology: Research and applications.* Cambridge: Cambridge University Press.

Borkovec, T.D., & Castonguay, L.G. (1998). What is the meaning of empirically supported therapy? *Journal of Consulting and Clinical psychology, 66*, 136-142.

Burnham, J. (1986). *Family therapy.* London: Tavistock.

Burnham, J. (1992). Approach-method-technique: Making distinctions and creating connections. *Human Systems: The Journal of Systemic Consultation & Management, 13*, 3-26.

Callan, A., & Littlewood, R. (1998). "Patient satisfaction: Ethnic origin or explanatory model?". *International Journal of Social Psychiatry, 44*, 1-11.

Carr, A. (2001). *Family therapy: Concepts, process and practice.* Chichester: Wiley.

Carter, R.T. (1995). *The influence of race and racial identity in psychotherapy: Toward a racially inclusive model.* New York: John Wiley and Sons, Inc.

Cecchin, G. (1987). Hypothesising, circularity, and neutrality revisited: An invitation to curiosity. *Family Process, 26*, 405-413.

Chang, T., Yeh, C.J., & Krumboltz, J.D. (2001). Process and outcome evaluation of an on-line support group for Asian American male college students. *Journal of Counseling Psychology, 48* (3), 319-329.

Chen, C.P. (1995). Counseling applications of RET in a Chinese cultural context. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 14*, 117-129.

Cheng, A.T.A. (2001). Case definition and culture: Are people all the same? *The British Journal of Psychiatry, 179*, 1-3.

Cheng, L.Y.C. (1991). Sino-therapy: Is it necessary? Is it possible? *Bulletin of the Hong Kong Psychological Society, 26/27*, 71-80.

Cheng, T.A. & Williams, P. (1986). The design and development of a screening questionnaire (CHQ) for use in community studies of mental disorders in Taiwan. Psychological Medicine, 16, 415-422. In P-L. Li, S. Logan, L. Yee, & S. Ng. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of Public Health Medicine*, 21 (1), 74-80.

Cheung, F. M. (1995). Somatisation. In T-Y. Lin, W-S. Tseng, & E-K. Yeh (Eds.). *Chinese societies and mental health.* Hong Kong: Oxford University Press.

Cheung, F.M. (2002). Psychological symptoms among Chinese in urban Hong Kong. *Social Science and Medicine, 16*, 1339-1344.

Chinese Culture Connection (1987). Chinese values and the search for culture-free dimensions of culture. *Journal of Cross-cultural Psychology, 82*, 143-167.

Commander, M.J., Cochrane, R., Sashidharan, S.P., Akilu, F., & Wildsmith, E. (1999). Mental health care for Asian, Black and White patients with non-affective psychoses: Pathways to the psychiatric hospital, in-patient and after-care. *Social Psychiatry and Psychiatric Epidemiology*, 34 (9), 484-491.

Crocker, L. & Algina, J. (1986). Introduction to classical and modern test theory. Fort Worth, TX: Harcourt Brace Jovanovich. In B.S.K. Kim, D.R. Atkinson, & P.H. Yang. (1999). The Asian values scale: development, factor analysis, validation, and reliability. *Journal of Counseling Psychology, 46*, 342-352.

Department of Health (1993) *Health of the Nation: Ethnicity and Health.* London: HMSO.

Department of Health. (1995a). *Carers (Recognition and Services) Act.* London: HMSO.

Department of Health (1995b). *The Patient's Charter and You.* London: HMSO.

Department of Health. (2000a). *National service framework for mental health: Modern standards and service models.* London: HMSO.

Department of Health. (2000b). *The Race Relations (Amendment) Act.* London: HMSO.

Descartes. R. (1596-1650). In G.W. Farthing (1992). *The psychology of consciousness.* New Jersey: Prentice Hall.

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Erens, B., Primatesta, P. & Prior, G. (2001). *Health survey for England: The health of minority ethnic groups 1999, volume 1: Findings.* London: The Stationery Office.

Fairclough, N. (1995). Critical discourse analysis: The critical study of language. London: Longman. In C. Willig (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Buckingham: Open University Press.

Farthing, G.W. (1992). *The psychology of consciousness.* Prentice-Hall Inc., New Jersey, USA.

Fernando, S. (1989). *Race and culture in psychiatry.* London: Routledge.

Flaskerud, J.H. (1986). Diagnostic and treatment differences among five ethnic groups. *Psychological Reports, 58,* 219-235.

Flaskerud, J.H. (1990). Matching client and therapist ethnicity, language and gender: A review of the research. *Issues in Mental Health Nursing, 11,* 321-336.

Flaskerud, J.H., & Liu, P.Y. (1990). Influence of therapist ethnicity and language on therapy outcomes of southeast Asian clients. *The International Journal of Social Psychiatry, 36,* 18-29.

Fredman, G. (1997). *Death talk: Conversations with children and families.* London: Karnac Books.

Fry, R. (1993). Adult physical illness and childhood sexual abuse. *Journal of Psychosomatic Research, 37,* 89-103.

Furnham, A., & Henley, S. (1988). Lay beliefs about overcoming psychological problems. *Journal of Social and Clinical Psychology, 6,* 423-438.

Furnham, A., & Li, Y.H. (1993). The psychological adjustment of the Chinese community in Britain – a study of two generations. *British Journal of Psychiatry*, 162, 109-113.

Graves. T. (1967). Acculturation, access and alcohol in a tri-ethnic community. *American Anthropologist, 69*, 306-321.

Hall, C.C.I. (1997). Cultural malpractice: The growing obsolescence of psychology with the changing U.S. population. *American Psychologist, 52*, 642-651.

Hall, E.T. (1976). Beyond culture. New York: Anchor Press. In L. Robinson (1998). *'Race', communication and the caring professions.* Buckingham: Open University Press.

Hayes, H. (1991). A re-introduction to family therapy: Clarification of three schools. *Australian and New Zealand Journal of Family Therapy, 12*, 27-43.

Helman, C.G. (1994). *Culture, health and illness: An introduction for health professionals.* Wright: Bristol.

Henwood, K.L., & Pidgeon, N.F. (1992). Qualitative research and psychological theorising. *British Journal of Psychology, 83*, 97-112.

Hofstede, G. (1980). *Culture's Consequences.* USA: Sage Publishers.

Home Office. (1999). *The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William McPherson of Cluny.* London: The Stationery Office.

Hope, J. & Van Loon, B. (1998). *Introducing Buddha.* Cambridge: Icon Books.

Hui, C.H., Triandis, H.C., & Yee, C. (1991) Cultural differences in reward allocation: Is collectivism the explanation? *British Journal of Social Psychology, 30*, 145-157.

Iwamasa, G.Y., Sorocco, K.H., & Koonce, D.A. (2002). Ethnicity and clinical psychology: A content analysis of the literature. *Clinical Psychology Review, 22*, 931-944.

Joffe, H. & Yardley, L. (2003). In D. Marks and L. Yardley (Eds.) *(in press). Research methods in clinical and health psychology.* London: Sage.

Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshleman, S., Wittchen, H., & Kendler, K.S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*, 8-19.

Kim, B.S.K., Atkinson, D.R., & Yang, P.H. (1999). The Asian values scale: development, factor analysis, validation, and reliability. *Journal of Counseling Psychology, 46*, 342-352.

Kleinman, A. (1977). 'Depression, somatisation and the "new cross-cultural psychiatry"'. *Social science and medicine*, 11, 3-10.

Komiya, N., Good, G.E., & Sherrod, N.B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47*, 138-143.

Krause, I-B. (1994). Numbers and meaning: A dialogue in cross-cultural psychiatry. Journal of the Royal Society of Medicine, 87, 278-282. In N. Patel, E. Bennett, M. Dennis, N. Dosanjh, A. Mahtani, A. Miller & Z. Nadirshaw (2000) (Eds.) *Clinical Psychology, 'race' and culture: A training manual.* Leicester: BPS Books.

Krause, I-B., & Miller, A. (1995). Culture and family therapy. In S. Fernando (Ed.) *Mental health in a multi-ethnic society: A multidisciplinary handbook.* London: Routledge.

Kwok, C. F-Y. (2000). *The tormented mind.* Toronto: Pendulum Books.

Lau, A. (1997). The mental health of Chinese children and young people in Britain. In L. Yee, & S. Au (Eds.*) Chinese mental health issues in Britain: Perspectives from the Chinese Mental health Association.* London: Mental Health Foundation.

Lau, A., & Takeuchi, D. (2001). Cultural factors in hep-seeking for Child behaviour problems: value orientation, affective responding and severity appraisals among Chinese-American parents. *Journal of Community Psychology, 29*, 657-692.

Lau Chin, J., Huser Liem, J., Domokos-Cheng Ham, M-A., & Hong, G.K. (1993). *Transference and empathy in Asian American psychotherapy: Cultural values and treatment needs.* USA: Praeger Publishers.

Lee. E. (1997), (Ed.) *Working with Asian Americans*: A guide for clinicians. New York: The Guilford Press.

Lee. R., Rodin, G., Devins, G. & Weiss, M.G. (2001). Illness experience, meaning and help-seeking among Chinese immigrants in Canada with chronic fatigue and weakness. *Anthropology and Medicine*, 8, 89-108.

Lee, W.M.L. (1999). *An introduction to multicultural counselling.* USA: Taylor & Francis.

Leong, F.T.L., Wagner, N.S., & Tata, S.P. (1995). Racial and ethnic variations in help-seeking attitudes. In J. G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander (Eds.). *Handbook of multicultural counseling.* USA: Sage Publications.

LeVine, R.A., & Campbell, D.T. (1972). *Ethnocentrism.* New York: Wiley.

Lewis-Fernandez, R,. & Kleinman, A. (1994). Culture, personality and psychopathology. *Journal of Abnormal Psychology, 103*, 67-71.

Lin, K., Inui, T.S., Kleinman, A.M., & Womack, W.M. (1982). Socio-cultural determinants of the help-seeking behaviour of patients with mental illness. *Journal of Nervous & Mental Disease, 170,* 78-85.

Lin, T-Y., Tseng, W-S., & Yeh, E-K. (1995) (Eds.). *Chinese societies and mental health.* Hong Kong: Oxford University Press.

Lipowski, Z.J. (1987). 'Editorial: Somatisation: Medicine's unsolved problem'. *Psychosomatics*, 28, 294-297.

Li, P-L. ,& Logan, S. (2000). *The mental health needs of Chinese people in England: A report of a national survey.* London: Chinese National Healthy Living Centre.

Li, P-L., Logan, S., Yee, L., & Ng, S. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of Public Health Medicine, 21,* 74-80.

Lin, T-Y., Tseng, W-S., & Yeh, E-K. (Eds.) (1995). *Chinese societies and mental health.* Hong Kong: Oxford University Press.

Littlewood, R., & Lipsedge, M. (1982). *Aliens and alienists: Ethnic Minorities and Psychiatry.* London: Allen & Unwin.

Luk, C.L., & Bond, M. (1992). Chinese lay beliefs about the causes and cures of psychological problems. *Journal of Social and Clinical Psychology, 11*, 140-157.

MacCarthy, B. (1988) Clinical work with ethnic minorities. In T. Watts, (Ed.), *New Developments in Clinical Psychology.* Leicester: British Psychological Society Books.

Maslow, A.H. (1967) Neurosis as a failure of personal growth. Humanitas, 3, 153-170. In R.J. Comer. (1995). *Abnormal Psychology.* (2nd Ed.). USA: W.H. Freeman & Company.

Matt, G.E, & Navarro, A.M. (1997). What meta-analyses have and have not taught us about psychotherapy effects: A review and future directions. *Clinical Psychology Review, 17,* 1-37.

Matsushima, N. M., & Tashima, N. (1982). Mental health treatment modalities of Pacific/Asian-American practitioners. San Francisco: Pacific Asian Mental Health Research Project. In L. Uba (1994). *Asian Americans: Personality patterns, identity, and mental health.* New York: The Guilford Press.

McGoldrick, M., Pearce, J.K., & Giordano, J. (Eds.). (1982). *Ethnicity and family therapy.* New York: The Guilford Press.

McPherson, W. (1999). The Stephen Lawrence Inquiry: Report of an inquiry by William McPherson of Cluny, advised by Tom Cook, The Right Reverend Dr John Sentamu, Dr Richard Stone. London: The Stationery Office.

Minuchin, S., & Fishman, H.C. (1981). *Family therapy techniques.* USA: Harvard University Press.

Mordkowitz , E.R., & Ginsburg, H.P. (1986, April). The academic socialization of successful Asian American college students. Paper presented at the meeting of the American Educational Research Association, San Francisco. (ERIC Document Reproduction Service No. ED 273 219). In W.M.L. Lee (1999). *An introduction to multicultural counselling.* USA: Taylor & Francis.

Nadirshaw, Z. (1999). Clinical psychology. In K. Bhui, & D. Olajide (Eds.). *Mental health provision for a multicultural society.* London: Saunders.

Nagayama Hall, G.C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502-510.

Nagayama Hall, G.C., Bansal, A., & Lopez, I.R. (1999). Ethnicity and psychopathology: A meta-analytic review of 31 years of comparative MMPI/MMPI-2 research. *Psychological Assessment, 11*, 186-197.

National Health Service Executive Task Force. (1994). *Black mental health- a dialogue for change.* London: HMSO.

National Institute for Mental health in England (NIMHE). (2003*). Inside Outside: Improving mental health service for Black and Minority Ethnic communities in England.* London: HMSO.

National Statistics Bureau website. (2003). Retrieved April 22, 2003, from http://www.statistic.gov.uk

Palazzoli, M., Cecchin, G., Boscolo, L., & Prata, G. (1980). Hypothesising- circularity-neutrality: Three guidelines for the conductor of the session. *Family Process, 19*, 3-12.

Parker, G., Gladstone, G., & Tsee-Chee, K. (2001). Depression in the planet's largest ethnic group: The Chinese. *American Journal of Psychiatry, 158*, 857-864.

Parkes, C.M., Laungani, P. & Young, B. (2000). *Death and bereavement across cultures.* London: Routledge.

Parkman, S., Davies, S., Leese, M., Phelan, M., & Thornicroft, G. (1997). Ethnic differences in satisfaction with mental health services among representative people with psychosis in south London: PRiSM study 4. *British Journal of Psychiatry, 171*, 260-264.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nadirshaw, Z. (2000). *Clinical psychology, 'race' and culture: a training manual.* Leicester: British Psychological Society Books.

Patton, M.Q. (1990). Qualitative evaluation and research methods (2nd Ed.). Newbury Park, CA: Sage. In Barker, C., Pistrang, N., & Elliott, R. (1994). *Research methods in clinical and counselling psychology.* Chichester: John Wiley & Sons.

Pearlin, L. I., Mullan, J.T., Semple, S.J., & Skaff, M.M. (1990). Caregiving and the stress process. *Gerontologist, 30*, 583-594.

Pedersen, P.B., Draguns, J.G., Lonner, W.J., & Trimble, J.E. (Eds.) (2002). *Counseling across cultures.* (4th Ed.). Thousand Oaks, CA: Sage Publishers.

Ponterotto, J. G., Casas, J.M., Suzuki L.A., & Alexander, C.M. (Eds.). *Handbook of multicultural counseling.* USA: Sage Publications.

Poortinga, Y.H. (1971). In J.W. Berry, Y.H. Poortinga, M.H. Segall, & P.R. Dasen. (1992). *Cross-cultural psychology: Research and applications.* Cambridge: Cambridge University Press.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change. *American Psychologist, 47,* 1102-1114.

Race Relations Unit, Birmingham City Council. (1996). *The Chinese in Birmingham: A community profile.*

Robinson, L. (1998). *'Race', communication and the caring professions.* Buckingham: Open University Press.

Rogers, C.R. (1951). Client-centred therapy. Cambridge, MA: Riverside Press. In R.J. Comer (1995). *Abnormal psychology* (2nd Ed.), W. H. Freeman and Company: USA.

Rossi, P.H. & Freeman, H.E. (1993). Evaluation: A systematic approach (5th Ed.). Newbury Park: Sage. In Barker, C., Pistrang, N., & Elliott, R. (1994). *Research methods in clinical and counselling psychology.* Chichester: John Wiley & Sons.

Safran, J.D. & Muran, J.C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* New York: The Guilford Press.

Sainsbury Centre for Mental Health. (2002). *Breaking the circles of fear: A review of the relationship between mental health services and the African and Caribbean communities.* London: Sainsbury Centre for Mental Health.

Salmon, P. (2003). How do we recognise good research? *Psychologist, 16,* 24-27.

Sartre, J.P. (1895-1980). In R.J. Comer (1995). *Abnormal psychology* (2nd Ed.), W. H. Freeman and Company: USA.

Shaw, C.M., Creed, F., Tomenson, B., Riste, L., & Cruickshank, J.K. (1999). Prevalence of anxiety and depressive illness and help-seeking behaviour in African Caribbeans and White Europeans: Two phase general population survey. *British Medical Journal, 318*, 302-306.

Shia, G. (1997). Chinese medicine and mental health. In L. Yee, & S. Au (Eds.) *Chinese mental health issues in Britain: Perspectives from the Chinese Mental Health Association.* London: Mental Health Foundation.

Shon, S.P., & Ja, D.Y. (1982). Asian families. In M. McGoldrick, J.K. Pearce, J. Giordano (Eds.). *Ethnicity and family therapy.* New York: The Guilford Press.

Shostrom, E.L. (Producer). (1966). *Three approaches to psychotherapy.* [Film]. Santa Ana, CA.: Psychological Films. In P.D. Akutsu, C.H. Lin, & N.W.S. Zane, (1990). Predictors of utilization intent of counseling among Chinese and White students: A test of the proximal-distal model. *Journal of Counseling Psychology*, 37 (4), 445-452).

Singelis, T.M. (1994). The measurement of independent and interdependent self-construals. *Personality and Social Psychology Bulletin, 20*, 580-591.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J.A. Smith, R. Harre, & L. Van Langenhove (Eds.). *Rethinking methods in psychology.* London: Sage.

Sue, D.W. (1981). *Counseling the culturally different: Theory and practice.* New York: Wiley.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: theory and practice* (2nd Ed.). New York: Wiley.

Sue. S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 33, 1-22.

Sue, S. (1990). Culture–specific strategies in counseling: A conceptual framework. *Educational Psychology: Theory and practice*, *21*, 424-433.

Sue. S. (1998). In search of cultural competence in psychotherapy and counselling. *American Psychologist, 53,* 440-118.

Sue, S. (1999). Science, ethnicity and bias: Where have we gone wrong? *American Psychologist*, *54*, 1070-1077.

Sue, S., Fujino, D.C., Hu, L., Takeuchi, D.T., & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*, 533-540.

Sue, S., & Morishima, J.K. (1982). *The mental health of Asian Americans.* San Francisco: Jossey-Bass.

Sue. S., Nakamura, C.Y., Chung, R. C-Y., & Yee-Bradbury, C. (1994). Mental health research on Asian Americans. *Journal of Community Psychology*, *22*, 61-67.

Sue, S. & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, *42*, 35-45.

Suinn, R. M., Rickard-Figueroa, K., Lew, S., & Vigil, P. (1987). The Suinn-Lew Asian Self-Identity Acculturation Scale: An initial report. Educational and psychological measurement, 47, 401-407. In B.S.K. Kim, D.R. Atkinson & P.H. Yang, (1999), The Asian Values Scale: Development, factor analysis, validation, and reliability. *Journal of Counseling Psychology, 46*, 3, 342-352.

Sumner, W. G. (1906). *Folkways.* New York: Ginn. In J.W. Berry, Y.H. Poortinga, M.H. Segall, & P.R. Dasen. (1992). *Cross-cultural psychology: Research and applications* .Cambridge: Cambridge University Press.

Szapocznik, J., & Kurtines, W. (1980). Acculturation, biculturalism, and adjustment among Cuban Americans. In B.S.K. Kim, D.R. Atkinson & P.H. Yang, (1999), The Asian Values Scale: Development, factor analysis, validation, and reliability. *Journal of Counseling Psychology, 46*, 3, 342-352.

Takeuchi, D.T., Sue, S., & Yeh, M. (1995). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*, 533-540.

Tata, S.P., & Leong, F.T.L. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese-Americans. *Journal of Counseling Psychology*, *41*, 280-287.

Triandis, H.C. (1995). *Individualism and collectivism.* Boulder, CO: Westview.

Triandis, H.C., Leung, L., Villareal, P., & Clack, M. (1988). Individualism-collectivism: Cross-cultural perspectives on self in group relationships. *Journal of Personality and Social Psychology, 54*, 323-338.

Tseng, W-S., Qiu-Yun, L., & Yin, P.Y. (1995). Chinese societies and mental health. In T-Y. Lin, W-S. Tseng & E-K. Yeh (Eds.). *Chinese societies and mental health.* Hong Kong: Oxford University Press.

Tseng, W-S., & Streltzer, J. (Eds.) (1997). *Culture and psychopathology. A guide to clinical assessment.* USA: Brunner/Mazel, Inc.

Uba, L. (1994). *Asian Americans: Personality patterns, identity, and mental health.* New York: The Guilford Press.

Walker, J. (1995/1996). Using systemic ideas with individuals. *PSIGE Newsletter, 55*, 19-22.

Watzlawick , P., Weakland, J., & Fisch, R. (1974). In E. Jones (1993). *Family systems therapy: development in the Milan-systemic therapies.* Chichester: Wiley.

Webster, A. (1997). Stress and culture: Working in partnership with community groups. *Clinical Psychology Forum, 105*, 27-30.

White, M. (1991). Deconstruction and therapy. Adelaide: *Dulwich centre newsletter.*

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Buckingham: Open University Press.

Wong, G., & Cochrane, R. (1989). Generation and assimilation as predictors of psychological wellbeing in British-Chinese. *Social behaviour, 4*, 1-14.

Wrenn, J. (1962). In P.B. Pedersen, J.G. Draguns, W.J. Lonner, & J.E. Trimble (Eds.) (2002). *Counseling across cultures.* (4th Ed.). Thousand Oaks, CA: Sage Publishers.

Wright, S., Bindman, J., Thornicroft, G., & Butcher, M. (2000). *Thematic review of NHS R&D funded mental health research in relation to the National Service Framework for mental health.* London: Health service research department, Institute of Psychiatry.

Yee, L. (1997). Chinese carers of people with mental illness. In L. Yee, & S. Au (Eds.) *Chinese mental health issues in Britain: Perspectives from the Chinese Mental Health Association.* London: Mental Health Foundation.

Yee, L., & Au, S. (Eds.), (1997). *Chinese mental health issues in Britain: Perspectives from the Chinese Mental Health Association.* London: Mental Health Foundation.

Yeung, E. (2003). In C. Davis. Closed minds. *The Guardian Society, Social care, Wednesday May 14th*, 127-128.

Zane, N.W.S., Hatanaka, H., Park, S.S., & Akutsu, P. D. (1994). Ethnic-specific mental health services: Evaluation of the parallel approach for Asian American clients. *Journal of community Psychology, 22*, 68-81.

APPENDICES

Appendix 1 – Letter of ethical approval for the study

University College London Hospitals NHS
NHS Trust

The Joint UCL/UCLH Committees on the Ethics of Human Research: Committee Alpha

Chairman:
Professor André McLean

Please address all correspondence to:
Iwona Nowicka
Research & Development Directorate
UCLH NHS Trust
1st floor, Vezey Strong Wing
112 Hampstead Road, LONDON NW1 2LT
Tel. 020 7380 9579 Fax 020 7380 9937
e-mail: iwona.nowicka@uclh.org

Dr NE Pistrang
Sub-Department of Clinical Health Psychology
UCL
Gower Street
London
WC1E 6BT

07 June 2002

Dear Dr Pistrang

Study No: **02/0142** *(Please quote in all correspondence)*
Title: **Experience of counselling and therapy within the UK Chinese culture**

Thank you very much for letting us see the above application which was reviewed by the Chairman and agreed by Chairman's Action. There are no objections on ethical grounds to this study going ahead.

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

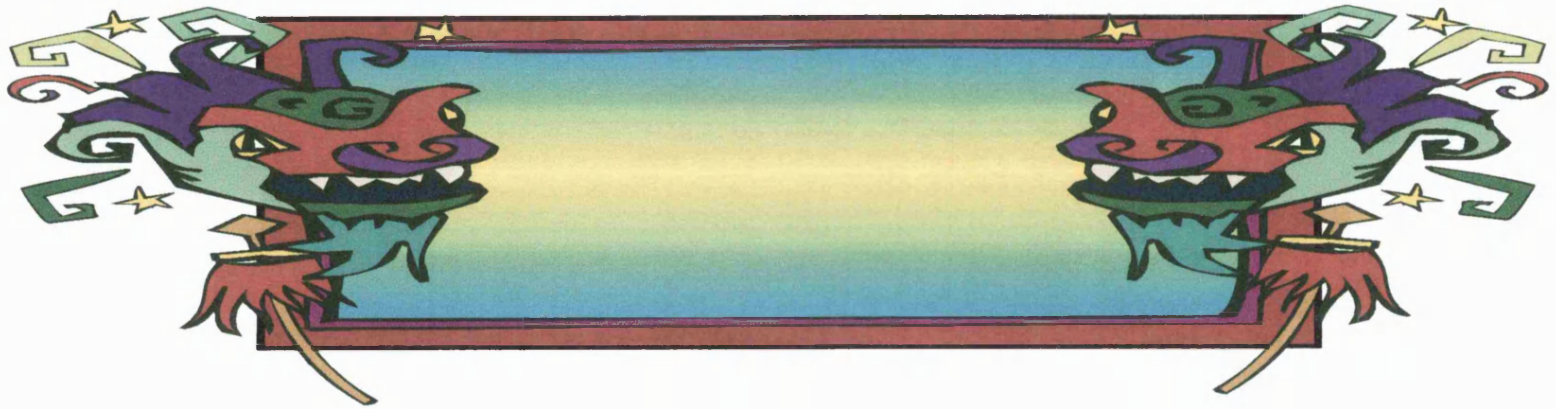
Professor André McLean, BM BCh PhD FRC Path
Chairman

/comalpha/aml/ijn/07/06/02

UCL HOSPITALS

UCL Hospitals is an NHS Trust incorporating the Eastman Dental Hospital, Elizabeth Garrett Anderson and Obstetric Hospital, Hospital for Tropical Diseases, The Middlesex Hospital, National Hospital for Neurology & Neurosurgery and University College Hospital.

CHINESE PEOPLE NEEDED!! PAYMENT OF £7.50



Hello,
I am an English-speaking Chinese student doing a study on how counselling/therapeutic services for the Chinese community living in London may be improved. I am a looking for any English-speaking Chinese people who have seen a counsellor or therapist for help.
All you need to do is tell me about your experience and all the information is strictly confidential.
You will receive a payment of £7.50 for your time (it will take about 1hr).
Please help!
Contact: Jenny on

Thank you!

Appendix 3- Covering letter sent to all participants

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Dr Nancy Pistrang, Senior Lecturer in Clinical Psychology
Jenny Jim, Trainee Clinical Psychologist

Telephone:

Date

Dear

Confidential

Experiences of counselling and therapy within the UK Chinese culture.

A Research Study

Thank you for your interest in our study. The enclosed information sheet outlines our reasons for conducting the research and explains what taking part would involve. I am undertaking this research as part of the Doctorate in Clinical Psychology at University College London and am supervised by Dr Nancy Pistrang, Senior Lecturer in Clinical Psychology. We very much hope that the findings from this study will benefit Chinese people who take the step to seeking help from a counsellor or therapist.

I will phone you in the next week or so to answer any queries you may have about the study and to see if you would like to take part. Please do not hesitate to contact me on 07766 148186, if you would like to discuss any aspect of the study before then.

Yours faithfully

Jenny Jim
Trainee Clinical Psychologist
University College London

Version 1: May 2002

Appendix 4- Information sheet for client participants

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Dr Nancy Pistrang, Senior Lecturer in Clinical Psychology
Jenny Jim, Trainee Clinical Psychologist

Telephone:

CONFIDENTIAL

Experiences of counselling and therapy within the UK Chinese culture

Information for volunteers

We are inviting you to take part in a research study. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of this study?
The study aims to find out about the experiences of Chinese people who have seen a counsellor or therapist for help with psychological problems. We know from previous research that ethnic minorities, especially the Chinese population, are often reluctant to seek help from outside the family. We hope that, by getting the views of people who have sought help, this study will give us a better idea of how to improve the services available for Chinese people.

What does taking part involve?
Should you decide to take part, you will be interviewed by Jenny Jim, who is a postgraduate student at UCL (and is of Chinese background herself). The interview will ask about your experience of counselling or therapy and how you decided to seek help. You will also be asked to fill out some short questionnaires. With your permission, we will tape the interview, so as to have a complete record of what was said. The whole session will last about an hour to an hour-and-a-half. You can choose to be interviewed at the Chinese National Healthy Living Centre or at University College London, whichever you prefer.

Confidentiality
At all stages of the study we will take care to respect the privacy and right to confidentiality of participants. All information collected will be kept confidential, and we will use numbers instead of names to identify the interviews and the questionnaires. Each interview will be transcribed (made into a written copy) and any identifying information will be deleted. All the data will be kept at UCL (under the care of Dr Nancy Pistrang), and no one apart from the researchers will have access to the information. In writing any articles for publication based on this research, we will not reveal the identity of anyone who took part. At the end of the study, the tapes will be erased; the transcriptions of the interviews will be kept until after the study is published.

Do I have to take part?

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. If you would like to participate, you will be given this information sheet to keep and be asked to sign a consent form.

Ethical approval
All proposals for research are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the joint UCL/UCLH Committee on the Ethics of Human Research.

Further Information
Please do not hesitate to contact Jenny Jim (phone number and address above) if you have any questions about the study.

Version 1: May 2002

Appendix 5- Information sheet for therapist participants

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Dr Nancy Pistrang, Senior Lecturer in Clinical Psychology
Jenny Jim, Trainee Clinical Psychologist

Telephone:

CONFIDENTIAL

Experiences of counselling and therapy within the UK Chinese culture

Information for counsellor/therapist volunteers

We are inviting you to take part in a research study. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of this study?
The study aims to find out about the experiences of Chinese people who have seen a counsellor or therapist for help with psychological problems. We know from previous research that ethnic minorities, especially the Chinese population, are often reluctant to seek help from outside the family. We hope that, by getting the views of people who have sought help, as well as of those providing help, this study will give us a better idea of how to improve the services available for Chinese people.

What does taking part involve?
Should you decide to take part, you will be interviewed by Jenny Jim, who is a postgraduate student at UCL (and is of Chinese background herself). The interview will ask about your experiences of being a counsellor or therapist and what you consider to be important in working with Chinese clients. You will also be asked to fill out some short questionnaires. With your permission, we will tape the interview, so as to have a complete record of what was said. The whole session will last about an hour to an hour-and-a-half. You can choose to be interviewed at the Chinese National Healthy Living Centre or at University College London, whichever you prefer.

Confidentiality
At all stages of the study we will take care to respect the privacy and right to confidentiality of participants. All information collected will be kept confidential, and we will use numbers instead of names to identify the interviews and the questionnaires. Each interview will be transcribed (made into a written copy) and any identifying information will be deleted. All the data will be kept at UCL (under the care of Dr Nancy Pistrang), and no one apart from the researchers will have access to the information. In writing any articles for publication based on this research, we will not reveal the identity of anyone who took part. At the end of the study, the tapes will be erased; the transcriptions of the interviews will be kept until after the study is published.

Do I have to take part?
You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. If you would like to participate, you will be given this information sheet to keep and be asked to sign a consent form.

Ethical approval

All proposals for research are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the joint UCL/UCLH Committee on the Ethics of Human Research.

Further Information
Please do not hesitate to contact Jenny Jim (phone number and address above) if you have any questions about the study.

Version 1: May 2002

Appendix 6- Consent form for all participants

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Dr Nancy Pistrang, Senior Lecturer in Clinical Psychology
Jenny Jim, Trainee Clinical Psychologist

Telephone:

Experiences of counselling and therapy within the UK Chinese culture.

CONFIDENTIAL

CONSENT FORM FOR VOLUNTEERS

Please read the following questions carefully and circle either 'yes' or 'no' as appropriate in each case:

Have you read the information sheet about this study?	**Yes/No**
Have you had an opportunity to ask questions and discuss this study?	**Yes/No**
Have you received satisfactory answers to all your questions?	**Yes/No**
Have you received enough information about this study?	**Yes/No**

Which researcher have you spoken to about this study?

_____
(name of researcher)

Do you understand that you are free to withdraw from this study at any time and without giving a reason for withdrawing?	**Yes/No**
Do you agree to take part in this study?	**Yes/No**

Participant's full name: .....
Participant's address: .....
.....
.....

Signed (participant): ..... **Date:** .....

I hereby confirm that I have provided an information sheet and have discussed the implications of participating in this research with the above:

Signed (investigator): ..... Date: .....

Version 1: May 2002

Appendix 7 - Demographic information sheet for client participants

Identity number: **CONFIDENTIAL**

Experiences of counselling and therapy within the UK Chinese Culture

Background information sheet for clients

Please answer each of the following questions.

1. Your gender: Male or Female (please circle one)

2. Your age.....
3. Your occupation.....

4. Your highest qualification.....

5. How would you describe your Chinese background?
   .....
   ..

6. Are you first or second or third generation Chinese?.....

7. If applicable, please state your religion.....

8. Are you currently in therapy?.....

9. If Yes, how long have you been seeing your therapist for? (please state frequency e.g. once a week **and** number of sessions)
   .....
   .

10. If No, how long ago did you stop seeing your therapist? (please also state frequency e.g. once a week **and** number of sessions that you had)
    .....
    ..

11. What problem/s did you come for help with?

.....
.

12. Have you ever worked with a counsellor/therapist prior to this time?

.....
..

13. Please tick the living situation best describes your own:

Living on own	.....
Living with family of origin	.....
Living with friends/flatmates	.....
Living with extended family	.....
Living with partner with or without children	.....
Other, please specify	.....

Appendix 8 - Demographic information for therapist participants

Identity number: **CONFIDENTIAL**

Experiences of counselling and therapy within the UK Chinese Culture

Background information sheet for therapists/counsellors

Please answer each of the following questions.

1. Your gender: Male or Female (please circle one)

2. Your age.....

3. Your occupation.....

4. Your highest qualification.....

5. How would you describe your Chinese background?
.....

6. Are you first or second or third generation Chinese?.....

7. If applicable, please state your religion.....

8. How long have you been in the counselling profession?.....

9. What relevant qualifications do you have?
.....
.....
.....

10. What would you say is your main theoretical orientation?
.....
.

11. What would you say are the main problems that you work with?
.....
.....
.....

Appendix 9 - The Asian Values Scale (AVS; Kim et al. 1999)

Asian Values Scale

For each item please put rating from 1-7 based on the following scale:

1	2	3	4	5	6	7
Strongly Disagree			**Neither Disagree or Agree**			**Strongly Agree**

1. One should not deviate from familial and social norms. ____
2. Modesty is an important quality for a person. ____
3. One need not remain reserved and tranquil. ____
4. One should think about one's group before oneself. ____
5. Occupational failure does not bring shame to the family. ____
6. The ability to control one's emotions is a sign of strength. ____
7. One's family need not be the main source of trust and dependence. ____
8. One need not focus all energies on one's studies. ____
9. One should have sufficient inner resources to solve emotional problems. ____
10. One should be able to question a person in an authority position. ____
11. One's achievements should be viewed as family achievements. ____
12. One should not make waves. ____
13. Parental love should be implicitly understood and not openly expressed. ____
14. One should not be boastful. ____
15. Family's reputation is not the primary social concern. ____
16. When one receives a gift a gift, one should reciprocate with a gift of equal or greater value. ____
17. Children should not place their parents in retirement homes. ____
18. One should be humble and modest. ____
19. One need not be able to resolve psychological problem's on one's own. ____
20. Following familial and social expectations is important. ____
21. The worst thing one can do is bring disgrace to one's family reputation. ____
22. Elders may not have more wisdom then younger persons. ____
23. One need not conform to one's family's and the society's expectations. ____
24. One should consider the needs of others before considering one's own needs. ____
25. One need not achieve academically to make one's parent's proud. ____
26. Children need not take care of their parents when the parents become unable to take care of themselves. ____
27. One need not to follow one's family's and society's norms. ____
28. Educational failure does not bring shame to the family. ____
29. One need not follow the role expectations (gender, family hierarchy) of one's family. ____
30. One should be discouraged from talking about one's accomplishments. ____
31. One need not to control one's expression of emotions. ____
32. One should avoid bringing displeasure to one's ancestors. ____
33. Educational and career achievements need not be one's top priority. ____
34. Younger persons should be able to confront their elders. ____
35. One should not inconvenience others. ____
36. One need not minimise or depreciate one's own achievements. ____

Appendix 10 - Semi-structured interview schedule for client participants

Explanation

Hello and thank-you for agreeing to take part in this study. I am doing this study to help me get a better idea of your experience of seeing a therapist. There are no right or wrong answers; I am only looking for your honest opinions. Please be as open as you can. I would like to know a bit about how you first thought about coming to speak to someone, as well as, what you expected the experience to be like. I am interested in what you have thought has gone well and also about any difficulties you may have encountered. Please treat the next hour or so as a conversation and please feel free to ask me to clarify questions at any point.

Section 1: History of contact

- Tell me how you came to be seeing a therapist.

- Before you came what sorts of ideas or expectations did you have?

- What things made it harder or easier to see a therapist?

- Tell me what you thought the therapist could help you with?

- In what way?

- Who else do you think could have helped you?

- Who else knows about your problem?

Section 2: Relationship with therapist

- How have you found talking to a therapist?

- Tell me how you feel about your therapist.

- Give me an idea of what your appointments are like?

- Have they asked you to do things or given you suggestions

- How comfortable do you feel with them?

- Have you talked about the general aims of therapy with your therapist?

- How important is it that you both agree?

- How do you tell your therapist if you disagree with things they ask you to do?

Section 3: What has been un/helpful in therapy?

- Thinking back to your time in therapy, what do you think has been helpful about your experience?

- In what way?

- Tell me more about that.

- Can you give me some examples?

- Did it matter to you whether your therapist was Chinese or not?

- In what way?

- Tell me more about that.

- Can you give me some examples?

- Are there any particular cultural values you think played a part in your experience?

- What were some things that were unhelpful?

- In what way?

- Tell me more about that.

- Can you give me some examples?

- Do you think cultural values played a role the way you or your therapist dealt with your problems?

- In what way?

- Tell me more about that.

- Can you give me some examples?

- In general how do you think therapists help people with their problems?

Section 4: General cultural issues

I have read about some values or ideas that some researchers think are more prominent for Chinese people when they come to see a therapist for help. Could I ask whether they had any relevance at all to your experience?

(If the following have not been mentioned in the course of the interview, I will follow on with these prompting questions)

Stigma/ Shame/ Face

- Often researchers have referred to a stigma/ shame/ loss of face relating to help-seeking – what is your experience regarding this?

- Can you give me some examples?

Role of the family

- Often researchers suggest that for Chinese people, the family or close friends appear to be very important (linked to a sense of self) – do you agree and if so how do you think this has impacted on your experience?

- Can you give me some examples?

Directiveness of the therapist

- Some researchers have suggested that Chinese clients may prefer therapists that are more directive- what are your views on this?

- Can you give me some examples?

- Lastly, can you think of anything that I have not asked you about that you think is important for me to know to understand your experience?

- Do you think you have been able to give an accurate account of your views today?

Appendix 11 - Semi-structured interview schedule for therapist participants

Explanation

Hello and thank-you for agreeing to participate in this study. I am doing this study to help get an insight of your clinical work with Chinese clients. I am interested in your experience as a therapist. There are no right or wrong answers; I am only looking for your honest opinions. Please be as open as you can. I would first like to ask a few questions about your general experience as a therapist and then would like to focus on your work with Chinese clients. Please treat the next hour or so as a conversation and please feel free to ask me to clarify questions at any point.

Section 1: Therapist Background

- Tell me about your experience of working as a therapist (duration, theoretical orientation).

- What kinds of clients have you worked with?

- What kinds of problems do you generally deal with?

- How do most clients get to see you?

Section 2: What is helpful in therapy?

- What is your view on what is helpful in approaching or doing therapy?

- In general, how do you think therapists help people with their problems?

- Do you discuss the goals of therapy? (or set tasks)

- Can you give me some examples?

- Is there anything that you have found to be unhelpful?

- Can you give me some examples?

Section 3: What is important to know when helping Chinese clients?

- Is there are difference in the way you work with Chinese and non-Chinese clients?

- Can you give me some examples?

- Do you think Chinese clients relate to you differently?

- Can you give me some examples?

- What are important factors affecting your work with Chinese clients?

- Can you give me some examples?

Section 4: General Cultural Issues

I have read about some values or ideas that some researchers think are more prominent for Chinese people when they come to see a therapist for help. Could I ask whether they had any relevance at all to your practice?

(If the following have not been mentioned in the course of the interview, I will follow on with these prompting questions)

Stigma/ Shame/ Face

- Often researchers have referred to a stigma/ shame/ loss of face relating to help-seeking – what is your experience regarding this?

- Can you give me some examples?

Role of the family

- Often researchers suggest that for Chinese people, the family or close friends appear to be very important (linked to a sense of self) – do you agree and if so how do you think this has impacted on your work?

- Can you give me some examples?

Directiveness of the therapist

- Some researchers have suggested that Chinese clients may prefer therapists that are more directive- what are your views on this?

- Can you give me some examples?

- Lastly, can you think of anything that I have not asked you about that you think is important for me to know to understand your experience?

  - Do you think you have been able to give an accurate account of your views today?

Appendix 12 - An example of a 'gestalt'

Gestalt (CP8):

A talkative man who expressed himself with humour and genuinity. He conveyed a sense of 'losing the fear of emotions' and that therapy has somehow been akin to an emotional 'resurrection'. For him, seeing a non-Chinese therapist was very important in helping him achieve the above.

Appendix 13 - An extract of an interview

Extract of an interview with (CP8) 5-10 minutes into the interview:

1- What did you expect when first saw therapist?
2- One thing I wanted to change at the time was that I wanted to be in a relationship without having world wars all the time because I knew I had a very...well I had rage really (laughs) not only anger the rage could be triggered quite easily in a relationship. Not so much by friends but its always the partner who triggered the pain and rage inside of me and I hated that and wanted that gone so by then I had stopped thinking that it was all the other person's fault 'they're attacking me. They're provoking me' I didn't think that way anymore so that is why I wanted individual therapy to try to get rid of the rage
3- And how did you think the therapist could help you?
4- because I used that 50mins a week as my chance to explore safely...explore the rage because outside the room I feel scared to get in touch with the feelings. I am getting better now after a year and a half now so I am getting better doing it outside the therapists place
5- Uhmm
6- but at the beginning I just hope that by talking about it with her she would guide me to think in a way that...from a more objective perspective I think because I knew I had always been q radical.
7- Uhmm
8- I did things like either 0 or 100 I was always like that, always been like that and I didn't like that either so I kind of gave myself in really so the therapist can have a chance to talk about my rage (laughs) and what she thinks about it with me, so that was my hope
9- Were your hopes met? - how was a typical session?
10- That woman who I saw for only 3 weeks she umm...I didn't feel particularly supported maybe because I had just started so may be I hadn't learned to trust her yet. Not because she's bad
11- Uhmm
12- Actually I remember that month I felt much worse than I had always been
13- Umm
14- cos I started about all the stupid...not stupid but horrible things that happened to me when I was small
15- uhmm
16- I remember feeling in a lot of pain at that time and I kind of blamed her (laughs) for making me feel a bit miserable
17- uhmm
18- and then that visa thing meant I had to stop and then when I knew I would try to stay it occurred to me that I could go back to that therapist whom my partner and I used to see together as a couple cos she already knows me
19- umm
20- so I went back there and started seeing her in either July or August 2001 and I have been seeing her every week til now and with her well instantly when I went back it is easier for me to trust her because I know this person already and she knows me already and I found it easy to talk about things with her and I like her because she not only spontaneously guides me to the right path but I also asked questions like as this person does this or says this to me and it makes me feel angry, upset because it makes me feel criticised and I hate feeling criticism as my parents spent their whole like criticising me and what should I do? A strategy, mechanism to cope with life. She would come up with a couple of suggestions that you can actually do
21- right

22- so she is not being really vague of what you should do, you can do to cope with life and I like that about her. But also she talks about an overall picture of my fuck ups (laughs)
23- umm
24- yes I found that really helpful
25- what does overall picture mean to you?
26- Well with her I have to talk about, like why I can not take criticism at all in adult life even like constructive ones
27- Uhmm
28- Its because when I was little no matter how hard I worked, even if I got and A-plus on my report card my father would say, 'A-plus is just A-plus' and if spelt an English word wrong, I remember this example 'correspondent' is 'd-a-n-t' and I spelt 'd-e-n-t' and I still got an A-plus but the teacher said 'oh that's misspelt' then I thought he would be pleased but he said 'I thought your English was good' (said in a sneering tone of voice)
29- umm

Tabulation of excerpts, theme labels and their connection with Chinese cultural values (CP8):

CP 8 (pg, para, Li)	Units	Themes	Connection with research on Chinese values and therapy (C= consistent with, I= inconsistent with)
6, 88, 1-7	I actually prefer that she is not Chinese because I always believe or at least I feel that in Chinese families that there is always this taboo view- you don't really discuss your feelings and after all the study of the mind came from the west and I think it is for the best that I want to do...well for my the therapist being from westerner well she is like a white sheet of paper that I feel comfortable starting with	Emotional suppression Inhibitive influence of culture	C = Stigma re: mental health issues and emotional expression I = benefits of single ethnic mental health services and ethnic matching

First and second-order themes (CP8):

Second order theme	First order themes
Emotional expression is 'normal'	Emotional suppression Emotional 'disability', having to 'mind-read' Emotional dissociation, having to be a 'robot' Humans are emotional creatures
Ownership	Owning the problem Owning the therapy Obligation to therapy/ therapist
Therapist as a meta-perspective	Therapist as objective 'guide' Therapist as observer
Therapy as insight	Gaining insight Novel coping strategies Finding coherence between past and present Gaining a formulation or 'overall picture'
Therapy as learning process	Therapist as teacher Therapy as a learning curve
Therapy as catharsis	Emotional purging Letting it all out
Stigma and negative experiences relating to culture	Rejection by family Inhibitive influence of culture Negative value inherent in the Chinese language re: emotions

Appendix 16 - An example of a visual representation of first and second order themes