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University of Southampton

Faculty of Environmental and Life Sciences

School of Health Science

"Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work".

by

Hubert Fanka

Thesis for the degree of Doctor of Clinical Practice

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Abstract

Faculty of Environmental and Life Sciences School of Health Science

"Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work".

Hubert Fanka

Background: England has a multicultural society and so, health professionals will engage with clients from culturally and racially diverse backgrounds. Research suggests that psychological therapists are not adequately prepared or trained to practice cross-culturally, even though multicultural competence is recognised as a key component of mental health policy and professional codes of conduct. In particular, research is lacking on how psychological therapists experience cross-cultural practice in an unlike racial and cultural dyad.

Study aims: The aims of the present research were to explore and understand psychological therapists' lived experience of cross-cultural practice, and to identify the successful elements as well as the difficulties of cross-cultural therapeutic work.

Design: Seven practising psychological therapists (four White British and three African-Caribbean) were interviewed about their cross-cultural work using a semi-structured format. Their accounts were analysed using Interpretative Phenomenological Analysis (IPA).

Findings: Four themes were identified: (1) The mastering cross-cultural/racial practice; (2) barriers to effective cross-cultural/racial work; (3) cross-cultural/racial learning in practice; (4) supervision/support as a "potential" site for cross-cultural fertilisation. These four themes culminate in the overall finding that: participants felt unprepared and inadequately trained to practice cross-culturally, but over time and with ongoing training and supervision, their experiences shifted progressively to mastery of a range of culturally competent skills. The findings, while supporting previous cross-cultural therapeutic work literature, have also clarified complex and important issues regarding training and supervision.

Recommendations: Within psychological therapeutic cross-cultural work, the initial and ongoing training, learning and supervision of therapists should foster experiential learning and encourage mindful exploration of own racial biases and identity, encouraging personal and professional self-exploration at both individual and group levels. Cross-cultural reflective practice, collaborative

practice and group supervision are seen as a means to reinforce and nurture therapists' willingness to transform and competently adapt their cross-cultural therapeutic work as required. The innovation of a Cultural Formulation and Supervision Group (CFSG) is proposed as an alternative to mitigate the challenges associated with current one-to-one models of supervision and offers an environment where professionals can willingly and safely discuss difficult situations, self-explore and learn new approaches and skills in a non-judgmental and safe environment.

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Research Thesis: Declaration of Authorship

Print name: Hubert Fanka

Title of thesis: "**Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work".**

I declare that this thesis and the work presented in it are my own and have been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: Hubert Fanka .....Date: April 2021

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Definitions of terms

African-Caribbean

The term African-Caribbean in this research refers to people and their offspring with African ancestral origins and Caribbeans who migrated to the United Kingdom (UK). The term has geographical, social and cultural meanings. For the purpose of this research, the term will refer to people who are Black in colour, mixed in colour and who were born in an African or a Caribbean family either abroad or in the UK. The use of the term African-Caribbean will remain mindful of the historical context (colonisation), cultural context (traditions), geographical context, religious context and the implications these may have on the stance of cross-cultural psychotherapies.

White British

Most White people born in Great Britain, although British citizens, do not regard themselves as British and prefer to state their national identity as English, Scottish or Welsh. People born in England are called English or British and can say that they live in England, Britain and/or the UK. The use of the term White British will also remain mindful of these preferences and focus more on the common cultural, racial and historical shared identities. The focus will be on White psychological therapists who identify themselves as British, English, Scottish or Welsh.

Psychological Therapist

In this study, the term Psychological therapist refers to psychologists, psychotherapists or counsellors who engage in talking therapies with clients on a one-to-one or group level. They would have specialised in a therapy modality, have been accredited within a professional body and currently be working within a public, private or voluntary organisation.

Acculturation/enculturation

Within the therapeutic context, it is a cultural modification (formal or informal) of an individual, group, or people by adapting to or borrowing traits from anothers' culture; it can also be defined as a merging of cultures following partial or prolonged contact with a different culture. Therefore, the term acculturation will refer to learning appropriate behaviours of the host culture and enculturation will refer to learning the appropriate behaviour of a person's own culture. These two processes shape who psychological therapists think they are and what they do in their clinics. In this research, understanding professionals' acculturation (cultural modification) and enculturation towards African-Caribbean and White British clients could pave the way to recommendation for effective interventions and training and perhaps ongoing support systems.

Definition of Culture, Race, Ethnicity (see Appendix A)

Abbreviations

ACT: Acceptance and Commitment Therapy

BABCP: British Association of Behavioural and Cognitive Therapists

BACP: British Association of Counselling Psychologists

BAME: Black Asian Minority Ethnic

BPS: British Psychological Society

CBT: Cognitive Behavioural Therapy

CFT: Compassion Focused Therapy

CMHT: Community Mental Health Treatment Team

DBT: Dialectical Behavioural Therapy

DOH: Department of Health

DRE: Delivering Race Equality

HPC: Health Professional Council

IAPT: Improving Access to Psychological Therapy

IPA: Interpretative and Phenomenological Analysis

MCKAS: Multicultural Counselling Knowledge and Awareness Scale

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

REM: Racial Ethnic Minority

SHFT: Southern Health NHS Foundation Trust

UK: United Kingdom

UKPC: UK Council for Psychotherapy

USA: United State of America

Chapter 1 Introduction

1.1 Personal position

This thesis is the research component of a Doctorate in Clinical Practice course. The objective is to equip students with the applied skills and knowledge for high level leadership and strategic healthcare roles. It comprises both modular taught components and a major piece of clinically focused research. I have successfully achieved the taught modules. This thesis is presented as a substantial piece of field work which focuses on exploring and understanding the salience of race and culture in therapeutic work.

Therapeutic work has dominated the theory and practice of psychological therapy since it first developed as a healing modality. Formal psychological therapies have been predominantly developed in Western societies (dominant culture therapist on dominant culture patients) and may not be as relevant to different cultures (Benson & Thistlethwaite 2008). This has implications for therapists working across-cultural boundaries and current practice, opinions, attitudes and perceived problems as they relate to cultural issues may vary. The focus of cross-cultural psychology continues to place emphasis on the testing of hypotheses that are derived from conventional psychological theories. As such, greater importance appears to be placed on how traditional, Western, psychological approaches can be effectively applied to minority ethnic clients, whilst taking into account the differences that arise due to ethnicity and race.

As a psychological therapist working in the UK for 17 years, and a Black African man with long-held religious beliefs, I have often questioned the culturally determined nature of psychological therapy. The normative assumption in the National Health Service (NHS) is that people in psychological distress need psychological therapy. However, this helping approach is influenced by Western culture and may be challenging when applied to people from different cultures.

During my years of training in the UK as a psychological therapist, I was surprised by the lack of teaching related to culture, ethnicity, and race. Most of my tutors were White British, and the curriculum lacked cultural references and diversity. The training was not enough to prepare one to work effectively across-cultural practice. This has, at times, led me to make assumptions that there might be some uncomfortable feelings when talking about ethnicity and race in psychotherapy. The current model of cross-cultural supervision continues to face difficulties: the method of supervision relies heavily on the supervisor and supervisee experiences and a willingness to engage in multicultural issues, within the backdrop of a lack of training, lack of interest and perhaps the inability to fully comprehend the complexity of working with clients from a different cultural background (Dressel et al. 2007). It is from these identities and positon that I examine the cross-cultural experiences of psychological therapists working in England. The aim is to enhance clinical practice and training by understanding the effects of differences in culture and race in the delivery of cross-cultural/racial therapeutic work.

In order to do this research, I have taken a “critical realist” position which recognises that we construct our social reality through language, but also that a world exists beyond our social constructions (Eatough & Smith 2006). This is consistent with the views of the phenomenologist Heidegger, and in particular, his concept of the “person-in-context” (Larkin et al. 2006). Different perspectives can produce different interpretations of the same phenomenon, which is relevant when considering the influence of the values and assumptions of the researcher on the qualitative study. This is why an interpretative and Phenomenological analysis (IPA) will be used to explore the experience of cross-cultural therapeutic work.

1.2 Psychotherapy and culture

The components of psychotherapy are well established but continue to lack cultural dimension because they are Western and White-centric. Formal psychological therapy is a culturally condensed

healing practice that was created from a specific cultural approach and dedicated to a specific cultural context (Wampold 2007). This has created a means in which psychological therapists adopt and use universalised principles to explain and deal with individuals from different cultures with different experiences. These issues bring to light the challenges of formal psychological therapies in the context of a specific cultural background. The perception of talking therapy as a helping relationship is worldwide and universal. However, there are certain variables inherent in every culture that give psychological therapy a deeper meaning in its efforts to help promote better relationships with self, with others, and with the entire universe. This thesis will therefore bring culture and race to the meaning of psychotherapy and how this is experienced from different Phenomenological perspectives.

Across the broad spectrum of therapies, the literature reveals that Western practitioners who have attempted to use traditional forms of healing (counselling, psychotherapy) within the public and private sector, with African-Caribbean clients, have reported considerable difficulties within the therapeutic relationship; therapy process; cultural beliefs and religion; confidence and competence; supervision and collaboration (Farsimadan et al. 2007). Little literature and research have focused on non-native psychological therapists' experience and none of the research in the UK has focused exclusively on exploring African-Caribbean and White British Psychological therapists' experience of working respectively with White British clients and with African-Caribbean Clients.

According to Rogers (1957), in order for constructive personality change to occur, it is necessary and sufficient that the following conditions exist and continue over a period. These conditions are presented in box below

Box 1: **Rogers (1957) therapeutic conditions**

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, termed the therapist, is congruent or integrated into the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding

These mutual factors are the dominant ingredients for engagement and it is within these components that Western therapies fail patients from other cultures (Sue & Sue 2007). These six components are shaped by cultural expectations of the patient and also the level of cultural openness and humility of the professional delivering the service. All psychological therapists agree that the therapeutic relationship is paramount to all successful therapeutic work. The therapeutic alliance is the trust between the therapist and the patient that allows them to work together effectively. It is what helps the patient believe that their therapist has their best interest at heart, and might be the most important part of beginning talking therapy and the healing process. Many studies indicate that the therapeutic alliance is the best predictor of treatment outcome (Safran et al. 2009; Martin et al. 2000; Bender 2005; Ackerman & Hilsenroth 2003). However little consideration has been given to how race/culture shapes this relationship.

1.3 Therapeutic relationship and culture/race

The therapeutic relationship between client and therapist accounts for the largest contribution to outcome in the common factors (Lambert & Barley 2002). The therapeutic relationship is defined as "the feelings and attitudes that therapist and client have toward one another and the manner in which these are expressed" (Gelso & Carter 1985:159). This definition is widely accepted in the field

and was used by The Evidence-Based Therapy Relationships (Norcross & Wampold 2011). Evidence of the power of the therapeutic relationship has been reported in over 1,000 studies (Orlinsky et al. 2004). Fuertes et al. (2006) reported finding that, for therapists, the perception of a strong therapeutic alliance with clients and feeling that clients experience them as competent correspond to higher overall work satisfaction. Kottler and Hunter (2010) noted how the therapeutic encounter can impact and instigate profound change in the therapist as well as the client. The most recent findings on evidence-based therapy relationships echo this idea of adapting the therapy to clients and highlight the need to integrate treatment methods, therapy relationships, therapist qualities, and client characteristics and diagnoses in order to achieve the most effective outcomes (Norcross & Lambert 2011).

Client and therapist relationship formation at the very start of psychotherapy and the therapist's ability to form a positive alliance have been shown to be predictive of outcome (Baldwin et al. 2007). Fitzpatrick et al. (2006) found that, when clients interpret critical events occurring early in therapy as positive, they increased their openness to exploration. They reported this openness manifested in greater client self-disclosure and an increased tendency to make use of input. These results were also associated with more positive feelings toward the therapist. Additionally, Westra et al. (2011) found that greater early therapist positive reaction to clients, especially liking, enjoyment, and positive attachment was linked with significantly less client resistance. Hubble et al. (2010) highlight that the research on the therapeutic relationship emphasizes the importance of the therapist's role in developing a positive, meaningful relationship by not only meeting the client where they are, but also by soliciting feedback from the client regarding the therapy experience, making commitment for an ongoing process of compassionate self-awareness and implementing cultural humility (which allows a shared power dynamic in the relationship that increases communication while decreasing unhelpful assumptions) (Green and Dekkers 2010; Hook 2014). Cultural humility therefore, may be the best tool for self-reflection, self-exploration and exposure to controversial and sensitive topics within cross-cultural interractions. According to Tervalon and Murray-Garcia (1998), the concept of

cultural humility is the process of committing to an ongoing relationship with patients, communities and colleagues that requires humility as individuals to continually engage in "self-reflection and self-critique" (P.118). Cultural humility encompasses recognition of learning needs and acting accordingly, while having openness to the other's cultural stance to gain awareness (Hook and Watkins, 2015).

One important question here remains – what is the impact of race and culture in the formation of meaningful therapeutic relationships? Culture and race are important aspects to be considered in the therapeutic encounter and it is conveyed in how people interact and what they communicate in a therapeutic context (Bhugra & Mastrogianni 2004). Unfortunately, despite a reseach culture of diversity issues, racism and cultural adaptation to therapeutic work (Rathod et al. 2015), practitioners continue to struggle with cross-cultural/racial therapeutic work. This study aims to explore the experience of psychological therapists who have had experience of working with clients from different races and cultures with the rationale that this will help advance strategies for effective cross-cultural/racial therapeutic work.

1.4 Contribution to the field of psychotherapy practice

A number of qualitative studies have shown certain therapist behaviours and skills to be influential in the development of a positive therapeutic relationship. Ackerman and Hilsenroth (2003) found several therapist attributes and behaviours conducive to building a positive relationship with clients: respectfulness; interest; openness; flexibility; warmth; trustworthiness; honesty; and confidence. They reported the following behaviours as helpful in forming a positive working alliance in therapy: attending to clients' experience; reflection; accurate interpretation; exploration; and facilitation of affect expression (Ackerman & Hilsenroth 2003). Hilsenroth and Cromer (2007) emphasized the need for therapists to be especially aware of the therapeutic relationship at the earliest stage of therapy, which they argued was the best opportunity to form a positive relationship and shapes how

the relationship develops over the course of treatment. A strong therapeutic alliance may be developed in the initial sessions when the therapist conveys: support; empathy; confident collaboration; exploration; activity; warmth; competence; active listening; respect; understanding; and nonjudgment. The elements found to be effective in a therapeutic relationship were: goal consensus; collaboration; and positive regard. Those elements that fell into the 'positive but unsatisfactory research' to evaluate were: congruence/genuineness; repairing alliance ruptures; and managing countertransference. It is assumed here that challenges associated with congruence, repairing therapy rupture and managing countertransference are likely to occur in cross-cultural/racial therapeutic encounters, given the historical differences, cultural heritage and spirituality. In an attempt to adapt the therapeutic relationship to client characteristics, the following methods of adapting are demonstrably effective: reactance/resistance level, preferences, culture, and religion and spirituality (Norcross & Wampold 2011). The obvious challenge when practising psychotherapy involves dealing with clients or psychological therapists who present with conflict in their life resulting from cultural clashes, because they may never be acculturated in one pure culture. Many clinicians often fail to understand this and mistakenly assume that all individuals are free to engage in Western world ways of thinking and have the knowledge required to comprehend, facilitate or engage in treatment - consequently failing to consider the dynamic of the culture and other relevant health factors. There is therefore, a continued need to understand the subjective relationship between ethnicity and the delivery of psychological therapy to ensure the provision of appropriate services across ethnicity (Department of Health 2005).

There are many factors that can be damaging to the therapeutic relationship which may negatively impact the outcome of therapy. Norcross and Wampold (2011) mentioned a number of elements previously identified by researchers as ineffective or damaging to the therapeutic relationship. These are all negative therapist behaviours which encompass hostile, critical, pejorative, and blaming stances which use a confrontational style (Miller et al. 2003); making unverified assumptions (Lambert & Shimokawa 2011): therapist rigidity; inappropriate self-disclosure; criticalness; over-

structuring of sessions (Ackerman & Hilsenroth 2003); therapist-centered observational perspective (Orlinsky et al. 2004); and employing a 'one-size-fits-all' approach (Norcross & Wampold 2011). These therapeutic damaging behaviours can be amplified by cultural and racial difference. This study will therefore explore psychological therapists' views and mindful awareness of these behaviours and the challenges they face in their ability to act opposite to these damaging behaviours in a cross-cultural/racial context. There is a need for professionals to take their time to understand the belief systems, values, and traditions that are different from their own (Hughes 2006) and it is vital for psychological therapists to use a model of cultural identity in order to understand what can hinder and promote an effective therapeutic relationship and outcome (Alladin 2002).

This research focuses on psychological therapists' (and White British) experiences of psychotherapy with racially/ethnically and culturally unalike clients (African-Caribbean or White British), and how they have experienced difference as emerging during these experiences. This research aims to access and investigate how differences in race/culture have been a salient feature that manifests in the therapy room, as subjectively reported by African-Caribbean and White British psychotherapists. The study endeavoured to access subjective experiences relative to a contentious issue in psychotherapy research, namely race. What is relevant for this study is the salience of racial identity and its role in social, and inevitably dyadic and therapeutic interactions. Specifically, the study aims to disclose clinicians' experiences of the engagement process, working alliance, transference, and countertransference, therapeutic skills, outcomes, and supervision when working with racially dissimilar clients. The study aims to inform understanding how race/culture is experienced by psychological therapists in a cross-cultural/racial dyad and within the clinical space.

Although there is significant research on the practice of psychotherapy, few studies have investigated the therapeutic encounter from the therapist's perspective and examined the impact of cultural differences on therapeutic work. The purpose of this study is to explore the experience of cross-cultural differences within the therapeutic process for both African-Caribbean and White

British psychological therapists in their therapeutic encounter with respectively White British and African-Caribbean service users. As greater understanding of the role common factors play in the therapy process has been gained, more attention has been paid to the therapeutic relationship. However, much of this research still overlooks issues of diversity such as race/ethnicity and how they may impact therapist variables and client perceptions. To gain a better understanding of this gap, it is important to first review the existing research on the cross-cultural therapeutic encounter and how diversity has been previously addressed in this line of inquiry.

1.5 Drivers for the study

The study is informed by national mental health policy and professional guidance for psychotherapists. Inequality of access for current Black and Asian Minority Ethnic (BAME) formerly BME (Black and Minority Ethnic) communities is a well-recognized reality for many psychological therapy services (Edridge 2004). This results from a number of barriers and failings, ranging from the very straightforward question of the availability of foreign language support through to attitudinal challenges that result from mainly Eurocentric-focused health understandings of cultural diversity in both the expression of mental health problems and their treatment (Nadirshaw 1999; Williams et al. 2006).

Much has been published around race equality and discrimination within health services (DoH 2007b; Race Relations/Equality Act 2010), which will inform this project. The British Psychological Society (BPS) has also published guidance around training staff to work in more culturally sensitive ways (Patel et al. 2006), together with the challenge of recruiting more ethnically diverse psychological therapists (BPS 2004, Maxie et al. 2006; Hays & Iwamasa 2006; Hays 2001; Workforce Race Equality Standard 2020). The requirements of the Mental Health National Service Framework (DoH 1999) regarding non-discriminatory services take account of the Race Relations/Equality Act 2010 in striving to promote race equality. It falls within the framework of the Delivering Race

Equality in Mental Health Care action plan (DoH 2005) to ensure that access to psychological therapies is not hindered by ethnicity, culture or faith. It also aims to fulfill many of the service requirements for both Race and Gender identified by the Single Equity Scheme (2007).

The vision for DRE (DoH 2005) aims for: a service characterised by 'less fear' among minority communities and service users; increased satisfaction with services; a reduced rate of admission to psychiatric inpatient units; a reduction in the disproportionate rates of compulsory detention of Black and minority service users in inpatient units and a more balanced range of culturally appropriate and effective therapies. Inequality in mental health services has been recognized to be a part of a much wider problem of institutional racism in most public services (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003; Macpherson 1999).

The British Psychological Society (BPS) and the British Association of Behavioural and Cognitive Psychotherapists (BABCP) are urging their members to work in more culturally sensitive ways (BPS 2017; BABCP 2017. However, knowledge is lacking as to how to do this or what it feels like for psychotherapists when they seek to work in more culturally sensitive ways. This study advances understanding of such practices by exploring psychological therapists' experiences of cross-cultural/racial therapeutic work.

1.6 Research aims and objectives

This is a qualitative study involving interviews with accredited psychological therapists in the UK. This research explores the experiences of psychological therapists who work therapeutically in the cross-racial/ethnic dyad. The study aims to explore the experiences of race, ethnicity, the culture of African-Caribbean and White British practising psychological therapists within the therapeutic encounter. The research objectives are to:

1. Examine clinicians' experiences of the working alliance, therapy processes and techniques and supervision and training when working with racially dissimilar clients.

2. Understand how race/ethnicity/culture has been experienced as a theme when working between races by the psychological therapist within the clinical space.
3. Explore the experiences of race, ethnicity, the culture of African-Caribbean and White British practising psychological therapists within the therapeutic encounter.

The question guiding the research is this: How do White British and African-Caribbean psychological therapists view, understand and make sense of their experiences of working in an ethnically and racially different therapeutic dyad?

The following sub research questions will be addressed:

1a How do psychological therapists in a cross-cultural relationship (where client and therapist differ by race/ethnicity, religion, culture) perceive and experience their therapeutic work?

1b How do psychological therapists understand and make meaning of the impact of their cross-racial/ethnic/cultural differences on their engagement work?

1c How do psychological therapists understand and make meaning of their cultural competence training and supervision?

For the purposes of this study, the cross-cultural differences examined will be limited to two multicultural domains: race and culture. This will be explained further in chapters two and three.

1.7 Structure of the Thesis

This thesis has six further chapters**.**

Chapter 2 provides the research context and gives a detailed literature review around cross-cultural/racial therapeutic work, exploring key variables: positive therapeutic skills, therapeutic relationships, working with race, racial micro-aggression, racial identity development and cross-

cultural/racial training and supervision. Gaps in the literature are explored to underpin research questions in line with the relevance of the study.

Chapter 3 presents and explains the study design and justifies why a qualitative methodology was chosen for this study. It defines the research paradigm from a critical realist epistemological philosophy. The method of this study is detailed, outlining the research design, sampling of participants, the recruitment process, the data collection, ethical considerations and finally, the data analysis plan for the research, namely Interpretative and Phenomenological Analysis (IPA).

Chapter 4 details the process of data analysis leading to the findings from in-depth interviews with seven participants, all psychological therapists with experience of cross-cultural/racial therapeutic work. The chapter presents the steps followed to identify main themes using IPA (as described by Smith et al. (2009)) and the generation of four final interpretative themes.

Chapter 5 discusses the findings of the study and presents all four superordinate and final themes. The analysis process is further detailed to offer a more finely detailed exploration of each theme, delineating how it was specifically experienced by participants and providing interview extracts to illustrate and support the findings. The participants' own words - mostly descriptive phrases and paragraphs - are used within the interpretation. The findings are explored in depth under four superordinate themes: mastering cross-cultural/racial practice; the barriers to effective cross-cultural work; cross-cultural learning in practice; and supervision/support as a 'potential' site for cross-cultural fertilisation.

Chapter 6 discusses findings in the context of historical and current literature concerning cross-cultural/racial therapeutic work. The study is evaluated for its validity and quality using Yardley's (2000) four criteria for assessing validity and quality in qualitative research. The relevance of the study is presented and its implications in clinical practice are discussed as are the study limitations and proposals for future research. Finally, chapter 7 provides a conclusion and summirises the key messages.

2 Chapter 2 Literature review

2.1 Introduction

The study is based on a critical evaluation of relevant research and evidence related to cross-cultural psychotherapy. The literature review identifies and synthesises knowledge of specific outcomes of previous studies, identifying strengths and limitations of the evidence and highlighting gaps in the literature that underpin the importance of this study. This study searched literature from the following sources: internet; websites; published and unpublished data; policy documents; reports and books (through manual searching). This chapter will explore literature around the efficacy of psychotherapy research, followed by a review of the research on the effectiveness of psychotherapy interventions, highlighting the emergence of the empirically supported treatment and evidence-based practice movements in addition to the research on common factors in psychotherapy. The review will take into account psychological therapists' (psychologists, psychotherapists, and counsellors) perspectives, experiences and views on the process content and challenges/barriers of cross-racial/cultural therapeutic work. The existing literature on therapeutic engagement in a cross-cultural context is reviewed in line with important facets of psychological therapy: training; spirituality; therapeutic relationship; therapeutic engagement; supervision and continuing professional development. It will take account of the cultural and geographical context when it comes to delivering therapy in the UK and the implications this may have on the stance of cross-cultural settings.

2.2 Literature search process

As this research was undertaken over seven years of of study, the first literature search was undertaken in September 2016. In December 2020 this literature was reviewed and updated. To

conduct such a review the following process was followed using carefully chosen databases (see Table 1).

Table 1: **Databases and rationale for choice**

Databases	Rationale for choice
CINAHL	One of the most commonly used nursing databases providing up to date information from 1982 (Polit & Beck 2008), useful to identify broad and relevant health care related professional literature
PsycINFO	Produced by the American Psychological Association containing literature on all aspects of psychology (Craig & Smyth 2007). Therefore, relevant for the research question
Delphis	Contains allied and complementary medicine database literature from 1967 to the present which could inform the question
MEDLINE	Has literature on medicine, nursing, psychiatry, Allied Health and dentistry and could possibly provide literature in relation to a variety of applications of cross-cultural/racial therapeutic work/encounters
EMBASE	Was utilised due to its emphasis on medical literature covering wide-ranging specialties and reports on health care advances (Fleming & Fenton 2002) and was accessed to provide a broader view than psychology alone.

These databases provided access to quality information from a wide range of journals, reports and editorials which informed the general understanding of the subject (Beecroft et al. 2006). Table 2 (below) identifies details of the search strategy, terms used on each database and how searches were refined. The search terms used are categorised in sections and are appropriately selected in accordance with the database applications to provide consistency and continuity in outcomes. Boolean Logic operators (AND, OR) were applied in order to link and combine the categories of terms to retrieve the most relevant results from the searches.

Table 2: **Search terms and Boolean Logic "OR" used for each column/search**

TERMS S1	**TERMS S2**	**TERMS S3**	**TERMS S4**
psychologist OR counsellor OR psychotherapist OR clinical psychologist OR counselling psychologist OR therapist	cross-cultural therapy OR cross-cultural differences OR cross-racial therapy OR multicultural counselling	therapeutic engagement OR therapeutic relationship OR cultural competence OR cultural awareness	training OR supervision OR support OR learning

The Boolean operator "OR" was used to combine the terms in order to access research that might be relevant to any term identified in each group.

The Boolean operator "AND" was used to combine the group's terms and access papers relevant to a combined group of terms. For example, "S1" was combined with "S2" using the Boolean operator "AND". The result of this combination was labelled under the heading "S5". "AND" was then used again to combine "S3" with "S4" and the results labelled as "S6"and finally the Boolean operator "AND" was then used to combine S5 AND S6 which provided the final paper results for screening and selection.

Accessing evidence: To narrow the search results for relevance, inclusion and exclusion criteria were developed (Craig & Smyth 2007; Fitzpatrick 2007a & 2007b) (Table 3).

Table 3: **Inclusion criteria and rationale**

Inclusion criteria / Exclusion criteria	**Rationale for inclusion criteria**
Articles published in the English Language.	Appropriate and easy to access and read. Avoids misinterpretation arising from translation.
Studies carried out in the interval year 2000-2020.	To ensure that research is up to date and relevant to contemporary practice.
Any research design	Any could produce data relevant to the topic subject.
Studies undertaken within psychotherapy or counselling practice	For findings to be transferable and to retrieve data relevant to my research question.
Studies that focus on psychological therapist experience of cross-cultural work	Transferable to relevant clinical setting and research question.
Studies involving cross-cultural/racial therapeutic dyads.	Data relevant to the research question

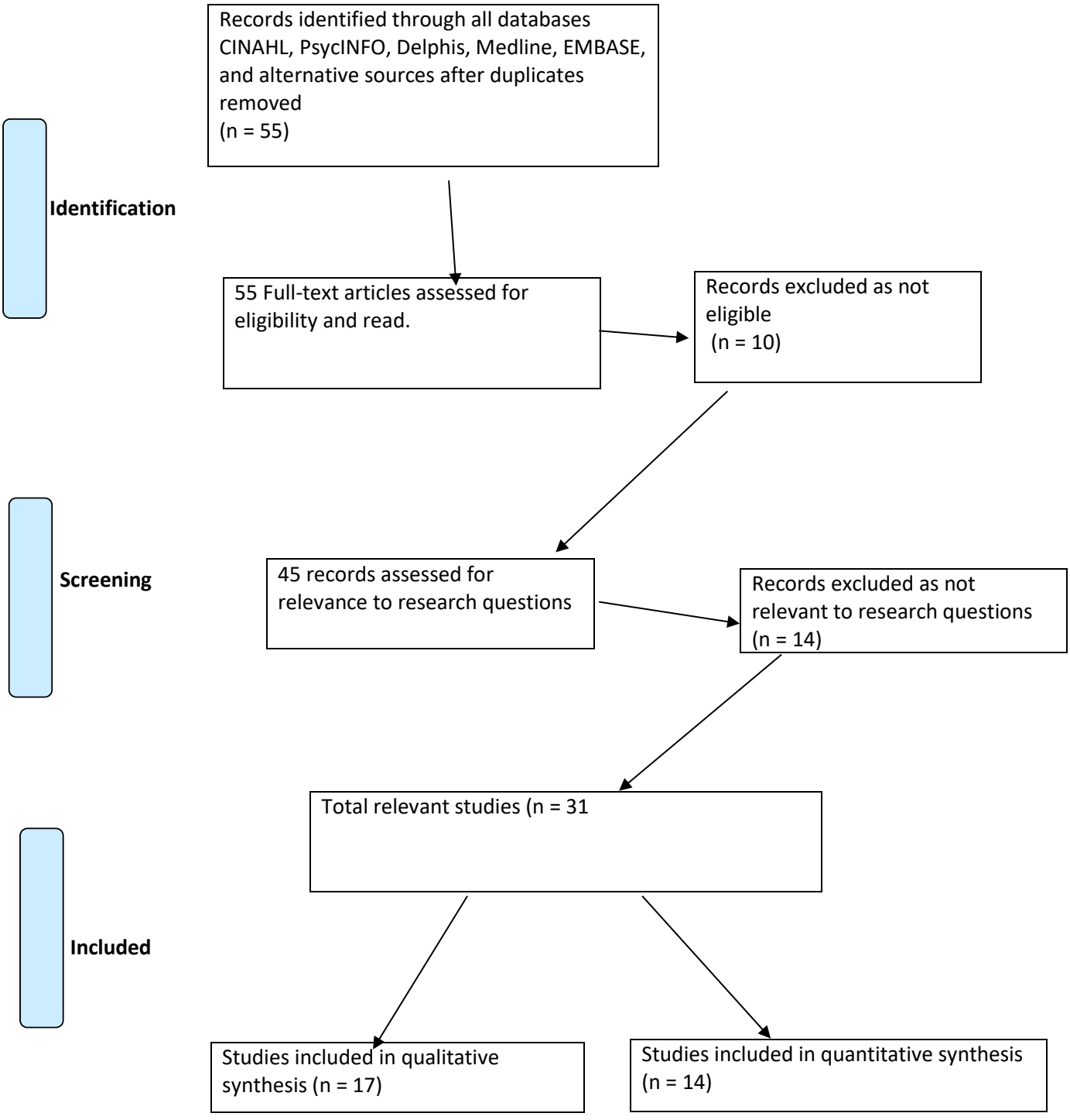
Through the search methods described, 55 studies were identified as relevant to the research question. Following a closer inspection of these 55 studies (by scanning the abstracts of the articles retrieved), it was possible to reduce this number to 31 articles. A résumé of the process of establishing key evidence is presented in Table 4 and the adapted Prisma chart (Figure 1).

Table 4: **Process of establishing key evidence**

Criteria used
Categorisation process using subheadings and applying Boolean Logic – OR/AND.
Limit to English language within 2000-2020.
View similar articles.
Hand searching of latest journals reference lists.
Reading abstracts to assess inclusion/exclusion criteria status.
Detailed reading of remaining articles taking into account the relevance and content with regard to the research question.

After applying the search strategy (December 2020) the search history was recorded and results were saved and clustered into categories linked to their relevance within the process of psychotherapy in the context of therapeutic relationship, working with race, training and supervision. Figure 1 illustrates the process of literature identification, from screening, selection and final inclusion.

Figure 1: **Adapted PRISMA 1: Cross-cultural Therapeutic work literature search in 2020 (Moher et al. 2009)**



Studies included in this review were conducted in the Australia, Canada, Finland, Germany, New Zealand, the UK and the United States of America (USA). Several studies published discuss issues of race, culture and ethnicity in the context of psychotherapy. The studies reviewed used various approaches including:

1. Interviews studies (n=17)
2. Focus group studies (n=2)
3. Case study (n=1)
4. Meta-analysis studies (n=2)
5. Survey studies (n=2)
6. Questionnaire studies (n=3)
7. Trial studies (n=2)
8. Mixed methods study (n=1)
9. Systematic review (n=1)

The studies focused on cross-cultural/racial therapeutic work and all its facets including therapeutic engagement. Main themes were identified in the studies reviewed by taking into account both the sample and the perspective the researchers had taken. The research questions will encompass litterature which have been rouped together in each subheading as detailed in table 5 and clarify more in table 6.

In the first part of this review, grey literature was considered but were not part of the search result. This literature offers a strong background in understanding important aspects of cross-cultural and racial therapeutic work that were not identified in the literature search such as: therapeutic relationships, working with race, cultural adaptation, cultural competence, racial micro-aggression, racial identity development, and cross-cultural language.

The second part of the review considered cross-cultural psychotherapy research as identified in literature search results. Eleven studies focused on psychological therapists' experiences of cross-cultural work, six studies on multicultural competence, three studies on metric matching in psychotherapy, and eleven studies on cross-cultural supervision and training. The 31 papers (Appendix B) highlight the design methodology, participants, sample size, study settings, outcomes measures and study limitations. The following paragragh depicts research around the importance of therapeutic relationships in cross-cultural therapy. The table below presents themes and rationale and also itemises all references used for each theme.

Table 5: **Table of selected literature from cross reference reading and associated themes and rationale**

Themes and rationale	References
Therapeutic relationship in Cross-cultural therapy. **Rationale**: These papers focus on aspects of the cross-cultural therapeutic relationship and consider challenges and opportunities.	Sue and Zane (2006); Chang and Berk (2009); Norcross and Wampold; Nezu (2010); Greene (2007); Comas-Diaz (2006); Quinones (2007); Constantino et al. (2010); Fuertes et al. (2006); Hersoug et al. (2001); Luborsky et al. (1975 & 1988); Farsimadan et al. (2007)
Working with race in psychotherapy. **Rationale:** Both papers focus on the issue of race and the associated challenges when in cross-racial therapeutic work	Cardemil and Battle (2003); Knox et al. (2003)
Cultural therapeutic competent behaviours **Rationale:** These papers focus on essential elements of cross-cultural therapeutic competent behaviours and the challenges in implementing them.	Stuart (2004); Sue et al. (2009); Hansen et al. (2006); Roysicar et al. (2003); Griner and Smith (2006); Owen et al. (2010); Kelly and Roeddert (2008); Muran (2007); Gelso (2010)
Racial Micro-aggression in psychotherapy **Rationale:** These papers focus on covert/ overt intentional/unintentional attitudes, behaviours and words that can be derogative, hostile and invalidating in cross-cultural and racial encounter.	Sue (2010); Sue et al. (2007); Constantine (2007); smith et al. (2008); Sue et al. (2008); Sue et al. (2003); Sue and Sue (2008); Sue and Sue (2003); Sue and Capodilupo (2008); Messent and Murell (2003); Steel et al. (2006); Pope-Davis et al. (2002); Knox et al. (2003); Drogra et al. (2007); Sewell (2009); Thompson et al. (2004)
Racial identity development and psychotherapy **Rationale**: These papers present and offer training and effective tools depicting stages of racial identity development and their importance in cross-cultural/racial therapeutic encounter.	Cross (1970); Atkinson et al. (2004); Helms (1984); Cross (1995); Poston (1990); Parker and Schwartz (2002)
Cross-cultural language in psychotherapy **Rationale:** These papers focus on the importance of the style of communication through language (verbal/non-verbal) within a cross-cultural therapeutic encounter.	Kozuki and Kennedy (2004); Hays (2001); Owen et al. (2011); Sue and Lam (2002)

Table 6: **Selected 31 papers/literature from cross-cultural/racial therapeutic research (from search activity*)***	
Themes and rationale	**References**
Psychotherapy and cultural adaptation **Rationale**: These papers offer better understanding of the opportunities and challenges associated with adaptation of cross-cultural therapeutic process.	**Main references:** Bassey and Melluish (2012); Rathod et al. (2010); Constantine et al. (2004); Soto et al. (2018); Neville et al. (2006) (See Appendix 9.2: 1, 18, 31, 6 & 13) **Additional references using hand searches from reference list**: Neville et al. (2000); Ponterotto et al. (2002)
Black/BAME/Non-Western therapist experiences **Rationale:** These papers present non-Western psychological therapists' perspectives and experiences of cross-cultural therapeutic work	Spalding et al. (2018); Knox et al. (2003); Price (2015); Nino et al. (2016); (See Appendix 9.2: 2, 12, 15 & 29)
Western White Therapists experiences **Rationale:** These papers present Western White psychological therapists' perspectives and experiences of cross-cultural therapeutic work	**Main references**: Knox et al. (2003); Utsey et al. (2005); Burkard et al. (2006a); Fuertes et al. (2006); Hayes et al. (2016); Neville et al. (2006); Tol et al. (2005); Burkard and Knox (2004); Hare (2015); Dos Santos and Dallos (2012); Kanakam (2020) (See Appendix 9.2: 12, 16, 3, 9, 8, 13, 4, 10, 14 &11) **Additional references using hand searches from reference list**: Gushue and Constantine (2007); Pope davis et al. l (2002); Ponterotto et al. (2000); Sue et al. (2007); Kearney et al. (2005); Constantine and Sue (2007); Tol et al. (2005);
Ethnic/Racial matching perspective **Rationale:** These papers focus on the effects of matching client with therapists of the same or different race in cross-cultural therapeutic work	**Main references**: Cabral and Smith (2011); Chang and Yoon (2011); Imel et al. (2011); Zhang and Burkard (2008); Chang and Berk (2009) (See Appendix 9.2: 5, 30, 7 & 17) **Additional references using hand searches from reference list:** Kahatsu et al. (2000); Farsimandon et al. (2007); Constantine (2007); Zane et al. (2005); Dogra et al. (2007); Chang and Berk (2009)
Challenges of cross-cultural training for psychological therapists	**Main references:** Adetimole et al. (2005); Lee and Khawaja (2012); Martin (2015); Pieterse et al. (2009); Prosek and Michel (2016). See Appendix 9.2: 24, 25, 26, 27 & 28)

Rationale: This heading indicates literature around cross-cultural/racial training and its associated challenges and opportunities.	**Additional references using hand searches from reference list:** Constantine (2003); Arredondo and Toporek (2004); Dressell et al. (2007); Mori et al. (2009); Lago and Thompson (2003); Thompson-Miller and Feagin (2007); Sue (2006); Nolte (2007); Papadopoulos and Cross (2006); West (2011); Fernando (2010); Orlans and Van Scoyoc (2009)
Challenges of cross-cultural supervision for psychological therapists **Rationale:** This heading indicates literature around cross-cultural/racial supervision and its associated challenges and opportunities.	**Main references:** Burkard et al. (2006b); Chopra (2013); Utsey et al. (2005); Hird et al. (2004); Constantine et al. (2005); Toporek et al. (2004). (See Appendix 9.2: 19, 20, 16, 22, 21 & 23) **Additional references using hand search from reference list:** Constantine (2003); Arredondo and Toporek (2004); Dressell et al. (2007); Bernard and GoodYear (2009); Heppner (2006); Norton and Coleman (2003)

2.3 The therapeutic relationship in cross-cultural therapy

Although many studies on this topic are not included in the 31 selected papers, they provide good insight into cross-cultural therapeutic work. The main study selected under this heading is Fuertes et al. (2006) who found a strong positive association between clients' perceptions of their therapists' multicultural competence and ratings of the therapeutic alliance, including feeling understood and experiencing a trusting bond with their therapists.

It is evident that the therapeutic relationship is the most powerful component of therapy on which the therapist can have a direct impact. However, most of the existing research on the therapeutic relationship does not focus on the issues of culture-specific technique and client/therapist matching. There is very little known of how clients and therapists perceive their relationship within the therapy dyad or how this critical common factor works in the cross-cultural therapy situation. Although important theoretical concepts such as multicultural competence and cultural responsiveness are

often well-defined and extensively discussed in the multicultural psychotherapy literature, there remains a surprising lack of research exploring how they manifest in practice.

Many of the studies reviewed were based on potential clients or analogue situations rather than actual therapy encounters. Sue and Zane (2006) recommended that, in the notable absence of empirically identified models of treatment and therapeutic relationship strategies for cross-cultural psychotherapy, an intermediate goal of examining the therapeutic processes and phenomena is needed. Few studies have explored how therapist perceptions and experiences relate to the therapy process and outcome in real, cross-cultural therapy relationships (Chang & Berk 2009). In addition, recommendations have been made for future research to explore the contributions of both therapist and client and address the observational perspectives of therapists and clients in the relationship (Norcross & Wampold 2011). This can only be reached through qualitative inquiry into the lived experience of both relationship partners.

On a micro-level, every therapeutic encounter between client and therapist represents a cross-cultural relationship. Nezu (2010) contended that any difference, especially one that was present during an individual's development, is a potentially important aspect of that person's identity arguing that certain differences are inherently culturally bound and exist in a historical context. Therefore, they may have greater influence in an individual's everyday life and interpersonal relationships. Greene (2007) proposes that each individual has multiple overlapping identities and any given dimension of a person's identity may be more or less salient, depending on the context of the situation and the individual's developmental stage. She also highlights the general lack of psychotherapy research into individuals who are members of more than one socially disadvantaged group, specifically multicultural groups (Greene 2007).

Comas-Diaz (2006) pointed out that cross-cultural relationships are often fraught with missed empathic opportunities and that these therapy encounters require special attention to cultural issues, while also focusing on the client's individual needs. She also recommends modifying the

therapy relationship to the client's culture, working to understand the client's voice to develop trust and credibility and demonstrate cultural empathy (Comas- Diaz 2006). Quinones (2007:166) further stresses the need for therapists to "search and explore the meaning of differences and the ways they manifest in the client's behaviour, worldview, relationships, and in the therapeutic relationship"

Reviewing the impact of demographic variables on the formation of the therapeutic relationship with adolescents, Constantino et al. (2010) suggest that, to build a therapeutic relationship, therapists explore and make explicit, differences such as gender, age, and ethnicity early in the therapy process in order to build the therapeutic relationship. In a study of fifty-one psychotherapy dyads, Fuertes et al. (2006) found a strong positive association between clients' perceptions of their therapists' multicultural competence and ratings of the therapeutic alliance, including feeling understood and experiencing a trusting bond with their therapists. The same study also found that therapists' self-ratings on multicultural competence were significantly higher than their clients' ratings of them.

While the relationship between an improved therapeutic alliance and a client-therapist match on age, religious beliefs, and values is well-documented (Hersoug et al. 2001; Luborsky et al. 1975; Luborsky et al. 1988), the evidence is mixed for matches with ethnicity (Farsimadan et al. 2007; Fuertes et al. 2006). This seems consistent with the findings and practice recommendations of the Task Force in Evidence-Based Therapy Relationships that emphasized adapting therapy relationships to client characteristics (Norcross & Wampold 2011).

2.4 Working with race in psychotherapy

The main study selected under this heading is Knox et al. (2003) who found that patients in cross-racial therapeutic work may feel comfortable to broach cross-racial issues, while others may have as

many anxieties about addressing these as the therapist. Some other studies (not included in the 31 selected papers) were referred to based on their relevance for this study.

Socio-political change in therapeutic helping professions to promote their accessibility to diverse and previously marginalised populations is important. The ability to conduct effective psychotherapy with these diverse populations is increasingly recognised. While most therapists recognise the value of knowing one's own cultural and racial assumptions and core beliefs, many therapists still struggle to incorporate this into therapy with racially diverse or different clients (Cardemil & Battle 2003). Being willing to engage in open dialogue about race between therapists and clients is one-way. Therapists may achieve this, thereby strengthening the therapeutic alliance and improving the treatment process (Cardemil & Battle 2003). Cardemil and Battle (2003) observe that there may be different reasons why therapists struggle with conversation on race with their clients, including feelings of discomfort due to the emotive nature of the topic; concerns about being unintentionally offensive; and concern over the relevance and appropriateness to initiate these conversations.

There is no prescribed way for therapists and clients to engage in these issues although supervision and internal mandatory training is often seen as a requirement which potentially has limitations. The variables involved, such as the number of times the issue comes up and the intensity of the conversation, rely on several factors including the client's level of trust in the therapist and the therapist's comfort and openness on the issues and salience of race in the environment and context within which the therapy occurs (Cardemil & Battle 2003). It is clear from literature that addressing and talking about race and culture early in therapy helps and strengthens the trust needed for an effective therapeutic relationship and treatment outcome (Knox et al. 2003).

2.5 Psychotherapy and Cultural adaptation

The main studies selected under this heading are: Bassey and Melluish (2012); Rathod et al. (2010); Constantine et al. (2004); Soto et al. (2018) and Neville et al. (2006). These reviewed studies confirm

that the ability of White British and African-Caribbean psychological therapists to relate to racial and cultural issues is important for effective cross-cultural/racial therapeutic work. Bassey and Melluish's (2012) semi-structured interview-focussed study of cultural competence in the experiences of newly trained Improving Access to Psychological Therapy (IAPT) therapists to deliver cognitive-behavioural therapy, found that therapists could work in a culturally sensitive way. This view was also established by Rathod et al. (2010) whose qualitative study aimed to produce a culturally sensitive adapted version of an existing Cognitive Behavioural Therapy (CBT) manual for therapists working with patients with psychosis from specified ethnic minority communities. The respondent's groups confirmed that CBT would be an acceptable treatment if culturally adapted - which raises broad challenges ranging from skills acquisition to systemic and environmental changes. Constantine et al. (2004) used qualitative analysis to explore the experiences and perceptions of twelve multicultural counselling scholars with regard to the field of multicultural counselling. Participants noted aspects of being a multiculturally competent counsellor included open-mindedness; flexibility; a commitment to the field; active listening; knowledge and awareness of cultural issues; skilfulness in making cultural interventions; commitment to social justice issues; self-awareness; and exposure to broad and diverse life experiences. Most of the participants stated that challenges associated with being a multicultural psychologist included colleagues, institutions, and others' resistance toward and lack of support for multicultural counselling issues. Soto et al. (2018), examining cultural adaptations and therapist multicultural competence in two meta-analytic reviews, support therapeutic positive practices that help clients benefit from modifications to treatment that are related to culture. These views are further supported by Neville et al. (2006) who explored the association between colour-blind racial ideology and multicultural counselling competencies. Greater levels of colour-blind racial ideology as measured by the Colour-Blind Racial Attitudes Scale (Neville et al. 2000), were related to lower self-reported multicultural counselling awareness and knowledge as measured by the Multicultural Counselling Knowledge and Awareness Scale (MCKAS) (Ponterotto et al. 2002).

2.6 Cultural therapeutic competent behaviours

This section focuses on literature depicting the culturally competent characteristics and behaviours needed for effective therapeutic work, mainly based on the work of Sue et al. (2009). The majority of these studies, although not included in the main selected papers, are inquiry-based and offer important insight for the subject under investigation.

Some professionals continue to struggle to work with culture and race mainly because they lack skills and competence to do so. Cultural competence has been defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations (Stuart 2004). Psychotherapists' self-awareness of their own culture, their knowledge of minority cultures and their cross-cultural skills pertaining to work with BAME populations are some of the factors that influence the provision of culturally competent services (Sue 1998). According to Sue et al. (2009), the culturally competent psychological therapist has the characteristics presented below.

Box 2: **Sue et al. (2009) cultural competence characteristics**

1. Cultural awareness and beliefs: The provider is sensitive to her or his personal values and biases and how these may influence perceptions of the client, the client's problem, and the therapeutic relationship.
2. Cultural knowledge: The psychotherapist has knowledge of the client's culture, worldview, and expectations for the therapeutic relationship.
3. Cultural skills: The psychotherapist has the ability to intervene in a manner that is culturally sensitive and relevant

There is a dearth of literature on outcome research related to multicultural competency training for psychologists (Sue et al. 2009), including the lack of measures from evaluation of the impact of cultural competency on treatment. Sue et al. (2009) argues for research to clarify what works in cultural competency and how it works. A USA national study of one hundred and forty-nine practising psychologists found that respondents did not follow recommended multicultural competencies, placing greater value on personal and professional experience over guidelines and codes (Hansen et al. 2006). There is little research available on the psychotherapy process and

outcome with diverse groups which includes the impact of culture and and differences in the therapeutic relationship (Roysicar et al. 2003) and while some of the studies have suggested that adapting existing therapy approaches to specific cultural groups can be effective strategies (Griner and Smith 2006; Sue et al. 2009), Owen et al. (2010) point out these studies fail to take account of the effect of either therapist variables on or their adherence to the treatment model. This is a critical gap considering that even the most tolerant and antiracist individuals may hold implicit biases of which they are unaware (Kelly & Roeddert 2008). Muran (2007) proposes that the therapeutic relationship can be viewed as an ongoing intersubjective negotiation between the various identities of the client and therapist, in which differences such as race and culture are integral to the negotiation process. Gelso (2010) states that it is essential that the diversity status and multiple identities of both client and therapist are recognised to raise awareness of influences on the therapeutic relationship.

2.7 Racial micro-aggression in psychotherapy

This section focuses on an important aspect of cross-cultural therapeutic challenge and focuses mainly on the work of Sue et al. (2007 & 2008), Sue (2010) and Constantine (2007), on different forms of racial micro-aggressive behaviours and their possible impact on facets of therapeutic work. Although these papers were not selected and did not show up on the initial search strategy, cross-referencing from selected articles depicted the presence of this literature around racial micro-aggression in psychotherapy. Micro-aggressions are hidden, everyday exchanges that send degrading messages to a target and have been identified as 'therapy-destroying behaviours' (Sue 2010). Racial micro-aggression is commonplace in daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, communicating hostile, derogatory, or negative racial slights and insults towards people of colour. Racial and ethnic micro-aggression in everyday life can negatively impact the wellbeing of individuals, particularly those from racial and ethnic minorities. Micro-aggressions if perceived but ignored in therapy, may impact negatively on the

therapy process but little is known of whether micro-aggressions are addressed in therapy and if addressing them impacts positively upon the therapeutic relationship. This research is theory-informed and will take into account the racial micro-aggressions and concepts of cultural competence based on Sue et al.'s (2007) forms of racial micro-aggression (Box 3).

Box 3: **Sue et al. (2007) three forms of racial micro-aggressions**

1. Micro-assaults, or subtle assaults, which are verbal, non-verbal, or visual communication. These are usually directed towards people of colour, are often automatic or unconscious and intended to hurt the victim. Examples include name-calling, avoidant behaviour, or purposefully carrying out discriminatory actions against the target person or group
2. Micro-insults, which are characterized by communications that show rudeness and insensitivity and degrade a person's racial heritage or identity (Sue et al. 2007). This type of behaviour is frequently unknown to the perpetrator but sends a hidden insulting message to the person of colour who is targeted (Constantine 2007). Examples include ignoring, behaving coldly towards or being dismissive towards a person
3. Micro-invalidations, which are characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings or experiential reality of a person of colour. (Examples include telling a person from BAME (formerly BME) that their colour is not of note thus denying them their racial or cultural experience

Understanding the various forms of contemporary racial-aggression is key to becoming a culturally competent therapist in practice and in supervision (Smith et al. 2008). The psychological therapist is trained to listen, show empathy, be objective, value client's integrity, communicate understanding, and use professional knowledge and skills to help clients solve their problems. The therapeutic relationship is strengthened when the clients perceive the therapists as credible and trustworthy and they themselves feel understood (Sue et al. 2008). For effective therapy to take place, the therapist and client must together form a positive coalition (Sue et al. 2003; Sue & Sue (2008), referred to as a 'working relationship', 'therapeutic alliance', or the 'establishment of rapport' (Sue & Sue 2003). A therapeutic alliance is a major factor of any helping relationship, leading to a successful outcome and client's self-disclosure (Sue & Capodilupo 2008) and when clients perceive the therapeutic alliance as accepting and positive, a successful outcome is more likely to occur. Conversely if clients do not perceive their therapists as trustworthy and they feel misunderstood or undervalued, therapeutic success is less likely to occur, indeed leading to premature termination or

failure to return for future visits (Sue et al. 2007). Establishing a trusting relationship in a cross-cultural therapeutic setting raises challenges as White therapists may tend to engage in racial-micro-aggressions towards clients of colour, thus weakening the therapeutic alliance (Sue & Capodilupo 2008).

Cross-cultural psychotherapy has often grouped participants who are culturally different and constitute the minority ethnics in the Western environments as BAME. Research focusing solely on African-Caribbean individuals is lacking. This may be due to either little interest or that the dominance of Western culture in psychological research excludes African-Caribbeans within the research sample. In the UK, only few psychological therapists have an African-Caribbean background but the IAPT initiative has seen the training of more psychological therapists from ethnic minority backgrounds. Therefore, conducting this research and including participants that are from the African-Caribbean background is an important step going forward.

BAME populations often lack effective support from mental health services, compared to the major population (Messent & Murrell 2003; Steel et al. 2006) yet for clients whose ethnicity affects their use of mental heath services (Pope-Davis et al. 2002) ethnically aware therapy and the ethnic sensitivity of the therapist become a salient feature. Understanding the various form of contemporary racial micro-aggression is a key to becoming a culturally competent therapist in practice, training and in supervision (Sue et al. 2008) yet for psychological therapists, issues of race and culture raise problems.

Cross-cultural therapeutic encounters may feel uncomfortable to some practitioners and they might find it hard to address issues of differences. Qualitative semi-structured interviews with twelve psychologists from different ethnic backgrounds, revealed the discomfort and abstinence of some to address ethnicity in a therapeutic relationship even if the client specifically raises the issue (Knox et al. 2003). Practitioners may be reluctant to address ethnicity due to personal concerns of negative client perception of them in terms of trust, support, and friendliness (Dogra et al. 2007), all of which

are essential to the therapeutic relationship (Sewell 2009). Research into poor BAME engagement with formal psychological therapy, has identified several reasons such as mistrust, misperceptions of a White psychological therapist, racism, and the BAME perception of therapy (Thompson et al. 2004).

2.8 Racial identity development and psychotherapy

This section focuses on grey literature not included in selected papers. Using hand search and cross references allowed possibility of accessing literature that depicts models of racial identity development and the important role these might play in cross-cultural/racial therapeutic work. Racial identity models developed in the USA (Cross 1970; Atkinson et al. 1989) and UK (Helms 1984) offer training tools related to cross-cultural work which involve a series of stages and experiences that the psychological therapist goes through, enabling them to mature and relate to their own racial identity and others effectively. It is assumed here that all individuals regardless of their background and race, experience racial identity development. Helms' White Racial Consciousness Model (1984), although dated, remains significant to assist therapists explore their own racial identity and promote effective work with minority ethnic clients (Box 4).

Box 4: **White Racial Consciousness Model - five stages (Helms 1984)**

1. In the contact stage, there is an unawareness of the self as a racial being, a tendency to ignore or deny differences and acknowledge that minority groups exist as too uncomfortable to accept.
2. Disintegration - becoming aware of racism leading to feelings of guilt, depression and negative feelings. The response results in over-identification with minority ethnic people, the development of paternalistic attitudes towards them or a retreat into White culture.
3. Reintegration - expressed by hostility towards minority groups and favouring of one's own racial group.
4. The pseudo-independent stage represents an increased interest in racial group similarities and differences, together with a mental acceptance of other racial groups. There are also limited cross-racial interactions or relationships with certain minority ethnic people.
5. Finally, autonomy is reached when there is an acceptance and respect of racial similarities and differences. Differences are viewed positively and opportunities for cross-racial relationships are actively sought.

Black identity development involves going through stages simultaneously. Beginning with less awareness about their Black identity then progressing to internalize positive thoughts, not only about themselves as being Black but about other racial groups as well. Cross (1995) describes the Black identity development model (Box 5).

Box 5: **Cross (1995) Black identity development model**

1 Pre-encounter: ranges from salience race-neutral to anti-Black positions. Anti-Black racial stereotypes: positive attributes to White people, favours a Eurocentric cultural perspective and does not value multicultural education

2 Encounter racial prejudice: precipitates search for Black identity. Internalised encounter of racism – realises that own frame of reference is inappropriate. Begin search for new identity: Afro-centric person begins to emerge

3 Immersion– emersion transition stage: demolish old, construct new, White becomes inferior, oppressive, Black superior intellect. Extra-critical view of Black.

4 Internalisation of the new identity: to defend/protect person from psychological insults stemming from living in a racist society – sense of belonging, social anchorage – foundation to manage issues beyond Blackness

5 Internalisation– commitment: openness about being Black, positive self-esteem through commitment to express new identity

Poston (1990) described how biracial identity development can help therapists explore their own biracial identity and effectively work with other identitities (Box 6).

Box 6: **Poston (1990) biracial identity development stages**

1. Personal identity: sense of self unrelated to ethnic grouping; occurs during childhood

2. Choice of group: as a result of multiple factors, individuals feel pressured to choose one racial or ethnic group identity over another

3. Categorisation: choices influenced by status of the group, parental influence, cultural knowledge, appearance

4. Enmeshment/Denial: guilt and confusion about choosing an identity that isn't fully expressive of all their cultural influences; denial of differences between the racial groupings; possible exploration of the identities that were not chosen in stages 2 and 3

5. Appreciation: of multiple identities

6. Integration: sense of wholeness, integrating multiple identities

These racial identity stages are important tools to understand individual vulnerability and level of tolerance when in contact with cultural and racial differences. They identify that racial and cultural differences result from the social constructs that constantly influence everyday life including the therapeutic encounter. Obvious differences in individuals from minority cultures are often ignored

or wished away by those who are trying to be colour blind, yet race is an unavoidable aspect of modern and past society. Racial identity development is an important factor that can affect the therapeutic experience including training and supervision (Parker & Schwartz 2002).

2.9 Cross-cultural language in psychotherapy

In psychotherapy, communicating effectively through language in psychotherapy has been recognised to be important in cross-cultural/racial therapeutic work. Although the paper by Kozuki and Kennedy (2004) was not selected, it stresses the importance of being mindful of cross-cultural language issues in psychotherapy and suggests that it is only through understanding of language together with non-verbal cues interpreted by the therapist, that the client is able to communicate with the therapist. Formal psychotherapy often requires a Western-type dialogue which would mean that for clients not from the Western culture, language may create a barrier and and requires negotiation (Kozuki & Kennedy 2004). The BPS ethics code advises clinicians to be sensitive to language diversities of psychotherapy clients while other guidelines include strategies for working with diversity in clinical practice (Hays 2001; Owen et al. 2011). Typically, though these guidelines are global and fail to address any specific processes or interventions to be used in psychotherapy (Sue & Lam 2002).

2.10 Cross-cultural psychotherapy research

This section focuses more on the selected literature which includes: Non-Western therapist (BAME) experiences, Western White therapist experiences, ethnic and racial matching perspectives and challenges of cross-cultural training and supervision. Some literature, not included in the final 31 selected papers, will be considered for their relevance in supporting those selected.

Studies in cross-cultural therapeutic work, predominantly but not exclusively from America, offer few empirical studies, which focus on the therapist's experience of counselling clients from African-

Caribbean background and there is scant attention to literature that focuses on the lived experiences of African-Caribbean psychological therapists' therapeutic work with White British clients exclusively. Currently, there appears to be more known about the views and experiences of minority ethnic clients and this has been used to inform practice about how to most effectively work with this client group to develop best practice guidelines and competencies. Whilst this provides essential knowledge and insight about what is important to consider when working in a multicultural setting, our understanding of the therapist's point of view remains incomplete while we continue to lack awareness of the often-complex processes involved.

2.10.1 Black/BAME/Non-Western therapists' experiences

Spalding et al. (2018) in their qualitative thematic analysis explored eight Black, Asian and Minority Ethnic counsellors' experiences of working with White clients. This single example identified three overarching themes: training as colour blind; experiencing client reactions; and working with 'race' in the counselling process. Participants commonly described inadequate training around 'race' and culture, to manage encounters with issues of 'race' in the room but could not provide evidence for specific race or differences within the minority group. Knox et al.'s (2003) study used a qualitative approach to explore twelve African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. Results indicated that in this small sample, only African American psychologists reported routinely addressing race with clients of colour or when race was part of a client's presenting concern. Only European American therapists reported discomfort addressing race although all therapists questioned, perceived that discussions had positive effects. Price (2015) in a mixed method study examined the Black Therapist-White Client Counselling Dyad and the Relationship Between Black Racial Identity and Countertransference, uncovering the benefits as well as challenges of working in cross-racial dyads and Nino et al. (2016) thematically analysed strategies of thirteen foreign-born therapists used during therapeutic encounters finding four themes: making therapy a human-to-human connection; dealing with

stereotypes; what really matters; and flexibility, suggesting that developing a deep therapeutic connection using emotional attunement and human-to-human engagement was crucial for successful cross-cultural therapy**.**

2.10.2 Western White Therapists' experiences

Cross-cultural/racial therapeutic work can be experienced differently and the culture and race of the practitioner can have an impact on the way the process is experienced from both the therapist and patient perspectives. Studies examining Western/White therapist or patient experiences in cross-cultural dyads have found that White therapists, while comfortable addressing the impact their own ethnic, religious, and national identities have on their clinical work with clients, are uncomfortable discussing race (Gushue & Constantine 2007; Knox et al. 2003; Utsey et al. 2005).

A study exploring perceptions of multicultural counselling experiences found that clients rated cultural competence as critical (Pope-Davis et al. 2002), revealing also that clients were willing to forgive therapists' lack of cultural knowledge or sensitivity but were also more likely to blame themselves for their therapist's lack of understanding. Overall, it would appear that researchers have only a limited understanding of the effects of racial or ethnic responsiveness in cross-cultural therapy relationships (Ponterotto et al. 2000).

Self-disclosure was reported to improve the therapeutic relationship by exploring racism and oppression for the clients and recognising their own racist and oppressive attitudes. Burkard et al. (2006a) conducted a qualitative study with eleven European–American psychologists who described their experience of self-disclosure in cross-cultural therapy. This helped clients to move on to address other issues. Good supervision was invaluable to access the reasons for self-disclosure and how it fits with the counter-transference of the therapist, while keeping focus on the client (Burkard et al. 2006).

Measuring competence to identify important cross-cultural/racial skills, presents a major difficulty in the field of cross-cultural therapeutic work. Hayes et al. (2016) examined psychotherapists' outcomes with White and racial/ethnic minority clients and found that therapists differed in their effectiveness at reducing general distress across clients, with disparities within therapists' caseloads in their effectiveness with racial minority and White clients - concluding that multicultural competence can, and should, be considered in terms of measurable outcomes across client racial/ethnic groups. It is possible to identify multiculturally expert therapists who evidence competence with both ethnic minority and White clients and who might serve as models from whom the field could learn. Fuertes et al. (2006) in fifty-one therapy dyads, completed measures of therapist multicultural competency, the working alliance, and their satisfaction with therapy. Clients also completed measures of therapist attractiveness, expertness, trustworthiness, and empathy. Results showed strong associations between clients' ratings of therapist cultural competence and ratings of the working alliance, therapist empathy, and satisfaction. Therapists' ratings of their competence were associated with their ratings of the working alliance and satisfaction with their work.

High color-blind racial ideology has been linked to lower multicultural counselling competence. Neville et al. (2006) discovered that greater levels of colour-blind racial ideology might be indicative of lower levels of competency in multicultural. Critique to this study highlights that although the reason for not finding a statistically significant correlation between social desirability and multicultural competencies to the small sample size, a different result would not have been inevitable with a bigger sample and a major limitation in that the questionnaires used failed to uncover how therapists construct cultural therapy. Phenomenological empathy, recognising, understanding and working with and accepting patients’ unique cultural identity, are important positive therapeutic skills for psychotherapists and patients (Tol et al. 2005).

Psychotherapist's level of colour- blindness may impact on their ability to be empathetic and validating in cross-cultural counselling therapeutic work. Burkard and Knox's (2004) qualitative study investigated the effect of therapist colour-blindness on empathy and attributions in cross-cultural, concluding that the therapists' level of colour-blindness was directly related to their capacity for empathy and also to their attributions of responsibility for the solutions with an African American client but not with a European American client. Hare (2015) investigated how White clinicians engage in dialogue about race in cross-racial therapy with Black clients and found that the White clinicians surveyed made a variety of choices regarding talking about race in therapy with their Black clients. Although these clinicians felt it was important to talk about race in therapy, the findings revealed important differences in the choices they made as to how, when and why to talk about race in therapy with Black clients. These clinical decisions reflected a range of practices and beliefs including whether to take responsibility for broaching the subject of race, when in the process of therapy to broach the subject of race, and whether to talk about one's own race in the therapy. Dos Santos and Dallos (2012) also investigated the Process of Cross-Cultural Therapy between White Therapists and clients of African-Caribbean descent, disclosing that dominant cultural discourses reduced race and culture conversations from taking place in therapy and while the strategies used by participants seemed to enable them to maintain a positive therapeutic relationship and attend to the tasks of therapy, the absence of open discussion excluded fundamental aspects of the client's identity from the therapeutic milieu. The latest study by Kanakam (2020) explored the reflective experiences of twelve therapists working with British Ethnic Minorities with eating disorders revealing that they reported feelings of being restricted by service management, having a limited time to reflect on cultural issues, and personal concerns about being offensive or doing something wrong.

Sue et al. (2007) identified what they called colour-blind racial attitudes as a type of racial micro-aggression that may occur in clinical practice, which can lead to ineffective treatment (Neville et al. 2006). Therapists who are unaware of these prejudices may unintentionally create impasses for

clients of colour, which may partially explain well-documented patterns of therapy underutilization and premature termination of therapy among BAME (formerly BME) clients (Burkard & Knox 2004; Kearney et al. 2005). A therapist who endorses a high level of colour-blind attitudes may be more inclined to be unresponsive to racial issues and to the effect of racism on clients during counselling (Constantine & Sue 2007).

Although there is some support for culture-specific therapies for people of colour, the research is limited and the few studies available do not address the experience of either clients or therapists engaged in culture-specific therapy. The evidence we have on client/therapist matching with people of colour has demonstrated that matching clients and therapists by race/ethnicity may lower dropout rates and improve outcomes. Overall, however, the experience of people of colour in psychotherapy has largely been unexamined and there has been no research looking into how people of colour experience cross-cultural therapy relationships.

2.10.3 Ethnic/Racial matching perspective

The cultural and racial background of helping professionals can often be an important aspect to consider in multicultural therapeutic work. The effects of matching clients with therapists of the same race/ethnicity are explored using three variables: individual's preferences for a therapist of their own race-ethnicity; clients' perceptions of therapists across-racial and ethnic match; therapeutic outcomes across the ethnic and racial match (Cabral & Smith 2011). The therapeutic alliance is most likely strengthened under conditions of interpersonal similarity, so it seems reasonable that client outcomes should also benefit. Racial matching may improve client outcomes by enhancing mutual understanding between the client and therapist and reduce client concerns about being misunderstood (Kohatsu et al. 2000). This is supported by Chang and Yoon (2011) in their qualitative research study of twenty-three ethnic minority clients who were interviewed to assess perceptions of race in their recent therapy with a White therapist. The majority of ethnic minority clients believed that White therapists could not understand key aspects of their

experiences and subsequently avoided broaching racial/cultural issues in therapy. The interesting finding here is that many felt that racial differences were minimized if the therapist were compassionate, accepting, and comfortable discussing racial, ethnic and/or cultural issues. Imel et al. (2011) uses a qualitative approach to explore racial/ethnic disparities in therapist effectiveness and competence. Therapist effectiveness may depend partially on client racial/ethnic minority background, providing evidence that it is valid to distinguish between general and cultural competence. However, in this study, no rationale was given for the differences observed. Zhang and Burkard's (2008) study complemented this view with a survey that explored racial difference and the effect on client ratings of the working alliance and counsellor credibility. Analyses revealed that White counsellors who discussed these differences with their clients of colour were rated as more credible and as having stronger working alliances than those who did not discuss such differences. This outcome points out to the importance of having race discussions in a therapeutic context at all levels.

The issues of matching clients and therapist on the basis of ethnicity and race for a better therapeutic outcome remains an important aspect to be considered an evaluated. Farsimadon et al. (2007) looked at the effects of ethnic matching on therapy outcome, bond with the therapist and perceived therapist credibility. This British study found that ethnic matching had a positive effect on the above three aspects of therapy when minority clients expressed a preference for a therapist from the same ethnic group. Noteworthy though, is that the bond with the therapist and therapist credibility appeared stronger predictors of outcome than an ethnic match. In a study of African American clients' perceptions of their White counsellors, Constantine (2007) found that these expressions of more covert and frequently subconscious racist attitudes were predictive of a weaker therapeutic alliance, lower ratings of general and multicultural counselling competence, and lower levels of counselling satisfaction. The literature on racial and ethnic matching confirms that matching in itself is not necessary a condition for an effective therapeutic outcome and mismatching is not necessary problematic. In fact, studies indicate that racial and ethnic identity, cultural values,

cultural mistrust, therapist cultural competence and worldview match are more relevant to treatment outcomes (Zane et al. 2005). Presumptions of similarity based on race alone may result in disappointment when client and therapist have incongruent values. Dogra et al. (2007) suggested that the ethnicity of the therapist was considered less important than the personality and general demeanour of the therapist. This view has been shared in modern psychotherapy, suggesting that feeling understood may be an essential aspect of the therapeutic relationship for adolescents and is not unique to adults (Chang & Berk 2009).

2.11 Challenges of Cross-cultural training for Psychological therapists

Psychological therapists' unique preparation and training may not facilitate their ability to engage in effective treatment with diverse people in an increasingly multicultural world (Constantine 2003). Experience of supervision has varied from cultural issues being dealt with in great depth, to such issues being ignored (Arredondo & Toporek 2004). Difficulties include lack of training, lack of interest and the inability to fully comprehend the complexity of working with clients from a different cultural background (Dressel et al. 2007; Mori et al. 2009). Lago and Thompson (2003) highlight the need for culturally appropriate supervision and training for therapists through the exploration of power imbalances, historical implications and parallel processes between the client and the therapist, as well as between the therapist and the supervisor. Thompson-Miller and Feagin (2007) take this a step further by stating that all who want to study and practise counselling psychology should actively embark on the reframing of White-generated racist values that are embedded in social structures and inevitably seep into the therapy room and training. Training is an important aspect of therapeutic work and provides necessary skills to practice effectively. However, the cultural and racial element of therapeutic work can sometime be neglected and some training continues to struggle with the syllabi and the didactic process to stimulate cross-cultural effective learning. The challenge for BAME people remains their vulnerability to colour blindness and racism. Adetimole et al. (2005), examined the impact of insidious racism during training on three female

clinical psychologists who identify themselves as Black and who qualified from the same course at different times while Lee and Khawaja (2012) surveyed postgraduate clinical psychology students examining factors contributing to trainee psychologist perceived level of cultural competence. It was hypothesised that multicultural teaching, clinical experience, and supervision would be related to students' level of cultural competence. Clinical experience and supervision focusing on multicultural issues were found to be related to participants perceived cultural competence however, multicultural teaching was not. These results provide insight into how training institutions can facilitate future practitioner's competence in working with clients from different cultural backgrounds.

Martin (2015) investigated cultural awareness provision in training and the experience of supervising and being supervised in the context of "cultural awareness" in fourteen UK counselling training institutions. Results indicated a varied coverage of cultural awareness in the syllabi and in supervision which were similar to the study by Pieterse et al. (2009) in America. Whereas the findings identify social justice content as a growing presence in multicultural courses, there is a need to more clearly outline the fundamental points of distinction and overlap between multicultural competence and social justice advocacy in counsellor and counselling psychology training. Prosek and Michel (2016) examined the lived experiences of counsellor trainees who participated in a short-term study abroad program in Ireland. It was found that counsellor trainees self-reported transformative growth as a result of their cultural immersion. Specifically, counsellor trainees identified an increase in cultural self-awareness, other awareness, and global connection. The implications of applying transformative learning theory (and what is termed by Prosek and Michel (2016) as "the Multicultural Immersion Experience model,") to guide cultural immersion programs, are discussed and are relevant for multicultural training and cultural competence trainings.

Cultural competency is complex and not all of its components can be trained (Sue 2006). There are some practical strategies that can be taught but there are also more general processes, such as

scientific-mindedness and culture-specific skills that are linked to the general makeup of the therapists, or can be obtained by life experiences. Nolte (2007) supports Sue (2006) that exploring and utilising personal life experiences of therapists is a valuable and relevant professional developmental tool and White therapist should be challenged to take responsibility in dealing with culturally different clients rather than ethnic matching.

Despite the importance of cross-cultural training competencies, Lago and Thompson (2003) claim that many therapist trainings programmes in the UK do not address adequately how to work with clients from other cultures. However, Papadopoulos and Cross (2006) provide excellent guidance for trainee counselling psychologists to follow when faced with a culturally different client advising against relying on assumptions and stereotypes and suggesting treating each client as an individual even if they appear culturally similar to the therapist, in order to maintain curiosity and avoid complacency.

West (2011) paints a bleak picture of counselling psychology trainees in terms of dealing with clients from diverse backgrounds disliking the use of the word 'diversity' in training and in practice, because it represents an avoidance and fear of addressing the issue of race and racial difference. These perceived gaps in training further strengthen the need for the current study but also pose a question on how learning from the current study might be incorporated into future training.

One area which could be more explicitly addressed in training is openness about how therapists feel in the therapy room with a client from another culture and how difficulties they may encounter could be uncovered (Fernando 2010). Moreover, therapists need to feel empowered to reflect on their views and grow professionally (Fernando 2010). Lago and Thompson (2003) add that trainees need to be enabled so that they do not shy away from questioning the validity of the model with which they are working. Trainees and therapists also need the opportunity to create individual ways of healing that are appropriate for the individual client, understand their own reactions to to other racial and cultural groups and be involved with minority individuals outside the therapy setting to

widen their perspectives thus increasing respect towards the client's cultural and language needs. Orlans and Van Scoyoc (2009) explain that all current therapies are based on theories from White Western males and so carry the same cultural bias and for this reason, practitioners need to work with, explore and be open to the cultural differences in the therapy room and in the training of counselling psychologists.

2.12 Challenges of Cross-cultural supervision for Psychological therapists

Supervision is seen as an important component of therapeutic work and provide effective support and guidance to supervise. Psychological therapists' unique preparation and training may not facilitate their ability to engage in effective treatment with diverse people in an increasingly multicultural world (Constantine 2003). Receiving multicultural "one-to-one" supervision presumably would increase the psychological therapist's cultural competence skills. This current method of supervision relies heavily on the supervisor and supervisee experiences and willingness to engage in multicultural issues, but discussion of these varied (Arredondo & Toporek 2004) and suffer the inherent difficulties of lack of training, lack of interest and the inability to fully comprehend the complexity of working with clients from a different cultural background (Dressel et al. 2007).

Supervision can be challenging and complex and the presence of culture and race in the supervision room can amplify these challenges. Burkard et al. (2006b) used consensual qualitative analysis to explore thirteen supervisees of colour and thirteen European American supervisees experiences of culturally responsive and unresponsive cross-cultural supervision. Culturally responsive supervision resulted in supervisees who felt supported for exploring cultural issues, however, culturally unresponsive supervision appeared to produce more negative effects. No detail differentiated between general supervisory skills and supervisory skills associated with cultural and racial issues so how this process could be emulated is unknown. Chopra's (2013) literature reviews on cross-cultural supervision and also used case example to conclude the importance of competence in multicultural

supervision. The role of the supervisor and supervision techniques that facilitate multicultural supervision is given specific attention and the case example provided a better conceptualization of the techniques involved in multicultural supervision. Utsey et al. (2005) used a focus group to examine eight White counsellor trainees' reactions to racial issues in counselling and supervision and explore the underlying dynamics. This captured the complexity of the trainees' reactions to racially charged situations in counselling and supervision.

Discussion of racial identity in supervision concluded that the awareness of racial identity development in supervision can positively impact outcome (Constantine et al. 2005). In an examination of multicultural supervision competence in racially similar and different supervisor-supervisee dyads (Hird et al. 2004), differences between White supervisors and "Racial/Ethnic Minority" (REM) supervisors were noted resulting in REM supervisors being reported as having more multicultural supervision competence than White supervisors. In racially similar dyads, REM supervisors spent significantly more time addressing cultural issues in supervision than White supervisors. White supervisors also discussed cultural issues significantly more with racially different supervisees than racially similar supervisees. Supervisors differed in which cultural issues they discussed and considered applicable to supervision. However, this research only considers dyad (supervisee and supervisor) and did not consider the patient culture/or race even in racial similar supervision dyad. Even with Toporek et al.'s (2004) study, these problems in supervision experiences pointed out the need for further training and development from both the supervisors and supervisee.

"Supervision is a fundamental element of these monitoring functions that guide the profession in that it provides a means to convey necessary skills, to socialize individuals into the particular profession's values, ethics, protect clients, and monitor supervisees' readiness for ongoing practice" (Bernard and Goodyear 2009:3). Psychological professionals often face challenges when working across culture, causing therapists to feel overwhelmed or helpless and can result in burnout

(Heppner 2006). Supervision has been identified as an essential ingredient for the professional development of psychological therapists and it is mandated as a required part of professional training by state regulatory bodies, professional credentialing groups, and accrediting bodies.

In current practice, it is the supervisor's task to facilitate this turbulence of multi-directional development. This responsibility placed on the supervisor is huge in widening horizons to the professional's developing and evolving consciousness on cultural competence. Multicultural supervision encompasses the supervisor and supervisee exploring all the various aspects of culture that pertain to providing psychological services with culturally diverse clients (Constantine 2003). Indeed, the supervisory relationship is affected by the client's culture (Norton & Coleman 2003).

2.13 Summary of findings and gaps in the literature

Following this literature review, it is clear that the therapeutic engagement plays a significant role in the psychotherapy process. The relationship is the most powerful component of therapy on which the therapist can have a direct impact. Adding the cultural and racial factors makes it even harder for psychological therapists to engage in therapeutic work effectively using culture-specific techniques, client/therapist matching and tailoring interventions to client unique background and culture.

There is lack of research on how therapists perceive their relationship within the cross-cultural therapy dyad or how these critical common factors (therapeutic relationship, competence, training and supervision) work in the cross-cultural therapy situation. Although important theoretical concepts such as multicultural competence and cultural responsiveness are often well-defined and extensively discussed in the multicultural counselling and psychological therapies literature, there remains a surprising lack of research exploring how they manifest in practice.

In summary, the following significant gaps in the literature have been identified from this literature review:

1. Few studies have explored how therapist perceptions and experiences relate to the therapy process and outcome in real, cross-cultural therapy relationships (Chang & Berk 2009). In-depth understanding of therapist contributions and perspectives in the cross-cultural therapeutic relationship can be reached only through qualitative inquiry into their lived experience.
2. There is a paucity of empirical studies which focus on the therapist's experience of counselling clients from African-Caribbean background. There is no literature focusing exclusively on African-Caribbean and White British psychological therapists' lived experiences of cross-cultural therapeutic work in an unlike racial dyad.
3. Currently, there appears to be more known about the views and experiences of minority ethnic clients and this has been used to inform practice about how to most effectively work with this client group and develop some best practice guidelines or competencies. Whilst this provides us with essential knowledge and insight about what is important to consider when working in a multicultural setting, our understanding remains incomplete while we continue to lack awareness of the often-complex processes involved from the therapist's point of view.
4. Research around supervision only focuses on the supervisor and supervisee dyad which somehow neglects another element in cross-racial supervision: the race of the patient discussed in supervision even when supervisor and supervisee are from the same race. This context can also be seen as multicultural/racial.
5. The cross-cultural therapy literature appears incomplete regarding its knowledge base in the field of psychological therapy in the UK. There is a qualitative methodoLogical gap in the literature, so the Logical research step is to explore more subjectivity about psychological therapists' experience of cross-cultural therapy.

6. A plethora of theoretical research has been devoted to therapeutic engagement, however surprisingly few use qualitative approaches which may ‘’more clearly capture the complexity and meaningfulness of human behaviour and experience” (Morrow & Smith 2000:199).
7. A significant part of the literature originates from America and the applicability of the findings in the UK is questionable due to differences in ethnic mix, culture, traditions between the two countries and the racial historical tensions.
8. The current literature has extensive information regarding African-Americans’ relationship with therapy but what the literature does not address or define are the specific challenges faced by professionals working in the NHS in multicultural Britain.
9. There has been minimal research published that prepares Western and non-Western practitioners (psychologists, counsellors, psychotherapists) to work in the cross-cultural-racial therapeutic dyad.
10. A number of British authors have commented on the lack of significant research being carried out in Britain in the area of multicultural counselling (Lago 2006; Karlsson 2005).

2.14 Addressing the gaps in the research literature

The current research aims to fill the gaps in the research evidence outlined above by recruiting and interviewing a small sample of psychological therapists (White British and African-Caribbean) about their cross-cultural/racial therapeutic experiences. The research seeks to address how White British and African-Caribbean psychological therapists view, understand and make sense of their experiences of working in an ethnically and racially different therapeutic dyad and also focusing on complex issues that makes up the process of therapeutic work. The study will be mindful of what represents the cross-cultural therapeutic dyad and will also look at therapeutic engagement at all levels: the therapeutic relationship, the process of therapy, supervision, and training.

The specific focus will be to:

1. Examine clinicians' experiences of the working alliance, therapy process, and techniques, supervision and training when working with racially dissimilar clients.
2. Understand how race/ethnicity/culture has been experienced as a theme when working between races by the psychological therapist within the clinical space.
3. Explore the experiences of race, ethnicity, the culture of African-Caribbean and White British practising psychological therapists within the therapeutic encounter.

Emphasis will be given to understanding how 'lived experience' is addressed, by taking the perspectives of psychotherapists in clinical practice to generate knowledge. It is anticipated that understanding these experiences will contribute to adapting and tailoring interventions. This may also enhance greater understanding of professional difficulties, challenges and opportunities and possibly lead to improvements in training and in the delivery of cross-racial/ethnic therapeutic work.

In order to ensure an effective contribution to knowledge of cross-cultural therapeutic work, data will be analysed through an interpretive Phenomenological lens (see Chapter 3). This will allow for a detailed analysis of understanding of professional difficulties, challenges, opportunities and the new knowledge created in this study could lead to improvements in clinical practice and in the delivery of cross-racial/ethnic therapeutic work.

Palmer (2002) asserts that more research is needed to explore the attitudes of professionals towards multicultural practice, which he identifies as severely lacking presently. This is echoed by Lago (2006) who highlights that little attention has been given to the role of the dominant (White) majority which is surprising, given that the majority of therapists are likely to come from this group. This research will examine the views and experiences of psychological therapists and illuminate the difficulties and opportunities they experience in cross-racial therapeutic dyads. The research is limited to White British and African-Caribbean practitioners.

3 Chapter 3 Research Methodology

3.1 Introduction

This chapter will outline the philosophical rationale that underpins this qualitative study design and methodology. Details of pertinent ethical considerations and research methods employed are discussed.

3.2 Research paradigms: the critical realist epistemology philosophical position

The "critical realist" position taken in this research recognises that social reality is constructed through language, but also that a world exists beyond personal social constructs (Johnson & Duberley 2000; Eatough & Smith 2006). This is similar to the Phenomenological view of Heidegger, particularly his concept of the "person-in-context" (Larkin et al. 2006) whereby individual and different perspectives are relevant and can produce different interpretations of the same phenomenon. Merleau-Ponty (1962:106) asserts "all my knowledge of the world, even my scientific knowledge, is gained from a particular point of view" which has relevance when considering the influence of the values and assumptions of the researcher within qualitative studies. Predominantly, social science focussed research, psychology in particular, has been framed within a 'traditional' and historically dominant positivistic research paradigm (Ponterotto 2005: Morrow 2005). The positivist research paradigm, is based on the assumption of objective truth, by which answers and understandings can be uncovered by the application of classic quantitative reductionist methodologies, similar to those employed by researchers in the physical sciences. The concept of objective truth endorses a single vision of truth and subsequently disregards, and at times may stigmatize, all other truths of lived experience. This creates difficulties when exploring human experience which occurs in multiple, often intersecting, and occasionally contradictory contexts. This research recognizes the existence of a real world, real objects and real events, whilst admitting that

experiences and interpretations of the external world are partial, imperfect, and open to multiple meanings (Shipway 2010).

3.3 Choice of methodology and for qualitative research

To explore the lived experiences of race, ethnicity and the culture of African-Caribbean and White British practising psychological therapists within the therapeutic encounter, a qualitative research design was chosen, as it deals with human lived experience (Schwandt 2007:100).

McLeod (2011) defines qualitative research used in the psychotherapy field as a form of 'narrative knowing', rooted in Phenomenological experience. Miles et al. (2014) argue that words rather than numbers provide convincing research data which has potential for meaningful outcomes. Additionally, building theory by valuing ideas and opinions of individuals with personal experience of the phenomenon in question offers them an opportunity to express their meaning (McLeod 2011). "Qualitative inquiry deals with human lived experience. It is the life-world as it is lived, felt, undergone, made sense of, and accomplished by human beings that is the object of study" (Schwandt 2007:100). As this research intends to gain the understanding of the cross-cultural/racial phenomenon in the psychotherapy room from the psychological therapist's point of view, a qualitative approach is considered as the most viable choice, best suited to uncover the hidden complexities experienced by psychological therapists within the cross-racial therapeutic dyad.

Understanding the intricacy of meanings psychological therapists will present is only possible by permitting accessing participants' full descriptions of their realities and being open to findings (Miles & Huberman 1994) so qualitative methods are suitable for use to provide more in-depth understanding and exploration with a view to augmenting knowledge rather than seeking 'facts' and 'truths' (Barker et al. 2002).

3.4 Interpretative Phenomenological Analysis (IPA)

IPA is a relatively new qualitative technique developed specifically for the field of psychology but researchers using it have already generated numerous published studies, reflecting increasing confidence in its applicability and relevance (Biggerstaff and Thompson 2008). According to Reid et al. (2005), IPA encompasses many principles of good practice, including owning one's perspective, situating the sample, grounding in experience, and achieving coherence (Elliot et al. 1999). Phenomenology is a philosophical approach which aims to identify and explore lived 'phenomena' (life experiences) by looking at their particular social, cultural and historical contexts (Finlay 2011), opening up the way everyday experience is viewed. Phenomenological inquiry is rooted in the ideas of Husserl and Heidegger and its methods provide a powerful tool for research in the humanities (Wertz 2005) and for understanding individuals' intricate experiences in the therapeutic arena (Finlay 2011).

3.5 Husserl (1913) and the 'epoche' (reduction)

Husserl 's ideas sought to emphasise lived experience as a more authentic scientific foundation for exploring the world (Finlay 2011). He argued that exploring the essence of lived experience could be facilitated by what he called the 'epoche': the bracketing, or putting aside, of prior knowledge (whether scientific or experiential) to make oneself more open to intuiting fundamental meanings (Finlay 2011). Husserl's Phenomenological approach aims to capture the essential qualities of experience made possible through the Phenomenological attitude. In practice, this approach involves the researcher bracketing their natural, taken-for-granted knowledge of the world, immersing themselves in the narrative, and striving to determine the essence of experience (Smith et al. 2009). It requires exploration beyond surface appearances to delve deeply into the experience as expressed. Throughout the research process, the researcher strives to maintain a naïve and

curious stance, similar to and congruent with personal approaches to individual clinical work with patients, so it will seem natural and comfortable using this approach in this research.

3.6 Heidegger and hermeneutics

Heidegger (1927) criticised Hurserl's approach, arguing that in order to gain knowledge of the 'lived world', a series of interpretative steps between pre-understandings and current understandings are required (Finlay 2011). This approach to human existence is described as hermeneutic and a 'hermeneutic circle' explains the process of moving between parts and the whole (Smith 2010). A number of post-Heidegger phenomenologists (Todres 2007; Van Manen 1997) also challenge Husserl's ideas of bracketing, arguing that individuals cannot 'put aside' their embeddedness in a specific culture and history proposing that there is a need to work with, rather than bracket, fore-understandings when encountering new experiences. By becoming familiar with the new, fore-understandings can be re-evaluated (Finlay 2011). This technique finds a better place within the therapeutic encounter where despite differences and the presence of assumptions, the most important focusis the awareness of bias that is culturally and racially driven. The challenge when conducting Phenomenological research is to balance the use of self-reflection and personal experience. Hermeneutic researchers recognise the partiality of their pre-understandings (Finlay 2008). They need to manage this process carefully, avoiding becoming overly self-immersed or hyper-reflexive and thereby losing sight of the phenomena under investigation (Finlay 2011). Although there are variations on Phenomenological research methods, Giorgi (2009) asserts that core characteristics include research that is descriptive, employs reduction techniques, examines intentional relationships between person(s) and phenomena, thus providing information about the essence of the phenomena.

3.7 IPA: idiography

IPA is rooted in idiography - the study of the particular (Lewis-Beck et al. 2004). It seeks to pinpoint specific details of a phenomenon and how it is uniquely experienced (Smith et al. 2009). In the current study, a small sample is desirable to give priority to a detailed, systematic, case-by-case analysis. This idiographic approach offers a strong insight into a particular person's experience and their response to a particular situation in their cross-racial therapeutic experience. Essentially, the details of a specific case might also highlight dimensions of a shared commonality (Shinebourne 2011).

3.8 The rationale for selecting IPA over other qualitative methodologies

IPA works best with a relatively small sample of participants because it seeks to investigate each case deeply in pursuit of a fine-grained, detailed and rich account of each participant's 'life-world' (Smith and Osborn 2008; Smith et al. 2009). As such, a detailed approach is in keeping with the aims of this study over a broader methodology such as Grounded Theory which focusses on exploring individual accounts of experience for the purposes of comparing cases to construct theory (Strauss and Corbin 1990). Grounded Theory requires a sample size large enough to achieve 'saturation' to enable theory generation (Barbour 2007; Smith et al. 2009) but IPA requires only a small sample of participants to generate data from deep and detailed exploration of each case (Smith and Osborn 2008; Smith et al. 2009). This detailed approach aligns with the aim of this research which seeks to bridge this gap in the literature by following Kouriatis & Brown's (2011) recommendation that IPA be utilised to explore this under-researched area. Moreover, the present research seeks different perspectives by a mixed sample including African-Caribbean's Psychological therapists' experiences.

3.9 Limitations of IPA

IPA has been criticised for its over-reliance on language as a way of accessing individual experience. Consequently, this raises validity issues, especially where participants are unable to articulate the multiple layers inherent in their experience (Willig 2001). This was less of an issue with the current sample who rely upon language for their occupation as therapists. However, IPA does not claim to be able to access pure experience, acknowledging that humans are meaning-making creatures, therefore meaning applied to experience has much to offer in learning about a person's involvement with a given phenomenon. As such, it offers an insightful account of a particular sense-making process (Eatough & Smith 2006).

Another limitation of IPA is its failure to consider the constitutive role of language (Willig 2001) with arguments that, since language is socially constructed, an interview (for example) simply reflects how a person talks about an experience rather than constituting a description of the experience itself (Willig 2001). However, IPA does involve close engagement with an individual's language use and with what is unspoken, seeking meanings which are, necessarily, bound in the context of a person's life-world. Primarily concerned with language, it also invites the consideration of other elements of experience beyond language use such as non-verbal and facial expressions (Eatough & Smith 2006).

3.10 Research Design

In terms of design, an interpretative Phenomenological Analysis (IPA) was selected as the most appropriate study design. An increasing number of researchers are now demonstrating the usefulness of qualitative methodologies such as IPA (Smith et al. 2009; Smith & Osborn 2003; Biggerstaff & Thompson 2008) which are seen as enabling researchers to capture the complexities inherent in psychological phenomena (Bryman 1988). This study employs an Interpretative Phenomenological Analysis (IPA) research design and rather than quantity, emphasis is placed on

quality and depth of information and requires only a small sample of participants (Smith & Osborn 2008; Smith et al. 2009). (Details of the analysis process can be found in Chapter 4 – point 4.3).

3.10.1 Ethical approval

Ethical considerations are essential to any research study. This study adhered to the BPS (British Psychological Society), BABCP (British Association of Behavioural and Cognitive Psychotherapist) Ethics Principles and Code of Conduct. Ethical approvals were obtained from Health Research Authority (HRA), University Southampton ERGO and the NHS confirmation of capacity and capability by Southern Health NHS Foundation Trust (SHFT) was established before any potential participants were recruited to the study.

3.10.2 Sampling

Phenomenology is the most appropriate design for this study as it embraces multiple perspectives and seeks to understand experiences as they are lived and felt by psychological therapists in the cross-cultural therapeutic work, regardless of prior assumptions. Purposive sampling from a small and homogenous group of participants was utilised (Smith et al. 2009; Langdridge 2007). The target sample was ten participants. Seven participants (Three African-Caribbean psychological therapists and four White British Psychological therapists) were recruited in line with study objectives and the gap in cross-cultural literature. A sample of seven participants were recruited in accordance with IPA's requirement for a fairly small and homogenous sample (Smith et al. 2009). Moreover, the sample size is pragmatic with this doctorate in clinical practice research. In order to achieve the homogenous sample, I sought to recruit therapists with experience of cross-cultural/racial therapeutic work and also met the inclusion criteria.

3.10.3 Sample inclusion and exclusion criteria

Inclusion criteria were: participants must be accredited to a professional body (BPS, BABCP, HPC, UKCP, BACP), have at least two years experience of counselling clients from a different ethnicity to themselves (specifically African-Caribbean and White British) and receive some form of clinical supervision. Psychological therapists who were not accredited to a professional body or who had no experience of cross-cultural/racial therapeutic work were excluded from the study. Prior to recruitment, I ensured that all possible participants met the study's criteria by asking them to confirm that that they did meet the criteria.

3.10.4 Recruitment

The study was conducted at a large NHS Trust in the South of England UK. The initial recruitment phase identified psychological therapists connected with local psychology services. To ensure voluntary recruitment, all potential participants were provided with written details of the study including recruitment criteria (Appendix C), contact details and clear information that paricipants could withdraw from the study at any time and before the analysis of data. These were provided prior to signing a consent form to participate (Appendix D). Courtesy and permission-seeking emails were sent to local service leads together with an information sheet about the study (Appendix E) requesting that any interested individuals who met the inclusion criteria (Appendix F), contact the researcher by phone or email. To broaden recruitment possibilities, snowball sampling was used where peers and colleagues were encouraged to forward the study information sheet to psychological therapists they knew. Once contact was made with possible participants, those who expressed an interest in taking part were sent an invitation email (Appendix G) providing participants with information detailing the study and what participation would entail.

Participants were recruited from The Trust's psychology services (inpatient, outpatient, IAPT). Two groups of participants (Four White British Psychological therapists and three African-Caribbean

Psychological therapists), aged between 27 and 58 years were recruited under these procedures. They all described themselves as psychological therapists in current practice and their therapeutic experience ranged from 4 years to 35 years. For the purpose of the study, participants were requested to provide written demographic information (see Appendix H) as part of consent process prior to conducting the interviews. In recognition of the idiosyncratic nature of therapeutic work at the beginning of the interview, participants were asked to self-define their understanding of cross-racial/cultural therapeutic work.

3.10.5 Informed Consent

All interviewees signed a consent form before the the interview. The participant Information Sheet outlined the nature and purpose of the research and provided contact details for the supervisors. By signing the consent form, participant was confirming that they had read and understood the purpose of the study and their right to withdraw. The consent forms clearly stated that respondents had the right to terminate the interview at anytime and if they were unwilling to continue, their data would be excluded from the analysis.

3.10.6 Interview setting

Morrow and Smith (2000) stated that the physical environment of participant interviews in qualitative research has important implications regarding the rigour and trustworthiness of a study. As the physical setting of an interview can influence participants' verbal and behavioural responses (Patton 2002), careful consideration was given to the setting for each interview and participants were given choice of interview locations including their place of work. Participants were informed that selecting a location for interviews needed to meet the following needs: their personal comfort, convenience, privacy, and an appropriately low level of noise/distractions. All interviews were solely conducted by this researcher.

3.10.7 Data Collection

Semi-structured interviews were conducted between January and April 2020 using open-ended and non-directive questions (detailed in Appendix I). The interview schedule was short and concise to ensure that it is focused on the research topic, whilst also providing the flexibility necessary for participants to discuss issues that they considered important and may be overlooked by the researcher (Smith 2008). Compilation of the refined interview schedule (Appendix I) was informed by the research questions, relevant literature and research supervision.

Semi-structured interviews are often used to collect data in IPA studies especially for novice researchers (Smith & Osborn 2003). While unstructured or open-ended interviews are participant-led and hence less structured around researcher-led topics. Smith et al. (2009) do not recommend that novice researchers use them, deeming that participant-led semi-structured interviews can enable the researcher to be prepared and confident, thus creating a more comfortable research interview for participants (Smith et al. 2009). Pre-formulated questions of semi-structured interviews were useful, but, mindful of possible restrictions, a more open-ended questioning style, using the interview schedule as a guide was utilized which offered participants flexibility to steer the conversation within the scope of the broader themes under discussion (Ponterotto 2005). This also allowed opportunities to respond and follow up new and unanticipated issues raised by participant and explore explicit meanings (Kvale & Brinkmann 2009). As recommended by Smith and Osborn (2003), prompts were also incorporated where necessary in the interview to elucidate areas of discussion and allow participants to share their explorations to express and capture their unique experiences. The schedule was largely developed from relevant literature, clinical experience and supervision discussions.

All interviews were scheduled to last sixty-to-ninety minutes and with each participant's consent, were audio recorded. Each interview began with an informal greeting and an explanation of the purpose of the interview, as well as confirmation of the participant's consent to proceed. To 'break

the ice' the interview started with a very general question about the participants' experiences of their therapeutic work. This was followed by seven open-ended questions, designed to encompass aspects pertinent to the research question, namely, the therapeutic relationship; the use of therapeutic skills; supervision; and training. Questions became more focused on individual perceptions of difference in therapeutic work and the impact on the therapeutic process, progressively moving towards issues around supervision, training and professional development. Participants were encouraged to elaborate on different points as they saw fit.

At the end of the interview, participants were invited to discuss any concerns which may have arisen during the interview. After the interview, the researcher's initial thoughts and reflections were recorded to highlight areas of particular interest noted during the interview process. All interviews were recorded, checked for completeness and transcribed by this researcher.

3.11 Data management and maintenance of ethical standards

This research adheres to the General Data Protection Regulation (GDPR), Data Protection Act (2018) and the University of Southampton Policies and Procedures regarding data protection and confidentiality. Data, such as interview recordings, transcripts, and demographic information are retained and stored in accordance with the university archive policy. Interviews were transcribed and transferred to electronic data information spreadsheets and all data stored on a password-protected computer, to which the researcher had sole access. The original data will be destroyed after the completion of the thesis and ten years thereafter as stipulated for a qualitative study (Data Protection Act 2018). Each interview was matched with a unique ID, to ensure identification of a particular interview within the data collection, but with neither participants' names or initials. Each participant was given a pseudonym to further protect confidentiality. All participants will remain anonymous throughout the research and all personal information disclosed will remain strictly

confidential. (Issues of anonymity and confidentiality in reporting were discussed with all participants before their participation).

Ethical principles (confidentiality, participant's rights, and potential distress or risk) were upheld and considered at all times. Before the interviews, participants were fully briefed on the purpose of the study verbally and in writing. Informed consent was sought after thoroughly reviewing each participant's risk for potential harm, including strong emotional reactions that may result from their participation. To gain mastery and immersion of the data, each interview audio recording was listened to multiple times and recordings compared to each transcription to ensure accuracy. All interview recordings, transcripts, and field notes are stored on a personal password-protected laptop computer in a locked filing cabinet, to ensure safety and confidentiality (Patton 2002). The research undertaken conforms to the principles embodied within the Declaration of Helsinki (2013).

3.12 Chapter Summary

This chapter has presented the research paradigm and the philosophical stance underpinning this study. In order to explore how psychological therapists, working with culturally/racially diverse populations negotiate their cultural/racial differences in the psychotherapeutic encounter, IPA was chosen as the most appropriate methodology for this qualitative research. In this study semi-structured interviews were used to collect data from seven psychological therapists who work with clients from a different culture/race. IPA techniques were used to elucidate research findings. Following Smith et al.'s (2009) Phenomenological method and stages, ethical principles were upheld throughout the study.

4 Chapter 4: Identifying themes from empirical data

4.1 Introduction

This chapter presents the analysis process leading to the findings from in-depth interviews with seven participants, all psychological therapists with experience of cross-cultural/racial therapeutic work. The main themes identified from analysis will be presented and explored. It is important to highlight that the themes described, emerged from analysis of data are linked to the research question. Extracts from interviews are included to illustrate and support the findings and emphasise their individual idiographic nature to be consistent with IPA sensibilities. Mindful that meanings are complex and multi-layered, the emergent themes are explicated not as assertions of fact but more as an indication of what appeared more important and pertinent in the narrative of participants.

4.2 Biographical and demographic details of the seven participants

The sample includes seven participants of mixed gender with ages ranging from thirty-two to fifty-five years. All participants live and work in the UK, four of them are British Nationals, and three them are African-Caribbean s. The participants' qualified experience in years ranged from four to thirty-five years. All were trained in institutes within psychotherapy and psychologist traditions and all are accredited with the British Association of Behavioural and Cognitive Psychotherapy. Three practitioners described their psychotherapeutic orientation as integrative (a mixture of various therapeutic treatment models). Two participants worked from the systemic approach and specialized with psychosis and two other participants described their work as dialectical and behavioral (a model of treatment used for patient diagnosed with borderline personality disorder). The psychotherapeutic approach could have relevance in a way therapist engage and formulate and relate to difference and to patient subjective and unique experience. The participants were asked to complete a brief demographic form prior to their interview (Appendix H). A more detailed

biographical and demographic description of each anonymised participant are presented in Appendix K.

4.3 Data analysis

Using IPA techniques (as outlined in chapter 3 page 73), interview data were transcribed and analysed using IPA Phenomenological process (Smith & Osborn 2003; Smith et al. 2009). Phenomenological qualitative research is an inductive process and as such, themes and patterns must be permitted to emerge from the data throughout the analysis (Patton 2002; Wertz 2005). This emergent stance is congruent with constructionist and critical theory paradigms, which place primary emphasis on the voices of participants and their interpretations of meaning. After transcribing the data into a word document for each participant, each transcript was reviewed line by line and initial themes, linguistic comments and the researcher's interpretation noted. Notes were colour coded to demarcate each part of the analysis process. An essential part of the data analysis process in qualitative research is immersion with the data so reviewing the transcript data was an iterative and reiterative process to enable a better understanding of the tone and texture of each interview while being mindful of clues alluding to the lifeworld of the participant (Smith 2009). By highlighting significant passages, cutting and pasting portions of the interview text, and using notes to flag key fragments, units of meaning were detected. Once the emerging structure of the phenomenon took shape, data were organised into the themes and sub-themes for each participant then matched and integrated - the themes from African-Caribbean's psychological therapists' interviews and the themes from White British Psychological therapists' interviews. An overall thematic structure emerged from integrating both sets of interview themes. There is significant overlapping of themes, as well as some themes that remain unique to each group. The data analysis procedures based on the Phenomenological methods and outlined by Smith et al.'s (2009) was considered. The overview of the strategies he proposes within the IPA are presented in box below:

Box 7: **Smith et al. (2009) IPA analysis stages**

1. Line by line analysis of the experiential claims, concerns and understandings of each participant
2. Identify emergent patterns – emphasising convergence and divergence, commonality and nuance
3. Development of a dialogue between researchers and what it might mean for the participants: more of an interpretive account
4. Development of relationships between themes
5. Organisation of this material to allow for analysis
6. The use of supervision, collaboration or audit to aid testing and development of the interpretation
7. The development of narrative usually theme by theme, evidenced with commentary and visual guides
8. Reflection on one's own perceptions, conceptions and processes

IPA researchers collecting data through semi-structured interviews often develop a 'prompt sheet' with a few main themes for discussion with the participants as a prompt for conversation only. In IPA the interviewee should lead the conversation. The transcripts were analysed with the original recordings and interview themes identified. The steps to Smith et al.'s (2009) IPA process were followed.

4.3.1 Phenomenological methods stages outlined by Smith et al. (2009)

4.3.1.1 Stage 1: Reading and re-reading

Engagement with data was achieved through reading and rereading the participant's descriptions one narrative at the time which were then transcribed. Absorption in the process allowed me to re-join with the participants' narratives in fine detail.

4.3.1.2 Stage 2: Initial noting

The aim of this stage was to yield a detailed and all-inclusive set of notes about the data by making comments to the narrative while staying close to participants' clear meanings. A summary of content, relations between different parts of the transcript and initial

interpretations was placed in the margins of the table. The comments started with simple descriptions and summaries of participant's experiences followed by linguistic comments and aspects which stood out. A more interpretative engagement with the text together with questions that arose from the narrative and the speculation on these meanings ensued, following the context a double hermeneutic. I remained mindful that these could be personal thoughts about participants' meanings rather than facts.

4.3.1.3 Stage 3: Developing emergent themes

For each transcript, the notes made (as described) were summarised to generate emergent themes. The aim here was to use the initial notes to map inter-relationships, connections and patterns and to pinpoint what was important in the various comments in each part of the transcript. This process involved developing emergent themes that reflected the researcher's descriptive, linguistic and interpretative notes. These emergent themes were noted on the left-hand column of the table to provide a clear overview of the initial emergent themes. Alongside this process, the researcher documented personal narrative Phenomenological descriptions to formulate understandings of participants' accounts and so get closer to their lived experience. The aim was to elucidate the experience and avoid getting caught up with the mechanics of thematic analysis which could have diverted attention from the phenomenon.

4.3.1.4 Stage 4: Searching for connections across emergent themes

This stage involved depicting the emergent themes in a way that illuminated important aspects of each participant's account. It was anticipated that a large number of emergent themes would arise from the transcript. Aspects were transfered into a word document and printed, creating a system of cut-out strips of emergent themes. This allowed clustering of

associated themes while noting those aspects/themes that appeared weaker. Once emergent themes were contrived, the process was repeated on the remaining transcripts.

4.3.1.5 Stage 5: Moving to the next case

Each new transcript was treated as an isolated account in the first instance with attention to 'step back' from what had been gathered from previous transcripts.

4.3.1.6 Stage 6: Looking for patterns across cases

Scrutinising each transcript, the researcher searched for patterns, connections and strong themes as well as peculiarities across accounts and, with all the main emergent themes for each participant on separate sheets of paper, recurrent themes, those that seemed inter-related, and those that controverted themes suggested by other accounts were observed across cases. The results were then tabulated to demonstrate the findings as presented in next sections of this chapter. The anticipated challenge was whether the main themes devised were comprehensive of the participant's experiences in the area under question. Moreover, it was challenging to consider how a theme might capture divergences within participants' accounts and how this might best be put into words especially when working with two racial groups and wanting to highlight similarities and differences. Utilizing research supervision refined themes and clarified processes. This is consistent with Smith et al.'s (2009) recommendation of independent audit to help demonstrate the validity of the analysis.

Throughout this process, regular consultation with supervisors and a self-reflective journal, (to evaluate the impact of personal bias in the analysis) enabled careful attention to the bracketing process. What emerged was a detailed description of lived experiences of the cross-cultural therapeutic work. This narrative contained numerous participant quotes used to illustrate and clarify the convergent and divergent themes that emerged in analysis. The contribution of knowledge this study brought to the fields of cross-cultural psychotherapy was also discussed and the impact that

participation in this study had on the individual participants and their ongoing therapeutic work were described. At the end of the interview, the reasearcher verbally thanked participants for their time and reflection and at the end of the analysis process, a letter was sent thanking them for their contribution to the study (Appendix J). The next section presents an overview of the main analytical process and stages as advocated by Smith et al. (2009).

4.3.2 Stage one: Initial ideas and Emergent Themes

Step one of Smith et al.'s (2009) process involves 'reading and re-reading' to become fully absorbed within the data and to start to run a descriptive account of the world which the participant lives. To gain knowledge and understanding with the content of each interview all the digital recordings were transcribed by the researcher immediately after each of the conversations and allowed reflection and researcher immersion with the data. This was potentiated by a constant return to the original recordings and transcriptions allowing further immersion into the narrative data by reiteratively reviewing the transcriptions and the digital recordings. This process was undertaken with each transcript separately in order to obtain a sense of the whole interview and to ensure that the participant of each unique interview remained the focus of that analysis (Smith et al. 2009).

During the first and second interview transcriptions, descriptive 'initial ideas' were recorded on 'post-it' notes and attached to the front page of each printed transcript. 'Initial ideas' were the initial thoughts, ideas and statements that became highly visible during the transcribing, reading and re-reading stages. The 'emergent themes' were recorded in pen on the right-hand column on the transcribed scripts (table below).

Table 7: **Example of the conception of an emergent theme**

Interview (Martha)	**Initial idea (Emergent Theme)**
It started when I became a trainee on the clinical psychology-training course. I did my training 1993 – 1996. We were asked which areas we would not like to have our placements in. I said I would go anywhere in the Wessex region, but not the Isle of Wight.	

And I'm someone that came from Birmingham, which is highly multi-cultural, I was fully aware of cultural issues at university when I did me under Grad, and that's why I said not the Isle of Wight, but I actually ended up being on the Isle of Wight and boy, did I feel like 'a fish out of water'. Just by the fact I was the only Black person going to and from Southampton to the Isle of Wight every day and to just see White faces wherever I was going, that's all I saw and feeling really quiet – you're new on a training course anyway – so I felt quite strange, it was a completely new way of being, working, taking on new information but I didn't feel that I could connect with anyone, so I felt disconnected from people and quite isolated. I can't remember now who I spoke to, but clearly, I spoke to someone who put me in contact with what they call the race and cultural special interest group that the BPS has set up and I got in contact with that group of people who were mainly city based, from London, Birmingham, Leicester so I met a number of people at those meeting so I actually felt part of a group. I felt connected with psychology then but being part of the Southampton cohort, I felt different from everybody and that was not good	FEELING (DIS)CONNECTED FEELING DIFFERENT
I did not notice any difference between myself and my colleagues at any point to be honest. I do not know whether that is because of my personality or the patients I was working with. The only times I noticed any difference was between myself being female and a male patient, that's when I noticed the difference or things that I needed to take on board or consider, or the way I was speaking. It was not about the colour of my skin. It was not in the NHS but when I was doing private work that is when I noticed a difference and that was brought up by the patient, with the patient saying you know what it must feel like, in terms of that person's difficulties. The assumption was that I must have gone through a hard time in order to get to the position that I had to. That only came from private patients interestingly, not NHS patients, that's when I noticed and there was a part of me that wanted to say – how do you know what my life has been like just because I am Black you are making assumptions about me – and that's what I had a problem with. I took that to supervision, and again I had to be careful which supervisor I took that to in terms of being able to have that conversation.	CLIENT ASSUMPTIONS ABOUT THERAPIST BACKGROUND BEING A BLACK FEMALE THERAPIST DIFFERENCES WITHIN GROUP SAMENESS versus UNIQUENESS BEING HUMAN CLIENT versus THERAPIST - ASSUMPTIONS/BIASES SEEKING SUPERVISION

Once steps two and three of the IPA process were completed for all of seven transcripts, the 'emergent themes' from all transcripts were recorded in a word file to show a comprehensive process. These collective 'emergent themes' could then be cross-examined to show commonalities and differences.

Four hundred and forty-three 'emergent themes' were recorded in all. Crossed signs were used to identify if the participant had this theme highlighted in the interview. Table 8 represents how these emergent themes were chosen and presented for all participants

Table 8**: Example of how emergent themes were presented for all participants**

Collective emergent Themes	Martha	Marie	Olga	Monica	Daisy	Christopher	Theo
Attention to assumptions and biases	X	X		X	X	X	x
Systemic biases	X				X		x
Understanding differences	X	X		X	X	X	x
Feeling (dis)connected	X				X	X	
Cultural adaptation		X		X	X	X	
Willingness	X					X	X
Being human	X	X		X	X	X	
Supervision model		X		X			
Experiential learning	X			X	X	X	
Racism	X	X			X	X	X
Therapeutic relations	X						
Cultural openness		X			X		X
Additional support	X					X	

Cultural knowledge		X		X	X		
Reflective practitioner					X	X	
Collaboration	X	X				X	X
Cross fertilisation	X				X	X	X

Van Manen (1990) compares this stage one process, to peeling an onion where layers of the onion resemble the different layers of the analysis stages including identification of themes and theme clusters.

4.3.3 Stage two: Sub-Ordinate Themes

A column, labelled ‘sub-ordinate themes, was added to the spread sheet. The ‘emergent themes’ were grouped together when commonalities appeared. Commonalities were denoted by the meaning of words and by interpretation of these meanings within the context of cross-cultural therapeutic work. Emergent themes, even with only one or two respondents were also considered as sub-ordinate themes if they were repeated and could be relevant. This led to seventy-one ‘sub-ordinate themes. Table 9 presents an example of two subordinate themes with accompanying emergent themes.

Table 9: **Example of two sub-ordinate themes with accompanying emergent themes.**

Sub -Ordinate Themes	Emergent Themes
Knowledge and skills acquisition	Learning prior training Learning through formal training Learning on the Job Learning from client Personal responsibility to increase knowledge Learning from experience Client as a teacher Rethinking training Experiential learning and training Collaboration Cross fertilisation
Supervision and support	Effective versus ineffective supervision Disparity of skills Supervision model Group supervision Specialist supervision Reflective approach Experiential approach Informal support Collaboration

This process is concordant with step four of the IPA process (Smith et al. 2009:92) which is concerned with 'searching for connections' across emergent themes. Occasionally words and phrases identified within the emergent themes were difficult to link together into one 'sub-ordinate theme' and without bias, these were kept independent. Steps four, five and six of the IPA process ran concurrently throughout the development of sub-ordinate themes to look across individual cases.

4.3.4 Stage three: Super-ordinate Themes

By repeating the process as set out in stage three, the sixty-five 'sub-ordinate themes' were reviewed and reduced to produce twenty-three' super-ordinate themes. In accordance with Smith et al. (2009a), this process was undertaken by hand (writing each 'sub-ordinate theme' onto separate

'post-it' notes that were then laid out) so that themes could be grouped in related clusters. Care was taken to avoid overlapping themes and avoid duplication. Both the 'sub-ordinate' and 'super-ordinate' themes relate to the researcher's interpretation of the seven participants' experience of cross-cultural therapeutic work. Table 10 highlights the relationship between the 'sub-ordinate' and 'super-ordinate' themes.

Table 10: **The relationship between sub-ordinate and super-ordinate themes**

Sub ordinate themes	**Superordinate themes**
1. Cultural immersion 2. Inculturation 3. Sameness vs uniqueness 4. Being human 5. Practitioner willingness and curiosity 6. Active engagement 7. Adjustment and adaptation 8. Awareness of own biases and assumptions 9. Learning from each other 10. Setting clear boundaries 11. Knowledge and skills acquisition 12. Understanding differences within group 13. Culture as central to treatment 14. Reflective practitioner 15. Learning from client 16. Racial dimension 17. Systemic formulation 18. Negotiating differences 19. Adjusting differences 20. Differences within 21. Boundaries 22. Power dynamic 23. Practitioner willingness 24. Awareness of own biases and assumptions	1. Cultural immersion/willingness 2. Cultural adaptation 3. Cultural competence 4. Human connection 5. Communication by observing limits
25. Systemic barriers (Institutional policies, Assessment and diagnosis tools, geographical and demographic disparity, Westernised tradition, Western model superior, institutionalised racism) 26. Practitioner stance 27. Quality of relationship 28. Relationship with race and culture 29. Patient attitude 30. Negative assumptions 31. Organisational fear 32. Collective fear 33. Individual fear	6. Systemic barriers 7. Personal Biases 8. Racism 9. Fear/helplessness 10. Lack of knowledge, insight and resources 11. Cultural distance 12. wilfulness and lack of willingness 13. lack of effective training and support 14. Racial/cultural identity and transformation

34. Therapeutic relationship (cultural distance, language issues, power imbalance, polarised and judgemental thinking, feeling disconnected) 35. Patient attitudes (cultural beliefs, client view of therapy, negative attitude, mistrust, assumptions, biases, racism in patient) 36. Cultural blind treatment approach 37. Feeling of lack of competence 38. Feeling shock 39. Inability to help 40. Feeling overwhelmed 41. Feeling helpless 42. Learning to work cross-culturally 43. Boundaries and expectations 44. Lack of support	
45. Learning prior to training 46. Learning through formal training 47. Learning on the job 48. Learning from the client 49. Personal responsibility to increase knowledge 50. Learning from practice 51. Knowledge and skills acquisition 52. Learning from experience 53. Rethinking training 54. Cross-fertilisation 55. Collaboration 56. Exposure	15. Differential learning/training (formal and informal) 16. Experiential learning 17. Learning through formal training 18. Learning on the job
57. Supervision and support 58. Individual vs Group supervision 59. Specialist supervision 60. Reflective approach 61. Experiential supervision 62. Cross fertilisation 63. Networking 64. Database 65. Networking	19. Individual vs Group supervision 20. Reflective and experiential approach to supervision 21. Cross-fertilisation 22. Networking and collaboration 23. Cultural interest group

After this stage had been completed, the process was repeated for further clustering to regroup super-ordinate themes into final interpretative themes.

4.3.5 Stage Four: Final Interpretative Themes

Examination of the remaining twenty-three 'super-ordinate themes' exposed that some 'super-ordinate themes' were closely inter-linked so, to reduce the risk of repetition in the writing and re-writing stage, the most closely linked themes were looked at together and refined resulting in four 'final interpretive themes' (Table 11).

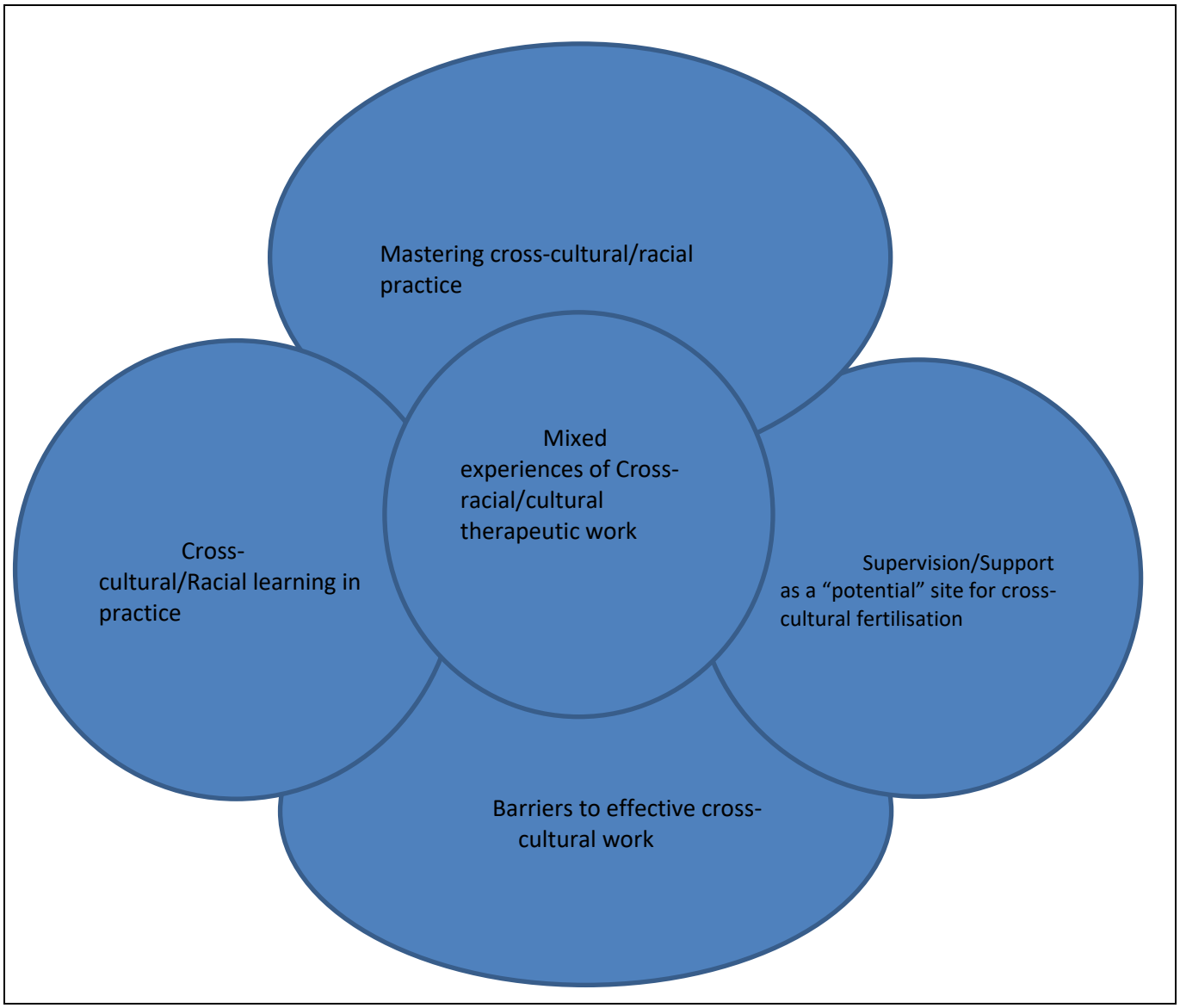
Table 11: ***Formation of 'final interpretive themes' from 'super-ordinate themes'***

Superordinate themes	**Final interpretative themes**
1. Cultural immersion/willingness 2. Cultural adaptation 3. Cultural competence 4. Human connection 5. Communication by observing limits	**1. MASTERING CROSS-CULTURAL/RACIAL PRACTICE**
1. Systemic barriers 2. Personal Biases 3. Racism 4. Fear/helplessness 5. Lack of knowledge, insight and resources 6. Cultural distance 7. Wilfulness and lack of willingness 8. Lack of effective training and support 9. Racial/cultural identity and transformation	**2. BARRIERS TO EFFECTIVE CROSS-CULTURAL/RCIAL WORK**
1. Differential learning/training (formal and informal) 2. Experiential learning 3. Learning through formal training 4. Learning on the job	**3. CROSS-CULTURAL/RACIAL LEARNING IN PRACTICE**
1. Individual vs Group supervision 2. Reflective and experiential approach to supervision 3. Cross-fertilisation 4. Networking and collaboration 5. Cultural interest group	**4. SUPERVISION/SUPPORT AS A "POTENTIAL" SITE FOR CROSS-CULTURAL FERTILISATION**

The four 'final interpretive themes' that constitute the Psychological therapist experience of cross-cultural therapeutic work are:

- Mastering cross-cultural/racial practice;
- Barriers to effective cross-cultural/racial work;
- Cross-cultural/racial learning in practice;
- Supervision/Support as a "potential" site for cross-cultural/racial fertilisation (Figure 2).

*Figure 2**: The final interpretive themes in relation to the study aim.***



An overview of the analytic process can be found on Appendix L

4.4 Chapter Summary

This chapter has discussed the management and analysis process of data generated from individual interviews with seven participants selected to lend understandings to address the research question. The analysis procedures chosen have been justified and the process to ascertain the resultant 'final interpretive themes' (n4) has been detailed.

5 Chapter 5: The findings from the interviews

5.1 Introduction

This chapter provides interpretation of the interview data collected from the lived experiences of cross-cultural/racial therapeutic work by seven psychological therapists. These findings derive analysed data gathered from semi-structured interviews. Examples of the participants own words (descriptive phrases and paragraphs) have been used to illustrate interpretations. The findings are explored in depth under four final interpretative themes: mastery of cross-cultural practice; barriers to effective cross-cultural work; cross-cultural learning in practice; and supervision/support as a "potential" site for cross-cultural fertilisation.

5.2 FINAL INTERPRETATIVE THEME 1: MASTERING CROSS-CULTURAL PRACTICE

Mastering cross-cultural/racial practice refers to a set of internal and external attitudes and behavious that facilitate effective cross-cultural/racial therapeutic work. For all participants in this study, mastering cross -cultural/racial therapeutic work is generated from fundamental aspects of therapeutic engagement where openness, curiosity, validation, contextual understanding and a non-judgemental stance are paramount. Participants expressed the need to 'just' be a validating human, able to communicate in a non-judgemental way and with compassion. Participants talked about their experience of cultural immersion, cultural adaptation, cultural competence, cultural willingness and curiosity, human connection and their communication style. Some participants demonstrated that their level of racial and cultural identity development prepared them to effectively tailor and adapt interventions.

5.2.1 Sub-theme 1.1: Cultural immersion and willingness

Cultural immersion refers to the act of immersing oneself in a different culture or going deeply into a culture that is not yours. This requires willingness and open-mindedness. Participants discussed their art of stepping out of one's own cultural comfort zone as opposed to importing cultural elements into one's own domain of knowledge and familiarity. Participants also shared their experience and details of interventions adaptations and how this could lead to improving their competence by willingness to notice and bracket preconceived ideas and assumptions about other races and cultures while in a psychotherapeutic encounter. Participants described being open-minded and curious about other cultures. Monica, an African-Caribbean therapist talked about her willingness to acculturate and transform to lead to a better understanding of her White patients describing how this *"came at my own will. Therefore, it my personal case I never felt that I was pushed or forced into adapting"* (Monica: 84-85) She added: *"Therefore, I had to rather learn the way that in this culture, in the UK, in England in particular, people relate to their emotional lives. What seems appropriate to them and what is not so I could gauge in the room how much suffering they had because they are deviating from their norm."* (Monica: 89-91).

The experiences of immersion are shared by White British participants. Mary, a White psychological therapist talks about her positive experience of immersion coupled with her genuine interest of knowing about other cultures and also coming across as interested: "*I think for me as well I have a lot of friends from different culture backgrounds just because of the area I grew up in, so I have a genuine interest in finding out about different cultures"* (Mary: 237-239). She also shared how important it is to approach clients by showing interest and curiosity in knowing about aspects of their culture in a non-judgemental way: "*You notice the differences between you and the client and I just try to be very curious about their experiences. Any experiences they have related to their culture I try to be interested about, try to learn about them, and try not to make assumptions that just because someone is from a certain culture and background, they might be a certain way*". (Mary 20-

24). Therefore, immersion is experienced as a balance act between being oneself at the same time being in the 'other person's shoes' achieved through mindful awareness of assumptions and judgements that might get in the way.

5.2.2 Sub-theme 1.2: Cultural adaptations

Participants in this study talked about their experience of cultural adaptation which refers to the process of making psychotherapy goals, content, language and process consistent with those of the target population, with the rationale of enhancing treatment credibility and outcome. Participants also talked about their experience of behavioural, cultural and treatment adaptations. The importance of being flexible and tailoring needs and behaviour depending on what is observed in the therapy room and the cultures present has been highlighted as being a fundamental aspect of cross-cultural/racial therapeutic work. Participants described the foundation of their adaptations based on their preferred psychotherapeutic modalities (CBT, DBT, ACT, CBT for psychosis; DBT). Some participants recognised that some psychotherapeutic models were more attuned to enable manoeuvre for adaptations while others were not flexible. It was also recognised that some psychotherapeutic models of treatment were more receptive to African-Caribbean patients because of an increased recognition of the role of individual belief systems and cultural environment.

Participants declared the importance of developing their own therapy style, congruent with therapy goals to promote appropriate adaptation. It would appear necessary to balance therapy style, the client expectations and patient expectations so balance seems important here to move between a flexible and rigid therapeutic style on a continuum. Also discussed was the dilemma of adaptation: keeping oneself within the treatment model and adapting effectively without deviating from evidence-based practice. Tension was also noticed by participants whilst balancing evidence-based approaches and practice-based approaches with the meaning of modality preference and choice. Monica for example stated: "*I think it is systemic. I think, I do not know about other Countries, I would like to think Britain is quite a long way ahead from what I know about other countries I*

actually think even that we are having this conversation, that you are researching this I think this speaks for itself. The kind of models to use, what is the recommended NICE guidelines for PTSD. So, it does not matter if you are Afro-Caribbean, you have to follow that model. Moreover, the client that is going to be on the receiving end using it with the therapist have their cultural experiences" (Monica: 416-422).

White British Psychological therapist participants described the importance of adaptation and also the challenges associated with their attempts to bring culture and race into their therapeutic work and modalities. Theo outlined one of his experiences of adapting his Cognitive Behavioural Therapy approach, often changing his therapy style and expectations depending on activity in the room and differences observed: "*I would take the usual CBT approach, diary keeping and we found it was not sitting comfortably, it was not helpful. I learnt quickly that his family were important to him, a lot of respect for elders, female elders particularly. There was a lot of storytelling; he wanted to tell stories to get his point across. So, we actually did away with my standard therapy and kind of went for stories, analogies that seemed to get through a lot more."* (Theo: 149-154). For Theo, the importance of adapting therapy materials and making therapy more reachable and understandable to the clients and being mindful that some materials may not have been tested on all cultural backgrounds was important: "*more geared up to questionnaires, rating scale, all sorts of materials being sent out in multiple languages. I know that most of the questionnaires have been validated on a Western, White, middle class people and been correlated on that. I would not take them as 100% accurate. Apart from that, I do not think I would make any alterations*". (Theo: 175-176; 179-181).

Theo also talked about looking at a more trans-cultural diagnostic approach rather than a Western construct of diagnosis and the importance of being sensible to the way mental illness manifest and is interpreted through patient culture: *"I am aware that different cultures have different terminology, different phrases for different experiences. Some cultures will feel the distress and have much more somatic presentations, which could be misinterpreted if I think you do not look at their cultural*

significance then you could end up with a completely wrong diagnosis because you have taken one approach and a different approach should have been taken." (Theo: 188-192).

Mary recognised that adaptation skills is part of her ongoing therapeutic work with all clients and pointed out the challenges of acknowledging cultural aspect of therapy adaptation. She therefore described the need to bring culture into adaptation by stating: "*we're quite used to adapting therapy but not always in that way that brings in the culture"*. (Mary: 392-393), adding: "*I couldn't say why did I adapt it in that way, was it specifically because of his cultural background and maybe that's something I could have explored more in terms of what's the expectation within your culture of how much you trust people…., it seemed like it was helpful at the time and I think to make it more culturally adapted it could be, you'd have to ask more about the culture"* (Mary: 367-369; 371-372). This was interpreted to mean that the process of adapation was not always culturally orientated or lacked cultural substances.

Formulation is an important component of therapeutic work. Different models are used to formulate patient difficulties and it is the responsibility of the therapist to facilitate this process including in a cross-cultural encounter. For example, Olga talked about her unique experience of adapting formulation using the CBT model: "*I think perhaps it's harder in a CBT formulation, I mean you can put in there the impact of power imbalance in racism but, I wonder if there are other formulations that would do that better."* (Olga: 123-125). This was therefore interpreted to mean that despite the individualised nature of formulation, the difficulties inherent to adapting template formulation remains a challenge because the cultural and racial element were not intergrated and the formulation model may be colour or culture blinded.

Daisy described adapting interventions and models and using one that is more congruent and receptive to the client culture, working with their belief systems but focusing more on distress and affect. "*I think it is about adapting models. I very much use Chadwick's cognitive model - is more about the distress and the relationship with the distress and for me that works well. It acknowledges*

what people's beliefs are but it does not try to challenge the belief, the work is around being able to manage the distress" (Daisy: 156-159). This was therefore interpreted to mean that certain theoretical model of treatment can be easily adapted to client from different culture.

Another important part of the therapeutic process is the ending and this process can have a profoung effect of patient depending on its negotiation and also taking into account the culture of the patient. For example, Daisy added the value of ending and how she adapted endings with client culture and preferences: "*I have noticed the importance of endings. People want to bring food, there's a sharing, people want to make a connection, a slightly different dynamic which I've noticed and I don't know whether that's by chance, I don't know but when we come towards the endings, us coming together and sharing something to eat and saying goodbye, that's different"* (Daisy: 165-168). This was therefore interpreted to mean that cultural elements are present in all phases of therapy (the beginning, the middle and the end) and all these phases need to be considered during the adaptation process. Tayloring approaches by integration of aspects of patient culture will enhance engagement and their recovery. Christopher added: *"I think they meet someone who understand them, who understands their culture. "(*Christopher: 219-220).

5.2.3 Sub-theme 1.3: Cultural competence

All participants talked about cultural sensitivity and the knowledge and skills set necessary to work effectively in a cross-cultural/racial therapeutic encounter. These specific skills enable psychological therapists to work effectively with race and culture. Participants described experiences of cultural competence from different perspectives: behavioural, emotional, cognitive and psychological. Participants labelled the importance of noticing their own assumptions and biases and acting conversely or bracketing them. Participants spoke about culturally competent approaches as a personal responsibility that is nurtured by therapist willingness. Mary for example talked about important attributes and behaviour that facilitate cultural effective interventions: "I *think for me it is just coming across as interested and non-judgemental and curious… I suppose to have quite a gentle*

approach maybe, the validation, curiosity" (Mary: 232-233,329). This was therefore interpreted to mean cultural competence is an ongoing process with opportunities and challenges. The importance of noticing and being mindful about differences but also similarities, surfing and balancing between the two. Mary for example added: *"Both the people I have worked with who were from an African-Caribbean background were a similar age to me and that is something I guess I hope might facilitate some engagement. So, as well as differences there are some similarities…, what I am thinking now is the middle ground, to have some knowledge but ultimately ask the questions of the person in front of you specifically about culture".* (Mary: 62-64; 434-435).

Paticipants described cultural knowledge and an important aspect that facilitate cultural competence. Mary for example shared her experience of cultural knowledge and the impact this could have on the therapeutic relationship. She spoke about her own informal ways of learning from others cultures: *"I have learned a lot from friends from different cultures about the kinds of things they experience that people obviously are not doing intentionally but it gives quite a powerful message to them"* (Mary: 86-88). Moreover, knowledge and awareness of patient spirituality has been recognised as an important aspect of cultural competence. Daisy for example talked about the importance of working with spirituality for African-Caribbeans, being guided by them and integrating their belief systems into the formulation: "*But what isn't explicit is the spirituality and the importance of spirituality and I've really had to be guided by the service user, and be guided by them and had to come from a position of not knowing and really being curious to inform the formulation and the next steps because it's not about changing someone's belief system* (Daisy: 32-35). Daisy reiterated this same view, highlighting the value of acknowledging structural challenges and validating the painful struggle of going through the adaptation process:" *It has been hard. It is also about acknowledging – I worked with a man who came from a very strict Muslim background and had a very different belief system as to what was going on for him. A very strong family background, I spent time with him at the Mosque, I took my shoes off, and it was difficult because I was a female. I spoke to one of the elders, it was a real learning experience for me, and as the elder said, you have*

your beliefs and a reason for your beliefs. so, it's been very difficult trying to navigate that and sometimes I haven't been able to navigate that because the person's beliefs are so strong but it's about giving options" (Daisy: 204-209; 211-213).

Being guided by the patient was highlighted as another effective way of improving competence and effective cross-cultural/racial therapeutic work. Theo for example talked about his experience of being guided by the client and how engaging that process was for both himself and the client: "*She took quite a delight in me being interested and open, wanting to learn about it, being honest, and saying I am not going to pretend that I know because I do not. I need you to educate me and that was very helpful. I did not want to fall into the trap of making assumption and seeing things from my perspective because of a lack of understanding or lack of knowledge."* (Theo: 72-75).

Acting against urges to ignore cultural issues was highlighted by participants as a way to help improve competence and engagement. For example, emphasis on the risk of White psychological therapists ignoring difference and the importance of 'stopping and breathing' to reconsider all factors rather than pretend there are no issues, assumptions or biases: *". We all get into routines of doing things and we need to sometimes stop and breathe and consider other factors and other things assumptions can be on both sides of the table. People can be making assumptions about my background and me and maybe guarded in responses therefore. Therefore, I think it is a two-way street. There is also the recognition of our own cultural background and influences that would have come into play even before we came into a job that can influence things. It is almost that you could be biased and not realise you are biased"* (Theo: 92-98). Olga, a White psychological therapist talked about her experiences of bracketing her assumptions and finding ways of understanding someone else's experience by acknowledging emotional expressions of difference and distress. *"Yeah, and I suppose also making sure that you're not making assumptions about something for them that might be normal or not distressing, we might think would be distressing, because culturally it might be different*". (Olga: 132-134). Mary also shared similar experiences, highlighting the importance of

noticing differences whether about age, culture or race and also understand experiences from a cultural perspective: *"I think they may sometimes think that I do not understand and maybe I do not always understand what somebody from a different culture's experiences is like"* Mary: 35-37).

An African-Caribbean psychological therapist spoke about his culturally competent CBT skills during assessment and formulation of his White British client's difficulties. He described his willingness to understand client perspectives and the relevance of their presentation from a cultural perspective: *"Once again, I follow what CBT in terms of assessment and formulations. In the assessment with someone coming from a different background, when I'm assessing White British people, I try to incorporate a lot, I try to understand their cultural perspective, how their symptoms might be related to or linked to any cultural perspectives and I do find, especially when I have worked with people"* (Christopher: 90-94). African-Caribbean Participants discussed changing their therapy approach (using metaphors and stories) and also using aspects of their own cultures to enhance patient understanding and promote effective interventions: "*I was going to say the humour. I like my sessions – I blend them a lot with humour, but I have to know my patient well in order to be appropriate with humour and I have not gone wrong before with any patient; just a little bit of humour, some metaphors, they connect with it so much that even whey therapy is coming to an end they are asking for an extension in therapy and they are asking will I do it after the therapy"* (Christopher: 333-337).

5.2.4 Sub-theme 1.4: Human connection

Human connection refers to the therapeutic connection at human level, feeling understood and being recognised as persons. This connection is deepened by the communication style which reflects a sense of warmth or concern for the other as a person. Participants shared notions of effective blending and adaptation which translate to being human and having 'sameness' in the therapy room. These characteristics enable the person to be central to the interaction. African-Caribbean psychological therapists all recognised this as a unique and helpful aspect of their practice. Monica

talked about her shared humanity approaches even though differences were acknowledged. *"I guess in my head it boils down to that shared humanity, and I find myself using that expression".*

Human connection was highlighted by many participants as an important skill that facilitate effecticve cross-cultural work. Martha for example shared this view and reiterated that as we are all human, establishing a therapeutic human connection is paramount. "*When you connect with someone on a human level the colour of your skin does not matter. I suppose I don't highlight that there are differences between, what I look for is what's common between us*". (Martha:73-75). This was therefore interpreted to mean human connection is key to the formation of effective therapeutic relationships in therapy.

5.2.5 Sub theme 1.5: Communication by observing limits.

Communication is an important aspect of cross-cultural therapeutic work and can influence the formation of a therapeutic relationship. The therapist can facilitate cross-cultural communication by showing and understanding of how clients uniquely express their perspective. Observing limits to communication is taking into account all professional and ethical boundaries and ensuring that own actions are not seen to be outside of professional and ethical boundaries. The communication encompassed verbal, non-verbal and body language requiring clarification from the patient. Participants all shared that the style and mode of communication was important and could either enhance or destroy the therapeutic relationship and outcomes. For example, Theo spoke about his way of balancing this approach to communication in his cross-cultural work. *"very often the person wanted to hold hands with the therapist, on head on the shoulder, or wanted a cuddle and a lot of the clinicians found this very difficult as we've been told not to do that, mustn't touch. Nothing unprofessional, not sexual but caring act that to that person felt very important, more important than anything that was being said".* (Theo: 207-211). Daisy a White psychological therapist talked about important aspect of communication: "For *me the key things would be the importance of*

listening, not holding assumptions and a genuine want to understand and to focus on what the patient wants or needs as opposed to what the therapist wants or needs". (Daisy: 85-87)

Martha, an African-Caribbean psychologist described how she varied her communication style according to patient diagnosis and presentation: *"I suppose that's why I 've chosen people with a personality disorder to work with because I get them and they get me and the way that people with that type of disorder like to be engaged with is to be open and up front and not tip-toe so it suits me, that personality. When I'm working with somebody more psychotic, I do notice I have to change my way of being with that person, I'm a lot more English I would say, a lot more – not respectful – but how I engage with them I'm quieter, I'm less of my boisterous self".* (Martha: 121-126). This was regarded as a sign of communicating within cultural limits and within boundaries.

Participants highlighted the importance of being mindful of patient belief system and pacing communication accordingly. Mary a White British psychologist for example, talked about the pacing communication to adapt to a patient's presentation and belief system. *"The difference in the belief system. The unknown, finding it a bit harder to just relate very easily like you might do It may take me a bit of time, but I can get, I can do this, it's not something to be scared of even though there is still some anxiety there, I feel like it's something I feel like I can do*" (Mary: 315-317). Martha added her cultural and personality attributes pointing out the advantages and disadvantages of using certain communication styles during her therapeutic sessions or in supervision and training: *"irreverence is not a problem for me and I don't know if that's the culture I was brought up in that you just tell it like it is, you're just open and up front about things and you don't tip toe, so that has always helped me and I don't know whether that's because of my Caribbean background or what, but that's just how we are. We're not the stiff upper lip type of people and I think that's probably helped me"* (Martha: 110-115). This was regarded as a sign of effective communication by observing and stretching limits by using aspect of own cultural communication style and heritage to enhance therapeutic work. Christopher added his experience of communication with White British clients,

indicating that communication becomes easier when patients are more receptive to racial and cultural differences than when they hold assumptions because of lack of knowledge: *"I have had patients who have come in and the moment they see me, like patients who are White British, they say which part of Africa are you from - I like Bob Marley, I have eaten this food from Ghana, Nigeria etc. I do not know why they do this but when we have started conversations like that, I have seen that patients end up engaging really well and you can tell these are patients who have some knowledge about other cultures, about the African-Caribbean culture"* (Christopher:241-245).

5.3 FINAL INTERPRETATIVE THEME 2: BARRIERS TO EFFECTIVE CROSS-CULTURAL/RACIAL WORK

The barriers to effective cross-cultural work refer to racial and ethnic factors that may act as impediments to the therapeutic process. Psychological therapists shared their experience and views around obstacles and barriers to effective cross-cultural therapeutic work. These barriers can negatively influence the therapeutic relationship, process and outcomes. Practitioners' views varied from systemic difficulties, lack of cultural knowledge/awareness, limitations in culturally appropriate skills, 'fear factors', low levels of identity development, limited/variable training and support systems and geographical challenges. Participants all agreed that increasing awareness and problem solving these difficulties can lead to effective preparation and delivery of psychotherapeutic services to culturally diverse populations.

5.3.1 Sub theme 2.1: Systemic Barriers

Systemic barriers refer to policies, practice and procedures that result in some people receiving unequal treatment or being excluded. Participants talked about some of the systemic challenges that limit cross-cultural/racial therapeutic work. Mary, a White British psychologist, when asked about the challenges she experienced in her practice she began by describing the systemic challenges ranging from assessment referral to access of psychological therapies services: *" I think the only*

other thing I was thinking about is why I haven't worked with many people from different cultural backgrounds when we know that there are lots of people out there who may have mental health difficulties and I think it is something about how our services is set up, the barriers that people might experience to get to the psychology---I'm reflecting on that I haven't worked with many people from different cultural backgrounds and I wonder why" (Mary: 650-654; 657).

Participants referred to structural power and systemic biases with regards to mental health treatment of African-Caribbeans and felt this should be acknowledge and dealt with effectively rather than leaving it as the sole responsibility of the psychological therapist. Olga for example acknowleged the way African-Caribbean patients present late into service and how they are treated differently: "Caribbean *patients and the way they present to services. I think that we should be emphasising structural power, the impact of that on people of being treated differently and I think that should be in our formulations and understanding of mental health problems"* (Olga: 331-333). Ola continues by stating that it was important that White British psychological therapists show willingness and shared interest in the area of cross-cultural/racial therapeutic work and support it rather than dismiss it as an area of interest for solely African-Caribbean psychological therapists: *"It is a difficult issue. In our Trust, for example, there are a number of therapists from different cultural backgrounds like yourself but you might not want to be the person that everyone goes for support. It's difficult, it could be unhelpful in that it's like you're from that background so you must know everything about that and so"* (Olga: 298-301).

Another systemic challenge that was raised by participant is the geographical challenges and the impact this is having on White British therapists' exposure to work with African-Caribbean patients. Theo, a White British Psychological therapist for example highlighted the need to do more in this area and pointed out on the geographical challenges and exposure at clinical and at training level: "*I would like to do more; I have done more in the past when I was working in parts of the Country. Nottingham is supposed to be the most average for race, age and because of that, you had a lot*

more training, a lot more input because you were seeing a much larger variety of people" (Theo: 396-399). This was therefore interpreted to mean than the proximity and exposure to geographical areas that are familiar with African-Caribbean population may help with the cultural competence development. However, the lack of exposure to geographical challenges can leave practitioners vulnerable to ineffective engagement when a client from African-Caribbean background is presented to them. Martha, an African-Caribbean Psychologist shared her experience of feeling strange, lost and disconnected having trained and practised in a multi-cultural area of the country, then moving to a White dominated area: *"I felt quite strange, it was a completely new way of being, working, taking on new information but I didn't feel that I could connect with anyone, so I felt disconnected from people and quite isolated. I can't remember now who I spoke to, but clearly, I spoke to someone who put me in contact with what they call the race and cultural special interest group that the BPS has set up and I got in contact with that group of people who were mainly city based, from London, Birmingham, Leicester so I met a number of people at those meeting so I actually felt part of a group"* (Martha: 15-22). Theo on the other hand, shared his experience of exposure to multicultural work in different parts of the country and how this has been helpful for him working in a less multicultural area of the country: *"I have much less experience locally. I worked for number of years in Nottingham City and did some additional training in Birmingham so a much greater ethnic mix of not only colleagues but also clients. I think I have had much more frequent experience in previous years than current"* (Theo: 14-18).

Participants highlighted systemic challenges associated with African-Caribbean diagnosis prevalence and the way they present to services. Daisy for example, stressed the potential risk of neglecting the needs of African-Caribbean patients who often come under a particular diagnosis that does not match service priorities: *"I think for me the majority of patients I have seen for psychological work from an Afro-Caribbean background have been patients who experience psychosis. I have seen people for shorter pieces of work, which tended to be around formulation, the stabilisation of symptoms and in the community's longer-term work"* (Daisy:16-19). Daisy appears to see the

relevance of differences and complexity within diagnostic categories especially psychosis and with African-Caribbean patients whose needs might be forgotten because of complexity and risk adding to their cultural background: *"I also feel that for people from different ethnic backgrounds that the models that we have is not a one size fits all and we need to think about the impact of spirituality, the impact of family dynamics, because there are differences in terms of how they see the therapist, about males, its internalised, how readily available they would be to talk about distress, all of those things need to be considered and part of the therapeutic process*" (Daisy: 144-151). Daisy probed her experience of working with an African-Caribbean with psychosis and how she moved between approaches to make sense of the patient experience by integrating aspects of their cultural beliefs and the dilemma/clash that this can cause: "there *has been a clash between what patient's traditional healer is saying and I need to listen and give in and be respectful to them. In addition, we have named it, that there are 2 different approaches. It is not that one is right and one is wrong, it is that there are 2 different approaches"*. (Daisy: 196-199).

Participants also associated political climate and how easy it it for White practitioner to pretend and inadvertenly reinforced feelings of rejection from minority clients. Martha for example, noted the impact of the current political climate on peoples' negative assumptions and behaviour towards foreigners: *"If we look at the issues around Brexit and how that's had an impact on people wanting to leave this Country because they feel isolate or that they're not welcome, the issues around race, privilege – We seem to be blind to what is going on and pretending it is not there and that it's not happened and carry on as normal"* (Martha: 306-310). This was therefore interpreted to mean that what happen in wider society can also have implications in the therapy room.

Monica an African-Caribbean psychological therapist talked about systemic failures/biases and the correlation between geographical areas and the number and availability of explicit policies that favour effective multi-cultural/racial therapeutic work: *"I do not know much about the existing policies for example in my Trust. However, I know that in more multi-cultural parts of the Country*

there are very explicit policies in the Trusts to address bias and discrimination" (Monica: 223-225). She also suggested that the health system failed to integrate cultural and racial differences in policy and education for practitioners to develop competence when working with racial differences: *"My perception is that there is a system of health, no awareness on clinician's well-being, client's wellbeing; actually, it is so important to help people be healthy, mental and physical health"*. (Monica: 408-410). This was therefore interpreted to mean that wider systemic failure can lead to local services not incorporating diversity and culture in their policy. Martha proposed systemic changes to make cross-cultural learning and practice part of the fabric of practice by making sure that everything we do has a cross-cultural element incorporated to it: *"it suddenly becomes part of people's practise. Talking about it is one thing. Nevertheless, I find if you change the paperwork and you change how you assess people it then becomes part of the fabric of people's practise"* (Martha 343-346).

5.3.2 Sub-theme 2.2: Personal Biases

Personal biases refer to therapists' individual assumptions, misinformed opinions, or subtle prejudices that might alter their understanding of the person's problems. Psychological therapists shared their experience of working with difference and associated biases, all describing bias as implicit as well as explicit, potentially affecting all aspects of their work within cross-cultural/racial therapeutic dyads. Monica shared her experience of bias (conscious and unconscious): "*I will have conscious and unconscious bias, that's also part of our share humanity we all have biases. I feel I do not normally have much time because of caseloads to reflect much about that. I notice in my case a few I would never say I notice every time I'm with a White native British client that I notice all of my biases no but I notice that my judgement is crawling into my listening. It feels very uncomfortable"*. (Monica: 209-213). This demonstrates the difficulties inherent in noticing biases and acknowledging that one requires courage and willingness to name internal and external biases. From the African Psychological therapist perspective, Christopher shared the different experience of connection when

working with similar or dissimilar dyads: "*you can tell that when you are seeing someone from the other side, from the White British side, you can see, it's that unspoken thing, but you can see that right from the start you have to do a lot of work in building the trust relationship. But when you are sitting in front of an African-Caribbean patient for instance you see that there is that connection straight away*" (Christopher: 268-272). Christopher sees the dilemma of White patients who, fearful, will devise strategies to avoid allocation to an African-Caribbean psychological therapist allocation: "*sometimes some of the patients come in and they don't want this therapist and we find it very difficult and sometimes when we sit and are talking about this, we bring all this into the frame and we don't know if they are doing that because they want to maximise the effects of therapy or if they are doing it because they are racist, for instance. So that why I started to say it is quite political*" (Christopher: 310-313). Christopher added that when the patient sees past these differences and if their experience is positive, they may feel confident to share their experience of assumptions and biases with their therapist at the end of treatment: *"she told me that she feels proud that she stuck with her therapy and I sometimes I know that although they are not spoken or said, when people come in and they realise that the therapist is from the other side of the race, they are more likely to make some assumptions*" (Christopher: 325-327). Martha an African-Caribbean psychologist shared a similar experience and recognised the importance of patience and perseverance to put the person in context: "*I think because I had been seeing her over a period of time, that feeling I had about her reluctance to engage with me had just gone away because she had got used to me, I think that's what it is*". (Martha:145-147).

Therapists talked about their own assumptions about patient behaviour and the possible implications in the therapeutic process. Christopher for example described a mixed experience of engagement with White British clients and their assumptions of race which may facilitate or hinder this: *"the first few sessions because the patients are getting you know and they are showing hesitation in opening up, it is very difficult to tell if their hesitation is linked to you being from the other side of the race, or it's because they are sat in therapy with you"*. (Christopher: 589-592)

Christopher also shared his experience of dealing with resistance and misunderstandings leading to confusion: *"I get confused honestly, I feel really confused, not knowing what is going on. In addition, sometimes I am asking myself is it me or is it them. What is actually going on!"* (Christopher: 186-190).

Alternatively, Theo a White Psychological therapist talked about the need to stop, think and explore any covert or overt barriers: *"In addition, I think the whole thing about assumptions and biases is just stopping and thinking is there anything getting in the way.".* (Theo: 114-115) This was therefore interpreted to mean that exploring cultural aspects of patients being mindful of areas of practice that could be misunderstood because of assumptions and bias is really important in cross-cultural therapeutic work. Mary a White Psychologist described the conscious and unconscious nature of assumptions and used self-monitoring and reflection to act and seek out support and supervision: '*It can be so unconscious, you can do things so unconsciously that, so I guess the main thing that comes to mind is that reflection afterwards, supervision, trying to think through what's going on in the room and any assumptions to become aware of them but I think sometimes you know*". (Mary: 96-99). Olga in the other hand noted how easy it can be cluster cultural backgrounds and geographical areas and likewise cluster assumptions and apply these in stereotypical ways: *"if we group everyone together and say everyone who is from India or everyone from Africa, like its one big place, and it's not is it, its multiple countries with different cultures, histories and religions so it's quite a big thing to get your head round. That's the difficulty, you don't want people to make assumptions so you want people to ask the person tell me about"* (Olga:276-279). This was therefore interpreted to mean that awareness of her own cultural and racial biases in the moment and acting opposite or asking for clarifications when unsure is key to effective cross-cultural therapeutic work.

5.3.3 Sub-theme 2.3: Racism

Racism refers to all covert and overt racial discrimination. Ignoring institutionalised or systemic racism can negatively impact therapeutic work. All participants shared thoughts around the salience

of race and ethnicity in the therapeutic context and were motivated to be sensitive in practice. For many psychological therapists, a general appreciation of the importance of race and culture does not equate to a clear understanding of whether, when and how to bring up issues in therapeutic work. Practitioners shared experiences of witnessing covert/overt racism and associated discomfort. The expression of covert and subconscious racist attitudes in cross-cultural/racial therapeutic work, either in the therapy room, in training or in supervision were noted. Monica an African Psychological therapist shared her experience of being 'targeted' because of her background and the difficulty to differentiate between it being a racist attitude or it being a mental/ psychological problem: "*I have been, a few times, on the receiving end of that sort of rejection upfront at least explicitly on the grounds of culture, colour of skin, accent*" (Monica: 163-164). Monica carried on talking about examples of covert racism and rejection that are negatively reinforced by systemic failures: *"The client had said they would not see someone like them and it shocked me and the team, made up mostly of White, native British people were silent, but I could not".* (Monica: 185-186). As a coping strategy, Monica made references to how she will often pretend racism is not happening and making herself not notice: *"I guess it would be safe to say that at least part of me as a therapist, as a human actually probably pushed that away a bit, I didn't want to think about that so I guess honestly all the time that I walk into a room with a client it's almost as if I'm not aware of that, I make myself somehow unaware."* (Monica: 66-69). Like Monica, Christopher, another African-Caribbean psychological therapist, shared similar experiences taken from his engagement with a White British client from the point of referral, treatment and supervision: *"I think sometimes when people from a White British background find out they have been allocated to me, some of them have welcomed the idea with open arms. Some of them have also shown some resistance to the point where people have said to me that they would rather work with someone from a White background and I have to respect their views. I have had some difficulty, not grave difficulties but I've had instances of disagreement with supervisors"* (Christopher: 24-28). Theo a White British psychological therapist spoke about the extent of racist attitudes and how unconscious these can be: "*I remember going to*

a conference or talk I cannot remember how long ago, years ago, it was about culture and race, they said put your hand up if you are racist. Some put their hand up most people did not. Most people looked uncomfortable. They gave the talk, discussion and then asked the same question at the end and almost everyone in the room, including myself put their hands up. (Theo: 103-107).

Theo goes on to share his experience of dealing with racism in supervision - this time from a White supervisor to the case of an African-Caribbean client: *"I have had an issue in the past. I would not go so far as to say I have thought the supervisor was racist. It is not quite to that level. Well, it is, well it is. However, I have felt they have been less understanding and they have been encouraging me to discharge somebody and push that person away"* (Theo: 280-285). Participants talked about how easily racial attitudes can be blindly dismissed at individual systemic levels: *"It is very subtle and as you say people are blind to it, even the individual might be blind to it and the whole system seems to be blind to the impact of being different, being part of a minority, not really quite taking that on board and what that feels like"* (Martha: 298-300). Mary another White British psychologist shared her experience of racial micro-aggression created by often unintentional, attitudes and assumptions. She mitigated this by reflecting on her own background*: "I am not intentionally trying to be racist but there might be assumptions there. I think I do become aware of my own cultural background and do sometimes feel a bit privileged as compared to other people who are not from a White, British culture. I definitely become aware of that. It is a tough one in terms of the assumptions that I might make"* (Mary: 74-78). Olga described her experience and her awareness of racism in clinical practice and associated feelings (shame, embarrassment and powerless). Racism can be perpetrated from White British clients towards African-Caribbean psychological therapists and within the health system: "*as a White therapist I'm aware when colleagues have experienced racism from clients, that has happened for you where people have said I don't want to work with you, that happened on one occasion didn't it? I know other colleagues who have had racial abuse in the places they live which feels absolutely abhorrent and horrifying and it's difficult to – you know you want to stand by them with that but we feel a bit powerless, we can't change individual people who behave in unacceptable*

ways" (Olga: 309-314). The above participants views are therefore interpreted to mean that racism (overt or covert) remains a concern and is experienced or perpetrated by patient and also professionals. This has a negative impact on the therapeutic process (assessment, engagement, supervision and training).

5.3.4 Sub-theme 2.4: Fear/helplessness

Psychological therapists all agreed that cross-racial therapeutic encounters can be anxiety provoking at all levels. Psychological therapists also talked about concerns of coming across as racist or even raising emotionally-charged issues by saying something offensive or not knowing when and how address race and waiting for clients to initiate discussions about race. This can lead to a passive attitude as opposed to an active one that promotes ongoing learning, exposure and introspection. Monica strongly shared these views and pointed out the dilemma and conflicts in place: *"A lot of conflict, anger, frustration, resentment, bitterness. Because of their cultures, ethnicities. There is no way this is not going to be playing out in the therapeutic room. Why do we have to train every year now for fire awareness and not for cross-cultural encounters. With colleagues as well*" (Monica: 462-465). Monica spoke openly about the fear of this unknown territory and the difficulties in observing or stretching one's own limits: *"I would fear, I might be wrong, but I would fear if I entered that space of discussion with, I do not know sociological or cultural discussion with a client that wouldn't be appropriate in the realm of the therapy, you know where it got so emotional and personalising that the boundaries there might be breached"* (Monica: 150-153). She added how fear functions and stated the following: *"I think it is a place of fear, discomfort, upsetting the other person but also upsetting myself if I lose the therapist status and the other person asking me, taking the driving seat. However, they are not the trained person, I am so I have the responsibility of retaining a degree of what is happening and I do not feel I have the training for that"*. (Monica: 288-291).

Participants talked about the function of the fear and the actions that follows. Daisy described the fear function and pointed out to avoidance of uncomfortable feelings: *"I also think there is a fear of*

being racist by asking certain questions. Therefore, it is giving people confidence to do things therapeutically and being ok with not having all the answers and checking in, do I have it right and tell me if I do not have it right. Nevertheless, that is difficult for professions". (Daisy: 298-300). Mary shared a similar view stating: *"I cannot think of something in the moment but sometimes people might be thinking should I say that or what people will think if I say I'm thinking this about this person. Therefore, my worry about being perceived as racist might get in the way"* (Mary: 106-108). She added: "*Perhaps the unknown, will I be able to understand this person's experience, what will they feel about working with me, so some anxiety, some apprehension, that kind of what should I expect, maybe something there*" (Mary: 261-263). This was therefore interpreted to mean that psychological therapist behaviour and attitudes in cross-racial/cultural therapeutic work as being motivated by fear as opposed to exposure to the unknown and to what appears to be uncomfortable and associated with upsetting all aspects of the therapeutic dyad: *"It is from a place of fear. A fear of something. So, it is fear of being misunderstood, fear of spoiling the therapeutic relationship especially where one is already established. It is fear of upsetting the client and maybe a fear of upsetting yourself"*. (Monica: 275-278)

Some participants pointed out the link between fear and the society/systemic issues, including the lack of time to stop and think and even consider where to get the support or access relevant information: "*I think society gets in the way; people are scared of things they do not know or understand I think time, people are busy and do not have time to consider, not knowing where to start and access information".* (Theo: 574-576). Theo added that one avoided shameful feeling emanating from a lack of racial and cultural insight: *"Your lack of knowledge, insight and own biases. You may be shameful of your own biases coming into play"* (Theo-383-384).

5.3.5 Sub-theme 2.5: Lack of knowledge, insight and resources

Psychological therapists expressed frustration that despite recognising deficits in their own professional knowledge of cultural issues within a multicultural society, few resources enabled self-education to improve understanding and work with difference. Poorer knowledge and understanding of clients' cultural heritage can impact treatment outcomes as shared in Theo's example of working with a Black African-Caribbean patient whose body language and the way they spoke could be easily misunderstood: *"I've worked with a couple of Black Afro-Caribbeans who can be quite loud and expressive at times which I felt fine with, but some other people might take as being aggressive, it was just how they spoke, whether that was a cultural thing or them particularly"* (Theo:457-459). This was therefore interpreted to mean that lack of knowledge, lack of insight and resources can have a negative impact on cross-cultural therapeutic work.

5.3.6 Sub-theme 2.6: Cultural distance

Cultural distance refers to differences in values and communication styles that are rooted in culture. These emerge as a major stressor for practitioners or patients who are bilingual and going through the acculturation process. Psychological therapists talked of their own challenges of acculturation, transformation and their lack of proximity to other cultural heritages and their struggle to address patient acculturation challenges: "*I suppose I can only rather try to understand what that might have been like for her to rather feel not accepted in another country because of how you look and culturally you are from a different background"* (Olga: 98-100). Martha seems to make an interesting observation about ways to improve cultural distance and the challenges: "You *check it out, it is part of your job, not that you sit there ignorant and expect the patient to give you everything. That you are removed from it, that you are different from that so that therefore puts you in a, I do not know, a one up position, it depends upon what the assumptions are of the therapist. However, that expectation that people should check out people's cultural backgrounds as part of your work I do not*

think is there" (Martha: 331-335). This was consequently interpreted to mean that the way in which practititioners and patients associate with culture is mixed from cultural proximity to cultural distance and heavily dependent on people acculturation and racial identity development level.

5.3.7 Sub-theme 2.7: Wilfulness and lack of willingness

Willingness refers to practitioners doing just what is needed, listening carefully and acting with awareness and connection while wilfulness refers to refusing to tolerate the moment and make required changes and, if unaddressed, can lead to giving up. Some psychological therapists highlighted wilfulness attitudes and behaviours in therapeutic contexts, supervision and training and Theo referred to wanting to do just what feels comfortable and not giving oneself enough time to stop, think and consider alternatives: *"I think the challenges particularly if you are a therapist and not long experienced, we are comfortable to do it in the way we have been shown. You have to have the confidence to break out of that and do things differently"*. (Theo: 218-220). Theo added that tutors and supervisors' attitudes can nurture that willingness: "*because of the tutors it made you stop and think about the other students on the course from different ethnic backgrounds and it made you question and analysing. I think we all get into habits what feels comfortable. It made you think am I doing this because it feels best for me or am, I actually doing what best for the patient. And it made you want to stop and change things to give that person the best chance of success*" (Theo: 229-234). Daisy shared similar experiences, this time talking about the trainee's wilful behaviour and attitudes in training and not seeing this as an important aspect of their therapeutic work: *"I am White British; X comes from a Black Caribbean family by background. We wanted to get people to consider their own backgrounds and the impact that that brings into their therapy. It was interesting. Our rating for the training was the worst I have ever had. It might be that my training was horrendous, it might be that, but what I found was people not willing to consider how their backgrounds impact on the therapeutic style. And when we talked to the group about this is going to be different, we're going to ask you what you bring from your own backgrounds and what you bring*

to the therapy and yes, we did bring in some case examples and that sort of thing, but it was not received well. So, there is work to be done, and it could just be that we did it really badly, that is a possibility". (Daisy: 332-340) She added that the wilful attitudes and behaviour is another way of avoiding the uncomfortable feelings associated this introspection: *"Yes, they feel uncomfortable. So, I think that is something we need to consider when doing training, is people being willing to look into themselves a little bit more and the impact that brings"* (Daisy: 344-345). Daisy elaborated, by sharing her experience of shock when she experienced these attitudes during psychological therapist training: *"It really shocked me when we did the training session, how unwilling some people, and the poor assumption that we made that people would be willing to do that, because they were therapists* (Daisy: 355-356). This was therefore interpreted to mean that in cross-cultural therapeutic engagement, is not just about having the skills, knowledge but is more about practitioner willingness to transform by acknowledging their weaknesses and strength and using the adequate resources for exposure and experiential learning.

5.3.8 Sub-theme 2.8: Lack of effective training and support

Lack of effective training and support refers to the lack of multicultural training among practitioners to effectively and adequately work with clients of culturally different backgrounds. Psychological therapists all shared their views on their overall training and the level of effective support and pointing out the lack of up-to-date training and limited resources and opportunities for exposure to multicultural issues. When asked about training, Olga reiterated this perspective: *"I guess for there to be more training available for people about working with people from different cultural backgrounds because we do not have that much training. I had some training from 20 years ago but I cannot remember most of it probably. I can remember bits of it but it is not something that probably, regularly gets revisited, there's CPD, unless you go on a specific training day for example and obviously, we have limited resources and you don't get many opportunities so I think it would be good for it to be revisited perhaps"*. (Olga: 204-209).

Martha an African-Caribbean psychological therapist then expanded on the quality of training, highlighting the lack of meaningful connection with cultural and racial issues, explaining that the training content and the overreliance on personal reading to mitigate and advocate: "*No connection with race and cultural issues. It was seen as this is how it is, looking at the White majority and not taking on board of looking at somebody's identity and how important that was and how somebody's grown up, none of that was discussed so that's definitely something that was lacking and it was only by doing my own reading and connecting to people, and the special interest group that you find other people – that's how I understood the impact of cross-cultural issues on somebody's development and somebody's mental health* " (Martha:283-287).

Olga sees the relevance of regular training updates (as with mandatory training) rather than ad hoc courses: "*I think that all mental health professionals should have regular updates. I remember when I joined the Trust there were regular updates and you had to do your diversity training and that was it for the rest of your career. You had done your day on diversity, I am laughing, but it is not funny really is it, it is ironic. If you look at our mandatory training, I do not think it figures, why are people not having their diversity training updated regularly?"* (Olga: 367-371). She commented on difficulties of accessing resources such as getting necessary training (to help adapt interventions effectively) and knowing where to seek appropriate support when feeling stuck: "*I am aware there was a research study recently in the department recently where they were looking at culturally adapted CBT but I've never had any training in that so I wouldn't be using anything from that approach because I don't know how to do it, so I'm aware of my limitations. I think if I felt it would be helpful, I might try to seek out advice and guidance but it knowing where to go for that*" (Olga: 216-219). Mary offered similar views to 'normalise' cross-cultural/racial training and support more by making it compulsory: *"I think it definitely could by putting it on the agenda more. It is not always on the agenda whether that is in training or supervision*" (Mary:156-157). The above experiences were therefore interpreted to mean that there are issues and difficulties identified around training that

impede practitioner growth. These difficulties include: lack of up-to-date training, lack enthusiasm, to limited ressouces and lack of experiential exersice.

5.3.9 Sub-theme 2.9: Racial/cultural Identity and transformation

Racial cultural identity and transformation refers to practitioners' sense of self as a result of cross-cultural/racial immersion and acculturation/enculturation. Psychological therapists shared their strengths and limitations of cross-cultural/racial therapeutic work, pointing out their difficulties with a level of racial identity transformation and confidence to self-reflect and improve. Monica, an African-Caribbean psychological therapist, shares her willingness to acculturate and transform and work with differences: *"I guess coming here that is probably why I stayed because I felt reasonably comfortable enough to have room in my mind and in my heart to appreciate the differences between how things are done here and expectations and biases to back home"* (Monica: 104-106). She added that her exposure to other cultures has created a willing and open space for transformation: "*I have travelled so much in my life and different cultures and I have a space inside me so I wouldn't be hurt by that personally, but it would hurt me as a human, so that is the bit because I would feel when someone tells me something like that I cannot work with you because of your race or ethnicity or when someone tells that to me that person is really incurring to me a violation of everything that stands for humanity*" (Monica:192-196). This was therefore interpreted to mean that growth and transformation through racial identity stages is key to cross-cultural therapeutic work. Assumptions can be made here that the more advanced practitioners are in their racial development stages the more confident and comfortable they are to work with patients from different races and cultures.

5.4 FINAL INTERPRETATIVE THEME 3: CROSS-CULTURAL/RACIAL LEARNING IN PRACTICE

Cross-cultural learning in practice refers to all aspects of learning (formal and informal) that contribute to or hinder effective therapeutic work. All participants shared experiences of cross-cultural/racial therapeutic training and the associated opportunities and challenges with current

models. Finally, participants shared their views on the current support packages including the supervision model, pointing out insufficiencies and also sharing some of their proposals for better and effective support systems for cross-cultural/racial therapeutic work and support.

5.4.1 Sub-theme 3.1: Differential learning/training (formal and informal)

Differential learning and training refer to various methods of cross-cultural/racial knowledge transfer that raise challenges while encompassing positive outcomes. Participants shared their different experiences of training in cross-racial and cultural issues and talked of about a mixture of formal and informal learning and the limitations with nurturing awareness of personal assumptions biases and consequently leaving practitioner unprepared for effective cross-cultural work. Monica for example shared this lack of focus stating: *"when I was training that was never ever spoken about. We were maybe a cohort of 30 people and roughly I would say at least 12 of us were minorities and never ever was the business of bias and how that can impact on a therapeutic relationship on the mental health of the therapist and the wellbeing of the therapist, the effectiveness of the therapist – never ever was that raised ever. So, it was as if, also they were doing what I do sometimes when I enter the room for my session sometimes as if that big elephant is back*" (Monica: 227-232).

Martha makes an interesting observation on feeling abandoned during her training*: "As a trainee I felt on my and I was so angry at the course for ignoring my needs I suppose"* (Martha: 161-165). Daisy spoke of current training limitations and felt these to be too simplistic: *"To be honest I think the cultural awareness on Trust Learning and development (LEAD) probably is not fit for purpose. How does that help something that is soo complex?"* (Daisy: 433-434). Discussing local Trust-level training, Daisy outlines the shortcomings of insufficient and untargeted training. She feels a more reflective approach to training may have more relevance for adaptive approaches to cross-cultural and racial issues: "*It felt as though I didn't learn anything and it didn't point to anything meaningful within my practice and I know that's not because I've had amazing training because my training didn't cover it either. I feel it is not quite, as it should be".* (Daisy: 446-448)

Olga goes on to talk about the importance of updating training, and focusing more on raising awareness of unconscious bias, racial attitudes and micro-aggressions that can be present in a therapeutic encounter: *"I suppose I think if the Trust has that as part of its Induction, it's a long time since I did Induction as well, but I don't think you can just do that once and then work for the NHS for 30 years. Things change and move on and we all need opportunities to be reminded that if we're going to engage with diversity in a helpful way then people need opportunities to recognise, they might think they've not got unconscious biases or not being unconsciously racist, but they might be and so therefore those are the kind of things you need to remind people about"* (Olga: 377-382). She then asserts the need for ongoing training to build on academic learning: "*Like I said I haven't had any, I don't think I have, not specific training since I did my doctorate which was 20 years ago when I did at the beginning of the course, I did have quite a significant amount about race and power but I can't remember that because that was 20 years ago. I did further CBT training where it did not figure at all"* (Olga: 359-362). Moreover, Christopher shared his assumptions about the adequacy of training and how unaware he was until he faced challenges and resistance in practice from White British patients, perhaps coming from a place of racial bias: *"Given the sort of training I received I thought that I had been equipped because I had been living in the country for over 16 years and also having a very good knowledge about the people and the culture in this country, I thought the training had equipped me to work with people, especially from a White background, unfortunately when they have been allocated to me and they have shown their resistance I have felt a little bit uncomfortable with it myself*" (Christopher: 42-51). The above shared experiences were therefore interpreted to mean that participants felt unprepared to work cross-culturally and leaving them vulnerable and overwhelmed in practice when faced with patients from a different culture.

Participants also talked about the invisibility of trainers from different race and cultures as an element that might perpectuate the power imbalance and amlify the risk of colour-blind approach to training. Monica for example talked of the necessity of having trainers from different cultures and race and adds another element that of fear during training especially when the majority of trainers

are from the dominant racial group: *"they were all White native British and I think it might be difficult for them to bring it up for fear of offending and not quite knowing how to approach that for fear of being misread by us as minorities. I do not know but to teach and inform the training of psychotherapists in this country"* (Monica: 235-237). Olga felt that recruitment of more psychological therapists from different backgrounds could be positive: *"I guess increasing the number of clinical psychologists and psychological therapists from different backgrounds. Therefore, I know the BPS are looking at that now. So, for training, making sure there's not unconscious bias going on in selection which we know exists, so I think that's one-way things could change because then you've got more people in the profession who are bringing that thinking with them and potentially challenging other people to include that thinking in their psychological work with clients"* (Olga: 348-353). This was therefore interpreted to mean that the quantity and the quality of training is lacking and the 'invisibility' of African-Caribbean and other ethnic minority groups may not only reinforce a colour-blind approach but also exacerbate an avoidance of experiential learning.

5.4.2 Sub-theme 3.2: Experiential learning

Experiential learning is learning that occurs from experience. All participants talked about the importance of enhancing learning by moving away from traditional teaching methods to embrace experiential learning approaches involving experimentation and reflection. These approaches are essential to help practitioners and students examine their own racial/cultural awareness, attitudes and beliefs and explore their level of racial identity development. Monica for example emphasised the importance of helping professionals to not only to develop cultural and racial awareness but also make it more experiential: *"It has to be not just awareness. We are talking about the bread and butter of health care. We are talking human and human; it has to be experiential*" (Monica: 87-88). She also goes on to recognise the possible uncomfortable nature of the approach and insisted on the need for role play, open discussion and debate: *"Surely, there should be the opportunity for people to take turns. A very simple script. Who would now like to play the role of the clinician and then*

have a discussion and debate? I fear that might be too much for some people" (Monica: 503-504). She reiterated role play in training with scripts that depict different areas of learning including feelings of discomfort: "*Very good sensitive script and lived theatre"* (Monica: 492).

Martha, an experienced trainer, shared her experience of facilitating experiential training and the perceived advantages of this approach**: "***When I used to do the cultural training, it was always about your experience. It is about the individual's experience of the assumptions that people make about culture so I think it needs to be more experiential. So, thinking about the theory as well as your practise. In addition, about you the person on both sides of that, so how do I bring the two together, the bridge between practise and theory? By applying it to yourself, making it more experiential. That is what I would be looking for"* (Martha: 360-364). She also emphasised the observed challenges of experiential teaching: *"People do not like to go, there do they? It is like - I do not want to do role-play – because it brings up people's feelings of fear and shame. It is uncomfortable because you are making them feel vulnerable, and when they feel vulnerable and seeing it as a weakness, they do not want to go there. For me it is about how to we create humanness rather than thinking about technique all the time. I always say to all of my supervisees that you are human first and technique comes later, so it is the human connection that I am interested in all the time"* (Martha: 368-373). She goes on to reiterate the value of being reflective, having an enquiring and curious mind, developing a Phenomenological stance and also using imagery to enhance learning: *"It is about enabling people to have an enquiring mind - just keeping that enquiring mind. That is the message you want to be giving people. The message the trainer gives to the delegates. The messages you give are through your didactic teaching but also about – you do imagery work with people, you do practical with people and having ongoing training so it is part of peoples training packages"* (Martha:381-386). Theo added his thoughts about experiential learning through reflective practice and group discussions: *"you stop in your tracks and consider and have small group discussions and just think and re-appraise"* (Theo: 564-565).

Given the extent of diversity, Mary shared thoughts about how group discussion enabled focussed learning to raise difficult issues and conversations rather than sole reliance on formal question-and-answer training: *"I wonder, because there is a lot of diversity in the Trust, because when I think about my colleagues, there is a lot of diversity, so perhaps having like some group discussion about it and getting people more used to talking about it and having those conversations. I do not think for me any type of written training, where you read something yourself and answer questions, is going to achieve that*" (Mary: 600-604). She talked about reflective training and experiential training as positive ways forward to take the cross-cultural training to a level that would equip people to be more effective: *"What I like to hear about personally is examples, where somebody will talk about how they have adapted therapy in a culturally sensitive way and how they have done that and what that's been like. That always helps me so I can think ok that is how I can do it that is what it might look like"* (Mary: 616-618). Mary shared that this practical perspective could foster more exposure, interest and willingness to engage: *"Therefore, I think there needs to be more and I think it needs to be training that fosters as an interest rather than a tick-box exercise which I have to do to show I am culturally competent, rather something that is ongoing*" (Mary: 643-645). Olga similarly emphasised the importance of helping people recognise and name cultural and racial biases: *"I think just reminding people that those biases exist. That you can slip into or be relating to your colleagues or people that you work with, and we all have those about all kinds of things, don't we?"* (Olga: 393-394). She added that targeting and becoming aware of unconscious racial bias in training and also naming and exposing covert and overt racist bahaviour is key: "*talking about the difference between not being racist and being anti-racist. It was about saying actually are you going to actively call out and do something about racism rather than not being racist yourself, which is a whole other step is not it. I think young people are more aware of all of these areas, so the people coming into the profession now are more thoughtful about difference, so gender, sexuality, race, I think they're much more aware than we were, when I was training 20 years ago*" (Olga: 403-408). The above shared experiences were therefore interpreted to mean that participants benefit from learning cross-

cultural skills through experiential content such as role play and exposure (learning by doing). For training programs to be effective and fit for purpose, a combination of didactic and experiential learning is advocated as a means to enhance multicultural competence.

5.4.3 Sub-theme 3.3: Learning through formal training

Psychological therapists shared their experiences of learning about cross-cultural/racial issues through their formal educational training leading to their professional qualification. Although the usefulness of the training was recognised at the time, little opportunity to practice was noted with most training offered by people from a different cultural background, giving rise to thoughts about the motivation and willingness of White British trainers to facilitate training in this area. Mary shared these strong views: *"We had some training as part of our clinical psychology training and I do remember thinking some of it was helpful. That was very much at the time. I think at the time you think this is good, this is helpful and then it's actually not having regular opportunities to practise cross-cultural working that it goes off my radar*" (Mary: 579-582). Mary also presented the systemic failures of training, putting cultural/racial issues under the banner of 'difference' and therefore diluting its importance:" I *do not know if I have done any training specifically on culture, it's more under the general banner of difference, so you think about any differences*" (Mary: 589-590).

Olga on the other hand recognised the training needs and awareness for not only own cultural heritage but also to uncover unconscious biases and their impact on the therapeutic relationship. She also suggested mindful insight on recognising cultural differences even within the same cultural or racial group: *"I think probably the training needs to focus on recognising what your own culture is, understanding that different cultures have different experiences and about your own unconscious biases, it needs to be about that and then just thinking if there are any potentially particular obstacles to forming a therapeutic relationship with somebody. You might want to know general things about a cultural but do not assume that they apply to that person because they might not"* (Olga: 447-553). Daisy shared similar views about the challenges of recognising difference within the

same cultural group*: "Its awareness, awareness is different from training. African cultures for instance, Africa is an enormous continent, and the difference within are enormous* (Daisy:282-283). She goes on to recognise her insufficient formal training and gives some suggestions about ways to improve training: *"there's ways of training, there's the classroom-based training, but for me there's the training with the service user – and I know that we do have within our Trust specific groups, CAST for instance who come and train so I wonder whether there's room to help or to consult, to give consultation and advice to people"* (Daisy: 262-265). Theo talked more about the importance of nurturing interest and willingness from psychological therapists: *"Education is one thing to look at. Something like that you should, be compulsory, but have it open for everybody. Some people will go to something because they have an interest in that and other people won't and it's often the people that choose not to go to it are the ones you want"* (Theo:361-364).

Practitioners suggested ways to improve and review training packages by helping practitioners to notice biases and also spot cultural and racial invisibility issues in the therapeutic room. Monica for example stated: "*The bias already in existing training. It would involve review of existing training to spot biases. We review the package of training in the Trust, within the existing package of mandatory training and see if we can spot that invisibility, that elephant in the room*" (Monica: 531-532). She suggested ways to improve experiential learning through teaching materials and examples: "*I think first of all education about the issue of bias, what is bias, give examples for types of bias and then give very concrete particular examples of bias around skin colour, accent, different cultures, ethnic minorities etc. So how that can impact interaction with colleagues and clients and then also testimonies from people from the Trust and wider UK, there would be testimonies, videos where they would volunteer and they would say this is me, I'm a psychological therapist, from a minority, I've had bias from clients, colleagues, sometimes I think they have assumptions, they think I don't understand certain processes because I wasn't born or raised her. How do you think that person might have felt? Then bring the video back for consideration and see the person giving the testimony saying this is how I felt*" (Monica: 474-483). Martha on the other hand suggested systemic changes,

incorporating/embedding cultural and racial aspects into mandatory training: *"From the top to the bottom and from the bottom to the top. It's about not necessarily having separate training, as people will think it's just paying lip service to it, but every piece of training incorporates race and cultural issues within the training. This is just coming out of my head, but even some of the mandatory training needs to also incorporate race and cultural issues. It is incorporating it as part of everything that we do"* (Martha: 400-403). She shared her experience of improving training as an African-Caribbean trainer and also how to influence change at board level to help shift cultural perceptions: *" The only thing that I would say is that being a Black trainer I always used to think that people were going to attack me or think where did I come from and what were my credentials?…When I do my training now, I love everybody, you've got lots to tell me, I've got lots to tell you, we're here to share, we're going to have a good time and I don't have any of that anymore and that's because I've changed my view and changed my belief, that's been the difference for me"* (Martha:416-418; 425-426). Talking about formal training, particiapants experiences were congruent in that they all had some teaching during their formal training (academic and local service induction). However, this training was deemed insufficient, inadequate and barely targeted important aspects of effective cross-cultural growth and competence. This has consequently led to practitioners looking at other way of growth such as 'learning on the job.'

5.4.4 Sub-theme 3.4: Learning on the job

'Learning on the job' refers to cross-cultural learning by experience after professional qualification. Most psychological therapists saw insufficiencies in training and emphasised their experience and needs to learn about cross-cultural racial issues while practising because their formal could not cover everything. Daisy for example described the importance of exposure and also geographical challenges. She referred to this approach as a 'learning curve' in which the patient is involved and provides clarification and education where appropriate: "*For me, I will be honest, it has been a learning curve, the client and I have learnt together. It's not something I have ever received specific*

training on but it's something that is very much apparent and part of the therapeutic process because people's experiences inform their views and how they present at the time" (Daisy: 25-32). Daisy felt she has learned more about culture through her job and having 'training case' *"It was really working with a particular service user that taught me so much about the importance of culture"* (Daisy: 223-224). She emphasised the advantage of having a long training case that facilitated in-depth formulation and understanding of the patient as a whole: *"It was a training case and I had the opportunity to work with him for a year and I worked with him through the transition from in the community, he became exceptionally unwell in terms of his risk to himself, so it was in an inpatient setting, and through that year transitioned in and out and there were things that we can absolutely formulate and understand around his family dynamic, the development of his difficulties and beliefs about self and then there were some things that just didn't fit and that was what prompted the need to consider the whole person"* (Daisy: 228-233).

Practitioners talk about the geographical challenges and ways to overcome these. Theo for example offered ways to deal with geographical challenges and lack of exposure to multicultural issues by pointing out alternative ways of learning on the job: *"I think you could do case studies, supervision; general discussion points can be useful. You cannot make patients just appear. I think it would be useful but I think you would get many clinicians thinking what is the point, as we do not see people from that group. They would not see the validity in wasting time going off if we do not see people from that group"* (Theo: 440-441). Mary on the other hand referred to the personal responsibility of learning on the job and being willing to explore cultural and racial issues: *"Yes, I think its personal responsibility as well rather than relying on your training, just to say to myself from now on I'm going to become more aware of my cultural assumptions because for now I think it's gone off my radar"* (Mary:167-169). Martha however reiterated this perspective of learning in action through discussion, reading and collaboration with other psychological therapists, thus having more choice and confidence from whom to seek support: *"I remember Mr X who was my supervisor and the director of the course at one point and I remember talking to him about things and he was able to*

talk about that more because he'd moved around the country a lot so he was quite experienced about that and was able to have discussions around that but generally I had to do my own reading and support myself around those issues…I suppose because of my experience of lack that I talked about, being the only Black person on a White course with a middle-class group of people, I suppose in a way it did equip me because I had to sort myself out" (Martha: 173-177; 277-279). The above data suggest that learning to work cross-culturally is an ongoing, never-ending process. This learning varied between for formal learning (formal and mandatory trainings) and informal learning on the job through readings, discussions and reflection on own practice, supervision, and willingly seeking cultural immersion opportunities through long training case or case discussion.

5.5 FINAL INTERPRETATIVE THEME 4: SUPERVISION/SUPPORT AS A "POTENTIAL" SITE FOR CROSS-CULTURAL/RACIAL FERTILISATION

Most fully qualified psychological therapists work under supervision and improving skills and expertise through peer consultation or guidance from a supposedly more experienced practitioner is viewed as important to help ensure that the interventions offered by therapists are both high quality and up-to-date. Psychological professionals in particular often face challenges when working across cultures, causing them to feel overwhelmed or helpless, possibly resulting in burnout, thus supervision is imperative.

Psychological therapists talked about their experience of cross-cultural/racial supervision and the challenges associated with institutional discomfort. They highlighted the need for flexibility and consideration for group supervision with the rationale that nurturing not only willingness to develop personal cultural identity but also addressing self-growth issues through experiential learning and exposure would be beneficial. The challenges of supervision ranging from supervisor uncertainty to variations in cultural competence levels and types of supervision dyads and cultural settings, have been discussed by participants.

5.5.1 Sub theme 4.1: Individual versus Group supervision

Regardless of whether supervision is done in groups or individually, the experience has the potential to deeply influence participant therapeutic work. The learning from supervision benefits both the client and the professionals involved as long as they are willing to participate in the process. Olga begins by sharing her experience of supervision and the complexities when many cultural experiences are involved: *"if I am working with somebody from not my culture does not mean I cannot do a good piece of work, I think it goes the other way round as well. We have all been trained to do what we are doing in our culture, your culture is different, your host culture where you come from is different and you have had that experience of adapting to a different culture"* (Olga: 434-437). Daisy started by discussing her positive experience of peer supervision and how she was able to seek support from another psychological therapist who was familiar the patient culture: *"I remember the case. In addition, we were really relying on you to talk me through for her, for that lady, the impact of her experiences and how that would have shaped her views in relation to the voices she was experiencing" (Daisy: 372-374).* Daisy also commented on the willingness of supervisor and supervisee to bring up cultural issues in the supervision space*: "in terms of supervision, it really depends on the supervisee bringing to supervision or a supervisor being aware. Therefore, that is what I would say in terms of supervision" (Daisy: 325-326).* She therefore thinks of individual or group supervision as an important space to nurture bias-awareness*: "I think group supervision is important to help identify your biases" (Daisy: 108).*

Theo a White British psychological therapist shared his experience of individual supervision with a White British supervisor who was racist and dismissed any racial and cultural issues, sharing how this left him uncomfortable, annoyed to not follow his advice: *"It felt uncomfortable. It felt they were more closed off than I was. It is as if I am coming to you for supervision and they were more of a closed book and not being considerate and more open. I felt you should be better at telling me and I am "bloodier" open than you are. Pardon my language. That has felt more annoying to me*" (Theo:

295-298). Theo added his experience of managing this supervisor: "*To be perfectly honest, there is a part of me that just thought 'sod it' I will just do want I want to do anyway. I did ignore what was being said to me because I felt right. There is also a bit of me that felt sorry for the lack of knowledge*" (Theo: 302-304). Theo his difficulties in dealing with these racist attitudes in supervision: "*I think that supervisor attitude is very very sad and they are doing the therapy for the wrong reasons. I think that is a sadness. I think you need a certain amount of confidence to recognise your limitations, the holes - and say hey I do not understand about this. I think many people like to try to bluff and pretend that they know and they do that by keeping away from it and saying this is how we do it"* (Theo: 374-378). Theo also talks about educating the supervisor: "*Trying to educate the supervisor, give a different perspective or consideration and leave them with a different outlook, version, and viewpoint*" (Theo: 317-319).

Martha offered alternative group approach to supervision to get more perspective and the opportunity to share opinions and experiences: *"I suppose when you are thinking about the cross-cultural work it is systemic, so I think it works. I suppose group supervision helps, because then you have other people's views, other people's opinions and they are coming from their experiences, their backgrounds and that influences what you hear"* (Martha: 220-223. She emphasised the added value of group supervision: *"Well, I would say exposure but also it is a richer experience and a dynamic experience rather than it being quite safe, not sterile, but it is one dimensional when it's you and your supervisor, but a group supervision does help with that. In addition, people bring their experience with them so I can see where that would work"* (Martha:227-230).

African-Caribbean participants, shared their experiences of receiving supervision from White British psychological therapist and talked about the struggle to synchronize with all cultures (patient, supervisor and supervisee). Christopher for example stated: "*All my supervisions I've had, I have received from White British supervisors and what I have found is that they help me to understand better what I take into supervision about the White British patient because they seem to come from*

*the culture and they understand and they help translate that understanding properly. Sometimes the patient's perspective in terms of family or their perspective in terms of some other dynamics I don't get, I don't understand it, because although I've lived in the country for 16 years, I still don't understand a lot of the cultures and the things they do, so when I go into supervision, they are very good at explaining and a good support from the White British supervisor" (*Christopher 383-393). Christopher shared the challenges of taking details of working with African-Caribbean patients to supervision: *"The challenges have been mainly about taking African-Caribbean into supervision because I seem to understand them from a perspective, because you know we get training at university that doesn't cover cross-cultural therapeutic interventions but I use my practical example as an African and apply some of the dynamics, bringing in family, sometimes food culture, even religiosity, church which I know is something that is liked a lot by people from the African community. Sometimes you would go into supervision and when I discuss or share my formulation, the supervisor might be giving their view from a different perspective because they do not understand the culture"* (Christopher: 397-404).

Participants talked about cross-cultural supervision boundaries and difficulties in observing them. Olga for example shared that: *"It is as sometimes you are working out what the boundaries of supervision are, does that make sense? Like about what is you and your stuff that you might have other ways of dealing with, what are the boundaries of supervision, and that is quite hard sometimes to know"* (Olga: 532-536). She goes on to emphasise personal boundaries: *"personal boundaries. Yeah, not cultural. What is the boundary of what you bring to supervision and what is the boundary of what you manage or are aware of in other ways that you do not bring to supervision?"* (Olga: 540-542).

Theo shared his experience of receiving one-to-one supervision from an African-Caribbean supervisor emphasising on its qualities: *"I was doing supervision with a supervisor who was from South Africa. What was helpful to look at there was him giving me his perspective on growing up,*

what was the norm. I do not know if that was to his family or a cultural thing. He said there was a lot more respect, you knew the rules a lot of respect for elders and people in authority and how that impacted on the work I was doing and getting me to see it from someone else's perspective" (Theo: 252-257). Theo also shared his challenges of supervision with a White British psychological therapist who brought an African-Caribbean's case into supervision *"In supervision, I have had it with people discussing a case and brought it to my attention that there are gaps and it makes you feel a bit of a fool and stupid for not considering it but then you do not know what you do not know*" (Theo: 271-273). Monica on the other hand, talked about her experience of having a White British supervisor and the wilfulness to discuss cultural issues: *"When I have had White native British supervisors I have never been asked in any situation in therapy or supervision, do you think that what is going on here is that your client is from a minority or you are from a minority so they may not have the skills as supervisors to broach that conversation with me*" (Monica: 297-300). Mary offered a similar view and pointed out her limited experience of cultural issues in one-to-one supervision: *"I think my experience of supervision is that it is a very good space, a very helpful space to have those kinds of conversations and I feel I've been quite lucky in that respect and that it's something I would be able to talk about. I think for me it has just not been on my radar, as we do not see that many people from different cultural backgrounds"* (Mary: 477-480).

Mary goes on to share her views about the appropriateness of group supervision and its advantages to add perspectives and exposure:" *I think it helps and possibly not even in the sense of just race and culture but diverse in other ways as well. I think that adds more perspectives and enriches discussion… And it just opens your eyes to other things that are going on to what's on your agenda* (Mary: 507-508; 513). Daisy also discussed the advantages of group supervision as a platform to talk about experience but also hearing about other people's experiences to know you are not on your own, so validating the difficulties within cross-cultural work and offering familiarity by using a model similar to a DBT consult group support: *"If it works, if it works and it depends on your team, but if you have a team that you trust and you work well together. It is a little bit like – what I find for me*

what I've learned in supervision is stages. Therefore, if you have people where it is a relatively fragile team they will go with a safe subject. If you've got a team that's beginning to build, they'll start to ask questions, whereas if you've got an established team that functions well, they will ask the questions, I see it at a DBT consult, I see it in the reflective practice sessions that we run" (Daisy: 386-391). She finished by reiterating the usefulness of group supervision in encouraging people to talk when they may have otherwise chosen not to. This somehow challenged the avoidance of bringing cross-cultural and racial issues into supervision: "*Because you know, you will be asked the questions. So, anything, you don't want to talk about and they you're asked about the thing you don't want to talk about. It is very clever how it is done. To pull somebody in to talk about the things they would not necessarily talk about, yes, I do think a group would be helpful because there are many cultures within a group. Moreover, lots of experiences"* (Daisy: 396-400). Daisy therefore, emphasised the advantages of having a reflective group where people attend willingly and can bring different understandings: *"space it's nice for that reason because people do bring different understandings and that I feel is very very helpful and when you have a team that is used to having, the nursing team in particular, to having reflective spaces* (Daisy: 406-408).

Olga shared her experience of receiving supervision from the African-Caribbean supervisor pointing out the difference in approach: direct and used stories and metaphors which helped make the supervision positive in that you left feeling enthusiastic: *"I have thought about that in supervision and if the trainee had somebody from a different background, I would consider that with them but with the limits I described earlier I wouldn't be thinking about cross-cultural adaptations because I don't know about those*" (Olga: 245-247). She also commented on ways of improving individual supervision by nurturing and creating a reflective space: *"Well I suppose supervision ideally should be self-reflective or reflective so when I'm supervising people who are developing as therapists, I am always trying to encourage them to have a reflective space, not just what are you doing with this person technically, but how does it feel for you and what are you bringing, what are you finding*

difficult or easy - I am always thinking about the reflection and the therapeutic relationship as being key and so would think about that with people" (Olga 253-258).

Monica in contrast, talked about missing pieces in the current one-to-one cross-cultural supervision model and the possibility of having a supervisee and a supervisor who are both unaware of cultural and racial issues that might be clinically relevant leaving them ignored: *"something is missing in the supervision process. Not surprisingly since none of us has been trained to see those factors as important, clinically relevant"* (Monica: 345). She added a comment and made reference to case of real blindness: *"I think it is a case of real blindness. It is almost making people invisible because that is a major part of our lives."* (Monica: 327-328). She ended by describing avoidance in supervision and assume this might be a combination of lack of training, fear and wilfulness: *"I think its fear of something. Also, lack of training"* (Monica: 304). The above data are interpreted to mean that participants were able to learn through regular one-to-one supervision despite the challenges identified. Most participants also relied on less formal support and sought out peer support. Participants akcknowleded limitations associated with current one-to-one model of supervision and talked about group supervision as a more effective way to support and nurture practitioner cultural competence.

5.5.2 Sub-theme 4.2: Reflective and experiential approach to supervision/training

Most psychological therapists had expressed the importance of reflection and an experiential approach to cross-cultural supervision. Monica emphasised sharing experiences and gaining validation: *"I am here thinking that would be wonderful to have that opportunity. And then as themes, what you said, validation, feeling comfortable, safe, that it is confidential so hopefully people would feel safe"* (Monica 387-389). Theo talked about a discussion-based approach as non-intimidating together with encouragement to reach out, mix and immerse with other communities/cultures: *"I think more discussion based rather than standing up with PowerPoint slides. I think more small groups sitting around, less intimidating is better for people. I think*

sometimes immersing people within a culture can be useful…. Sometimes I think our education is too structured, I think that can be a better learning experience, visiting places, a community group (Theo: 550-552; 557). He also commented on the added benefits of group supervision: "*I think with a group one is good if you have people from different cultural backgrounds. You get a wider perspective on things that can be a helpful approach. That could be a useful thing to do*" (Theo 354-356). Mary however, emphasised more on a group reflective practice approach: *"it could be reflective practice that you make it about culture and get people to share their experiences, you know difficult experiences or positive experiences. I think there is something important to talk about it and practice having conversations rather than just reading about it*" (Mary: 631-634).

5.5.3 Sub-theme 4.3: Cross-fertilisation

Cross-fertilisation refers to the way in which cross-cultural/racial knowledge and skills are nurtured and kept alive by practitioners through ongoing learning, exchanges and collaboration. Martha for example talked about ways in which cross-cultural knowledge and skills are fertilised through exposure and collaboration with other areas that are more advanced and more exposed to cross-cultural work: "*We do, that is how I got my connection and was able to feel able to do the course because of other people in other areas. In addition, I do want to hear about other people, it would great if we could get people from say the London areas to talk to use. However, we do anyway, we do talk to other areas and hear what they say about their services, how they supervise and we do a lot of that cross fertilisation*" (Martha:259-263) she then explains that *"Knowledge and experience is being fertilised and it is about being able to share their experiences with our experiences and then create something here"* (Martha: 267-268).

5.5.4 Sub-theme 4.4: Networking and collaboration

Collaboration and networking have been recognised here as an important support path in cross-cultural/racial therapeutic work. Psychological therapists talked about ways to improve outcomes in

cross-cultural/racial therapeutic work through networking and collaboration at local, family, institutional and spiritual level: *"I'm thinking about now how the way we're set up to work is in quite an individual way. So, you're sat with the person in front of you trying to make sense of that experience and trying to consult with other people in that person's family or from that family might help to develop that understanding rather than focusing just on an individual* (Mary: 199-202). Daisy on the other hand talked about collaboration with spiritual and traditional practices as a validating approach for the patient and another way of nurturing unique understanding and engagement: *"When I went to the mosque in Southampton the elder told me things I did not know about?… Being someone who experiences visions and for him talking to me about what that means and the specialness of that experience…All of those things that are seen in traditional practices"* (Daisy: 309-311;317). Daisy also emphasised that collaboration and connectivity between services and working in partnership and organisations (public or religious) promotes person centred recovery: *"And also that if we think about how the NHS is moving and the importance of connectivity between services and being more in partnership with our third sector organisations, physical health and the needs led service – all of those sorts of things that are all drivers for change – how does culture impact on people accessing certain services. If you have someone who is much more introverted, much more private, so like you say, how you bring in models of connectivity. We look at things – the focus now is on Wellbeing Centre, Recovery Colleges, charitable organisations but what about the church, the mosque"* (Daisy: 542-548). She also commented on collaboration with spiritual leaders when dealing with African-Caribbean clients: *"In terms of what people's options are before coming to therapy and that is different from a White, British point of view. It is usually I have had this medication and this medication and this medication and this has not worked and I have been sent for psychology. Whereas for people who I have met from an Afro-Caribbean background I cannot think of 1 person who hasn't sought a spiritual healer, sought their advice, and is still very much often involved with them*" (Daisy: 176-181).

Mary shared her successful experience of collaboration with extended family: *"Yes, and the person I worked with from an African-Caribbean background did live with extended family and I did get more of an understanding of the importance of extended family and the roles within that family from working with that person individually"* (Mary: 214-216).Theo discussed the importance of knowing alternative groups of people or even an individual you can reach out for support: *"However, I think it is seeking out, and if you do, the group or person you have gone to for support is really open and receptive to those questions that approach of wanting to share cultural identify. I get the feeling many people do not do that. I have not done it that often, but on a couple of occasions to increase knowledge and understanding*" (Theo: 335-338). Theo also shared his experience of successful collaboration with family: "*I cannot recall anyone specifically, sorry, from a Black Afro-Caribbean background. I am thinking of other cultural backgrounds. I've done one of two things - either I've spoken to the individual's wider family to get a different perspective but also there's been situations where Indian, Asian families where I've talked to someone, its informal supervision, I've sought out somebody from the same cultural background to say I'm stuck, can you sort this out"* (Theo: 326-331).

5.5.5 Sub-theme 4.5: Cultural interest group.

A cultural interest group was identified as an important way to consult and share experiences of cross-cultural therapeutic work and seek support from each other. Some psychological therapists appear to see the relevance of a such groups where experiences are shared and fertilised. Mary for example stated: *"People sharing positive practise, examples, I do not know if that would be in regular training updates or even that could be written, I would still be interested to read how someone has adapted"* (Mary: 622-623). Christopher proposed having a pool of supervisors at Trust level but recognised the resources challenges: *" I think if resources weren't a restraint, we should have a pool of supervisors within the Trust so if you are going to present a patient from the African-Caribbean community for instance, you would have, not necessarily a Black or African-Caribbean person, but*

someone who is well versed in African-Caribbean therapy or providing psychological therapy so that we can go to them for supervision" (Christopher: 425-428). Theo suggested improving communication and creating a local Trust database of supervisors that are willing to offer help and support in this area: "*Well, there is nothing formalised. We are from different cultural backgrounds. There is not a database somewhere where you can go and choose. There is not that availability. I do not know how else – a lot comes down to communication. I think we are poor at stuff like that within the Trust. You know who you know but you don't know who else there is, there may be someone else in the Trust with experience you can go to get help and support but if you don't know them or a friend of yours you never get contact, you never share that*" (Theo: 343-348).

5.5.6 Reflection/Final thoughts

The majority of the psychological therapist were asked to share their final thoughts and reflection around their overall experiences. Monica felt that the research was timeless and could possibly contribute to some changes and perhaps inform best practice. She talked about collective and individual fears:" *I think it is a wonderful research to do and I hope you will go on to get findings that can inform changes and policy and psychological therapy practices. I have noticed it can be quite emotional because I wasn't tearful or anything but I could feel that it is part of the fabric, it not something that is embroidered on someone's shirt, it is actually someone's skin, maybe I wasn't aware so thank you for that. I am noticing now more maybe a fear, organisational fear, collective fear, fear that anything like training for cross-cultural encounters and practises. Could fear fuel discrimination because some people, whether they are from a minority or not they might not want to do go there and actually being asked to do it can be challenging? Perhaps organisations might have the fear that their own staff would raise claims which means they like to think of me as a just a member of staff very well trained. Thank you very much for asking me to think about my colour of my skin, my accent, my clients, something we didn't cover but I couldn't help thinking that might be an obstacle to implementing change so I guess it is going to be a journey but if that front is beginning to*

be fought. The research is qualitative experiences; they are very powerful much more powerful than quantitative. Thank you for giving me the opportunity" (Monica: 546-557).

Mary spoke about the usefulness of the conversation and how this made her stop and think and become aware of her own biases and racial micro-aggressions which she said she will pay more attention in the future: "It *made me think that I need to be more aware of what my own assumptions are particularly. I think that's something where I got stuck in trying to articulate them and I think that's something, like the micro-aggression, to pay more attention to, because I guess you know I like to think I'm not doing that, but it probably is quite likely that I am in some way and for me that's what's come out of it to pay more attention to assumptions and I think awareness is always the first stage, and that what you do with it after that is important and if it's not in your awareness then it's going to be harder to be effective*" (Mary: 662-668).

Olga also talked of an increased level of awareness with regards to supervising an African-Caribbean psychological therapist and the dilemma and fear associated with working with staff who are culturally different: *"The only thing I would say about talking to you about your study, I know we talked about your study when I was supervising you, but I don't think we talked that much about your own experiences of being here, and what it was like for you, I don't know that we did talk about that, so I'm kind of aware of that, it's made me more aware of that I think (Olga: 495-498)*.

Olga offered her final suggestions around improving cross-cultural therapeutic work and made reference more to a systemic change, change at all level of society, using supervision and training as a way to nurture this change and develop people through their stages of racial identity development: *"Personally, I think for improvements to happen it has to happen at all different levels of the system. There's a societal level at which we have to tackle institutional racism, unconscious bias, equal opportunities for people and as a society we have to acknowledge the impact of those things on people's mental health, you know people more likely to not get through education, living in poverty how that impacts on mental health as well, facing racism on a daily basis and then we then*

have to think about how we're thinking about that as mental health professionals in ongoing training and supervision" (Olga: 549-555).

Theo valued moving away from 'one size fits all' to become more flexible: "*I do not really know what to say there, I will be honest. In formulation, we have a template and I do not think one size fits all. We need to have a kind of a template but be flexible with that particular person and their lived life and experiences*" (Theo: 509-511). He shared his deep feelings around supervision and its' 'becoming a lottery or a matter of luck' to have an effective supervisor who is open minded and also has a high level of racial identity development: *"Now, I think people have the supervision with whom they have the supervision with. Because of that it is curtailed somewhat. You might be lucky, have someone very open, from a different cultural background, but not everyone will have that, so you are a bit stuck with the discussion and how far you can go. So, I do think that if the patient felt a cultural element was coming into play either causing difficulties, or impacting or things might have been missed, then having access to someone from the same or other cultural background would extremely helpful"* (Theo: 520-525). Theo added challenges of geography, differences in cultural language and the role of religion and education: *"I feel if I compare myself to 20 years ago, I am not as 'on the ball' or as knowledgeable because I was doing more work than now, but it did not feel as if you were doing anything different because it was the norm. Reading through the guidance on this sheet, I was trying to remember what I had forgotten. I felt in the past I was a lot more in tune with that than I am now because I am not using it. I think education, making it accessible and I think our current format does not make it accessible because you come along if you have a special interest but the vast majority maybe do not. Moreover, you keep saying should there be changes in therapy, a different format and I am trying to think that through and consider that. I just think communication should be better. I think we have a lot more skills we do not utilise and we fall short on"* (Theo: 535-545).

Theo also suggested ways to improve cross-cultural/racial therapeutic work: *"I think if you do not understand something - ask, wanting to be educated is a good place to start. Maybe as a specialist,*

you may be a little bit less anxious. I was also taught when I was first training don't use complex jargon or words, if there's a simple word use that instead because if people don't understand they won't ask you. So, we've got to be careful how we explain things and the language we use with anybody but I think also in return if there is terms or local lingo or dialect or some phraseology, we have to ask what that means rather than just assuming or ignoring it, and if there's a custom or tradition or outlook, philosophy on life, or it could be serving to keep someone kind of stuck. They could be experiencing voices that could be a very positive, comforting thing rather than us jumping in saying this is bad, who we to say are. It is not doing anything as well that is going to potentially infringe that persons identify, background, and being open and honest. In addition, looking at ourselves and look at our own biases that come into play even without us knowing (Theo: 580-592).

Daisy shared her feelings and how the research made her stop and reflect on own personal biases and the willingness to face difficulties. She also talked about demographic and diagnostic challenges and how important it is to realise these when planning and commissioning care: *"I guess the thing that talking to you today has made me reflect on is cross-culturally is there a bias towards people from certain backgrounds experiencing certain – being more predisposed to certain difficulties – does that make sense. And whether when we are considering the planning of our services whether that needs to be brought into account because we have our services commissioned and we base it on population and its very generic population, population tends to be based on numbers as opposed to that nuance and in terms of NHS planning – because it has made me think have I ever seen someone from an Afro-Caribbean background that has an EUPD and I've never ever seen that, and why is that, having worked in both community and acute settings, not seen that. Whereas if I consider the services users I see with psychosis, a much smaller group of people referred but a higher incidence if you were to look at prevalence*" (Daisy: 518-527).

5.6 Chapter summary

This chapter has presented my interpretation of the lived experiences of seven psychological therapists' cross-cultural therapeutic work via four final final interpretive themes. These are: "mastering cross-cultural practice; barriers to effective cross-cultural work; cross-cultural learning in practice; and supervision/support as a "potential" site for cross-cultural fertilisation"**.** These interpretations emanated from presented accounts of individual experiences during semistructured interviews. This chapter has detailed the similarities and differences in experiences within the current UK health delivery system but has also highlighted implicit complexity, linked to systemic biases which are amplified by ongoing racial and cultural variables.

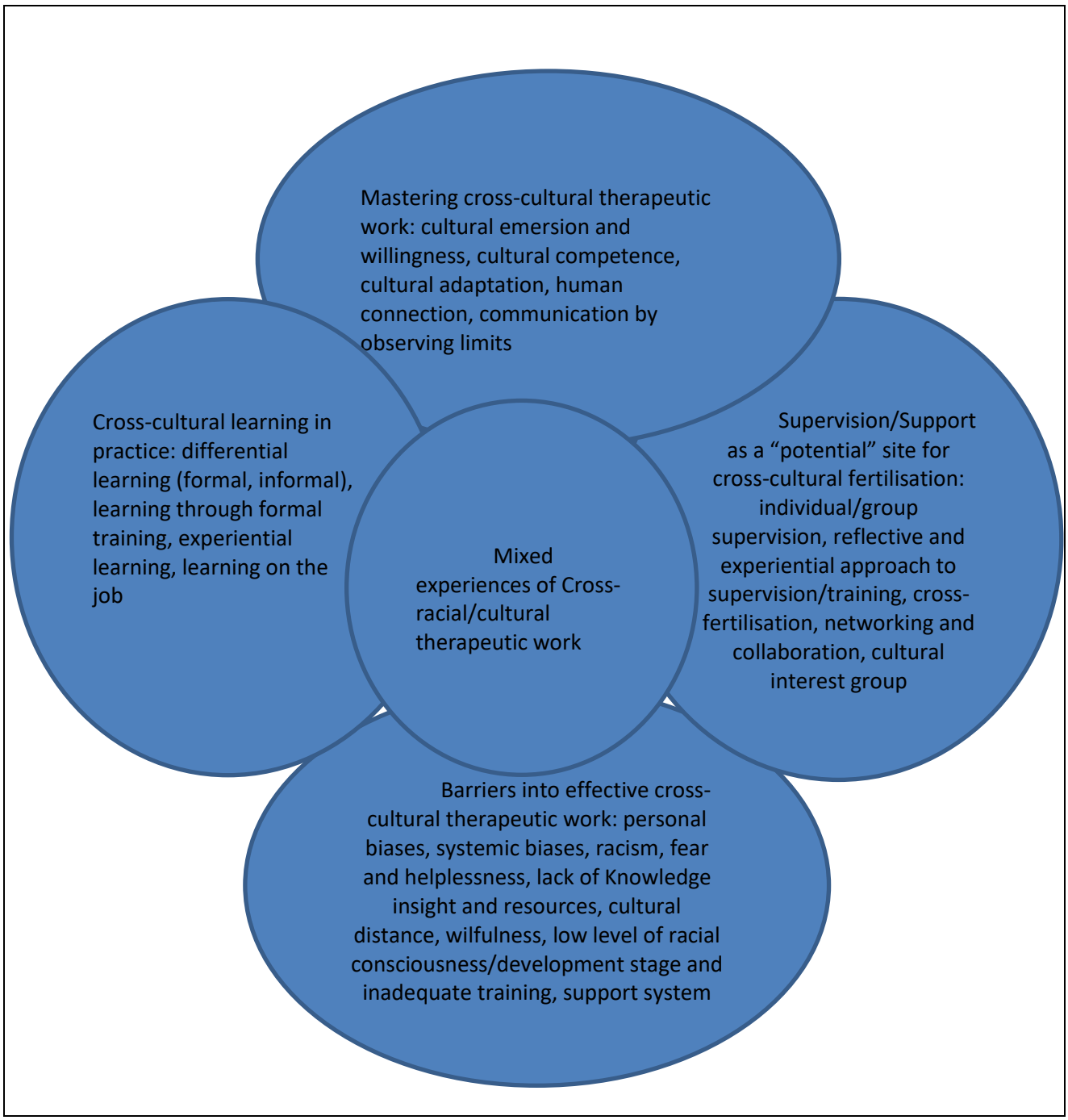
6 CHAPTER 6 Discussion

6.1 Introduction

This chapter will discuss the research findings within the wider context of past and current published literature and explore if previously identified gaps in the literature may be filled by new knowledge generated from this study. Application and discussion of the literature within this chapter will raise understanding of the themes exposed by this study and consider the implications of findings for cross-cultural psychological practice. The particular characteristics and demographics of study participants are relevant and accounted for to make sense of the findings. Participants shared their experiences of effective work and described the development of their competence and learning. These narratives support the consensus view in the literature, that working cross-culturally/racially requires a specific set of cultural competencies.

The Final Interpretative themes and Super-ordinate themes are embedded in the practitioners' experiences of cross-cultural/racial therapeutic work and in exploring these themes and the sub-themes (Figure 3) with the wider literature, commonalities and overlap are evident. The following discussion of the literature focuses on cross-cultural/racial therapeutic practice in relation to the super-ordinate themes encompassing the aspects: therapeutic engagement; cultural competence; training and supervision.

Figure 3: Main themes and sub-themes associated with psychological therapist experiences



The participants described very specific challenges that arise from issues of cultural difference, and training and support systems when working with clients' backgrounds (making culture central to treatment). All practitioners, shared their positive experiences of attempts to master a number of

complex and culturally specific aspects of psychological practice as a means of overcoming these challenges.

6.2 MASTERING CROSS-CULTURAL/RACAL PRACTICE

The study found that participants shared experiences of working cross-culturally/racially and described the positive skills and attitudes associated with their perceived competence in practice and how they made culture central to therapeutic work. These positive experiences varied and appeared dependent upon practitioner level of exposure, experience, the degree of personal understanding of their cultural heritage and their Phenomenological attitude to difference. All participants in this study, used fundamental aspects of therapeutic engagement to gain mastery in their cross -cultural/racial therapeutic work (adjustment and adaptations, active engagement, openness; curiosity; validation; contextual understanding; non-judgemental stance;) to explore perceived differences of the cross-cultural therapeutic relationship and context. This finding may reflect participant confidence of working cross-culturally. These approaches to cross-cultural/racial psychotherapy are supported by the literature (Sue & Zane 2006; Chang & Berg 2009; Nocross & Wampool 2011) together with the demonstrated raised awareness of personal and cultural assumptions and willingness to act conversely as appropriate. This willingness to engage in open dialogue about race and culture with the patient strengthens the therapeutic alliance and is congruent with the views of Cardemil and Battle (2003). The 'tri-partite model of multicultural competence' organises elements for competence over three dimensions: awareness; knowledge; skills (Sue 2001) which were echoed by the descriptions of all study participants. While the skills and knowledge components resemble other therapeutic competencies, 'awareness' is unique in its demands for therapists to acknowledge their own values and personality, highlighting the need for the practitioners' intrapersonal awareness of culture to attain multicultural competence as advocated by Sue (2001).

White British participants in this study preferred to gain cultural knowledge from the clients themselves rather than rely on their pre-existing cultural knowledge which could lead to stereotyping. These findings fit with those of Lathopolous' (2007) research with mental health professionals, and, with particular regard to the White British participants, who, possibly ignorant about the details of the country of origin and culture of every client in advance, suggested that finding out about the country of origin of the client and cultural information to test with the client was essential for effective cross-cultural practice. Lathopolous (2007) advocated such approaches counter dangers inherent in excessive focus on learning a set list of cultural knowledge instead of responding to the individual client's cultural specificity. Critics of multicultural competence models concur, as lack of such responses to the client risks leading to stereotypical attributions and impeding effective engagement (Brown 2009; Ota Wang et al. 2001; Stuart 2004).

Significantly, all participants in this study reported applying distinct multicultural competence elements in their work with clients (skills; knowledge; awareness;) reflecting Sue's (2001) three-part model and, by reporting including both 'therapeutic relationship' and 'personality' elements, showed similarities to those areas identified in four-factor models based on interactional 'relationship' processes with minority clients (Sodowsky et al. 1994), and personality factors (openness; flexibility; commitment to multicultural work;) as described by (Constantine et al. 2004). Some participants specifically identified the importance of a strong therapeutic relationship between the practitioner and the client as important for success within cross-cultural practice. This is unsurprising given the (previously identified) importance of the therapeutic relationship for successful psychological practice generally (Messer & Wampold 2002).

The findings from this study identified individual cross-cultural practice elements: cultural immersion and willingness; cultural competence; cultural adaptation; human connection; effective communication; and with some participants insisting cultural interest, maintaining reflective practice and flexibility – all being key elements of effective cross-cultural practice. Participants suggested that

immersion, interest and seeking out cultural differences in many aspects of their lives would nurture flexibility and reflection on their own practice and offer an ongoing process of learning, all of which were important elements in working effectively across cultures. These findings emulate the literature on intrapersonal elements of cross-cultural competence namely, the identification of personality factors (such as the personal openness) and personal transformation processes as being supportive of the development of multicultural competence (Constantine et al. 2004; Fowers & Davidov 2006). Self-exploration is also identified as an additional process that supports flexibility (Fowers & Davidov 2006) and maintains flexible boundaries within effective therapeutic work and cross-cultural practice (Lathopolous 2007).

Participants referred to their cultural humility as key into shaping effective therapeutic behaviour, despite ongoing anxiety and discomfort created by racial and cultural differences. Therapists may have anxiety around their effectiveness and try to avoid appearing incompetent. Instead, they may learn from their discomfort and anxiety about cultural identities, which is an important criterion for growth. Cultural humility here focuses more on therapists' development and values regarding working with diversity. Humility develops therapists to approach their cross-cultural work with an attitude of openness and engagement in a dynamic process of growth by acknowledging and owning limitations and striving to express openness and interest in the client's salient cultural identities (Hook et al 2013). Cultural competence has no end state but instead need to be approached with humility which functions to continue growth and development over time (Tervalon et al. 1998). Cultural humility is seen as the foundation of developing strong multi-cultural orientation. It involves an awareness of one's limits to understanding a client's cultural background and experience and additionally, focusing on own interpersonal skills by being interested in and open to exploring the client's cultural background and experience. The culturally humble therapist does not assume their cultural perspective is the right one, but rather, they recognize that there are several valid ways of viewing the world and developing a sense of one's beliefs and values (Hook, 2014) Therefore, an attitude of cultural humility is congruent with the phenomenological stance.

The shift from cultural competence as an end state to humility brings into line theory and research on the importance of developing a strong multi-cultural orientation for work by focusing on ways of doing (cultural competence, knowledge and skills) and ways of being (cultural humility and taking advantage of cultural opportunities) with diverse clients (Owen, 2013; Owen et al. 2011). Cultural and racial differences may create misunderstandings with clients, or may conversely, lead to an enhanced therapeutic relationship that results in increased growth. Equally, cultural similarities may lead to over-identification with one's clients, or may result in a close bond. The main objective seems to be to explore how to engage with other's cultural identities in a way that promotes connection rather than alienation. Learning to 'get comfortable' with acknowledging one's own limitations, owning them, and viewing them as opportunities to grow and connect with difference at a deeper level appears to underpin humility, openness, interest, and flexibility (Hook and Watkins (2015).

All participants raised the importance of opposing their own assumptions, prejudice and racism as an important element of cross-cultural and racial therapeutic work which is congruent with available literature (Constantine 2002; Middleton et al. 2005; Vinson & Neimeyer 2000; Constantine & Ladany, 2000). It is notable that these additional elements appear related to characteristics of the practitioner (White racial identity development; Black racial identity development; White racial consciousness), and to personal and professional experiences (social and clinical).

African-Caribbean therapists shared the challenges and importance of their experience of immersion and, given system expectations and their commitment to deliver evidence-based practice interventions, described working hard to meet these expectations and overcome challenges, citing tolerance and patience as key skills. Regardless of these structural and systemic challenges, African-Caribbean practitioners described high levels of immersion in comparison to their White British counterparts. The cultural immersion process has been hypothesized to be one of the most powerful factors in promoting cross-cultural/racial competence (Heppner et al. 2012). An

investigation into the value of a cross-cultural immersion programme in promoting students' cultural journeys was seen as an important activity to promote cross-cultural competence (Heppner & Wang 2014) and move practitioners away from cultural encapsulation (Heppner et al. 2012). Through immersion into a different culture, identity development and challenges take place. Immersion behaviour offers a multitude of professional and cultural activities that help to connect with many different cultures and learn first-hand about social, historical, cultural, and political issues. Several researchers have underscored the importance of cultural immersion in developing cross-national cultural competencies (Heppner 2006; Wang & Heppner 2009; Heppner et al. 2012) however, although cultural immersion is recognised as important by White British therapists, challenges remain at implementation level with difficulties being associated with both systemic issues and a willingness to prioritise this locally.

Mastering cross-cultural/racial practice involves the level of culturally adaptive interventions and associated behaviours used. All participants in this study shared their experiences of cultural adaptations and described important aspects of adaptation as well as the challenges of adaptation in therapeutic work. This corresponds to recommendations from Government initiatives (DRE 2005) that advocate the need to adapt and adjust delivery of care to accommodate the impact of globalisation and enable delivery of person-centred care, a key aspect of which is the development and delivery of culturally-adapted interventions that benefit ethnic minority groups in developed countries and the majority ethnic groups in developing countries. The developing interest in the need for culturally adapted interventions has been followed by a number of authors who advocate it as key to culturally competent interventions (Rathodet al. 2017; Rathod & Kingdom 2014; Naeem et al. 2015a; 2014; Naeem et al. 2015b; Naeem et al. 2016; Rathod et al. 2010; Rathod et al. 2013; Rathod et al. 2015; Rathod et al. 2019; Rathod et al. 2020).

Participants shared the importance of acknowledging cultural context of the patient and nurturing their capacity for empathy as an important factor impacting the development of an alliance. This is

echoed by Fuertes et al. (2006). Hays (2009) and Newman (2010) have explicitly stated that cultural competency is a foundation principle of CBT. Atkinson et al.'s (2007) description of how psychotherapists work with the uniqueness of the individual while taking into consideration the (therapeutic) context'. The findings from these studies reinforces Atkinson et al.'s (2007) description of the identity psychotherapists in which he said how they work with the uniqueness of the individual but take into consideration the context. Acknowledging the different and the reciprocal qualities of assumption moves the therapy process forward and expands on Duan et al.'s (2011) findings about major assumptions being difficult to transfer from one culture to another, hence the need for adaptation.

The idea of self-exploration has been recognised as a key factor in developing culturally competent attitudes to therapeutic work (Riggs 2009; Holt Garner 2006; Pakes & Roy-Chowdhury 2007; Lago & Thompson 2003). Self-exploration in terms of development of racial identity and attitudes towards people from other cultures, were all suggested areas of focus. The findings of the present study are in line with the literature in the way they demonstrate that the participants are aware of the situated nature of knowledge in their minds (with regards to their own identity and ability to notice and act in opposition to their prejudices and assumptions) and this augmented attention to the individual, promotes better listening, acknowledges difference, raises awareness of assumptions and avoids pathologizing. These 'good' skills provide hope within a gloomy picture (Owusu-Bempah & Howitt 2000) of overwhelming stereotypical and Eurocentric assumptions in therapy. It is within this same line of thought that Griffin (2000) understands the role of psychologists as 'cultural ethnographers' working within the culture, who listen better, acknowledge the differences in the room and balance how to use background knowledge appropriately.

All participants in this study shared the key elements of effective blending and adaptation, all expressing the basis as being genuinely human and having "sameness and humanness" characteristics in the therapy room to place the client as central. From the findings, the construct of

universal human experience taps into the debate about the constancy of the intercultural context (Erskine 2002; Fernando 2002) and the existence of overarching qualities all humans have (Yalom 2008; Kagawa-Singer & Chung 2006). The idea of the existence of universal human experience reinforces the assumption that there are basic overarching commonalities for all humans and cultures (Triandis & Berry 1980), and taking the individual out of context, leads to universality. This is also congruent with findings presented by Kozuki and Kennedy (2004) about clients' experience of being treated as 'cultureless' and therefore misunderstood. To some degree, the universality of human potential points to cultural and colour-blindness aspects that have been excluded (Holt Barrett & George 2005; Delgado & Stefancic, 2001) and this relays to Eleftheriadou's (2006) warning that if difference is too great, therapy is unlikely to work. What exactly creates 'too big a difference' is undecided, but in general there appears to be a notion of expanding beyond cultural levels and just treating one another as people without the complication of the cultural context.

Finally, and with regards mastering cross-cultural/racial practice, all participants recognised the role of effective communication and observing own limits by being open minded and able to learn from patients if necessary. Some participants described the difficulties with communication especially when the patient's primary language was not the same as theirs. Communications across-racial and cultural groups are complex and subject to distortion and previous authors have emphasised the importance of communication in cross-cultural racial therapeutic work (Bhui & Bhugra 2004). Cardemil and Battle (2003) identify the need to 'get comfortable' with conversations about race and ethnicity in psychotherapy, and transformations in communication styles need to be acknowledged. It is impossible to ignore cultural variances within and outside the therapeutic setting but an over-reliance on cultural variables may also be counterproductive, therefore a more balanced approach and awareness could be wiser. Unawareness can serve to perpetuate the ignorance and divisions between professionals and in the therapist-client relationship. The way forward is for clinicians to be more culturally aware (Mckenzie-Mavinga 2004) and have open, honest conversations about culture

and diversity in the therapy room and all contexts, to enable more natural communication about this topic.

6.3 BARRIERS TO EFFECTIVE CROSS-CULTURAL WORK

Participants in this study shared their experience and views regarding obstacles and barriers to effective cross-cultural therapeutic work. These barriers can negatively influence relationships, process and outcomes of therapy and participants' views varied from systemic difficulties, variability or lack of cultural knowledge/awareness, limitations in culturally-appropriate skills, fear factors, a lower level of identity development, limited or variable training and support systems and geographical challenges. A number of barriers to successful cross-cultural practice were identified and grouped into a typology of barriers consisting of different domains: personal biases; systemic biases; racism; fear and helplessness; lack of insight; cultural distance; wilfulness; low levels of development in stages of racial consciousness; inadequate training; and poor support systems.

The systemic practice barriers that emerge in the present research are very similar to those found in the research literature including the lack of access to cultural interpreters and insufficient client time (Minas et al. 2007). Practitioners also identified the impact of systemic barriers on their experiences and on the effectiveness of their practice with their clients. Specifically, all participants experienced strong feelings of helplessness and frustration when confronted by systemic barriers, this being more prominent for African-Caribbean therapists. In this study, skills deficits, such as stereotyping and imposing own values, were identified as barriers to effective practice by the interviewees. Participants indeed noted that some of these aspects of therapists' practices were barriers to working cross-culturally. Again, communication was the first barrier identified. Ample literature points to communication as a barrier to building relationships with clients and the therapeutic process (Constantine 2007; Minas et al. 2007; Steel et al. 2006). The present findings support

previous research and point to the importance of working effectively with clients and interpreters (if needed) as a way to mitigate this barrier.

Participants disclosed some of the systemic challenges and failures that limit cross-cultural/racial therapeutic work including inequality in health care provision and planning, geographical challenges, local policies and procedures and the training systems in place. African-Caribbeans are less likely to ask for mental health support than their White British counterparts (Cooper et al. 2011). This is despite research identifying that minority groups as a whole, when compared to the White majority, report higher levels of psychological distress and a marked lack of social support (Erens et al. 2001). Studies reporting the reasons for Black people being less likely to attend for mental health consultation provide a variety of explanations, focussing both on suspicion of what services may offer (Karlsen et al. 2005) and the concern of Black clients that they may experience a racialised service with stigma (Marwaha & Livingstone 2002). Different understandings and models of mental illness may also exist (Marwaha & Livingstone 2002). African-Caribbean people significantly benefit from targeted therapy services (Afuwape et al. 2010) yet inequalities in access to mental health services still exist. The DOH (2003) admission that no national strategy or policy specifically targeting the mental health or care and treatment of Black people was in place, nor that a need to develop a mental health workforce capable of providing efficacious mental health services to a multicultural population was seen as a priority, has sadly, not yet been taken forward by the Government despite evidence-based success (DOH 2009). Current findings illustrate the systemic consequence of limited or non-existent cross-cultural practice training for trainee practitioners and ongoing local training when qualified, are in line with previous research where 85% of mental health staff reported their professional training left them unprepared for cross-cultural clinical work (Stolk et al. 2008; McConnochie et al. 2012).

This study suggests that therapists experience strong negative emotions (frustration) about the impact of systemic barriers preventing them from developing their cultural competence and working

effectively with their clients including: the biased nature of commissioning services not taking account of geographical challenges; the lack of funding to develop alternatives resources and promote effective collaboration with external resources; and the strict time limits for treatments not accounting for the additional time required to provide culturally appropriate treatment for minority clients. These types of barriers are concordant with barriers of previous research in which mental health professionals identified insufficient funding for interpreters (Renzaho 2007), lack of program funding and high caseloads (Minas et al. 2007).

Other obstacles to cultural competence have been outlined in this research: difficulties addressing one's personal biases; the tendency to avoid unpleasant topics such as racism and homophobia and accompanying emotions; the challenge of accepting responsibility for actions that may directly or indirectly contribute to social injustice. These views are echoed in the literature (Sue 2001). The task of the therapist, particularly therapists with no experience with oppression, must learn to recognize their own privilege and simultaneously manage accompanying feelings of guilt or shame experienced. These variances may impact positively on the therapeutic relationship, development of rapport, client experience, and treatment effectiveness (Kelly & Greene 2010; Dyche & Zayas 2001). Shonfeld-Ringel (2001) writes that awareness of the influence of the therapist's power and authority on the treatment process, and on social, political and psychological levels are important variables in the cross-cultural therapeutic alliance.

The impact of racial micro-aggressions was identified in this research as an important aspect of cross-cultural/racial therapeutic work. This corroborates previous work on the experience of African Americans (Sue et al. 2008; Constantine 2007; Constantine & Sue 2007; Knox et al. 2003, Torres et al. 2010). Racial micro-aggressions are considered a pervasive, dynamic manifestation of demarcation between the experiences of dominant White culture and that of people of colour (Sue 2003), and so have major consequences for marginalized groups (Sue 2003; Sue 2010). Research by Rivera et al. (2010) identified major domains for micro-aggressions including: ascription of intelligence; second

class citizen; pathologizing communication style/cultural values; characteristics of speech; and criminality and invalidation. This current study outlines that navigating the racially micro-aggressive experience in therapy is delicate and appears more challenging for White practitioners who either noted that micro-aggression had occurred during the session or realised its occurrence after the appointment. Awareness of racial attitudes is essential when working with clients of diverse racial, ethnic, and cultural backgrounds (Utsey et al. 2008). Being a culturally competent and humble therapist involves understanding, accepting, and incorporating awareness of micro-aggressions into effective multicultural/social justice therapeutic practices (Chung et al. 2008). This study clearly identifies that all practitioners regardless of their cultural heritage and racial profile require this awareness and humility.

In this study all African-Caribbean therapists shared their experience of racism, actual or perceived, and how challenging it is to manage. Subtle forms of racism may be thoughts never to be verbalized and therapists may be under the illusion of doing good work with clients, unaware that powerful negative messages may be impeding the quality of trust and engagement in the alliance. The exploration of issues of race throws light on how structures of power and privilege operate. According to Thompson and Neville (1999), the dynamics of race are based on dialectics of deprivation and domination, powerlessness and control and privilege and rejection. Racism has evolved from being an overt and obvious form of discrimination and prejudice to subtler forms such as aversive racism or implicit stereotyping, (DeVos & Banaji 2005) and racial micro-aggressions (Sue et al. 2007). Racism has been examined as a variable that informs the dynamics between clinician and client (Ridley, 2005).

Understanding how a person of colour makes sense of race and similarity/dissimilarity between client and clinician on the treatment relationship, can assist the therapist in responding in a way that strengthens the alliance and fosters the client's growth (Chang and Yoon 2011). It is through exploration of the subtle and unconscious dynamics that occur within the dyad that therapeutic

practice and intervention can be shaped to be more culturally sensitive, informed, and inclusive. All practitioners in this research recognised the importance of being aware and acting to oppose overt and covert racist behaviour. Carter (2003) noted the importance of recognizing the systematic, covert, subtle, and unconscious ways in which racism operates so that the potentially traumatic impact of it on the mental health of people of colour, can be better understood in the therapeutic situation. The particularity of this study is that practitioners discussed racism at all levels of relationship and within therapeutic, training and supervision encounters. Exploring racism in the room as a practical feature, embeds and reinforces the therapy initiatives (Waldegrave et al. 2003) involving checking with the clients if they have ever experienced marginalisation. Talking with clients about racial ideas that the client and the therapist may themselves hold, takes into account the clients' perspective, and points to reciprocity. This does not seem to have been fully explored in the literature.

The manifestation of racism in the therapy, training and supervision room connects well to Greene's (2005) social constructionist argument that if oppressive ideologies are avoided in the therapeutic context, they not only aid social injustice but also encourage the development of psychological distress and systemic/personal biases. As the therapist's shame and guilt fuels avoidance of the issue of racism (Greene 2005), it further promotes the power of the privileged few. Accepting and respecting the client's racist ideas demonstrates perfectly how societal relationships are played out in the therapy room (Kareem & Littlewood 1992). This study depicts the African-Caribbean therapist's dilemma and difficulties of managing clients or colleagues perceived/witnessed racist views, (reflected in the narrative of a White British therapist) leading to Sue's (2005) call for everyone including therapists, not to remain bystanders when witnessing racism but to challenge and take a share of responsibility to deal with culturally different clients (Nolte 2007).

All therapists agreed that cross-racial therapeutic encounters were sometimes anxiety provoking. White British therapists were concerned that they would not know when and how to address race

issues and would be perceived as racist if they waited for clients to initiate discussions about race, if they raised emotionally charged issues or inadvertently said something offensive. These fears may lead to passive rather than the active attitudes which promote ongoing exposure, introspection and learning. In this study, White British practitioners in their therapeutic work with culturally diverse clients, encountered clients whose past experiences with oppression hindered the development of a trusting relationship. It is common for clients of marginalized and historically-oppressed groups to approach practitioners with feelings of suspicion and distrust associated with past experiences of racial and cultural bias, discrimination and oppression (Baruth & Manning 2006). This unconscious process of bringing past conflicts into therapy (known as transference (Sue & Sue 2008)) was acknowledged by therapists in this research. Therapist countertransference, defined as those responses to the client that are based on the practitioner's past significant relationships and experiences with persons in the client's cultural group can also create barriers to effective cross-cultural/racial therapy (Ponterotto et al. 2000). Therefore, both transference and countertransference should be recognised and understood for an effective cross-cultural/racial therapeutic relation relationship (Ponterotto et al. 2001).

Practitioners in this research discussed proximity and cultural distance and how these shaped their practice, suggesting that greater cultural distance (intra and extra) between practitioners and patients or colleagues, makes it difficult to undertake effective cross-cultural psychological work. In the conceptual literature, cultural distance has been identified as a barrier to effective cross-cultural work (Stolk et al. 2008). It appears that cultural distance may impede effective cross-cultural practice even when the practitioners are able to practice in a culturally competent manner with clients from cultural backgrounds more similar to themselves (Baruth &Manning 2006).

Practitioners in this study identified the training difficulties (either indifferent or inadequate) to adequately prepare them for effective work in cross-cultural/racial setting. Extensive literature suggests that "traditional" and "culturally insensitive" training, leads to ineffective cross-cultural

therapeutic work (Sue and Sue 2008). Ponterotto et al. (2001) highlighted the lack of multicultural therapeutic training among professionals to provide effective cross-cultural therapy, but despite the revision of many psychotherapy/psychology training programs to include issues pertaining to race, culture, and ethnicity, it remains problematic that practitioners have not received adequate multicultural/racial training to effectively work with clients culturally/racially different backgrounds (Sue & Sue 2008).

Practitioners in this study shared experiences of immersion and transformation and all agreed that, depending on their background, these experiences emanated from their willingness rather than wilfulness to progress into positive transformation stages of racial development. Linehan (2015) stipulates that 'willingness' is listening carefully, acting from a wise mind and doing what is needed by acting with awareness and showing connection with integrity. Conversely, wilfulness is refusing to tolerate the moment and make any changes needed, thus doing the opposite of what works. Taking these two concepts in the field of cross-cultural/racial therapeutic work helps to understand practitioner experiences and frustration depending on their willingness or wilfulness perspective in practice. Depending of their racial background, this has implications for progression through their racial identity development.

Racial identity has been identified as an important concept when examining cross-cultural relationship development. Racial identity theory refers to an individual's racial self-conception as well as his or her beliefs, attitudes, and values in relation to other racial groups. Racial identity development is a maturational process in which an individual uses more complex cognitive-affective ego statuses to perceive themselves as a racial being. It is assumed that individuals develop racial meanings about members of their affiliated and reference racial groups. There is a relationship between racial identity and the quality of the practitioner - client relationship and it is possible that the psychological meaning that individuals attribute to their race and racial group affiliation can determine how a client and practitioner will interact with each other. Importantly, a difference in

the racial identities of practitioner and client may become a barrier to effective cross-cultural therapy, but differing levels of racial identity development between parties is influential (Sue and Sue, 2008). For example, an African-Caribbean practitioner may be more effective with a White British Client if they have progressed through all the Black racial identity development stages as described by Helm (1986) and yet, clients and practitioners of the same cultural group may experience tension or lack of rapport as a result of differing levels of racial identity development (Sue and Sue, 2008). Multicultural therapeutic approaches have evolved to encompass the role of racial identity development but research suggests practitioners' reactions to therapy, the therapeutic process, and patients are influenced by racial identity, with effectiveness connected to the clinician's ability or inability to assess the cultural identity of clients or their colleague practitioners (Sue & Sue 2008). Studies also indicate that perceptions of discrimination are influenced by the racial identity status of people of colour (Hall & Carter 2006; Pieterse & Carter 2010) with racial identity potentially offering a form of psychological protection for Black Americans when encountering racism or discriminatory experiences (Cross 1995).

Participants in this study recognise socio-political influences and levels of acculturation and inculturation as factors which shape identity. This seems especially the case for therapists from an African-Caribbean background which is explained by Helms (1986) and Sue and Sue (2008) by the experience of navigating different worlds, existing and living in a society centred on the White hegemony while also simultaneously living within the sometimes-invisible world of people of colour. Pieterse and Carter (2010) caution that racial identity in and of itself might not have specific utility with regard to protecting against the psychological harm associated with racist incidents and attitudes, but nonetheless is an important variable to consider. It is in understanding where a client or a therapist is - in his or her racial identity development, the socio-political factors informing his/her experience and perspective, as well as how it may affect how racial interactions are perceived and internalized, that clinicians can have a deeper grasp of the client's narrative and how they experience cross-racial interactions (Sue & Sue 2008).

6.4 SUPER-ORDINATE THEME 3: CROSS-CULTURAL LEARNING IN PRACTICE

All participants shared their experience of cross-cultural/racial therapeutic training and the associated opportunities and challenges associated with current provision. Participants discussed current support, highlighting areas of need and sharing proposals for more effective mechanisms to sustain learning and development for cross-cultural/racial therapeutic work including a combination of training updates focussing on experiential learning, effective collaboration and networking.

There is a requirement for cross-cultural and knowledge and skills to be taught in all undergraduate and postgraduate psychology courses as well as therapeutic training and mandatory local service training for developing practice. Notably, in discussions of learning to work cross-culturally, no participant in this study mentioned learning relevant skills, knowledge or awareness through any 'formal' content in their psychology/therapeutic training programs. Previous research suggests that this lack of training has affected the confidence and competence of practitioners who reported lacking confidence in an ability to work cross-culturally (Stolk 2005) and with culturally diverse clients (McConnochie et al. 2012). Ranzijn et al. (2006) and Lee and Khawaja (2012) identified a cross-cultural training deficit for psychology/therapy trainees and limited or absent cultural content in university programs, which together with this study's findings, suggests that focus on cross-cultural competencies in training is timely.

Recommendations are made for didactic and experiential multicultural content to be included in programs (Smith et al. 2006). Such training suggests a moderate to higher rating of multicultural competence, positively affected client perception of the multicultural competence of psychologists and increased the length of the counselling relationship (Worthington et al. 2007). Results in the present study show that most learning about how to work cross-culturally occurred once participants were already working with clients in practice. They described a learning process of: actively engaging in professional development; seeking supervision from cultural consultants and experts in cross-cultural work; increasing their cultural knowledge through research; seeking out

cultural immersion opportunities; learning through immersion in cross-cultural work with their clients; and collaborating with external services and networks.

Practitioners in this study also highlighted the insufficiencies in the focus and models of training as lacking substance and exposure to experiential practice. Given that experiential learning has been identified as particularly useful to enhance multicultural competence (Lee & Khawaja 2012; Vereen et al. 2008), it appears that the absence of such training opportunities may be undermining the development of multicultural and cross-cultural racial competence. Professional development appears to have continued throughout participants' professional careers, suggesting participants' ongoing interest in cultural issues and a need for ongoing professional development for cross-cultural psychological practice. Cultural knowledge acquisition and reflective practice development seem particularly characteristic of working cross-culturally. Concurring views note that multicultural competence should be described as an ongoing learning process rather than as a 'tick-box' set of skills to be acquired (McDermott 2010; Stuart 2004).

It is intriguing in the present research that participants from African-Caribbean backgrounds described experiences of cultural immersion during their early lives as the first part of their learning process for working effectively clients from different ethnicities. Most White Bristish participants noted that contact with culturally diverse individuals prior to becoming practitioners offered them important insights, built their awareness of themselves as cultural subjects, and helped them to develop cultural ease around clients who are culturally different from them. This was the case for White British practitioners who have worked in multicultural geographical areas. These findings also suggest that practitioners' own experiences of migration/acculturation and inculturation and their cultural immersion in the earlier stages of their lives, support their development of multicultural competence as professionals in later life (Sue & Sue 2008).

Findings in this study support that the practitioners' personal experiences provided the means through which they learnt to work cross-culturally and racially. Indeed, research evidence

particularly points to the effectiveness of providing psychology/psychotherapy trainees with experiential cross-cultural learning opportunities such as cultural immersion, cross-cultural supervision and clinical experience with clients from different cultures in improving self-reported levels of multicultural competence (Lee & Khawaja 2012; Pope-Davis et al. 1997; Vereen et al. 2008). These results suggest that, whether in early life or through training programs, the direct experience of cross-cultural/racial contact is important in learning to work cross-culturally. Didactic training methods alone appear insufficient to foster cross-cultural competence and need to be complemented with experiential learning. Practitioners in this study described the quality and quantity of their training for multicultural competence, and while psychology programmes report including didactic and experiential multicultural content in their undergraduate and graduate programs (Smith et al. 2006) the quality and quantity of multicultural competence training varies significantly in content and method of training across programmes (Pieterse et al. 2009). Despite this diversity it seems that training in multicultural competence has a positive impact on the perceived multicultural competence of future psychotherapists (Smith et al. 2006; Worthington et al. 2007). Evidence suggests that the addition of experiential training opportunities such as cultural immersion, cross-cultural supervision all significantly improve multicultural competence (Carlson et al. 2012; Hansen et al. 2006; Vereen et al. 2008). This research suggests the need for education to maintain this distinction by infusing specific standards of multicultural training throughout the curriculum (Arredondo & Arciniega, 2001; Pieterse et al. 2009). It has also been suggested that experiential education is a key vehicle for fostering multicultural competency (Seto et al. 2006).

Similarly, Arredondo and Arciniega (2001:269) noted that trainees/practitioners benefit from role-playing and interactive debate in the multicultural course, since "students must acknowledge their 'hot buttons' about racism, privilege, and oppression, either as recipients or as beneficiaries".

6.5 SUPER-ORDINATE THEME 4: SUPERVISION/SUPPORT AS A "POTENTIAL" SITE FOR CROSS-CULTURAL/RACIAL FERTILISATION

Supervision is a mandatory requirement for professional training by State regulatory bodies, professional credentialing groups, and accrediting bodies. Supervision monitors and guides the profession ''in that it provides a means to convey necessary skills to socialize individuals into the particular profession's values, ethics, protect clients, and monitor supervisees' readiness for ongoing practice" (Bernard & Goodyear 2009:3). Most fully qualified psychological therapists work under supervision to improve their skills and expertise through peer consultation/guidance from a more experienced practitioner. Supervision is a valuable aspect of professional psychology and helps to ensure that the interventions offered by therapists are both high quality and up-to-date. A consistent finding in the literature is that cultural issues are infrequently discussed in supervision, even when there is a racial/cultural difference between supervisor and supervisee (Burkard et al. 2006). Practitioners in the current study described the insufficiency of one-to-one model of supervision. For less experienced professionals, being comfortable in the role of therapist or supervisor can be difficult while incorporating multicultural issues into supervision or therapy in a constructive way can be challenging, even for experienced professionals. This likely leaves the person unable to address multicultural issues in a meaningful way, even if that person is highly aware of and excited about these. The literature shows that experiences of supervision range from cultural issues being dealt with in great depth, to being ignored (Arredondo & Toporek 2004). Reasons may include: lack of training; lack of interest; and the inability to fully comprehend the complexity of working with clients from a different cultural background (Dressel et al. 2007; Mori et al. 2009). This reflects the experiences shared by participants in this current study that when multicultural issues were raised in supervision, they received little or no follow-up or deeper exploration. This seems more disturbing than not having these issues raised at all. Supervisors rarely follow up comments of multicultural issues, inferring these occurrences as unimportant and easily

ignored. Burkard et al.'s (2006) examination of culturally unresponsive events found such incidents impacted negatively on supervisee satisfaction with supervision, discouraging raising multicultural issues.

The dilemma raised by some practitioners in this study gives rise to a question: How can psychological professionals be expected to incorporate multicultural issues into their practice if their supervisors: do not nourish curiosity about multicultural issues in supervision; do not assist supervisees in multicultural skill development; and actively discourage attention to multicultural issues by ignoring these issues when they are raised explicitly in their one-to-one supervision session? Supervisees may often be inexperienced as supervisors in multicultural issues, meaning they may struggle to incorporate multicultural issues in supervision because of discomfort or unfamiliarity with their role, which then results in them not being exposed to multicultural issues or not being challenged when these issues are raised. The problem is not that multicultural issues are not raised in supervision, but rather that multicultural/racial issues arise but are glossed over, not followed up, or seemingly ignored. Therefore, even experienced supervisors in psychological therapies have difficulties in addressing multicultural/racial issues.

Practitioners all pointed out the importance of supervision and support, recognising that developing in this area cannot rely solely on formal training. This view is echoed in the literature. Sue (2006) outlines the complexity of cultural competency for while some practical strategies can be taught, there are more general processes, such as culture-specific skills that are linked to the general makeup of the therapists or obtained by life experiences, that cannot. Nolte (2007) agrees with Sue (2006) that exploring and utilising personal life experiences of therapists may not only be harmless but a valuable professional developmental tool. Nolte (2007) notes that the literature largely focusses on the clients' culture and she claims that the culture of the therapist is equally relevant.

As the fields of psychological therapy have evolved, there is a general consensus that culture and cultural aspects of identity play a pivotal role in psychotherapy and supervision interactions and

their outcomes (Inman 2006). Practitioners in this current study highlighted effective and ineffective cultural practices that affect successful supervisory processes and outcomes and pointed out the relevance of cultural factors and the decision/willingness to include them in supervision to face ongoing challenges adding to inadequate preparation, issues of race culture and differential power in the supervision room. These issues and challenges have been highlighted in previous research (Burkard et al. 2006; Dressel et al. 2007; Mori et al. 2009).

All participants in this study have had experiences of supervising and being supervised. Their experiences as supervisor and supervisee on cross-cultural issues points to insufficient resources to boost therapist confidence in cross-cultural/racial working. While there is a consensus that multicultural supervision is judged to be an important activity by many practitioners in this study, ways to effectively and appropriately conduct multicultural/racial supervision are still somewhat undefined and challenging. This view is echoed by Arredondo and Toporek (2004). Multicultural supervision encompasses the supervisor and supervisee exploring various aspects of culture (race; ethnicity; religion) that pertain to providing psychological services with culturally diverse clients (Constantine 2003). Indeed, the supervisory relationship is affected by the client's culture (Norton & Coleman 2003).

Practitioners in this study describe key premises underscoring the culturally responsive supervisory process: Culture and ethnicity are active, ongoing, ever-changing processes that are essential for discussion in supervision while broad issues including the institutional, ethnic and racially diverse supervisors, and supervisor multicultural competence are to be considered. These aspects have been partly investigated in relation to multicultural supervision (Norton & Coleman 2003; Constantine et al. 2005). Lago and Thompson (2003) highlight the need for culturally appropriate supervision and training for therapists through the exploration of power imbalances, historical implications and parallel processes between the client and the therapist, as well as between the therapist and the supervisor. Thompson-Miller and Feagin (2007) take this further by saying that all who want to study

and practise psychotherapy should actively embark on the reframing of White-generated racist values that are embedded in social structures and inevitably seep into the therapy room, training and supervision.

Findings from the literature are congruent with the experiences raised by some practitioners in this study but some differences are noticeable (Constantine et al. 2005). Supervisees have reported developing higher multicultural competence when multicultural issues were addressed (Burkard et al. 2006). Toporek et al. (2004) found that multicultural incidents in supervision influence the supervision process and the multicultural competence of both supervisors and supervisees. Some supervision literature indicates that the power imbalance inherent in supervisory dyads represents a potential source of conflict, leading both parties to feel at risk, particularly when cultural differences are present (Ancis & Marshall 2010; Daniels et al. 1999; Estrada et al. 2004; Manathunga 2011; Scheuermann 2011). Various authors have remarked upon the value of collaboration between supervisors and supervisees, noting that it requires mutual respect and understanding (Ancis & Marshall 2010; Scarcia-King 2011; Scheuermann 2011; Shupp & Arminio 2012; Shupp 2007).

Before supervisors can esteem supervisees' cultures, they must have a firm grasp of their own cultural identity and personal bias (Brinson 2004; Estrada et al. 2004; Manathunga 2011). They should distinguish the complexity of culture rather than converging on simplistic stereotypes (Manathunga 2011) and should initiate open negotiations about culture (Stock-Ward & Javorek 2003; Toporek et al. 2004) and share past and present shortcomings, presenting their errors and fears as education experiences (Ancis & Marshall 2010; Scheuermann 2011). In this study the majority of practitioners reported that some supervisors neglected these areas of development by solely looking at the therapeutic relationship and consequently ignoring how cultural differences and perceived stereotypes from the client impact both the therapeutic relationship and supervision – thus ignoring "the BIG elephant in the room". Emphasising technique and case management in supervision relegates cultural issues to be ignored or dismissed. Practitioners in this research raised

the fundamental question on how to create a safe atmosphere for both the supervisor and supervisee that enables courageous and effective exploration of issues of cultural difference within the challenging constraints of the current supervision model that seems to avoid cultural issues unconsciously.

The complex relationship between culture/race and supervision also leads to practical questions about the most effective methods for supervising professionals and ensuring development in the area. To achieve greater clarity and practicality, some participants propose a cross-cultural group model of supervision, with the rationale of integrating culture/race in supervision by including an authentic relationship forged between members, and nurturing their awareness, openness, and attention to cultural factors, including sharing personal struggles around culture, as discussed by Drewes (2008). This approach seems to be congruent with Shupp and Arminio's (2012) synergistic supervisory relationship which "results in success for both the individuals involved as well as the organization". The findings of this study support the notion that the most effective supervision "happens deliberately through an open, dynamic, and vital relationship between members of the supervisory group. Moreover, the findings emphasize the interrelationship of identity and supervision, demonstrating that culture is too important to be treated superficially by supervisors.

6.6 Summary of findings

This discussion has situated the findings of the current study in the context of the existing literature on cross-cultural therapeutic work. A number of key themes have been identified as providing important insights into therapists' experiences of cross-cultural/racial therapeutic work in an unlike dyad. The findings indicate that cross-cultural/racial therapeutic work is experienced from the clinical, training and supervision/support perspectives. These experiences varied and the challenges and associated opportunities are experienced from different perspectives and, depending on practitioner, their race, cultural exposure and background, stage of racial identity development,

predisposition from their therapeutic modality and the willingness to transform and oppose racial micro-aggression thoughts and behaviour. While some individuals identify themselves as capable and more in tune with cross-cultural/racial therapeutic work, some will still find it challenging, highlighting personal, systemic, training and supervision issues resulting from their experiences, as key areas for improvement. Some suggestions were made around clinical engagement processes and the training and supervision model that may foster experiential learning and exposure.

The study highlights therapists' need for self-reliance to safeguard their cross-cultural therapeutic work via recognition of their own cultural identity and the impact this has on them as individuals as well as an ongoing awareness and mindfulness of their assumptions, judgements, biases and racial micro-aggression behaviours which may be unconscious. The research raises the question of how therapists actually manage their cross-cultural/racial therapeutic space, given the limitations inherent to not only techniques adaptation, but also geographical, systemic, training and supervision challenges. While participants see raising their awareness of biases and being mindful of their vulnerability as an important facet of their therapeutic work, this raises the question of whether their denial of their vulnerability (acculturation, level of cultural identity development, willingness to transform) might prove detrimental to a more authentic and effective engagement style of cross-cultural /racial therapeutic work. These findings accord with those of existing research, which suggest that a therapist's mastery or lack of it have both positive and negative effects, not only on the therapeutic relationship but also on client engagement and therapy outcome.

Finally, the findings of the current study point out practitioners' challenges and difficulties around current ongoing training, learning, support and supervision approaches. Participants all agreed on the need to review training and supervision support systems by focusing on helping them move positively within their acculturation/inculturation phases, nurturing willingness to transform and making training more experiential by incorporating exercises that promote exposure and evoke threat, anger, shame, guilt from trainees and making them become more aware of their level of

identity development and its impact on their therapeutic work. This will provide evidence for the view that expansion and self-transformation from a place of willingness can be beneficial for cross-cultural/racial therapeutic work.

Regarding support and supervision, participants recognised the insufficiencies of current models pointing out other variables of cross-cultural/racial supervision encounters. By integrating the patient's race as a third presence, this would make it more of a supervision triad as opposed to a supervision dyad. For this reason, and given the variation and disparities in supervisors and supervisees' levels of cultural competence, acculturation and identity development stages, suggestions are made for cross-cultural/racial group supervision and consultation approaches that promote openness, exposure, sharing, collaboration and learning from others and in a non-judgemental space. It is important to keep in mind that every psychological therapist is at different stages in their racial identity developmental process and that support may look different for each individual, hence the importance of approaching group support from a Phenomenological perspective. It is important to point out that experiences of the African-Caribbean practitioners and the White British practitioners differ with regard to racial tension, service expectations, level of tolerance and all associated assumptions around supervision, training and cultural competence.

The strength of this study lies in its qualitative nature as it has resulted in a contribution of an emerging approach to cross-cultural work that promotes aspects of cultural competence and encourages racial and cultural discussion as part of therapy in the therapy room. Moreover, it is important for practitioners to self-develop and show willingness to explore and connect with their own cultural and racial identity to facilitate connection with patients' cultural and racial identity. The ability to operate the dialectic between race and culture in a non-judgemental way is a key finding from this research. Previous research focused on separate clusters of ethnic minorities in one cultural group and White Europeans/Americans in another, showing little understanding of differences within groups and perhaps some bias, tending to refer to members of the 'ethnic' group

as minority practitioners (Nezu 2010; Price 2015; Hare 2025; Burkard et al. 2006; Neville et al. 2006; Tol et al. 2005; Burkard et al. 2006; Gushue & Constantine 2007; Knox et al. 2003; Utsey et al. 2005; Beverly Spalding et al. 2018; Dos Santos & Dallos 2011).The present study is one of the first of its kind with a mixed sample from two exclusive races (White British and Black African-Caribbean) and a focus on the experiences of psychological therapists.

6.7 African-Caribbean and White British Psychological therapists' unique experiences of cross-cultural/racial work

African-Caribbean psychological therapists rated their cultural competence and awareness high and also recognised that their level of acculturation and their willingness to practice in a foreign culture and language prepared them for tolerance and endurance. Their past contact with the Western culture and, in some ways, their acculturation level, shaped their cross-cultural work positively. However, the majority of African-Caribbean psychological therapists discussed their experience of racial blindness, during their clinical work, in training and in supervision. Conversely, White British therapists talked about insufficient or inadequate training ad felt unprepared to work cross-culturally and effectively. Some suggestions are made about ways to improve training through experiential exercise and role play as a way to target hidden feelings and behaviour and improve racial identity development and cultural competence. African-Caribbean and White British therapists' unique experiences are sumarised respectively in tables below.

Table 12: **African-Caribbean Psychological therapists' unique experiences of cross-cultural/racial work**

Experience/competency	Positive/negative rating	**Rationale/evidence**	Discussion
High Cultural competence and awareness	**Positive**	Recognition that level of acculturation and willingness to practice in a foreign culture and language was good preparation for tolerance and endurance. Past contact with Western culture and professional expectations shaped their cross-cultural work positively	Good/advantageous knowledge of culture
Racial issues Racial blindness, during clinical work, training and supervision Target of racial micro-aggression behaviours from patients, colleagues and supervisors Perceived rejection from clients and detached reactions from colleagues Confusion/uncertainty about what was mental illness and what was racism (particularly in clinical work)	Emotionally Negative but some management strategies seen as Positive	Managed this through willingness to tolerate racial tension, pointing out issues of discrimination, and covert racism at personal systemic levels and using irreverence and a natural validating style in clinical settings, supervision and training	Being direct and radically genuine. Irreverence and natural validating style. Difference in culture and race was seen as challenging but carried some advantages - dependant on individual racial identity development stage; experiences; exposure; training level and professional grade; and personality, in accessing personal resources (to manage situations with humour and tolerance and thus maintain professional and collegiate working

Table 13: **White British Psychological therapists' unique experiences of cross-cultural/racial work**			
Experience/competency	Positive/negative rating	Rationale/evidence	Discussion
Unpreparedness for effective cross-cultural work Insufficient or inadequate training Geographical challenges and inadequate exposure to African Caribbean race/culture	Emotionally Negative but some management strategies seen as Positive	Those White British practitioners who came from a multicultural city and had good, ongoing contact with African-Caribbean's, describe a higher level of confidence working with race, however still pointed out some clinical, training and supervision challenges Some practitioners proposed the value of a local database of people available for extra support and others suggested changes to current models of 1:1 supervision to group support, guidance and consultation. Some suggestions were made about managing geographical challenges by nurturing collaboration between services from all areas of the country (North, South, East and West)	suggestions are made about ways to improve training through experiential and role play exercises as a way to target hidden feelings and behaviour and improve racial identity development and cultural competence This situation of unpreparedness has not helped bridge the gap of cultural distance
The necessity for therapy adaptation due to challenges of difference within racial groups	Positive	Some felt that going back to 'being human' and taking a humanistic stance will nurture skills congruent for therapeutic work. Positive predispositions to work cross-culturally/racially correlate to therapeutic approaches/modalities such as CBT for psychosis and DBT for borderline personality disorder with the common denominator of these approaches being the nurturing of unique and Phenomenological understandings of patient experience in non-judgemental and validating ways. These skills are transferrable to cross-cultural/racial work.	Individual needs as central remains the focus but difficulties remain around how much of this might contribute in to the denial of racial and cultural difference

Limitations of supervision: Supervisor experience and grade was not indicative of their cultural competence Supervisor making racist comments Lack of alternative source for supervision of consultation	Emotionally Negative	Incompetent supervision creates difficult supervision experiences necessitating finding alternative supervision where alternative support was scarce	current one-to-one model of one-to-one supervision has its limitations and group supervision might mitigates these challenges by offering a safe and reflective settings for discussion and experiential learning.

6.8 Relevance of demographic data

The demographic data from current research can be interpreted and also provide more insight and correlate with psychological therapist experiences of cross-cultural therapeutic work.

Age: the practitioners' ages varied from 32 years old to 55 years old and the majority were over 40 years old. Most had good experience of working in mental health and psychotherapy. Of note is that practitioners with experience of providing training were more advanced in their careers and also held senior positions within services.

Gender: majority of participants were female (female: n=5 male: n=2) which is representative of the current national picture of the dominance of women in psychological therapeutic work. Gender was a recurring factor commented upon in the research, by more than one practitioner when it comes to adding a gender variable and perception into cultural norms and raising implications for effective therapeutic work. The findings of this research may be influenced by gender.

Profession: the participants included: 4 clinical psychologists and 3 cognitive behavioural therapists. This is representative of current national recruitment trends for appropriately qualified professionals to undertake therapeutic work which is broadly similar and requires similar preparation and ongoing support.

Years of training and practice: All participants had at least 3 years of training for their professional qualification They also reported many years of practicing, and practice experience in-the-field ranged ranging from 5 years to 30 years. This breadth provided rich data and insight.

Therapy modalities: Participants' areas of interest varied and included personality disorder, psychosis, depression/anxiety and family work. All participants were professionally accredited (BABCP, BPS, and DBT accreditation society). One could easily conclude that these years of training and accreditation principles were enough guarantee and help practitioners provide the insight

needed for this research. Therapists using treatment modalities such as DBT and CBT for psychosis reported fewer difficulties navigating between cultural differences and seemed able to integrate the dialectic perspective into their cross-cultural work. The particularities of these therapies and modalities are that they promote therapist understanding of the patient's unique and Phenomenological experience. The research shows that patients receiving therapy based of these treatment modalities value therapist validation and understanding of their unique experience especially when considering personal, historical, social and cultural issues. The literature associated with the DBT treatment promotes specific agreement between the patient, the therapist and the consultation and supervision team. This agreement includes: consultation, phenomenological empathy, Dialectic, consistency, observing limits, stretching limits and fallibility agreement. All these clinical and practical agreements are positive predisposing factors to cross-cultural racial therapeutic work. On the other hand, modalities such as CBT for psychosis promote therapists' understanding of patients' unique experiences, personal validation and adaptations as key when working with clients from a different cultural background. The importance of being mindful of bias and judgement is advocated so that patient and therapist listen to each other without judgement.

Geographical: All African-Caribbean therapists were trained in the UK and lived in the UK for at least 17 years while the White British psychological therapists may have only spent a short holiday period in African-Caribbean countries. Participants with less experience in cross-cultural contact and who had not experienced geographical exposure to other races and cultures found cross-cultural encounters challenging. This was despite their training which they felt lacked exposure through experiential learning.

Therefore, the current demographics information provides an opportunity to reshape the approach to cross-cultural therapeutic work in all its aspects: clinical competence, training and supervision. The need to adapt DBT agreements into cross-cultural therapeutic practice as a fundamental base is an urgent requirement:

- Clinical cross-cultural therapeutic work agreements
- Cross-cultural training agreements
- Cross-cultural supervision agreements

These agreements will offer a baseline and a reminder of principles, behaviours and attitudes that favour cross-cultural/racial therapeutic work.

6.9 Limitations of the research

To date, most studies in the area of cross-cultural/racial therapeutic work have centred on patient narrative accounts, which, mostly qualitative, mainly focus on factors that may interfere with effective cross-cultural/racial therapeutic engagement from either the White therapist's perspective or from the patient perspective (Neville et al. 2006; Tol et al. 2005; Burkard et al. 2006; Gushue and Constantine, 2007; Knox et al. 2003; Utsey et al. 2005; Beverly Spalding et al. 2018; Olga Dos Santos and Rudi Dallos, 201). Most qualitative studies focus on White therapist experiences and few (other than Spalding et al. (2018) and Knox et al. (2003) consider African-Caribbean practitioners' experiences. None of the studies use IPA methodology.

Research into therapist experiences of cross-cultural therapeutic work have explored specifically colour-blind ideology that could be indicative of lower levels of competency (Neville et al. 2006), the understanding and acceptance of the client's world views as an important factor (Tol et al. 2005) and the use of self-disclosure to improve therapeutic relationships by exploring racism and recognising own racist and oppressive attitudes (Burkard et al. 2006). This present mixed sample study offers opportunities for participants to acknowledge the idiosyncratic nature and impact of cross-cultural/racial therapeutic work and how this is experienced. It considers the challenges/opportunities of key aspects of effective therapeutic work: therapeutic relationship; competence; training; supervision. In this way the present study seeks to broaden the scope of meaning and experience of cross-cultural racial therapeutic work as well as determining ways to

improve key areas of clinical therapeutic practice. Although IPA was deemed suitable for this research, it is important to recognise some limitations.

This is a small-scale research which was based on a one-off interview with individuals from a small sample. Nonetheless it offers unique insights. So, while findings may be limited in terms of generalisability they are still presented as theoretically transferable as a strength of IPA lies in the detailed deep nature of its analysis (Smith et al. 2009). Therefore, even if the sample of this study were smaller, deeper analysis would have been possible thus potentially offering further insights.

Additionally, interviews relied on participants' recollection of past experiences and subsequent interpretation which may have created discrepancies. Although, participants were at different points of their career when interviewed, most had substantial years of practice experience. Of note is a key finding of this study that cross-cultural therapeutic work is associated with race and culture in training and supervision so is broader than merely the therapist/patient context.

The research topic under investigation was an extremely sensitive one inviting participant to discuss and disclose potentially negative material about their practice. This could have prompted non-disclosure and/or discomfort for participants which a de-briefing discussion at the end of each interview may have uncovered? As it was, each participant was given an opportunity for any final thoughts about the interview and all stated they were unaffected.

As a novice researcher, it is acknowledged that inexperience in utilising IPA techniques may have limited analysis, but realising that "findings are interpretations of a range of possible meanings as fitting the hermeneutic nature of the methodology" (Finlay 2011:147), the systematic processes of analysis utilised, together with candid exposure of possible personal influence, goes some way to counter methodoLogical critics.

The role of the researcher as a co-contributor to the research findings is therefore required and both implicit and explicit. However, if this research were repeated, the researcher would dare to be more

creative in their interpretations, and perhaps play with other strategies outlined by Smith et al. (2009), such as polarization and contextualisation.

6.10 Clinical implications

The following recommendations for practice focus on encouraging new ways of thinking to challenge historical views at all levels of cross-cultural training, support and practice.

Having open conversations about culture and racial identity at the very start of therapy by being curious, and asking questions to explore thoughts around racial and cultural differences is important for all therapists but for White British practitioners particularly, it appears that confidence increases in adapting and delivering culturally competent therapy if questions about race, ethnicity and even the experience of racism are raised at early stage of therapy (Naz et al. 2019). One cannot assume racial identity only has significance to people of colour (Sue 2015). Racial identity is important regardless of racial background and must be addressed in therapy.

From a White British therapist perspective, awareness and connection to one's own racial identity is vital to avoid the harm of 'blindness' to the ways in which racial identity carries 'unearned privilege'. Ignorance of the impact and power of 'Whiteness' means remaining part of a system that upholds racial hierarchy (Angelo 2018; Sue 2015; Carter 2003) and this cannot be addressed without being aware of it.

The White clinician must be authentic about their genuine interest in patients' race-based experiences and service restrictions and continue to show curiosity and empathy to allow patients of colour to disclose and discuss their lived experiences of racism which could be part of their mental health problem (Melluish 2012). Actively engaging in conversations to learn about systems of oppression helps develop deep personal understanding of racial identity and unconscious bias and is imperative (Sue 2015) to uncover all difficulties within the therapeutic relationship (Rothman et al. 2012). It is acknowledged that cross-cultural/racial work can be emotionally draining, and can evoke

difficult emotions of shame, anxiety, guilt, sadness and frustration which, if invalidated, can reduce creativity and flexibility during cultural adaptations (Dodge 2019).

Moving away from time constraints would allow more time for therapists to sufficiently address wider social, racial, cultural, religious and adaptation issues and nurture awareness of differences and similarities, to meet the needs of individual patient. Adding time and support and slowing the pace may provide flexibility, and a foundation for a trusting relationship to promote confident, effective cultural competence and enable reflective practice to assist learning, nurture a safe and effective therapeutic collaboration with the patient (Owen et al. 2017) and encourage cultural sensitivity (Eister et al. 2016). This approach to reflective practice validates efforts to increase the cultural diversity of practitioners (Knox et al. 2003).

At service level, commissioners and service managers should develop a good understanding of the population served and ensure that all needs are fully met by providing appropriate resources and support. With such cultural and racial diversity amongst clinical staff and patients, systemic changes in the culture, based upon respect and curiosity when faced with difference should involve all service levels. Services should develop resources for support and consultation which would improve practitioner confidence and engagement in treatment.

Finally, services should promote cultural adaptations of interventions specifically for particular communities and and provide ongoing statutory and mandatory training and support on adaptation strategies. It would be refreshing if experts for working with diversity came from the non-BAME as well as BAME community, raising cultural issues to a high priority for all. Service providers should evaluate the multicultural competence of their employees through auditing practice, training and diversity policies.

6.11 Training implications

Participants in this study expressed the desire for ongoing training as a way to mitigate the shortcomings of initial training. Investment in additional training to support practitioners working with diverse communities, could include attending workshops and conferences where diversity, race and culture are considered as essential.

To promote effective cross-cultural/racial work (Boyle & Harris 2009) training should be collaborative and co-produced reciprocally between people using the service (such as patients with a positive experience and helpful insights for successful cross-cultural/racial therapeutic work) and clinical and management service colleagues. Additionally, collaboration with cultural advocate services could encourage collaboration and consultation. These measures, together with a reciprocally collaborative experientially focussed training would enable the safe exposure of attitudes and knowledge to nurture understanding of cultural and racial identity, raise practitioners' confidence and reduce anxieties and avoidance to engage in race, culture, ethnicity discussions in therapy sessions (Naz et al. 2019).

Naz et al. (2019) provide a useful framework for services to to consider and plan for service level training in cross-cultural issues and while this framework acknowledges the difficulties that staff from White backgrounds may experience in training which directly targets inequality and racism, it suggests constructive mechanisms for managing this.

Furthermore, it will be important to review minimal multicultural training requirement and develop: training which incorporates didactic, exposure and experiential learning; develop a robost monitoring and auditing system that will reinforce compliance to minimum standards.

6.12 Supervision implications

Supervision is part of the therapy process and good quality supervision is vital to ensure the provision of high quality cross-cultural/racial therapeutic work. Of note here is that cross-cultural one-to-one supervision is a role which does not correlate to years of experience or seniority within the profession.

Cross-cultural therapeutic supervisors require self-reflective skills to be aware of triggers/topics that heighten anxiety and discomfort in themselves and new therapists who may be hesitant to raise topics concerned with ethnicity, race and diversity during supervision due to fear of being exposed, getting it wrong or even being perceived as racist. Supervisors could benefit from cross-cultural peer discussion to reflect on such supervision issues together with specific cultural and race focussed training Patel (2004). Constantine (2003) argues that psychological therapists' unique preparation and training may not facilitate their ability to engage in effective treatment with diverse people in an increasingly multicultural world.

This study has highlighted that one-to-one supervision, relying on the supervisor/supervisee experiences and mutual willingness to engage in multicultural issues to stimulate cross-cultural racial discussion can be inconsistent and diverse (Arredondo & Toporek 2004). Difficulties include lack of training, lack of interest and the inability to fully comprehend the complexity of working with clients from a different cultural background (Dressel et al. 2007; Mori et al. 2009). Positive outcomes in multicultural formulation have been observed in group supervision (Gainor & Constantine 2002) and although the benefits of receiving one-to-one multicultural supervision have been documented (Duan & Rochlke 2001), using group supervision formats to address multicultural, cross-cultural/racial challenges (Gainor & Constantine 2002) could be beneficial. Group supervision has been associated with increased professional empathy and self-confidence (Benshoff 2001; Thomasgard & Collins 2003). There is scope to consider new ways of supervision in groups that may improve support. A preoccupation with cultural difference and high anxiety around BAME client

progress experienced by psychological therapists aiming for multicultural competence (Roysircor et al. 2003) heightens frustration within some traditional one-to-one supervision models.

This researcher has developed a proposal for change which aims to promote better supervision and support in the delivery of psychological therapies to all practitioners. This 'Cultural Formulation and Supervision Group (CFSG)' realises that in the group supervision setting, while potential relational pitfalls exist in other areas, the power differential is largely absent

The CFSG will comprise psychological therapists from all races and cultures who meet at regular monthly intervals, to present their cases, difficulties, reflective practice and practical questions. Counselman (2004) suggests a democratic approach in which all the members take responsibility for group work. Thomasgard (2003) also suggests that group utilize rotating presenters or co-moderators. This provides more opportunity to practice supervisory skills and is a more structured and fair way to present cases. It is up to the professionals in the group to determine how they would like the group sessions to be structured. With less need to impress or appease one another, group members may be more able to self-assess multicultural competence development, take needed risks, and honestly report the results of attempted interventions. By meeting regularly with a multicultural competence-oriented group, participants may be able to continue their multicultural competence development beyond that which they receive in regular supervision. If successful, this option will promote continuous development of psychological therapists and will extend its benefits to clients in cross-cultural dyads.

There are many benefits to the CFSG. Members meet with other professionals to feel validated, discuss difficult situations, self-explore, and learn different interventions and perspectives on cross-cultural psychotherapy, promoting a supportive environment and counteracting burnout. One important benefit of the CFSG is the absence of power struggles, because the professionals operate at the same level, which creates a trusting environment where members discuss their mistakes and

feelings regarding their clinical work. The end result is self-efficacy, trust, self-esteem, self-confidence and self-worth of the group members.

Interestingly, Ladany et al. (1996) found that the same information being concealed from supervisor's one-to-one is often disclosed to others, typically peers/colleagues or friends in the profession. The group supervision model proposed here formalizes a support system that appears to have already been widely in use informally.

6.13 Future research

Future use of a larger study using quantitative approaches to research this area could help capture the wider views of psychological therapists across larger geographical areas and psychology services could provide more scope for generalisation than that of a qualitative approach.

A prominent theme in this research is how therapists' professional identity interplays with their experience of themselves in grief. Further research in this area could broaden understandings of the ways in which a therapist's professional persona impacts their work and their experience of themselves in situations of extreme vulnerability. Emphasis should be given to cross-cultural learning and explore what practitioners from different cultures and race can learn from each other in their therapeutic practice.

6.14 Personal Reflection and exploration of my research journey

In this section, I outline the methods I use in order to reflect on my biases, achieve reflexivity, and allow the participants' lived experiences to remain the primary focus.

As a Black African and a qualified psychological therapist of ten years, I acknowledge that my ethnicity can be a challenge in a White-dominated profession. I believe I have grown personally and professionally through many emotional stages of defensiveness, denial, guilt, and acceptance of

myself, working for positive social change in a society where racism can be experienced. My racial journey which is something that affords me some degree of understanding of and for others.

I feel that I have come a long way in shedding my internalized biases regarding race and I am very sensitive to hateful attitudes that are contradictory to my faith and spirituality. I credit my religious beliefs as a Roman Catholic, along with the liberal and traditional values with which I was brought up, as setting the foundation for my personal growth as a psychological therapist. I am also an independent, critical thinking humanist and Phenomenologist who acknowledges the reality of multiple truths and refuses to endorse hypocrisy and injustice.

Growing within my professional career, I have worked hard to become more aware of the biases that I have internalized and have attempted to eliminate them from my worldview. I realize that this is an ongoing process, and it is likely that I still have a number of culturally blind spots in these areas. I also acknowledge that I have not had the lived experience of being a White person. I am authentic and do not pretend to portray myself as someone I am not. I strive to be culturally competent and empowering in my clinical work and in my research activities.

Because I have had personal experiences in the therapist role, I have a strong personal belief in the importance and power of the therapeutic work as a catalyst for positive change. This value, perhaps more than any other, has influenced my interest in this research study. I was fully aware of my biases in this area and, although the purpose of this study was to examine others' experiences of this phenomenon, I was mindful of taking the Phenomenological stance, and purposely used neutral language when asking about or discussing therapeutic work with research participants. In this way, I was able set my assumptions aside and honour their unique experiences to the best of my ability. In addition to being mindful of the values and biases mentioned above, there were a number of methods I followed to achieve and maintain reflexivity throughout this study.

I was self-reflective throughout the data gathering and analysis processes, in which I reflected on the personal thoughts and feelings that came up regarding the study (Morrow, 2005). I consulted

regularly with my supervisors. I discussed my reactions, requested feedback to highlight relevant issues and potential biases and for my interpretations to be challenged. I also regularly examined my attitudes and assumptions regarding psychotherapy, the role of the therapeutic work, and the meaning of interpersonal differences with White British colleagues, and supervisors during the data collection process. Using these approaches enabled me to enter the Phenomenological experience of my participants and to become a more effective qualitative research instrument.

While I bracketed my personal opinions and beliefs and minimised the impact of my identities throughout my work on this study, it was clear that who I was as a person and a researcher may have affected this process. As a psychological therapist, I have my personal bias regarding the value of psychotherapy. This bias reflected my decision to devote my life to a career in psychotherapy, specifically focusing on clinical work. I consider psychotherapy to be a positive yet challenging process, with the potential to be a healing and empowering force in peoples' lives. I personally identify as an integrative, humanistic, behavioural and cognitive psychotherapist who draws from a number of traditions but maintains a strong humanist core.

I acknowledge that, as someone who works from a primarily dialectic, behavioural and conceptual framework, I have a clear positive assumption towards the importance of the relationship in therapy. Throughout the process of conducting interviews and analysing the data, I was mindful of my biases and, by 'bracketing', did not allow them to get in the way of understanding my participants' unique points of view. I remained mindful of these biases regarding the nature of therapy and multiculturalism, as well as my personal socio-political worldview, for they could have become barriers to truly hearing opposing perspectives.

My peers and colleagues were consulted at an early stage of the study. Their thoughts helped identify benefits and risks of several issues that could come up, including the idea of recruitment challenges. In calling for participants, fewer responses than hoped were received, despite my best efforts to encourage people to engage with the research. Some colleagues provided potential avenues of

recruiting participants and a number of people, including my supervisors, provided much needed support and encouragement throughout the process, especially with regard to the recruitment difficulties. I feel that participants were taking a risk and granting me the privilege of entering into a meaningful relationship that holds a special place in their personal world.

Here I share some reflexive thoughts on the process of collecting data for this study.

At the start of the interview, I was struck at the courage of participants in sharing such profound experiences with me. Participants took the time to talk to me about their experiences during just one session. I wondered how much they would have come up with if we had had more time or even conducted a follow up interview? In my attempt to put participants at ease I sought to reflect on their openness during interviews and I made my appreciation for their disclosures explicit. I was clear with them that I was keen to hear about their unique experiences. Moreover, I retained a soft and non-judgemental stance throughout which was materialised by my genuine compassion and appreciation of their participation and experiences.

At the end of the 1st interview, a White British participant asked why I had chosen this area for research. I then shared my motivation among other things, which had ignited my interest in this area. I felt this softened the connection between the participant and myself. For the remaining six interviews I decided to share my reasons for conducting the research, disclosing my own experience of cross-racial therapeutic work to my participants as part of my introduction. I felt this promoted a level of rapport and safety that perhaps had not been there prior to my discussion with the first participant.

I was mindful of wanting to ensure participants were at ease and were being understood whilst they were daring to share such sensitive and important parts of themselves. Having said this, I am aware that this disclosure impacted the research. I am aware that my disclosure was based on my assumption that participants might benefit from my explicitly sharing my cross-cultural therapeutic experience. My decision to do this was situated in my desire to create a safe, understanding space.

However, I feel and hope that my curious and open stance, as well as my explicitly made intention to hear their unique stories, promoted an authentic revealing. Furthermore, through my disclosure, I gave voice to a central theme in this research: exposing one's vulnerability and encouraging an open dialogue about it.

I was also aware that this was a research process and not a therapy session. I was mindful not to hold a therapeutic stance in relation to participants, and to avoid offering interventions or interpretations. I found this particularly challenging given the sensitive nature of the phenomenon being explored and my background and experience as a psychological therapist. I was confronted with the tension of discussing a topic which evoked strong feelings while seeking at all times to navigate this terrain in a way appropriate to the research process and to participants 'experiences. Essentially, I had to ensure my interventions were not overly therapeutic in style.

I found it helpful that participants were psychological therapists themselves, with a clear understanding that the focus was on gathering information about their experiences rather than therapy as such. Nevertheless, the research interview explored extremely sensitive areas, and some participants showed emotion during data collection. I invited participants to continue sharing their feelings only if they felt comfortable. I took note of my own feelings and thoughts and prompted myself to bracket my assumptions about what these displays might mean.

During the de-briefing process, participants had an opportunity to share their experience of the interview with me. I was reassured to find that all of them had found the process useful, notwithstanding the distress it may have prompted. Some participants told me that this was the first opportunity they had had to think and talk about their experience in such depth, others reflected on how they were surprised at the material that emerged, and still others felt the process of being heard and witnessed in relation to their cross-racial therapeutic work was cathartic. This made me even more aware of how potentially transformative and impactful this research could be.

7 Chapter 7 Conclusion

This chapter concludes the study with key messages learned, and recommendations that could be ustilised by both clinicians and clinical researchers. The second part of this chapter will apply Yardley's (2000) criteria to assess the validity and quality of this research.

7.1 Key messages and recommendations

This research set out to explore White British and African-Caribbean experiences and understanding of cross-cultural/racial therapeutic work and how the perspectives and feelings evoked from working in an unlike racial dyad, make meaning. Due to personal cultural and racial identities of being an African-Caribbean psychotherapist who has worked with White British patients for 15 years and collaborated with colleagues through training, supervision and peer consultation, the possible influence of personal bias in this study was recognised. To overcome this the research was led by focusing on the *participants'* perspectives, allowing them to guide the research through *their* experiences.

The use of IPA methodology led to the creation of four final themes that are linked to clinician experiences in cross-cultural conditions. Participants identified both positive and negative ways in which differences in race and culture influenced their work with patients together with dynamics of training, support and supervision. Four themes were identified: (1) mastering cross-cultural/racial practice; (2) barriers to effective cross-cultural/racial work; (3) cross-cultural/racial learning in practice; (4) supervision support as a "potential" site for cross-cultural fertilisation. Participants described the overwhelming and disorientating experience of cross-cultural/racial work on an instinctual, personal, collective and systemic level. Participants felt unprepared and inadequately trained to be cross-culturally effective but work experience over time, particularly if augmented with ongoing learning, support and supervision enabled them to achieve mastery of a range of culturally competent skills. This research has identified many complex issues that confront psychological

therapists in their cross-racial/cultural therapeutic work, illuminating their experiences. The findings indicate that cross-cultural/racial therapeutic work is experienced from individual clinical, training and supervision/support perspectives which has uncovered various challenges and opportunities associated with each practitioner's race; cultural exposure and background; level of acculturation; stage of racial identity development; predisposition from their therapeutic modality; willingness to transform; and their ability to notice and act to oppose racial micro-aggressive thoughts and behaviour. While some practitioners identify themselves as capable and more 'in tune' with cross-cultural/racial therapeutic work, some still find it challenging, raising their personal experiences, systemic processes and training and supervision issues as key areas for improvement. Some suggestions were made around clinical engagement processes, and training and supervision models that could foster experiential learning, reflective practice and exposure.

The study highlighted psychological therapists' need to rely on themselves and safeguard their cross-cultural therapeutic work often via recognition of their own cultural identity and the impact this has on them as individuals, and ongoing awareness and bracketing of personal assumptions, judgements, biases and racial micro-aggressive (either conscious or unconscious) behaviours. The research raised questions of how therapists manage their cross-cultural/racial therapeutic space, given the limitations inherent not only to techniques adaptation, but also to geographical, systems, training and supervision challenges. While participants saw raising their awareness of bias and bracketing their vulnerability as important facets of their therapeutic work, this raises the question of whether denying their own vulnerability (acculturation, level of cultural identity development, willingness to transform, the quality of ongoing learning 'on the job') may prevent more authentic and effective engagement styles as opposed to the 'tick-box' approach to cross-cultural /racial therapeutic work commented on by some practitioners.

A particularity of this research is that practitioners all identified multicultural therapeutic knowledge and skills deficits, all recognising a need to improve these using supervision, training and alternative

resources. Distinctions can be made between general therapeutic skills, including active listening; empathy; and illustrating genuineness and specific skills that are central to working with a client who is culturally different such as: determining effective ways to communicate with clients (perhaps using a different style of thinking); information processing and communication; discussing race and racial differences early in the therapy process; engaging in multiple verbal and non-verbal helping responses; recognising responses that may be appropriate or inappropriate within a cultural context; using resources outside of the field of psychology, such as traditional cultural healers and spiritual leaders; and modifying/adapting conventional forms of treatment to be responsive to the cultural needs of the client (Sue & Sue 2008).

A major implication of the study is the need for working psychotherapist' ongoing professional development to overcome training deficits in cross-cultural practice with clients. Professional development activities that focus on experiential learning, cultural immersion and exposure to individuals from other cultures may be of particular benefit to realise that multicultural competence acquisition is an ongoing learning process demanding, personal transformation and willingness to develop awareness of themselves as a cultural being. This is why setting up and revising support structures that focus on professional and personal issues raised by the process of developing multicultural competence is crucial together with new ways of learning and seeking support.

A further implication from this study is the validation that therapists should actively and willingly develop, apply and maintain multicultural competence in their practice with clients. Important elements of this include developing cultural self-awareness; acquisition of specific cross-cultural knowledge; and developing the skill to the 'exposure phase' where experiential learning and supervision are pivotal in developing personal racial identity and understanding other levels of racial identity development. Cultural competence acquisition will develop and enhance practitioner's abilities to negotiate cultural differences in psychological practice, possess an understanding of

within-group differences and provide capacity to work, appreciate and celebrate diversity in clinical practice.

Results in the present study confirm findings in the literature that therapists do not receive sufficient training to support multicultural competence and effective cross-cultural psychological practice upon completion of training. Moreover, the development of culturally competent therapeutic services is not been currently achieved (Lee & Khawaja, 2012; McConnochie et al. 2012; Ranzijn et al. 2006). The findings, while supporting previous cross-cultural therapeutic work literature, have also clarified complex and important issues regarding the effectiveness of current training and supervision approaches.

The findings have ongoing implications for therapists and services. The recommendations propose encouraging new ways of thinking and talking about issues of race, ethnicity and culture and to question concepts that are perhaps taken for granted. Training and guidelines should support practitioners and encourage a curious stance, creativity and comfort in providing culturally appropriate and adapted therapy. It is therefore important to to transform training and include experiential and exposure opportunities to cultural immersion. Multicultural competence should be made as a requirement for registration in various psychotherapy professional bodies and the inclusion of cross-cultural teaching/practice, learning should be mandatory for the accreditation and reaccreditation process of psychological therapists. It is therefore important to develop minimum professional registration standards, minimum professional development requirements and compliance system that address effective cross-cultural therapeutic practice.

Cross-cultural therapeutic supervisors require their own professional development to support supervisees and be confident to encourage disclosure of topics regarding race, ethnicity and culture that may increase discomfort and anxiety. Group supervision is proposed here to mitigate some of the challenges within the current one-to-one model. The Cultural Formulation and Supervision Group (CFSG) has the advantage of creating an environment where professionals feel validated,

discuss difficult situations, self-explore, and learn different interventions and perspectives on cross-cultural psychotherapy. An important benefit of the CFSG is the absence of power inequalities, because professionals operate at the same level. This creates a trusting environment where members discuss their mistakes and feelings regarding their cross-cultural/racial clinical work, resulting in raising self-efficacy, trust, self-esteem, self-confidence and self-worth of the group members.

Finally, this research revealed psychological therapists' enthusiasm for working with culture, race and ethnicity albeit with acknowledgment of the barriers and opportunities at service, personal, clinical and system levels. Delicate steps relating to education and support can be taken to encourage new and creative ways of addressing the issues highlighted.

Perhaps the final word should go to one of the participants – Monica - who, rightly gave the following observation on institutional, systemic, individual and collective fears:" I *think it is wonderful research to do and I hope you will go on to get findings that can inform changes and policy and psychological therapy practices. I have noticed it can be quite emotional because I wasn't tearful or anything but I could feel that it is part of the fabric, it not something that is embroidered on someone's shirt, it is actually someone's skin, maybe I wasn't aware so thank you for that. I am noticing now more maybe a fear, organisational fear, collective fear, fear that anything like training for cross-cultural encounters and practises.* (Monica: 546-551).

Tne next sesstion will use Yardley's (2000) criteria to assess the validity and quality of this research.

7.2 Validity and quality of the research using Yardley's (2000) four criteria

The present study has sought to address each of Yardley's (2000) four criteria for assessing validity and quality in qualitative research.

7.2.1 Sensitivity to context

To enhance sensitivity in interpretation of participants' accounts, IPA used an idiographic focus on individual context and interviews were conducted in a way that facilitated participants' comfort of disclosure. The researcher showed empathy and was mindful of interactional issues checking for accuracy and using reflexivity which enabled identification of how the researcher role, their cultural, professional and clinical background and their passion for the topic, could impact the research process. During analysis and interpretation, the historical and social and professional contexts were acknowledged and the findings contextualised and compared to the literature.

7.2.2 Commitment and Rigour

Regarding rigour, this research involved and displayed detailed, systematic and careful preparation in each step of the research process namely: crafting of the research question, purposive sampling for reasonable homogeneity (Smith et al. 2009) designing and amending the interview schedule and transcription and analysis of the data. The results signal a commitment to participants' narratives, with an idiographic focus along with more general accounts designed to show where aspects of participants' experiences converged or diverged and all emergent themes were supported by narrative extracts and explored systematically in relation to existing literature in the field.The research process was supported throughout by the consistent guidance and monitoring of a research supervisor, particularly in relation to transcript analysis and extracted themes. This is in accordance with Smith et al.'s (2009) recommendation of independent auditing of research to demonstrate validity of analysis.

7.2.3 Transparency and Coherence

Each part of the research process has been described in detail and conclusions justified using clear, unambiguous language to present a coherent argument. An honest reflexive account of the

researcher's role in the research process has been offered, in line with IPA's methodology (Smith et al. 2009).

7.2.4 Impact and Importance

The findings of the study are personally enlightening and thought-provoking and have highlighted shortcomings in preparation and support for effective cross-cultural/racial therapeutic work which require knowledge, skill and attitudinal changes at personal and systemic levels.

7.2.5 Significance of the study

This research has a number of potential implications for practice. These implications apply to a mixture of clinical therapeutic engagement work, training and supervision with the rationale to improve cultural competence.

Talking about race and culture in therapeutic encounter can be difficult and many psychological therapists in this study felt that they are not adequately trained to do so. This reflects a larger societal difficulty and this constitutes a major gap in the helping professions field (Sue 2015). Ignoring racial and cultural identity in therapy sends indifference and invalidating messages to the receiver of services. In this study, psychological therapists shared their experiences of working cross-culturally and racially, providing them with an opportunity to share their views, methods of therapeutic engagement, personal reflections, difficulties and opportunities. This research demonstrates the need for further improvement from personal, systemic, educational and supervision/support perspectives.

In light of the rarity of research into Psychological therapists' lived experience of cross-cultural/racial therapeutic work and their involvement in clinical and therapeutic engagement work, training and supervision, this study constitutes a pertinent contribution to this under-researched area.

The emergent data reflects the study's more exclusive racial and cultural-balanced sample, an aspect which strengthens the credibility of the domain been explored and provides more detailed and rich data. The merits of this study are the target audience and the exclusivity given to White British and African-Caribbean practitioners. The themes of training and supervision emerge as prominent in the research transcripts as participants spent significant time exploring their lived experience of these issues making suggestions for improvements.

The relative paucity of research on cross-cultural therapeutic work presents a challenge for therapists who require effective training and an adaptive, non-judgemental support system that provides a safe, supportive environment By highlighting the complexity of therapeutic processes when therapists are in cross-cultural encounters, this research constitutes an invitation to training institutions and local mandatory training services to encourage more open dialogue, exposure and experiential learning opportunities.

8 Appendix A: Definitions of terms: Race, Culture, Ethnicity

Culture is a complex phenomenon and is difficult to encapsulate in a brief definition. As Squire (2000) explains, psychologists prefer an anthropological understanding of culture. (Squire 2000:2) states "*...psychologists lean towards a less hierarchical, more anthropological understanding. They look at culture as traditional and communicated meanings and practices, and focus on how* these *meanings and practices are lived individually, how they affect identities...".* Squire (2000) points out that habitually, psychology does not study or treat cultures from 'within' in an anthropological way but looks at culture from the 'outside' and makes comparisons. This cross-cultural style of enquiry rests towards the hypothesis that there are some basic predominant universal commonalities true for all humans and cultures (Triandis 2000b; Triandis & Berry 1980). Culture is therefore a motivating force behind our decision-making. Culture in this study is defined as the customs, attitudes and behavioural characteristics of a specific social group. Hofstede and McCrae (2004) define "culture" as "the collective programming of the mind that distinguishes the members of one group or category of people from others". Hofstede and McCrae (2004) revisited the link between culture and personality traits.

In the psychotherapeutic context, it may be impossible to be effective if one ignores the culture of the individual as this would neglect important individual aspects. A move towards exploring diversity in all its richness, termed a 'new cultural psychology', is presented by Shweder (1990) who suggests looking at people in their cultural context. Within this new framework, Griffin (2000) understands the role of psychological therapists as 'cultural ethnographers', working within the culture and applying psychology to it which would imply the consideration of the individual within his or her cultural background.

8.1 Distinction: race, racism, culture, and ethnicity

It is important to explain these notions and to draw rich distinctions between these in order to develop the understanding of the various opinions and discussions in this study. Ethnicity takes into account both racial and cultural ideas and embraces language and historical backgrounds (Fernando 2010). Ethnicity is best understood when positioned and contextualised and in practical terms, ethnicity is defined as a collection of culture, religion, skin colour, language, and family background (Fernando 2010).

Fernando (2002) offers a shortened definition for each term: race is largely about physical features; culture is of sociological origin; ethnicity is psychological because of its reliance on the identity of the person. Racism may be explained in relation to the habit of stereotyping. People interpret and make sense of the world by organising newly gained information into categories and applying this knowledge in subsequent situations (Calvin 1997).

Eleftheriadou (2006) proposes that stereotypes arise from individual anxiety about both working with people who are different from them and having a narrow ethnocentric worldview. Used here, 'ethnocentric' is described by Eleftheriadou (2006) as the use of the therapist's own culture as a norm against which other people are measured and, within the context in which therapy takes place, each therapist's background and psychological therapy theories all being significant. For instance, therapy models are ingrained in White individualistic Western Eurocentric societies (Orlans & Van Scoyoc 2009) and it is said that Asian, African, Hispanic and other non-Western cultures, and collectivist ideas are not addressed either in current models or in actual therapy (Waldegrave et al. 2003). This lack of consideration is significant. Even though it can be viewed as unintentional racism, it can be as harmful and dangerous as intentional racism (Pilgrim 1997).

In relation to unintentional racism, Owusu-Bempah and Howitt (2000) explored psychological research traditions and found that they both ignore the practices of psychologists and do not

consider the possibility that psychologists could be racist. In light of the power dynamics in the therapy room, discussing cultural differences may appear difficult and potentially antagonistic (Lago & Thompson 2003; Lago, 2010), which perhaps explains why it is sometimes avoided. Richards (1997) labels Freud and Jung as 'alleged racists', as they present some cultures as 'primitive' and others 'civilised'. As psychological therapy is at least partly informed by the work of Freud and Jung (Woolfe et al. 2006), it is important to give close inspection to the roles of culture and race in practice. Race is socially constructed and has implications for psychological therapy in terms of shaping therapy (Pope-Davis and Liu, 1998).

This added cultural and racial dimension is important in view of Greene's (2005) social constructionist argument. Greene (2005) elucidates that the power of the privileged few is reinforced by a lack of openness about diversity of any kind. This needs to avoid addressing difference stems from the therapist's shame and guilt at some level (Greene 2005). Shame and guilt stem from racism's socially constructed nature and due to this, racism inevitably enters the therapy room, alienating the client and making the therapist anxious (Moodley 2005).

Moodley (2005) scrutinises the utility of exploring transference and counter-transference as a traditional psychodynamic way of dealing with feelings in the therapeutic dyad and warns that this is not enough.

There is a need for professionals to take their time to understand the belief systems, values, and traditions that are different from their own (Hughes 2006). Alladin (2002) argues that it is vital for the psychological therapist to use a model of cultural identity in order to understand what can hinder and promote effective therapeutic relationship and outcome. Many Black African countries, for example, are affected by the effect of colonisation, that their culture has become progressively diluted, and that it can be difficult to encounter a pure traditional Black African culture. The obvious challenge when practising psychotherapy involves dealing with clients who present with conflict in their life resulting from cultural clashes, because they may never be acculturated or enculturated in

one pure culture. Failing to understand this and mistakenly assuming that all individuals are free to engage in Western or Black African world ways of thinking and have the knowledge required to comprehend and engage in treatment, can hinder effective therapeutic work.

In this study, ethnicity, or ethnic group, refers to a category of people who regard themselves to be different from other groups based on common ancestral, cultural, racial, national, and social experience. Ethnicity is primarily an inherited status. One must share a common cultural heritage, ancestry, history, homeland, language/dialect, mythology, ritual, cuisine, art, religion, race and physical appearance to be considered a member of an ethnic group. For the purposes of this study the term ethnicity has also been used, as it captures an individual's sense of identity and belonging, reflecting both culture and race (Fernando, 2010; Palmer, 2002) and thus will affect how people present themselves and relate to others, in this case, within the therapeutic process.

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9 Appendix B: Search process and selected articles

9.1 Building a search for each database

Search terms 1: psychologist OR counsellor OR psychotherapist OR clinical psychologist OR counselling psychologist OR therapist

Search term 2: cross-cultural therapy OR cross-cultural differences OR cross-racial therapy OR multicultural counselling

Search term 3: therapeutic engagement OR therapeutic relationship OR cultural competence OR cultural awareness

Search term 4: training OR supervision OR support OR Learning

Search on the 20/12/2020	**Delphis**	**CINAHL**	**MEDLINE**	**PsychINFO**	**Total**
Search terms 1: Psychologist OR counsellor OR psychotherapist OR clinical psychologist OR counselling psychologist OR therapist	1,296,803	89,112	62,231	264,042	1,712,188
Search term 2: Cross-cultural therapy OR Cross-cultural differences OR Cross-racial	171,950	2,913	13,361	63,203	251,427

therapy OR Multicultural counselling					
Search term 3: Therapeutic engagement OR Therapeutic relationship OR Cultural competence OR Cultural awareness	687,950	54,073	227,803	66,544	1,036,370
Search term 4: Training OR Supervision OR Support OR Learning	22,770,890	769,842	2,099,065	1,371,746	27,011,543
S5= COMBINE S1 AND S2 Duplicate removed	9889	220	336	4,512	14,957
S6= COMBINE S3 AND S4	142.970	10,916	23,437	21,755	199,847
S7= COMBINE S5 AND S6	575	39	29	126	769
STUDIES RELEVANT TO RESEARCH QUESTION FOLLOWING EXCLUSION	12	5	4	10	

9.2 Selected articles and highlights of the methodology, participants, the settings, the outcomes measure and limitations

	Study	Methods	Participants	Intervention	Key findings	Limitations
1	Bassey, S. and Melluish, S. (2012) Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: A template analysis focus study, *Counselling Psychology Quarterly,* 25(3), pp. 223–238.	Focus group	participants from three psychological therapy services.	Focus groups using a semi-structured interview. The interviews were recorded and transcribed, and the data analysed using template analysis.	Therapists can work in a culturally sensitive way without a comprehensive training based on cultural competence guidance. To be able to draw on personal and professional cultural experience may be a primary contributor to cultural competence. Training can augment experience and suggestions are made for how it may be improved	No clear indication of the race of therapist and possible colour blindness
2	Spalding, B., Grove, J., and Rolfe, A. (2018) *An exploration of Black, Asian and Minority Ethnic counsellors' experiences of working with White clients,*	Qualitative thematic analysis.	Eight BAME participants	semi-structured interviews which were analysed using counselling room, and developing ways of managing and working with these issues.	There were three overarching themes: Training as colour blind; Experiencing client reactions; and Working with "race" in the counselling process. These form a	a small-scale study and further research is needed, extending this to a wider geographical area, and using this to inform the development of more inclusive training programmes.

	Counselling and Psychotherapy Research, 19(1), pp. 75-82.				narrative in which participants commonly described inadequate training around "race" and culture, then dealing with the experience of encountering issues of "race" as they present in the room.	
3	Burkard, A. W., Knox, S., Groen, M., Perez, M. and Hess, S. (2006a) European-American therapist self-disclosure in cross-cultural counseling, *Journal of Counseling Psychology* 53, pp. 15–25	consensual qualitative research.	Eleven European American psychotherapists	use of self-disclosure in cross-cultural counselling was studied using consensual qualitative research	Results indicated that therapists typically shared their reactions to clients' experiences of racism or oppression and that these self-disclosures typically had positive effects in therapy, often improving the counselling relationship by helping clients feel understood and enabling clients to advance to other important issues.	Over reliance on self-disclosure possible biases
4	Burkard, A. and Knox, S. (2004). Effect of therapist color-blindness on empathy and attributions in cross-cultural counseling, *Journal of Counseling Psychology*, 51(4), pp. 387–397.	Qualitative Vignette case studies	Empathy and attributions of client responsibility for the cause of and solution to a problem were examined for 247 psychologists who were identified as having low, moderate, and high colour-blind racial attitudes.	Participants responded to 1 of 4 vignettes that controlled for client race (i.e., African American, European American) and client attributions regarding the cause (i.e., depression, discrimination) of a problem.	Analyses revealed that the therapists' level of colour-blindness was directly related to their capacity for empathy and also to their attributions of responsibility for the solution to the problem with an African American client but not with a European American client. No relationship was found between therapist colour-blindness and attributions of responsibility for cause of the problem.	Unclear strategies for identification of level of colour blindness.
5	Cabral, R. C. and Smith. T. B. (2011) Racial/ethnic matching of	Meta-analysis	Across 52 studies of preferences		Across 52 studies the average effect size (Cohen's d) was	

	clients and therapist in mental health services: a meta-analytic review of preferences, perceptions and outcomes, *Journal of Counseling Psychology 58 (4), pp. 537-554*		. Across 81 studies of individuals' perceptions of therapists Across 53 studies of client outcomes in mental health treatment,	conducted a meta-analysis of 3 variables frequently used in research on racial/ethnic matching: individuals' preferences for a therapist of their own race/ethnicity, clients' perceptions of therapists across-racial/ethnic match, and therapeutic outcomes across-racial/ethnic match.	0.63, indicating a moderately strong preference for a therapist of one's own race/ethnicity. Across 81 studies of individuals' perceptions of therapists, the average effect size was 0.32, indicating a tendency to perceive therapists of one's own race/ethnicity somewhat more positively than other therapists. Across 53 studies of client outcomes in mental health treatment, the average effect size was 0.09, indicating almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists.	The effects of racial/ethnic matching are highly variable. Studies involving African American participants demonstrated the highest effect sizes across all 3 types of e valuations: preferences, perceptions, and outcomes. No rationale an explanation is given for the highest effect on African American participants.
6	Soto, A., Smith, T. B., Griner, D., Domenech, R. M. and Bernal, G. (2018) Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews, *Journal of Counseling Psychology*, 74(11), pp. 1907-1923.	Meta-analyses	First: examining culturally adapted interventions, the average effect size across 99 studies Second meta-analysis on 15 studies of therapist cultural competence, the results differed by rating source:	summarize relevant research findings in two meta-analyses. In the meta-analysis examining culturally adapted interventions, the average effect size across 99 studies	Average effect size of the 99 studies was d = 0.50 (0.35 after accounting for publication bias). Second meta-analysis on 15 studies Client-rated measures of therapist cultural competence correlated strongly (r = 0.38) with treatment outcomes but therapists' self-rated competency did not (r = 0.06).	Overreliance on self-rating and possible biases

					research supported therapeutic practices that help clients benefit from modifications to treatment related to culture.	
7	Imel, Z.E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T. and Wampold, B. E. (2011) Racial/ethnic disparities in therapist effectiveness: a conceptualization and initial study of cultural competence, *Journal of Counseling Psychology* 58(3), pp.290-298.	Psychotherapy trial	Analyzed cannabis use outcomes from a psychotherapy trial (N = 582) for adolescent cannabis abuse and dependence using Bayesian multilevel models for count outcomes	Analyzed cannabis use outcomes from a psychotherapy trial (N = 582) for adolescent cannabis abuse and dependence using Bayesian multilevel models for count outcomes. First tested whether therapists differed in their effectiveness and then tested whether disparities in treatment outcomes varied across therapist caseloads.	Results suggested that therapists differed in their effectiveness in general and that effectiveness varied according to client racial/ethnic background. Therapist effectiveness may depend partially on client racial/ethnic minority background, providing evidence that it is valid to distinguish between general and cultural competence.	No rationale was given for the differences observed
8	Hayes, J. A., McAleavey, A. A., Castonguay, L. G. and Locke, B. D. (2016) Psychotherapists' outcomes with White and racial/ethnic minority clients: First, the good news, *Journal of Counseling Psychology*, 63(3), pp.261-268.	Trial	A sample of 3,825 clients seen by 251 therapists at 45 college counselling centres completed the Centre Counselling Assessment of Psychological Symptoms at the beginning and end of individual psychotherapy.	Cultural competence	Therapists differed in their effectiveness at reducing general distress across clients, and evidence was found for disparities within therapists' caseloads in their effectiveness with REM and White clients. Effect sizes were small. Disparities within therapists' caseloads were not a function of any therapist variable that was studied. Therapy outcomes were similar for White and REM clients. Therapist multicultural competence can, and should, be considered in terms of	The purposes of this study were to (a) investigate whether psychotherapists differ in their effectiveness with clients, (b) determine whether disparities exist within therapists' caseloads in their outcomes with White and racial and ethnic minority (REM) clients, (c) explore therapist factors that might contribute to observed therapist effects, and (d) identify whether treatment outcomes varied for REM and White clients. The client's number is higher than therapist one. Overreliance on self-report.

					measurable outcomes across client racial/ethnic groups. It is possible to identify multiculturally expert therapists who evidence competence with both REM and White clients and who might serve as models from whom the field could learn.	
9	Fuertes, J.N., Stracuzzi, T.I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersch, M. and Cheng, H. (2006) Therapist multicultural Competency: A study of therapy dyads, *Psychotherapy: Theory, Research, Practice & Training*, 43(4), pp. 480-490.	Questionnaire studies	Fifty-one therapy dyads completed measures of therapist multicultural competency, working alliance, and their satisfaction with therapy. Clients also completed measures of therapist attractiveness, expertness, trustworthiness, and empathy	This study examined the role of therapist multicultural competence (TMC).	Results showed strong associations between clients' ratings of TMC and ratings of the working alliance, therapist empathy, and satisfaction. Clients' combined rating of therapist expertness, attractiveness, and trustworthiness were not associated with their TMC ratings but were significantly associated with therapists' self-appraised TMC ratings. Therapists' ratings of their TMC were associated with their ratings of the working alliance and satisfaction with their work.	Reliance on self-reported questionnaires
10	Hare, E. J. (2015) *"Talking about race: how do White clinicians engage in dialogue about race in cross-racial therapy with Black clients?"* Master's Thesis, Smith College, Northampton, MA. https://scholarworks.smith.edu/theses/694	Qualitative study Doctorate Thesis	Open-ended survey questions were used to gather narrative data from 12 White clinicians who have conducted therapy with Black clients. The central question of this research study is: when, how and why do White	The study investigates how White clinicians think about their choices to broach the subject of race and their perceptions of the therapeutic alliance as it relates to conversations about race and racial difference. It also explores White clinicians'	The study found that the White clinicians surveyed made a variety of choices regarding talking about race in therapy with their Black clients. While all clinicians surveyed felt it is important to talk about race in therapy, the findings revealed important	Sample only included White clinicians and not Black clinician working with White client to compare outcome.

			clinicians engage in dialogue about race in cross-racial therapy with Black clients?	motivations regarding not broaching the subject of race, why they choose not to broach and how they perceive this choice as impacting the therapeutic alliance.	differences in the choices they made as to how, when and why to talk about race in therapy with Black clients. These clinical decisions reflect a range of practices and beliefs including whether to take responsibility for broaching the subject of race, when in the process of therapy to broach the subject of race, and whether to talk about one's own race in the therapy.	
11	Kanakam, N. (2020) *Exploring Therapists Reflective Experiences of Working with British Ethnic Minorities with Eating* Disorders. Prof Doc Thesis University of East London School of Psychology. https://doi.org/10.15123/uel.88829	Qualitative study Doctorate Thesis	Semi-structured interviews were conducted with 12 therapists in the UK, London and thematic analysis was used to analyse the data.	thematic analysis was used to analyse the data.	Shame was often cited as a barrier to accessing help. This had different influences on their therapeutic work, such as not questioning shame or linking this to a negative interpretation of parents. There was also the concept that ethnic minorities were more likely to present with emotional and interpersonal factors fuelling the ED, although this conflicted with the notion of the Western body ideal being an influence. Participants also revealed a feeling of being restricted by service management, having a limited time to reflect on cultural issues, and the worry about being offensive or doing something wrong.	Subtle steps can be taken to encourage new and creative ways of addressing the issues highlighted. Services and guidelines should support therapists through regular reflective practice on cultural issues. Hierarchy in teams could be addressed by encouraging diversity in decision making. To break down the perceived barrier of shame, the use of cultural genograms and cultural scripts could be encouraged to understand the ED context

12	Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A. and Ponterotto, J. G. (2003) African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads, *Journal of Counseling Psychology, 50*(4), pp. 466–481.	Qualitative study	Using Consensual Qualitative Research, 12 licensed psychologists' overall experiences addressing race in psychotherapy	Using Consensual Qualitative Research, 12 licensed psychologists' overall experiences addressing race in psychotherapy were investigated, as were their experiences addressing race in a specific cross-racial therapy dyad.	Results indicated that only African American psychologists reported routinely addressing race with clients of colour or when race was part of a client's presenting concern. European American psychologists indicated that they would address race if clients raised the topic, and some reported that they did not normally address race with racially different clients. When discussing a specific cross-racial dyad, African American therapists more often than European American therapists addressed race because they perceived client discomfort. Only European American therapists reported feeling uncomfortable addressing race, but therapists of both races perceived that such discussions had positive effects.	No comments of factors therapist fund helpful or unhelpful
13	Neville, H., Spanierman, L. and Doan, B. T. (2006) Exploring the association between color-blind racial ideology and multicultural competencies, *Cultural Diversity and Ethnic Minority Psychology*, 12(2), pp. 275–290.	Questionnaire study	The authors examined the association between color-blind racial ideology and self-reported multicultural Multicultural counselling competencies in 130 applied psychology students and mental health worker	Multicultural counselling competence. Exploring the association between color-blind racial ideology and multicultural competencies.	s. Results from 1 sample (n = 79) indicated that greater levels of color-blind racial ideology as measured by the Color-Blind Racial Attitudes Scale (Neville, Lilly, Duran, Lee, & Browne, 2000) were (1) related to	Overreliance on self-reporting questionnaires

			Sample 1: N=79 Sample 2: N= 51		lower self-reported multicultural awareness and knowledge as measured by the Multicultural Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) and (2) accounted for a significant amount of variance in MCKAS scores over and above that explained by self-reported multicultural training, social desirability, and participant race. Findings from another sample also provided empirical support for the link between higher color-blind racial ideology and lower multicultural case conceptualization ability (n = 51), after controlling for the influence of the number of multicultural course(s) taken. Implications of the findings and future directions are provided	
14	Dos Santos, O. and Dallos, R. (2012) The Process of Cross-Cultural Therapy between White Therapists and Clients of African-Caribbean Descent, *Qualitative Research in Psychology* 9(1), pp. 62-74.	Qualitative study Thematic analysis	Three British African-Caribbean psychotherapy clients and their White British therapists took part in one-to-one interviews.	This study explores clients' and therapists' experiences of cross-cultural psychological therapy with specific reference to issues of race and culture A thematic analysis was conducted on their interview transcripts; this drew on	The therapists described the demands of having to be vigilant about political incorrectness and balanced this against their positive identification with the client group. The clients described an unspoken rule ("no race talk in therapy") and outlined	It is argued that dominant cultural discourses minimise or prevent race and culture conversations from taking place in therapy. While the strategies used by participants seemed to enable them to maintain a positive therapeutic relationship and attend to the tasks of therapy, the absence of open

				social constructionist principles to focus on patterns of meaning in the participants' accounts	their strategies for distancing their "racial" selves from the therapy in order to make sense of their therapeutic experiences.	discussion excluded fundamental aspects of the client's identity from the therapeutic milieu
15	Price, T. A. (2015) "T*he Black Therapist-White Client Dyad: The Relationship Between Black Racial Identity and Countertransference*". Theses and Dissertations. 2769. http://preserve.lehigh.edu/etd/2769	Qualitative and mixed method design Questionnaires	A multivariate multiple regression analysis was proposed to examine the first research question; however, this analysis was not conducted due to an insufficiently low sample size (N=28). To examine the second research question, the Discovery-Oriented Approach (Mahrer, 1988) was utilized with qualitative responses from 27 therapist participants	Utilizing a mixed-method design, two research questions guided the present study: (a) Does Black racial identity predict countertransference reactions experienced by Black therapists when working with White clients? (b) What are the benefits and challenges that Black therapists self-report when working with White clients?	On the Black Racial Identity Attitudes Scale (Helms, 1990), mean comparisons did not appear to vary significantly based on themes; however, participants generally had high scores on the Internalization subscale. On the Therapist Response Questionnaire (Betan et al.., 2005), means were generally low across themes, with the exception of Positive countertransference. These results may suggest that participants in this sample had positive, stable racial identity and that these therapists enjoyed their work with White clients regardless of challenges faced. Qualitative results highlighted 29 themes regarding the impact of racial dynamics on the counselling process. Findings from the present study highlight the benefits and challenges Black therapists encounter when working in cross-racial dyads	Analysis of first sample not done due to low sample. Therapist self-report

					and provide implications for multicultural training	
16	Utsey, S. O., Gernat, C. A. and Hammar, L. (2005) Examining White counselor trainees' reactions to racial issues in a supervision dyad, *The Counseling Psychologist*, 33, pp. 449–478.	Qualitative study Focus Group	Working with a sample of 8 White male and female counsellor trainees, a focus group interview was conducted using vignettes that depicted racial issues in counselling and supervision situations.	This study examined the reactions of White counsellor trainees to hypothetical, provocative, cross-racial counselling and supervision dyads. It employed a qualitative methodology of inquiry to explore the underlying dynamics associated with cross-racial counselling and supervision dyads.	The focus group interview was transcribed, and themes and categories that captured the complexity of the trainees' reactions to racially charged situations in counselling and supervision were identified.	Little clarification on the content of this complex experience from trainee.
17	Zhang, N. & Burkard, A. W. (2008) Discussions of racial difference and the effect on client ratings of the working alliance and counsellor credibility, *Journal of Multicultural Counseling and Development*, 36, pp. 77-88.	Qualitative Survey	Fifty-one clients were surveyed	examine the effect of counsellor discussion of racial and ethnic differences in counselling.	Analyses revealed that White counsellors who discussed these differences with their clients of colour were rated as more credible and as having stronger working alliances than those who did not discuss such differences.	No indication on how to have these race discussions and the skills needed
18	Rathod, S., Kingdon, D., Phiri, P. and Gobbi, M. (2010) Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions, *Behavioural cognitive psychotherapy*, 38(5), pp. 511-53	Qualitative Study Data were analyzed thematically using evolving themes and content analysis	This two-centre (Hampshire and West London) qualitative study consisted of individual semi-structured interviews with patients with schizophrenia (n = 15); focus groups with lay members from selected ethnic communities (n = 52); focus groups or semi-structured interviews with CBT therapists (n = 22); and mental health practitioners who work with patients	The main aim of the study was to produce a culturally sensitive adaption of an existing CBT manual for therapists working with patients with psychosis from specified ethnic minority communities (African-Caribbean, Black-African/Black British, and South Asian Muslims). This will be based on gaining meaningful understanding of the way members (lay and	There was consensus from the respondent groups that CBT would be an acceptable treatment if culturally adapted. This would incorporate culturally-based patient health beliefs, attributions concerning psychosis, attention to help seeking pathways, and technical adjustments	Study associated with the experience of psychosis

			from the ethnic communities (n = 25). NVivo 8 was used to manage and explore data.	service users) of these minority communities typically view psychosis, its origin and management including their cultural influences, values and attitudes.		
19	Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D. A., Kozlowski, J. M., Hess, S. A. and Knox, S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision, *Journal of Counseling Psychology*, 53(3), pp. 288–301.	Consensual qualitative research	13supervisees' of colour and 13 European American supervisees'	experiences of culturally responsive and unresponsive cross-cultural supervision were studied using consensual qualitative research	In culturally responsive supervision, all supervisees felt supported for exploring cultural issues, which positively affected the supervisee, the supervision relationship, and client outcomes. In culturally unresponsive supervision, cultural issues were ignored, actively discounted, or dismissed by supervisors, which negatively affected the supervisee, the relationship, and/or client outcomes.	European American supervisees and supervisees of colour experiences diverged significantly, with supervisees of colour experiencing unresponsiveness more frequently and with more negative effects than European American supervisees No explanation for the disparity in experience
20	Chopra, T. (2013) All supervision is multicultural: A review of literature on the need for multicultural supervision in counselling. *Psychological Studies, 58*(3), pp. 335–338.	Literature review Case example	reviews current research literature on cross-cultural supervision	This paper discusses several aspects of multicultural supervision	it is important to be competent in multicultural supervision. The paper also describes the roles of the supervisor and supervision techniques that facilitate multicultural supervision. A Case example is provided for a better conceptualization of the techniques involved in multicultural supervision.	Case example not strong enough

21	Constantine, M. G., Warren, A. K. and Miville, M. L. (2005) White Racial Identity Dyadic Interactions in Supervision: Implications for Supervisees' Multicultural Competence, *Journal of Counselling Psychology*, 52(4), pp. 490–496	Qualitative Enquiry	Examining supervisory dyads consisting of a White supervisor and a White supervisee,	the authors sought to determine the effects of similarities and differences in levels of supervisor and supervisee racial identity schemas or attitudes on White supervisees' self-reported multicultural counselling competence and multicultural case conceptualization ability	White supervisees in supervision dyads characterized by more advanced White racial identity schemas reported higher self-perceived multicultural counselling competence and obtained higher multicultural case conceptualization ratings than did their counterparts in supervision dyads characterized by lower White racial identity schemas	Study only involving White supervisor and White supervisee
22	Hird, J. S., Tao, K. W. and Gloria, A. M. (2004) Examining Supervisors' Multicultural Competence in Racially Similar and Different Supervision Dyads, *The Clinical Supervisor, 23*(2), pp.107–12	Qualitative Study	White and racial/ethnic minority (REM) supervisors in racially similar and different su pervisor-supervisee dyads	This study examined differences in multicultural supervision competence between White and racial/ethnic minority (REM) supervisors in racially similar and different supervisor-supervisee dyads	Overall, REM supervisors reported more multicultural supervision competence than White supervisors. In racially similar dyads, REM supervisors spent significantly more time addressing cultural issues in supervision than White supervisors. White supervisors also discussed cultural issues significantly more with racially different supervisees than racially similar supervisees. Supervisors differed in which cultural issues they discussed and considered applicable to supervision	Little reference made regarding Black supervisor and White supervisee experience.
23	Toporek, R. L., Ortega-Villalobos, L.. and Pope-Davis, D. B. (2004) Critical Incidents in Multicultural Supervision: Exploring Supervisees' and Supervisors'	Qualitative Report study	Supervisors and supervisee	Reports of supervisors' and supervisees' critical incidents in multicultural supervision were used to (a) explore events in supervision that	Mixed finding in experience	Little context with regard to same dyad and patient discussed is from a different culture

	Experiences, *Journal of Multicultural and Development, 32*(2), pp.66–83.			influenced supervisees' multicultural competence, (b) explore how supervision was experienced differently by supervisors and supervisees, and (c) identify recommendations for improving multicultural supervision		
24	Adetimole, F., Afuape, T. and Vara, R. (2005) The impact of racism on the experience of training on a clinical psychology course: Reflections from three Black trainees, *Clinical Psychology Forum*, 48, pp.11-15.	Qualitative reflection	Three female clinical psychologists who identify themselves as Black and who qualified from the same course at different times within the last two years reflect on how insidious racism impacted on them as Black trainees	Three female clinical psychologists who identify themselves as Black and who qualified from the same course at different times within the last two years reflect on how insidious racism impacted on them as Black trainees	The paper outlines key experiences and provides recommendations for training courses, professional bodies and all clinical psychologists.	Small sample
25	Lee, A. and Khawaja, N. G. (2012) Multicultural training experiences as predictors of psychology students' cultural competence, *Australian Psychologist*, 48, pp.209–216.	Online Survey	One hundred twenty-seven postgraduate clinical psychology students completed an online survey battery that included demographic information, a social desirability measure, and the Multicultural Mental Health Awareness Scale.	The study examined factors contributing to trainee psychologists' perceived level of cultural competence. It was hypothesised that multicultural teaching, clinical experience, and supervision would be related to students' level of cultural competence.	Clinical experience and supervision focusing on multicultural issues were found to be related to participants' perceived cultural competence; however, multicultural teaching was not. These results provide insight into how universities around Australia can facilitate future psychologists' competence in working with clients from different cultural backgrounds.	Mixed findings
26	Martin, P. A. (2015) Cultural awareness in two UK Counselling Psychology settings: Initial	Questionnaire study	Both were sent out to UK Psychologists between March and May 2013.	This paper addresses this topic in a Counselling Psychology context by	The results of the training questionnaire indicated a varied coverage of the syllabi	Study did not address didactic materials and ways to deliver training

	Training and supervision, *The European Journal of Counselling Psychology 3 (2), pp.99-112*	Two questionnaires sent	14 UK Counselling Psychology training institutions. This was sent to all 3000 BPS Division members.	presenting and discussing two separate questionnaires. The first on cultural awareness provision in training was sent to all 14 UK Counselling Psychology training institutions. The second questionnaire related to the experience of supervising or being supervised in the context of "cultural awareness". This was sent to all 3000 BPS Division members. The purpose of the questionnaires was to find out about current practice, opinions, attitudes and perceived problems as they relate to cultural awareness.	from being inherent in the philosophy of a training course, to being a specifically targeted area of teaching and learning. The chief problem in offering such teaching is lack of time on the syllabus. Experience of supervision was also very varied, and ranged from cultural issues being dealt with in great depth, to the experience of such issues being ignored.	
27	Pieterse, A., Evans, S., Risner-Butner, A., Collins, N. and Mason, L. B. (2009). Multicultural Competence and Social Justice Training in Counselling Psychology and Counsellor Education: A review and analysis of a sample of multicultural course syllabi, *The Counselling Psychologist,* 37(1), pp.93-115	Descriptive content analysis	54 multicultural and diversity-related course syllabi	Article presents the findings of a descriptive content analysis of 54 multicultural and diversity-related course syllabi drawn from counselling and counselling psychology programs accredited by the American Psychological Association and the Accreditation of Counselling and Related Programs.	Results suggest that most courses adhere to the knowledge, awareness, and skills paradigm of multicultural competence. However, actual course content varies considerably. Whereas the findings identify social justice content as a growing presence in multicultural courses, there is a need to more clearly outline the fundamental points of distinction and overlap between multicultural competence and social justice advocacy in counsellor and	Focus on course content as oppose to didactic learning and skills acquisition

					counselling psychology training.	
28	Prosek, E. A. and Michel, R. E. (2016) Transformative Learning for Counsellor Trainees: Implementation of the Multicultural Immersion Experience Model, *International Journal for the Advancement of Counselling 38*, pp.61–76	Qualitative enquiry	counsellor trainees who participated in a short-term study abroad program in Dublin, Ireland	studied the lived experiences of counsellor trainees who participated in a short-term study abroad program in Dublin, Ireland	It was found that counsellor trainees self-reported transformative growth as a result of their cultural immersion. Specifically, counsellor trainees identified an increase in cultural self-awareness, other awareness, and global connection. The implications of applying transformative learning theory and the Multicultural Immersion Experience model to guide cultural immersion programs are discussed.	Reliance on Self-reporting
29	Niño, A. and Kissil, K. (2016) Strategies Used by Foreign-Born Family Therapists to Connect Across-cultural Differences: A Thematic Analysis, J*ournal of Marital & Family Therapy* 42(1), pp.123-138.	Thematic analysis	13 foreign-born therapists	A thematic analysis conducted to understand strategies 13 foreign-born therapists used during therapeutic encounter s	Four themes were identified: making therapy a human-to-human connection, dealing with stereotypes, what really matters, and flexibility. Findings suggest that developing a deep therapeutic connection using emotional attunement and human-to human engagement is crucial for successful cross-cultural therapy.	No indication o how to establish the human connection
30	Chang, D. F. and Yoon, P. (2011) Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships,	consensual qualitative research study,	23 ethnic minority clients were interviewed to assess perceptions of race in their recent therapy with a White therapist	In this consensual qualitative research study, 23 ethnic minority clients were interviewed to assess perceptions of race in their recent therapy with a	The majority believed that White therapists could not understand key aspects of their experiences and subsequently avoided broaching racial/cultural issue	Results suggest that participants' constructions of race are multidimensional little indication on how to acquire the skills

	Psychotherapy Research 21(5), pp. 567-582.			White therapist. Participants' responses were coded into an average of seven (out of 22) categories.	s in therapy. However, many felt that racial differences were minimized if the therapist was compassionate, accepting, and comfortable discussing racial, ethnic and/or cultural (REC) issues. A subgroup expressed positive expectancies of racial mismatch, and perceived disadvantages associated with racial matching	
31	Constantine, M.G., Melincoff, D.S., Barakett, M. D., Torino, G.C, and Warren, A. K. (2004) Experiences and perceptions of multicultural counselling scholars: a qualitative examination *Counselling Psychology Quarterly* 17(4), pp. 375-393.	Qualitative analysis	12 multicultural counselling scholars	This study explored the experiences and perceptions of 12 multicultural counselling scholars with regard to the field of multicultural counselling.	many of our participants noted that aspects of being a multiculturally competent counsellor included open-mindedness, flexibility, a commitment to the field, active listening, knowledge and awareness of cultural issues, skilfulness in making cultural interventions, commitment to social justice issues, self-awareness, and exposure to broad and diverse life experiences. Most of the participants also stated that a challenge associated with being a multicultural psychologist was colleagues', institutions', and others' resistance toward and lackof support for multicultural counselling issues.	No indication of race variation f counsellors

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Appendix C: Participant Information Sheet

Study Title: *Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work.*

Researcher: [redacted]

I am a Black African Psychological therapist and a self-funded Clinical Practice doctoral student at Southampton University (School of health sciences). I am interested in understanding the experience of White British psychological therapists working with African-Caribbean clients and the experience of African-Caribbean psychological therapists working with White British clients. My interest in this area comes from my own experience of being a psychological therapist to clients from other race/ethnic/cultures.

ERGO number: **48571**

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

The purpose of this study is to investigate the lived experience of psychological therapists in a cross-racial/ethnic/cultural therapeutic work. The study involves interviews with accredited psychological therapists who are currently working with one NHS Trust in the UK. This research will highlight the different experiences of the psychological therapists when working therapeutically in the cross-racial/ethnic dyad. The study aims to explore the experiences of race, ethnicity, culture of African-Caribbean and White British practising psychological therapists. Specifically, the study aims to explore these understandings by focusing on clinicians' experiences of the working alliance, therapy process and techniques, supervision and training when working with racially dissimilar clients. The aim is to gain better understanding of how race/ethnicity/culture is experienced by psychological therapists, within the clinical space.

The experiences of psychological therapists could contribute to awareness on factors that might hinder or improve the cross-racial/ethnic/cultural therapeutic/treatment process, which in turn might foster effective engagement and therapeutic outcomes. This study will help to advance training for a better delivery of psychological therapies in the cross-racial and ethnic dyad. There is currently very little research exploring the experience of Psychological therapists in the cross-racial therapeutic dyad and with culturally specific groups.

Why have I been asked to participate?
You have been chosen because you are an accredited African-Caribbean psychological therapist or a White British Psychological therapist with experience of working therapeutically and respectively with White British clients and African-Caribbean clients. By developing our understanding of the experiences of psychological therapists, the field of psychological therapy will help gain a more extensive understanding of challenges and opportunity in cross-racial/ethnic/cultural therapeutic work.

What will happen to me if I take part?
If you decide to take part in this study, you will be interviewed about your experience of cross-racial/cultural therapeutic work. The interview will last approximately between 60 minutes. You will be asked to sign a consent form. The interview will be audio recorded and securely stored. The interview will take place at a time and place that is convenient to you. The place should be quiet and where it is possible to hold a private conversation. Your responses will be anonymised and collated with all other responses by the researcher, in order to evaluate various perspectives and lived experiences. You will be given the opportunity the check-out your answers and make amendment after transcription of the interview data.

Are there any benefits in my taking part?
Your involvement will help us to better understand cross-racial therapeutic work and contribute to research in this area. Taking part in this study may also provide an opportunity for you to reflect on your experience and perhaps gain new perspectives and insights, which might also facilitate reflection on your own current practice.

Are there any risks involved?
This research will use your valuable time. It is not anticipated that the project will in any way cause distress to participants. However, the area of cross-racial therapeutic work is sensitive. You may experience a re-emergence of emotions relating to your experience or you may be reminded of difficult events or experiences that you have not thought about for some time. Nevertheless, the opportunity to reflect one one's work can be therapeutic and beneficial.

What data will be collected?
The corpus Data will include transcripts from audio recorded interviews, demographic information and the consent form. All information collected about you during the course of the research will be kept strictly confidential. There will be a limited number of people (supervisors) who may have access to the data and will also adhere to the confidentiality principles. No names or identifying characteristics will be used or any information that may lead to any participant being identified. Each interview will be matched with a unique ID, so as to ensure identification of a particular interview within the sample, but will neither contain participants' names nor initials. Your contribution will not be identifiable. All data produced from the interviews will have identifying data removed and any documents with participant information will be stored securely in a locked filing cabinet. The information that you do provide will be used to explore the phenomenon of cross-racial therapeutic encounters and may be used for publication in academic journals. It might be important to look at the data in years to come, so we will keep it

for ten years and then it will be destroyed. The information that you share will remain confidential. The research will adhere to the Data Protection Act (2018) and the University of Southampton Policies and Procedures with records to data protection and confidentiality. The analysed data will be anonymous. In terms of storage of data, such as interview recordings, transcripts, and demographic information, these will be kept in a locked cabinet at my NHS place of work. Interviews will be transferred anonymously to electronic data information spreadsheets, and all data will be stored on a password-protected computer, to which the researcher has sole access, with the original data being destroyed after the completion of the thesis and after 10 years.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential. Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential. Your contribution will not be identifiable. All data produced from the interviews will have identifying data removed and any documents with participant information will be stored securely in a locked filing cabinet. The research will adhere to the Data Protection Act (2018) and the University of Southampton Policies and Procedures with records to data protection and confidentiality. In terms of storage of data, such as interview recordings, transcripts, and demographic information, these will be in a locked cabinet. Interviews will be transferred anonymously to electronic data information spreadsheets, and all data will be stored on a password-protected computer.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part. If you want to take part, please email me with your contact details, so I can send you further information on the study. I will also send you two copies of the consent form – one copy for you to keep for your records and the other copy to sign and return to me.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. Your participation in this research is voluntary. If you decide to take part you may terminate the interview or audio recording at any time, decline to answer any questions and withdraw at any time without justifying your decision. Please be informed that you may also read a copy of your interview transcript if requested. I will ask that you complete a consent form on the day of the interview and this will be accepted as your informed decision to participate. If you withdraw from the study, we will keep the information about you that we have already obtained for the purposes of achieving the objectives of the study only.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent. The results help raise awareness on factors that might hinder or improve the cross-racial/ethnic/cultural therapeutic/treatment process, which in turn might foster effective engagement and therapeutic outcomes. This study will help to advance training for a better delivery of psychological therapies in the cross-racial and ethnic dyad. The results will be published in university and academic journals.

Where can I get more information?

If you would like to participate in the study, please contact me. The details are shown below. If you have any questions about participation, or any other queries, please do not hesitate to raise this with me. However, if you would like to contact an independent party please contact my supervisor.

Supervisors of study contact details

[redacted]

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.
If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable

information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

Thank you for taking time to read the information and considering taking part into the research.

11 Appendix D: Consent form

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[Date 14/06/19] [Version1] *ERGO number*: **485171** *IRAS Project ID:* **265102**

CONSENT FORM

Study title: *Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work*

Researcher name: [redacted]
Participant Identification Number*: TBC*

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (*insert date /version no. of participant information sheet*) about the study in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand that a recording is being made of this interview and will be securely stored until the research is completed, after which, the recording will be cleared.	
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the research has been completed	
I understand that I may be quoted directly in reports of the research but that I will not be directly identified (e.g. that my name will not be used).	
I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the research (within two months) without disadvantage to myself and without being obliged to give any reason.	

Name of participant (print name) …….
Signature of participant……...
Date……
Name of researcher (print name) ……
Signature of researcher……
Date……

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Appendix E: Recruitment Email to Psychology leads

Dear Manager,
I am an African-Caribbean psychological therapist and a Clinical Practice doctoral student at Southampton University (School of health sciences). I am undertaking a doctoral research. I want to gain deeper understanding of the lived experience of psychological therapists in a cross-cultural therapeutic work. The study aims to explore the experiences of race, ethnicity, and culture of African-Caribbean and White British practising clinical/psychological therapists within their therapeutic encounter.

The research study entitled*: Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work.*

I am looking for potential candidate for this research and thought some of your staff will meet the inclusion criteria. Would you please forward the attached research information and invitation to participate to all your psychological therapists and psychologists? They will be able to contact me directly through email/phone if they were interested.

If you have any questions/concerns, please do not hesitate to contact. Thank you in advance for your time and consideration.

Sincerely,

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Appendix F: Inclusion criteria for psychological therapists

Study title: *Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work.*

ERGO number: **485171**
IRAS Project ID: **265102**

Thank you for showing an interest in this study.
In order to ensure that the inclusion criteria are met please confirm in writing that the following apply to you:

Are you an African-Caribbean Psychological therapist with an experience of working White British clients?	☐
Are you a White British Psychological therapist with an experience of working African-Caribbean clients?	☐
Do you have an accreditation with the BABCP, BACP, UKCP, HPC, and BPS?	☐
I have received supervision regarding cross-cultural therapeutic work	☐

Please return your response to Hubert Fanka by email.
hubertfanka@nhs.uk

Many thanks

14 Appendix G: Email Invitation to participate in a qualitative research study

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You are being invited to participate in a dissertation research study entitled:

[Date 14/06/19] [Version1] *ERGO number*: **485171** *IRAS Project ID:* **265102**

Appendix G: Email Invitation to participate in a qualitative research study

Dear Potential Participant,
I am an African-Caribbean psychological therapist and a Clinical Practice doctoral student at Southampton University (School of health sciences). You are being invited to participate in a dissertation research study entitled*: Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work.*

Research question: What is the lived experience of psychological therapists' (African-Caribbean and White British) therapeutic work within cross-racial/ethnic dyad in the UK?

I want to gain deeper understanding of the lived experience of psychological therapists in a cross-cultural therapeutic work. The study aims to explore the experiences of race, ethnicity, and culture of African-Caribbean and White British practising clinical/psychological therapists within their therapeutic encounter.

Participation involves completing an individual in-depth interview that will last 60-90 minutes face-to-face. I have attached the study and participant information to this email. If you are interested in participating, please respond via e-mail. Once you receive the email, please review the consent form for more information. If after reading the consent form, you decide you would like to participate, please give verbal consent. The consent form is requesting your consent to, to participate in the in-depth individual interview. You will sign the consent form prior to the interview starting. I have also attached an electronic version of the consent document in case you would like to review it at this time. I have also attached the electronic version of demographic/background information to be completed and send to me. See participant's Information Sheet, consent form and demographic/background information sheet al.l attached to this email.

If you have any questions/concerns, please do not hesitate to contact. Your time and consideration are greatly appreciated.

Sincerely,

[redacted]

Appendix H: Background and demographic information

Name:

Age:

Sex:

White British or African-Caribbean:

Profession:

Professional body:

Years of training:

Years of practising:

Extra therapeutic training:

Any time spent in an African-Caribbean country:

Years of living in the United Kingdom:

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Appendix I: Interview Protocol for Psychological Therapists (open-ended interview questions)

Title of research: ***Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work.***

It should be noted here that this 'interview schedule' is intended to structure our conversation. It is a guide and I will welcome any additional comments and discussion. The interviews questions are not intended to be prescriptive and certainly not limiting in the sense of overriding the expressed interests of the participant.

Introduction - Explain the study and purpose of the interview including recording. Reiterate confidentiality and right to withdraw

Ask if everything is understood and if participant has any questions.

Obtain written consent and also collect demographic information if required
Begin the interview.

Can you begin by telling me your general experience of cross-racial/ethnic/cultural therapeutic work?

Could you tell me about your experience, challenges and opportunities of forming therapeutic relationship when working with people different from your own race/culture/ethnicity?

Can you tell me about your experience of assessment and formulation when working with people different from your own race/culture/ethnicity?

Could you tell me about your experience of treatment/techniques used when working with people different from your own race/culture/ethnicity?

Can you tell me about your experiences, challenges, and opportunity of cross-racial/ethnic and cultural supervision?

Can you tell me about your experiences, challenges, and opportunity of cross-racial/ethnic and cultural training?
Any final thoughts?

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Appendix J: Thank you letter

[Date 14/06/19] [Version1] *ERGO number*: **485171** *IRAS Project ID:* **265102**

Appendix: Thank you letter
Dear interview participant

I would like to thank you for your participation in my research project:

Understanding the Lived Experiences of White British and African-Caribbean Psychological Therapists: An Interpretive Phenomenological Analysis of Cross-cultural Therapeutic Work.

Your time, effort and support through participating in the interviews have been very helpful. I appreciate your openness and feel privileged to have heard your views, perceptions, and experiences of cross-racial/ethnic/cultural therapeutic work
If you would like a copy of your transcript, please let me know and I will forward it to you.

Once again thank you for your participation.

Yours sincerely

[redacted]

18 Appendix K: Biographical and demographic details of the seven participants

Participants Pseudonym	Martha	Marie	Olga	Monica	Daisy	Christopher	Theo
Age in years	Undisclosed	32	50	53	41	46	54
Gender	Female	Female	Female	Female	Female	Male	Male
Race	Afro-Caribbean	White British	White British	Afro-Caribbean	White British	Afro-Caribbean	White British
Profession	Clinical psychologist	Clinical psychologist	Clinical psychologist	Psychological therapist	Clinical psychologist	Psychotherapist	Psychotherapist

Professional body	BPS, BABCP, SFDBT, HCPC	HCPC, BPSBABCP BFT	BPS, BABCP	BABCP	HCPC BPS BABCP	BABCP	BABCP NMC
Years of training	20 years +	4	4	2	4	4	6
Years of practising	23 years	4	17	4	14	5	20
Years of living in the UK	All life	32	All life	22	All life	17	All life
Time spent in African-Caribbean countries	Only on holidays	None	None	22	Only on holidays 2 weeks	29	None

19 Appendix L: overview of the analytic process

Stages	Name of grouping	Comment	Descriptive or interpretative
Stage 1	Initial ideas Emergent themes	Initial thoughts from reading listening and re-reading each transcript were recorded on post-it notes and attached to the front of each transcript. These were holistic ideas. Interesting comments and phrases were highlighted from reading the transcripts. Emergent ideas were hand written in the right-hand column on each transcript. There were 443 key emergent ideas.	Descriptive ideas. Descriptive themes. These came from the text. This is a process of delineating meaning and clustering these units of relevant meaning.
Stage 2	Subordinate Themes	Interpretation was generated through determining themes from clusters of meaning and pattern themes (key emergent ideas). These came from collective transcripts. There were 65 central themes.	Interpretative Themes
Stage 3	Superordinate Themes	By considering the commonalities between the central themes, the numbers were further reduced to leave 22 core themes	Interpretative Themes
Stage 4	Final Interpretative themes	Core themes clustered further due to their commonalities to leave 4 themes for interpretation	Interpretative Themes

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