"It was quite helpful": an interpretative phenomenological analysis

of Indian fathers' experience of family therapy

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Abstract

Family therapy is not well utilised outside Western culture. The lack of literature exploring fathers' experience of family therapy is an issue that crosses many Eastern cultures. Literature has illustrated the importance of fathers in family therapy, but does not address cultural difference. As an Indian therapist, in an Indian family, with an Indian father the researcher investigated this issue from an Indian perspective. Consequently providing insight into Indian fathers' experiences of family therapy and advancing existing literature, helping counselling psychologists working with this client group to better understand and engage them, therefore helping the process of family therapy and development of services.

Interpretative phenomenological analysis was used to explore Indian fathers' subjective reports of meaning in relation to family therapy. Four Indian fathers, aged 38-64 years old, who had completed family therapy, were recruited from an organisation working with Indian families from a city in England.

Four super-ordinate themes emerged: "Indian fathers and their family", "east versus west", "the therapist" and "what is therapy?" Two findings emerged from the analysis; Indian fathers found family therapy to be a foreign notion, which proved to be a valuable experience and they found it useful to be matched to their therapist.

The study highlights the need for counselling psychology training to allocate more sessions on working cross culturally, which needs to be mirrored in CPD. Understanding Indian fathers' experience can help improve services and increase their engagement, and a community psychology approach is proposed to address this wider issue within the Indian community. The findings from this study help build the foundations for future qualitative research exploring Indian families and family therapy, such as investigating Indian fathers' experience of family therapy with a non-Indian therapist, which would help provide insight on whether the therapists' ethnicity has an impact on experience.

Critical Literature Review

This chapter introduces the topic area of Indian fathers and family therapy and provides a review of the current literature. The subsequent section summarises the literature and discusses the rationale for the current study.

Introduction

This chapter aims to contextualise existing literature within the subject area of Indian fathers and family therapy. The introduction will provide a brief overview on what is family therapy, the importance of the father within the family, and family therapy. This review synthesises current literature and argues that research is needed on Indian fathers' experience of family therapy.

Family therapy is an umbrella term given to a variety of psychotherapeutic approaches used for working with families. Within Western culture, the practice of family therapy developed during the second half of the 20th Century. A review of 20 meta analyses of marital and family therapy trials of various mental health difficulties across the life span found that around half of individuals in the treatment reported improvement after therapy, which was consistent at six and 12 months later (Carr, 2004). Individual therapy is not always sufficient. The family influences individuals' behaviour because they share the same environment therefore individual progress involves changes within the family system.

Family therapy is underpinned by the belief that the family is a unique social system with its own structure and patterns of communication. These patterns are determined by various factors such as the parents' beliefs and values, the personalities of all family members and the effect

of the extended family. As a result of these variables, each family develops its own unique personality, which is powerful and affects all of its members (Dallos & Draper, 2010).

Within the family, the role of the father in the child's life is of high importance in regards to their needs and intellectual encouragement. The father is a protective factor in the development of the child but can also contribute to the development of problems (Fonagy, Steele, Steele, Higgitt & Target, 1994). Carr (1998, p. 374) suggests if the father is present in family life, children are able to cope better with life stresses in the family. Where a father is involved with his children, the children display elevated "instrumental and interpersonal competence and higher self-esteem". Children's adjustment is closely correlated to whether the father has involvement and whether that involvement is positive within the family structure. Carr reports that fathers' attachment with their child gives the child safety and support, providing them with the foundations for developing internal working models for secure relationships with an older authoritative male. Fathers can contribute and help the mother to care for the children and they act as a model, which systematises positive family relationships. In regards to clinical practice, research illustrates the importance of the father within the family system, and thus the need for family therapy interventions to try and engage the father (Phares, Rojas, Thurston & Hankinson, 2010).

Western culture has created a context which marginalises the involvement of fathers in the family (Carr, 1998). Literature indicates that mothers in two-parent families spend more time with their children compared to fathers (Lamb, 1986). This has been mirrored in family therapy work, the concept of the "peripheral father" was first introduced by the family therapy pioneer Salvador Minuchin (Broderick & Schrader, 1991). Professionals commonly assume that fathers do not play an active role in childcare and they are difficult to recruit due to work commitments (Phares, 1992). Carr (1998) reported that the inclusion of fathers in family therapy enhances

the effectiveness of therapy. He came to this conclusion from research illustrating that if fathers are absent for therapy sessions, the dropout rate of the entire family is higher and the desired outcome of therapy is more difficult to achieve (Frielander, Wildman, Heatherington, & Skowron, 1994). Guttman, Sigal, Epstein and Rafoff (1971) compared families that demonstrated improvement in therapy and those that did not. They concluded that the factor which contributed to improvement was the involvement of the father. Webster-Stratton (1958) conducted a study comparing two groups of families with children with behaviour problems, one where fathers were involved in behavioural parenting training, the other where they were not. Although there was significant improvement in children's behaviour immediately after therapy in both groups, when compared a year later, only the group with the father's involvement had sustained the initial improvement.

Research on the importance of father involvement in family therapy work (Burns, Hoagwood & Mrazek 1999; Carr, 1998) does not specify whether these effects hold across cultures. This critical literature review therefore draws on and critiques a broad range of literature to contextualise and identify gaps in the research, the relevance to counselling psychology is considered throughout. The literature review will be broken down into the following subsections, Indian men and therapy, family therapy with Indian families, importance of fathers in family therapy and the father in the Indian family structure.

Reflexive Statement Part One

The reflexive statement section of the thesis aims to situate the researcher within the research, reflecting on how her attitudes, beliefs and experiences have influenced the research. It has been split into two parts; the first part discusses reflections prior to the research and the second part, which follows the discussion chapter, reflects on how the whole research process has

changed and influenced the researcher. The following section will use the "I" voice because it is based on the researchers' subjectivity and personal thoughts and reflections.

I am a 27 year old woman, and I come from a relatively Westernised Indian family. My interest in psychology began in my early teens because I was interested in other peoples' behaviour and intrigued by my own emotions and actions and since then I have wanted to pursue a career in it. At the start of the training for the professional doctorate in counselling psychology I was interested in exploring the topic area of Indians and therapy because of being Indian myself and I had interest in the area. There was also not much research done within this area. There were many assumptions about the Indian culture and Indian people not liking therapy within the literature. I wanted to challenge my own assumptions and the stigma around therapy within the culture by doing the literature review. What helped further narrow my topic of interest was my father and my family. My father is someone who I have always looked up to, he has inspired me to achieve, and influenced my strong work ethic and to better myself as a person. Members of my family have supported me with emotional difficulties and been an outlet for distress. This guided me to explore more specifically Indian fathers and family therapy because through general discourse I came to understand that my experience was not generally the norm. I felt frustrated at the literature, which painted Indian fathers as negative, distant and cold. I felt my experience went against it, as my father is very supportive.

I entered the topic area with a feminist view wanting to give a voice to a marginalised group. Prior to the review of literature I held a frustrated view on Indians in general and their perception of therapy. This was based on constantly explaining to extended family and people within the community what psychology is because they did not understand it. Elders within the family would often say "can you help my brain?" I disagree with most of the Indian traditions

and cultural norms and agree with a more Western individualistic culture having been born and raised in the UK. Like my father I constantly find myself caught between East and West. I'm faced with an internal turmoil with the conflicting Indian community and find myself searching for middle ground.

At the onset I formulated a subjective opinion based on my experience and discourse from friends and families that Indian fathers would not like family therapy. Although this is a generalised opinion it led me to carry out the critical literature review to challenge my beliefs. What struck me in the literature was the amount of general discourse and attitudes based on Indian stereotypes, some of which aligned with my own beliefs. This changed my frustration to curiosity around assumptions held within the literature, such as "Indians do not like therapy". My preconceptions about this topic area have had an impact on this critical literature review, as I initially began selecting literature that fit in with my existing biases, however I was mindful of this as I kept a reflective journal and reviewed it periodically, which helped me to recognise my biases and to review the literature objectively by including research that went against my preconceptions.

On reflection I was first caught up with biases and stereotypes and did not realise this until reading the first draft of my literature review. I needed to find a place within the literature which was balanced. I noticed that there was difficulty finding my own voice at the beginning. When I realised this I was mindful to put balanced literature within the literature review, such as immigration having an impact on the view of therapy. In hindsight I realise a parallel between the participants and I. I have stumbled across a cultural artefact indicating that it is difficult to find a voice against what everyone else is saying, which highlights conforming within the culture. With regards to therapy both therapists and clients are coming with unconscious biases.

I am now more mindful of biases when I am working with different cultures. I only learnt this through the research process. This raises the question that research evokes a different kind of learning and knowledge which needs to be reflected in training programmes.

Review of Literature

      Indian men and therapy. The first section gives an overview of men's reluctance to engage in therapy and then focuses on discourses of Indians and therapy.

Compared to women, men generally tend to engage less in therapy, as there are differences in both their help-seeking attitudes and behaviour (Good & Wood, 1995; Hammer, Vogel & Heimerdinger-Edwards, 2013). These findings seem to be consistent over time (MoellerLeimkuehler, 2003). Collier (1982) reported that one in three women seek help from mental health services contrasted to one in seven men. Freud (1937, as cited in McKelley, 2007) suggested that men's resistance to engage in therapy exists because it signifies a loss in their power and status, thus affecting the male ego. General discourse and attitudes indicate that factors such as men's lack of motivation, the shame associated with talking about feelings and the anxiety around being intimate can also affect men's help seeking behaviour (Berger, Addis, Green, Mackowiak & Goldberg, 2013). Other research has indicated that men dislike therapy because the process of therapy does not fit to the culture of masculinity (Rochlen & Hoyer, 2005). It is also argued that some men are socialised to avoid talking about emotions and disclosing weaknesses and prefer to problem solve without others help, thus hindering themselves from starting and benefiting from therapy (Berger, Addis, Green, Mackowiak & Goldberg, 2013; Good & Wood, 1995).

Guillebeaux, Storm and Demaris (1986) aimed to identify reasons why men do not engage in therapy. They used phone surveys to explore the experience of 35 men in America. The men

had attended at least one marital and family therapy session. The results indicated that the main considerations for men in attending therapy were: the price, recommendation from others, distance, type of centre and the therapist's reputation. Having previous experience of therapy was also an influential factor to men's openness to it later. Other factors such as threat of divorce by partner and difficult marital interaction were reported.

The literature does not address issues surrounding culture, for example being an Indian man and whether their cultural background further hinders them from initiating therapy. Therapy is a Western concept (McGoldrick, Giordano & Garcia-Preto 2005) therefore individuals from Indian backgrounds tend to be cynical and unconvinced by the benefits of it. Lago (2006) states that a huge number of theories of therapy have traditionally been embedded in central European, and more currently North American, culture. Thus, he argues, these theories are constrained, consequently limiting their applicability to people in a multicultural society. Research indicates that Indians underuse psychological services compared to their white counterparts (Hussain & Cochrane, 2004; Johnson & Nadirshaw, 1993). Their main source of emotional support comes from the family and they will only see a mental health professional if forced by a relative or friend (Baptiste, 2005). Johnson and Nadirshaw (1993) suggest that individuals from ethnic backgrounds get prescribed medication more readily than referred to therapy compared to their white counterparts. Their paper also talks about how, within Indian communities, marital and family relationships are often the source of mental health problems, which many therapists are in agreement with. Beliappa (1991) supports this attitude, reporting that Indian women felt that the family was inadequate support for them.

Baptiste (2005) reported that Indians under utilise therapy because of the distress related to the unfamiliarity of it. The culture places emphasis on a sense of privacy and non-disclosure to anyone outside the family unit. Evan (1999) indicated that despite using culturally sensitive

and competent therapies, trying to engage minority groups in therapy can be problematic. Literature does not define what is meant by "culturally sensitive and competent therapies". It is also based on attitudes and discourse with no explanation as to how these individuals came to these conclusions.

Individuals' help seeking behaviour and the way they manage and resolve personal difficulties is shaped by social and cultural norms and by what is regarded as distress within that community (Lago, 2006). Torrey (1972) suggested that within different cultures, what is viewed as problematic varies. Within Indian societies there is a lot of social anxiety about what others may think. Indian men have been reported to find it difficult to trust a therapist, a non-family member in discussing personal issues (Seegobin, 1999). This could contribute to why Indians generally engage less in therapy. Although the Indian community may not regard an issue as problematic, it is important to increase awareness of therapy, otherwise they will continue to be overlooked. There is an increase in young Indian women committing suicide because of interpersonal difficulties and family violence (Bhugra, 2002) and an increase in substance use amongst Indian men, which is a medium to cope with difficulties within the culture (Pannu, Bhala, Zaman & Zaman, 2009).

The way in which mental health is viewed within the Indian culture differs to the Western culture in that there seems to be even more stigma associated with mental health and with seeking treatment for Indian individuals. Mukherji (1995) suggested that Indian people delay accessing help and treatment because of societal allure and cultural sanctions. Kumar and Nevid (2010) state that overt displays of emotional instability are regarded as a poor reflection of the individual, which in turn reflects negatively on the family. Moreover, such "inappropriate" public displays of emotion maybe explained in the culture by physical illnesses, which are

deemed more acceptable within Indian culture (Steiner & Bansil, 1989; Chadda & Deb, 2013). The psychological burden and shame associated with mental illness can prevent Indian individuals seeking professional help and support (Youssef & Deane, 2006). Constantine, Kindaichi, Okazaki, Gainor and Baden (2005) found that Indian students would seek psychological help as a last resort due to the stigma attached. A study carried out in American psychiatric hospitals with Asian Indians found that as a result of the mental health stigma symptoms would not be identified early on by clinicians, and therefore Indian clients would not receive appropriate treatment due to individuals and family members denying the illness (Conrad & Pacquiao, 2005).

Immigration is also a factor that can influence Indian individuals' perception of therapy. Panganamala and Plummer (1998) found individuals who immigrated to the United States before the age of 10 were more likely to view psychological therapies positively, compared to individuals who immigrated at an older age. They surveyed 101 first and second-generation Asian immigrants on attitudes toward counselling and counselling behaviours. Their ages ranged from 13-65 years, and over half the sample was male. The findings indicated that immigrants with children may hold more negative views to therapy. However the paper does not further explain the reason for this. This study highlights the association between immigration and attitudes towards counselling as it can be inferred that men who have immigrated to western countries at an older age and have children, would view therapy negatively. It also suggests that individuals who have immigrated at a younger age and who do not have children will perceive therapy more positively. This may possibly be because they have had more exposure to Western culture consequently influencing their views. These findings can have implications on family therapy because Indian men who fit this criterion would not want to engage in family therapy or therapy in general. This could lead to further

problems with the family system and this group would continue to underuse psychological services. It would be helpful to explore individuals' subjective thoughts as to why they perceive therapy negatively.

Sue (1996) reports that Asian American men tend to take longer to acculturate into mainstream society compared to their female counterparts, which raises concern around psychological well-being. This could also be true of Indian men in the UK. Having large families can be a stress factor because they have the responsibility of taking care of every member (McLoyd, Cauce, Takeuchi & Wilson, 2000). Stress from immigration and
acculturation could also have an impact on Indian fathers' mental health (Chen, Sullivan, Lu & Shibusawa, 2003). These factors highlight the importance of having Indian fathers engage within therapy to help alleviate any stresses.

In summary, there are a number of factors which can cause distress in Indian fathers' lives, and numerous factors which make it difficult to engage Indian men in therapy. Cultural beliefs play a significant role in shaping an individual's values and beliefs which are maintained through generations by the family, and are underpinned by the community (McGoldrick et al 2005). These include gender issues surrounding loss of power and shame of expressing emotions, therapy being rooted in Western concepts, the social anxiety of what others may think about seeing a therapist, differences in what is seen as a problem in different cultures, and the stigma attached to mental health and immigration. From the literature it can be inferred that Indian men are disadvantaged in accessing psychological therapies as all these factors play a role in shaping their perception of therapy, inhibiting them in initiating and benefiting from therapeutic interventions.

This section contextualised current literature in regards to men and therapy and more specifically factors which can further add to the lack of engagement from Indian men in therapy. This in turn can have implications on family therapy interventions because if Indian men utilise therapy less because of the various factors discussed, they might consequently be less likely to make use of family therapy too. Therefore the following section will explore more specifically literature on Indian families and family therapy.

Family therapy with Indian families. Literature on marital and family therapy with Indians is generally lacking compared to other ethnic populations (Dupree, Bhakta & Patel, 2013). Family therapy has been shown to have particular importance for clinical work with Indians according to Steiner and Bansil (1989). The conclusions drawn from their paper were based upon their own experiences in treating a small sample of Indians, and from information given by Indian psychiatry residents. They argue that when working with Indians individually, therapists need to modify the therapeutic technique by incorporating the family in sessions or talking to family members after sessions. This is because of the close interpersonal relationship amongst the family members and the reliance on these relationships. Thus any change produced in one family member may not be accepted or tolerated by the family (Steiner & Bansil, 1989). The authors of this paper neglect to explain what kind of mental health issues or problems family therapy is useful for with this client group. Furthermore the focus of this study is on the therapists' experience and recommendations for working with this client group.

Dattilio and Bahadur (2005) discuss a case example of an Indian family who were seen by a clinical psychologist using a CBT approach. The family were referred by their GP due to struggles between the parents and their fifteen-year-old daughter, who, in demanding emancipation, went against the family's cultural values. The authors argue that CBT is both a

"versatile" and "universal" approach whilst working with Indian families because it works on individual cognitive patterns, and they emphasise a collaborative approach when working with Indian families. This paper raises the question on whether these findings can be generalised to all Indian families. Just because the authors say it works, does not necessarily mean it works with every Indian family. CBT has been constructed by a Western culture, thus it might not work so well with different societies. The authors do not explain what is meant by a "collaborative" approach, a term which is standard practice in most therapeutic approaches. Furthermore it would be helpful to also explore the experience of the family members. This would be helpful to address because it would enable insight into their subjective world and provide valuable feedback on how they are experiencing the delivery of therapy.

Following on from previous research that discusses how to work with Indian families, Khanna, McDowell, Perumbilly and Titus (2009) conducted a Delphi study with experts (scholars in family therapy and counselling) in the area of working with Asian Indian American families. The scholars were of Indian origin. Results suggest that therapists should incorporate particular techniques within their practice whilst working with Indian families. These include psycho-education on therapy, a more directive style, systems theory because it fits with the collectivist culture, and narrative therapy because of its emphasis on context.

Tewari, Inman & Sandhu (2003) suggested using a narrative approach when working with Indians as a method of expressing relational experiences that do not involve direct disclosure and show of emotions, because these are culturally difficult (Kumar & Nevid, 2010).

In summarising this section, existing literature on family therapy with Indians has provided useful information to help practitioners modify their therapeutic approach to working with them. However, there has been no focus on exploring the subjective experience of Indian clients experiencing family therapy. It would be beneficial to understand their experiences as it would

help counselling psychologists plan and implement more effective treatment services that cater for their needs more effectively. Furthermore the studies discussed do not address the importance of the father within family therapy work with Indians; it is not known whether they were involved or whether there were difficulties engaging the father (if included). This is important because literature illustrates that the father plays an important role within the family and consequently family therapy (Carr, 1998). At present no literature exists on the importance of the Indian father and family therapy. Therefore the following section will focus on general literature on the importance of engaging fathers in family therapy.

Importance of fathers in family therapy. In typical Western social constructions of the family, fathers are involved in guiding and encouraging their children when faced with challenges, and helping their autonomous explorations outside the family unit (Grossmann, Grossman, Winter & Zimmerman, 2002). In research investigating family therapy interventions, Phares (1996) reported that when parents are included in family therapy interventions it is more often the mother than the father who is involved. Various studies highlight the importance of the father's role in therapy. Prevatt (1999) found fathers help unearth underlying difficulties that may be overlooked when focusing on just the mother and child. Webster-Stratton (1958) reported a more positive interaction between mother and child when the father was present in the therapeutic process. Fathers' involvement in child-focused therapies is significant in providing comprehensive treatment for children and adolescents (Hecker, 1991). The inclusion of fathers in therapy has shown to improve the therapy (Burns, Hoagwood & Mrazek, 1999; Carr, 1998). Carr (1998) concluded that fathers play an important role within the family and consequently family therapy interventions.

Ang (2006) found that fathers help children to develop better relationships outside the family. She carried out a study on 51 Asian (Chinese, Malay, Indian and others) elementary school children who were at risk of behaviour problems. The Network of Relationships Inventory (NRI), which is a structured interview, was used to ask children to rate people in their social network on different types of social support or conflict. They completed one for their mother and one for their father. The Teacher-student Relationship Inventory was used to assess the teacher's opinion on their relationship with their students. Results demonstrated that children who viewed their father as supportive were more likely to have a more positive relationship with their teacher therefore seeking advice and help from them when necessary. A significant effect was not found for children's views of the mothers' supportiveness. Ang concluded that the results of this study have implications for clinical research and practice, particularly for child and family therapy. The paper emphasises the importance of the father because their support was shown to be correlated to the quality of relationship between aggressive children and their teachers. Having a positive relationship with the teacher serves as a protective factor and reduces aggression. Ang notes that fathers do matter, therefore it is important to have fathers present in therapy. However the focus of this study was primarily on elementary children with an average age of nine years; it fails to look at older children and it used a quantitative method therefore not interrogating the subjective experiences of participants.

Ang's (2006) study aimed to extend existing research by using an Asian sample however the Indian sample included is not a fair representative (only 12%). It does not state of what Indian sub-group the participants were. There is a tendency for various Indian sub-groups to be grouped together and therefore disregarding the unique characteristics of the divergent sub-groups (Durvasula & Mylvaganam, 1994). Durvasula and Mylvaganam (1994) found that Indians who follow the Hindu religion view themselves different to Sikhs. Therefore they argue that conclusions about particular sub-groups cannot be generalised to all other Indian groups.

However it is difficult to focus on one particular Indian sub-group as literature shows there is a lack of engagement of Indians in therapy generally (Hussain & Cochrane, 2004). Another critique of this study is that only children who were at risk of behaviour problems were included. Using the (NRI) whilst exploring a broader age group with other problem issues, alongside a qualitative research method, would be useful in identifying any associations to family therapy with the Indian father.

A national youth survey in Singapore (Ho & Yip, 2003) found that 75% of young people said they would turn to their mother first for advice on important decisions, followed by 65% who would go to their friends and lastly 57% who would go to their fathers. The father is an important figure in children's life, as research shows, father's involvement and support has positive outcomes in children, such as better academic performance, behaviour and attitudes (Amato, 1994; Lamb, 2004). This survey was done in Singapore and the sample used was of Asian background which assumes certain values and roles that are similar to Indians, for example, fathers adopt a more powerful position within the family compared to mothers, are the primary decision maker and control the finances within the family (Ang, 2006). This study implies that fathers have a less supportive role in the family because they are not sought for advice.

In summary, this section explains the importance of fathers in therapy. Conclusions drawn from research on fathers in family therapy come from quantitative studies and do not account for cultural differences. This is significant as the position of fathers differs between Indian and Western families, because the latter do not tend to assume as rigid family roles and are located within a relatively individualistic culture (Baptiste, 2005; Sue & Morishima, 1982). The Indian family adopts a more collectivistic culture, which values joint decision-making and placing the

needs and views of the family above individual ones (Medora, 2007). This difference in culture and family dynamics, and the possible influence of these differences in family therapy, is not considered in current literature.

The following section will provide a brief overview of the Indian society and family, and contextualise the place of Indian fathers within the family system.

The father in the Indian family structure. Over a period of time the Indian society has altered because of cultural, economical and social changes. However the family remains a significant tradition within the society and has continued to exist over time. India is a "collectivistic society" in contrast to an individualistic society (Chadda & Deb, 2013). Hue and Triandis (1986, p. 244) define collectivism as "a sense of harmony, interdependence and concern for others". This idea of collectivism is evident in Indian families from both the United Kingdom (UK) and America, with the notion of working together and putting the needs of the family first (Medora, 2007).

The Indian family usually involves both the extended and nuclear family, and it forms the basic part of society and the major emotive support for an individual (Medora, 2007; Pedersen, 1981) therefore they do not seek support from outside the family, which may be a contributing factor as to why Indians use psychological services less (Johnson & Nadirshaw, 1993). Emphasis is placed on social obligation, and social control is maintained within the family structure through shame and guilt (Ramisetty-Mikler, 1993). Individuals with close family ties who deviate from the families' rules would suffer tremendous shame and guilt (Baptiste, 2005; Sue, 1981).

Authority and leadership is determined by gender and age (D'Cruz & Bharat, 2001). Gender and age are important factors in shaping power within the Indian family structure: the elder males possess the most power and control. When the eldest son is mature enough, the male elder abdicates his authority to him. Sons are more valued within Indian families as they ensure status in the family and continue the family name and inheritance (D'Cruz & Bharat, 2001). There is also more preference for sons as they take care of parents in old age. The Indian culture has always shown more preference for sons (Arnold, 2001, Clark, 2000, as cited in Medora, 2007). Thus the literature implies that Indian men are socialised from a young age to acquire power and authority compared to their female counterparts.

The Indian family system assumes rigid and stereotyped social roles, which govern the position of the various family members (Ramisetty-Mikler, 1993). The structure is patriarchal, where the male is the authority figure and there is a segregation of the sexes (Chadda & Deb, 2013). Specific social rules apply to the different sexes, which are adopted through gender role socialisation (D'Cruz & Bharat, 2001). There are particular roles for Indian family members; these roles dictate demands, which individuals have to ensure they meet in order for the proper functioning of the family network. The father is regarded as the authoritive figure, is the main disciplinarian and makes the important decisions in the family, which are not questioned and he is often the sole breadwinner (Bhattacharya & Schoppelrey, 2005). He establishes rigid family rules and implements them, thus he is often viewed as stern, distant and less approachable than the mother (Shon & Ja, 1982).

Indian parenting tends to be authoritative, meaning they have the power and control. This applies more to the father (Jambunathan & Counselman, 2002). The way in which Indian parents raise their children is affected by immigration and their family experiences (Inman, Howard, Beaumont & Walker, 2007). Patel, Power and Bhavnagri (1996) found that regardless

of the child's gender, the longer Indian women lived in America the more likely they favoured American qualities in their children. In contrast, despite how long they had lived in America, fathers did not hold the same view, they held more traditional values especially for their daughters such as respect to authority. It seems Indian women are more flexible and adaptive in their parenting practices than their male counterparts.

In comparison, the Western world adopts a more individualistic culture where individuality, independence and self-sufficiency are emphasised (Chadda & Deb, 2013; Sue & Morishima, 1982). Western families tend not to have clearly defined roles for individual family members (Lee, 1997). The environment in which children from Western family systems are brought up is democratic (Lee, 1997) and they are involved in the rule making. Individualistic cultures, such as America and the UK, raise children to be dependent by encouraging them to make decisions for themselves and to think independently with more freedom of choice.

Literature seems to be contradictory as it suggests that the Indian culture is patriarchal, however at the same time it adopts a collectivist culture too. As mentioned earlier, a collectivistic culture upholds the view to priority being given to group goals, harmony and interdependence to be maintained, open conflict within the in-group to be avoided, and for reciprocity among in-group members. However Indian fathers have more power and control within the collectivist society, therefore implying that the collectivist nature only applies to some of the members, and excludes Indian fathers because they are the elder and authoritative figure.

The majority of the literature on Indian fathers within the family structure appears to be anecdotal and descriptive. The literature tends to be based on assumptions therefore lacking validity and reliability of such narratives. Research does not address individual differences in

Indian fathers, as mentioned earlier, Indians who have immigrated to Western countries at a young age were more likely to view psychological therapies positively, compared to individuals who immigrated at an older age (Panganamala & Plummer, 1998). The position of the Indian father could possibly be affected by immigration. Therefore an Indian father who immigrated to the UK or America at a young age may adopt a more idiosyncratic culture within the family due to being exposed to Western values and beliefs. Consequently this can contribute to their function within family therapy.

Summary of Literature and Rationale for the Current Study

This critical literature review started very broadly, with literature on men's engagement in therapy, issues surrounding loss of power, and shame in talking about feelings. Reviewing this segment of literature revealed that the literature on men and therapy does not take into account differences in culture. It then focused on factors that can contribute and further hinder Indian men from engaging in therapy. These factors include therapy being developed and rooted in Western ideas and theories, the social anxiety within the community about seeing a therapist, differences in what is regarded as a problem in different cultures, the stigma attached to mental health, and immigration. Due to these factors it can be inferred that there would be a lack of engagement from Indian fathers in family therapy interventions too.

The subsequent section of the review focused more on family therapy with Indian families. Literature in this area has emphasised the need for the therapist to utilise family therapy interventions for this particular cultural group (Steiner & Bansil, 1989). This literature is limited, and does not explore the importance of fathers in family therapy. The literature tended to centre on therapists' experience of working with Indian families and what they gleaned from it, rather than focusing on the family's experience of family therapy. Manthei

(2005) confirms that existing research tends to favour therapists' experiences over clients' experiences.

The following section of the review looked at the importance of fathers in family therapy more generally. Literature tends to focus on Caucasian clients, even though Ang (2006) attempted to address this using a quantitative approach, there still lacks literature exploring Indian fathers' experience of family therapy. The subsequent section gave an overview of the

Indian society and family, and how it differs from Western families. It explored the role of Indian fathers within the family system, where they adopt a more strict and disciplinary position. They are viewed as the head of the house and the problem solver. Although fathers have shown to have a significant place in family therapy and literature has shown their inclusion enhances the effectiveness of therapy (Carr, 1998) the role of culture has been ignored.

It seems Western trained professionals working with Indian families in Western countries, can either take on a universalist, or essentialist, position on cultural differences (Singh, Nath & Nichols, 2005). A universalistic view concentrates on the similarities between families regardless of cultural or ethnic difference. It tends to minimise the potential differences in culture, which seems to be the case in a number of studies; these studies assume that like Western families, all other families regardless of their ethnic origin adopt the same roles and functions. An essentialist position views culture as "fixed determinants of family structure and functioning" (Singh, Nath & Nichols, 2005, p. 282). An essentialist position tends to assume that all families from an ethnic group are the same therefore leading to stereotyped generalisations of ethnic groups. Thus therapists need to be cautious and careful not to make assumptions based on stereotypes, but instead be cognisant of these biases and elicit information from the family in therapy. Counselling psychology is situated between these two

divergent views, as the discipline emphasises the subjectivity of individuals and to work holistically, valuing their idiosyncrasies and acknowledging difference in experience (Strawbridge & Woolfe, 2010). Lago (2006) suggests that if therapists are not prepared to challenge their assumptions about particular ethnic groups, it makes it difficult for them to communicate effectively with individuals who are from different cultural groups.

The UK is a cosmopolitan society and the people accessing therapy services such as family therapy will become more culturally diverse (Pandya & Herlihy, 2009). Messent (1992) found that little work on family therapy and cultural groups in the UK has been done. This could be because of their lack of engagement in therapy. Oren and Oren (2010) states that in American literature, specifics to counselling Asian men is sparse. Furthermore it reinforces the need for research in the UK to explore Indian fathers experience of family therapy to better understand them, and to also "reformulate existing theoretical models for clinical intervention and to develop new ones that are attuned to the cultural uniqueness of these populations" (Ho, Rasheed & Rasheed, 2004, p.1). Sue and Sue (1999) state that although there has been more awareness of the mental health needs of ethnic minorities over the past ten years, clinical and counselling psychologists have in the past failed to meet the mental health needs of such groups.

"Only the client can reveal the meaning and benefit of therapy" (Elliot & James, 1989, as cited in Bonsmann, 2010, p. 31). Hodgetts and Wright (2007) state with more emphasis on evidence based practice and short-term therapy interventions in the UK, understanding the subjective voice of clients will be more important. The inclusion of clients' experiences of therapy would be in line with supporting the development of services, for example "The Ten Essential Shared Capabilities" in the NHS (NIMHE, 2004, as cited in Bonsmann, 2010).

The majority of research on father's involvement in therapy has been done on Caucasian populations; the findings from these studies have been used as the "norm". The subjective voice of Indian fathers in therapy or post therapy has not yet been addressed. This is important to consider, helping provide insight into their perception of family therapy, which would inform the work of the counselling psychologists by using research and evidence to help guide practice, which would be adhering to the philosophy of the discipline as a scientist-practitioner (DCoP, 2011). Exploration of this phenomenon would be in line with the ethos of counselling psychology, as it enables Indian fathers to express themselves, empowers them by working collaboratively (DCoP, 2011) and avoids fitting them into existing assumptions that are based on other cultural groups.

A collaborative approach needs to be adopted when working with clients in general because feedback from them is a useful way to understand and acknowledge what they did and did not find useful in therapy. It would be helpful for counselling psychologists to understand the functioning and dynamics involved in family therapy with Indian clients, with particular focus on Indian fathers; this is because literature has demonstrated the importance of fathers in family therapy interventions (Carr, 1998). Indian fathers' utilisation of family therapy needs to be explored because literature indicates that the position of the father differs in Eastern and Western families. This would be adhering with the counselling psychology ethos, helping improve practice (Strawbridge & Woolfe, 2010).

Conclusion and Research Question

There is a gap within the literature which fails to focus on the subjective voice of Indian fathers who have engaged in therapy, especially family therapy. The current study proposes to enable insight on what their experience was, what factors helped the process and aspects that could be

improved. Utilising qualitative methodology will be helpful to understand their experience and will help explore a phenomenon which has not yet been investigated. With this information, counselling psychologists working within current therapy services will be better able to cater and improve existing services to better suit the needs for this group. Furthermore this will enable counselling psychologists to understand Indian fathers' subjective voice, rather than fitting them into existing findings from research based on nonIndian groups, moreover empowering them (DCoP, 2011). This will help contribute to research in "deepening, expanding and testing theory" (Clark et al, 2004, as cited in Bonsmann, p. 31).

Method

Rationale for Methodology

Both quantitative and qualitative social research aims to see how society works, to explain social reality and to answer particular questions about certain instances of social reality. The two research methods differ in the way experience is theorised and explored.

Traditionally, quantitative methodology has been utilised in psychological research which aims to obtain accurate information about objective physical reality. This is done by maximising the accuracy of the observations via quantification of surveys and questionnaires, making sure that bias and inaccuracy are removed from observations. This can be done by ensuring that specific variables are isolated within the study from the environment where the data is collected, to avoid the possibility of other variables than the ones being studied accounting for the cause and effect relationship. Thus it adopts a positivists epistemology (Langdridge, 2007), proposing that by utilising logic and objective scientific methods a reality, a truth, an objective world, independent of ours, can be revealed. Thus the focus is on the importance of hypothesis testing, manipulating and measuring variables.

Qualitative research adopts a constructionist epistemology, in that our understanding of reality is constructed socially, meaning that individuals' thinking and behaviour is created by culture, language and social interaction rather than by an objective truth (Marks & Yardley, 2004). Consequently there exists "multiple realities" related with divergent groups and perspectives (Lincoln & Guba, 2000). Critics of the positivist position have suggested that it is impossible to eliminate subjectivity from our knowledge of the world (House & McDonald, 1998). Qualitative methodology focuses on the importance of understanding the meaning of experience and events as interpreted by the participant, thus it is participant led.

In contrast to quantitative research, qualitative methods are not concerned with isolating variables from their context and do not view human interpretations as bias. Instead qualitative researchers are concerned with these contexts and interpretations (including those of the researchers) that influence experience and understanding of the world. Contextualised, rich descriptive data are gathered from real life settings through interviews, encouraging emphasis on the individuals' perspective, and in the language used by the individual, reflecting on the social and subjective influences on the constructions of their interpretations.

The aim of the current research was to understand the subjective experience of Indian fathers who have completed family therapy therefore a qualitative methodology was considered more suitable. Experience and knowledge of reality is shaped by human culture and activities (Marks & Yardley, 2004), thus in order to answer the research question it was important to gain insight on what is meaningful to Indian fathers. A qualitative method enabled the researcher to develop a comprehensive study on a phenomenon, which would have been difficult to quantify because it was a topic which had not yet been investigated. The nature of the study was explorative, and a qualitative approach enabled the development of unexpected

findings.

IPA as a Research Methodology

Interpretative Phenomenological Analysis (IPA) was the qualitative method utilised for the current study. IPA aims to explore how individuals make sense of their personal and social world (Smith, 2008). It focuses on individuals' subjective reports, and looks at the process of meaning in relation to certain experiences (Smith, 2008). This method has predominantly been utilised in health psychology but it has become increasingly popular in applied psychologies such as clinical, counselling, educational and occupational (Smith, Flowers & Larkin, 2009).

This is due to its emphasis on individuals' perception and understanding of life experiences (Smith & Eatough, 2006). It enables researchers to conduct in-depth investigations of how individuals make sense of their experiences.

IPA draws on theory from three philosophical and epistemological bases: phenomenology, idiography and hermeneutics. IPA is phenomenological, in that it is committed to understanding individuals lived experience and their perception of an object or event. IPA practices idiography as it focuses on detailed in-depth analysis on understanding how particular phenomena are understood by particular individuals, in particular contexts (Smith et al, 2009). IPA is hermeneutic, which refers to study of interpretation. The researcher has a dynamic role and is trying to get an "insider's perspective" (Conrad, 1987, p. 53). A dual interpretation process is used (double hermeneutic), in which participants are trying to understand their world and the "researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al, 2009, p. 3). IPA is also influenced by symbolic interactionism (Eatough & Smith, 2008), which assumes that individuals act depending on the meaning that things elicit for them, and that meanings materialize based on social interactions with others (Blumer, 1969).

IPA has its theoretical roots in critical realism (Bhaskar, 1987) and the social cognition paradigm (Fiske & Taylor, 1991). The critical realism approach proposes there are stable aspects of reality, existing in parallel of human conceptualisation. The differences in individuals' experiences are due to the fact that they are experiencing different aspects of reality. The social cognition paradigm proposes that human speech and behaviour reveal these differences in meaning. IPA's phenomenological stance can also be positioned on a relativist's continuum in its view that truth is not universal but instead differs between individuals and

cultures e.g. Indian fathers' experience of family therapy will differ from their white counterparts. IPA in this instance is concerned with how Indian fathers' experience family therapy, therefore reality is constructed depending on their view of it (Willig, 2001). IPA adopts a contextual constructionist position because of its emphasis on context and experience. It also has influence from social constructionists due to its consideration of social, cultural and historical factors related to experience (Eatough & Smith, 2008).

Like other methodologies IPA has both strengths and weaknesses. The conceptualisation of the "role of language" within IPA has been questioned by Willig (2001). The approach has been criticised for not considering whether language alone can fully capture experience. Language is the tool used by people to communicate their experiences and can only form part of the way in which individuals communicate something they think or feel (Willig, 2001). Instead Willig (2001) says language "prescribes" (p. 63) what people can think and feel. Many people find it difficult to articulate their thoughts and feelings, therefore making it difficult for them to communicate their experiences. Willig (2001, p. 63) suggests that this restricts the "applicability of the method", as it cannot be used with people who are unable to express themselves. IPA aims to understand the experience of participants through their perceptions on various events, however it does not enable us to understand why these experiences occur and why there are individual differences. It is suggested that this is the researcher's job with interpretation. Thus phenomenological research methods are better able to describe experiences. It is also important to be conscious of the context that gives rise to experiences in order to understand participants' experiences better (Willig, 1999).

The same conventional research evaluation measures e.g. representative samples and suitable statistical analysis cannot be applied to qualitative methods because of the subjective nature of research (Touroni & Coyle, 2002; Yardley, 2000). There has been some apprehension

regarding the validity and reliability of qualitative methods such as IPA as the analysis process of data would differ for different researchers (Golsworthy & Coyle, 2001). Smith et al (2009) suggests that this can be overcome by having the data analysed by supervisors and professionals that are either involved with the research or are independent.

Rationale for the Utilisation of IPA

IPA was considered an appropriate method because of its epistemological fit with the research question, which aimed to explore the subjective experience of Indian fathers who have undergone family therapy. IPA emphasises the importance of understanding

individuals' lived experience and the uniqueness of their experience, which is parallel to the underpinning philosophy of counselling psychology (Strawbridge & Woolfe, 2010). Counselling psychology practice guidelines stress the importance of choosing a research method that is congruent to the values underpinning the discipline (BPS, 2005). Similar to IPA, counselling psychology valorises subjectivity and context in both research and practice (Orlans & Van Scoyoc, 2009). Counselling psychology adopts a pluralistic view, which appreciates the diversity of people with different cultures, experiences, beliefs and attitudes.

The pluralistic paradigm is rooted in humanistic, person-centred and post-modern principles (Cooper & McLeod, 2010). It is in opposition to the modernism view that claims there is one unifying answer to a question. The post-modern view suggests there are multiple answers depending on cultural, linguistic, political, personal and social factors.

As a counselling psychologist, the researcher's personal philosophy is to value the subjectivity of individuals. Coming from an Indian family and background has influenced the researcher's epistemological position, which tends to lean towards a constructionist stance due to its consideration of culture and context on experience. This in turn had an influence on the choice

of research method being IPA, which would allow the researcher to gain access to the world of the participants and the meaning they hold of their experience.

IPA was also considered compatible with the research question because it allows the researcher to acknowledge and use their own meaning of their participants' experience. IPA's emphasis on individual experience was of central focus in the study hence it deemed wellmatched to the research question. It is an exploratory method, which can be utilised for topics that have been under-researched (Smith & Eatough, 2006) and since the current study has not been explored, IPA was considered an appropriate fit to the research question.

IPA was considered an appropriate approach to address the research question; however other qualitative methods were considered but discarded such as discourse analysis (DA). This method like IPA is utilised for topics that have been under-researched. DA and IPA both focus on the use of language within the method of inquiry. DA and IPA diverge because of differences in the way social cognition is perceived. DA considers language and speech to be fundamental to the construction of social and psychological life. It focuses on how language is used to create versions of the world by placing emphasis on the role of language within the construction of it (Potter & Wetherell, 1987), adopting an anti-realist position. Within IPA, language is used to gain insight into individuals' thoughts, beliefs and experiences around the topic being explored (Chapman & Smith, 2002). When using IPA the researcher utilises language as a way of entering the clients' inner world. IPA holds the idea that experience is not completely constrained and defined by language, and allows the idea that feelings and thoughts can be talked about in a way that is not just societal i.e. relating to society or social relations. Thus IPA was selected to answer the research question because of its focus on individuals'

phenomenological experience rather than the dialogue they use, which was pertinent for the current study.

Grounded theory (GT) was also considered. GT facilitates the exploration of social processes (Willig, 2001) and leads to construction of a theory (Glaser & Strauss, 1967). GT aims to develop a universal model of a particular phenomenon. In contrast, IPA aims to gain an insiders' view of the participants' experience of their world. Whilst due consideration was given to the use of grounded theory, the focus upon the phenomenological world of Indian fathers, as opposed to the generation of an explanatory theory, supported the rationale for use of IPA. IPA's idiographic focus compared to GT was another reason it was chosen to answer the research question.

Participants

Previous research indicates that various Indian sub-groups tend to be grouped together (Durvasula & Mylvaganam, 1994), disregarding the unique characteristics of the divergent sub-groups. Conclusions about particular sub-groups cannot be generalised to all other Indian groups (Durvasula & Mylvaganam, 1994). However it is difficult to focus on one particular Indian sub-group, as literature shows there is a lack of engagement from Indians in therapy generally (Hussain & Cochrane, 2004), therefore proposing overly restrictive inclusion criteria at the outset might have obstructed recruitment. The experience of Indian fathers in family therapy was rare enough to define the boundaries of the sample. Recruitment of Indian fathers proved to be extremely difficult, therefore making it hard to select a specific Indian sub-group, based on the fact that only four participants were willing to take part in the study.

All four participants were recruited from an organisation, which provides family therapy for Indians within an urban area in England. Smith et al (2009) suggest a sample size of three to six participants in an IPA study. The sample consisted of four Indian fathers ranging from 38 to 64 years old. They were all of Indian background – two Sikhs, one Hindu and one Muslim. They had all completed family therapy, with an average of seven sessions.

The first stage of recruitment involved calling and e-mailing family therapy organisations and private therapists. Contact was made with a manager at an Indian family therapy organisation within England, unfortunately they reported having no clients who were willing to take part in the study. The manger signposted the researcher to their other organisation in England and contact was made with the administrator there. The researcher was later contacted by the family therapist, who was then sent copies of the participant information sheets and posters (Appendix A) which were displayed within their organisation. After some time the researcher was contacted via phone by the family therapist to explain that she had spoken to some of her prior clients who were interested in participating in the study. Initially six participants were interested to take part. The six Indian fathers' contact details were passed onto the researcher by the family therapist after they had given consent. The participants were contacted by the researcher and sent a participant information sheet either via email or post and a date was arranged for the interview.

Materials

An interview schedule was created using the guidelines given by Smith et al (2009) (Appendix D). The interview schedule provided a framework consisting of open-ended exploratory questions, including prompts to aid the interviewer to collect data. The questions within the

schedule were formulated deductively based on the literature review, and aimed to elicit participants to talk freely with little prompting from the researcher. The interview schedule began with more general questions to allow the participants to become relaxed with the subject matter, and then moved towards more specific questions (Smith, 2008).

Other materials used to conduct the research included a dictaphone to record the interviews, which was provided by the researcher. A room to conduct the interviews was provided by the organisation. Further materials included the recruitment letter and posters, participant information sheets, recruitment questionnaires, informed consent forms and the debriefing forms.

Procedure

The researcher went to the urban area in England for the day, therefore only had that one day to get all the interviews done. The researcher took a pragmatic decision that it was not necessary to go elsewhere to recruit. The data collection was influenced by circumstances such as location and availability of the participants, and the availability of the researcher. On the day only four participants turned up. The four participants were met at the organisation. One of the therapy rooms was used to conduct the interviews; access was confirmed by the family therapist prior to the interviews.

All participants were greeted and they were talked through the participant information sheet (Appendix B), they were asked whether they understood it and whether they had any questions. The consent forms (Appendix C) were signed and they completed the recruitment questionnaire (Appendix F), the interviews (Appendix D) were commenced thereafter, which were recorded. Sometime was kept at the end of the interview to debrief (Appendix E) the participants. All

four participants were thanked for their time and participation. The family therapist and administrator were informed that the interviews were taking place to safeguard everyone.

Analytic strategy

The first analytic step prior to transcription involved listening to each interview in full several times, and noting any thoughts, reflections and memories that were produced, to help become familiar with the data (Frost, 2011). This was also done to record the researcher's prominent observations about the transcripts and helped to bracket them off (Smith et al, 2009) whilst being immersed in the data. The four interviews were then transcribed verbatim. The individual recordings were then listened to again whilst reading the transcript (Smith et al, 2009). These initial stages were significant to ensure that the participants' subjective voice is at the focus of the analysis as suggested by Smith et al (2009).

The next stage of analysis involved making initial notes, which focused on the semantic content and the way language was utilised. The focus at this stage was tentative, where any key points were noted. This enabled the participants' individual voices to emerge and to be able to identify the way in which they "talk about, understand and think" (Smith et al, 2009, p. 83) about family therapy. The exploratory comments were noted in the left-hand column using different coloured pens on the transcripts, which incorporated descriptive, linguistic and conceptual comments.

The following stage involved developing and identifying the emergent themes and noting them in the right-hand column. This stage focused on the exploratory comments rather than the transcript itself. The emergent themes were grounded within the text and were abstract, drawing on psychological concepts and ideas (Smith & Eatough, 2006). The themes were a reflection of what the participants said, and of the researcher's interpretations.

The next stage involved identifying links across the emergent themes. This was done by writing them down on pieces of paper and using a large card to move the themes around on (Smith et al, 2009). This process helped recognise the similarities between some themes and the differences in others. The clusters of themes were given descriptive labels that communicate the conceptual nature of the themes (Frost, 2011) and a table was constructed (Appendix G). The above steps were repeated for all four participants. When moving onto the next participant's transcript it was important to treat it independently by bracketing off the themes from the previous one. This enabled new emergent themes to develop.

The final stage of analysis involved identifying patterns across the cases. This was done by laying out the four tables and looking across them (Smith et al, 2009). Some themes were relabelled or changed at this stage. A master table was then created which illustrated how clusters of themes are grouped within superordinate themes (Appendix H).

Ethics

Participants were informed that the information they shared in the interviews would be kept confidential, their identity would be protected, and kept anonymous. All data was kept in a safe and secure place at the researcher's home in a locked filing cabinet. Audio recordings were password protected. All data will be deleted once the doctorate is awarded. Consent forms were kept apart from the transcripts and participants have been identified by a separate code, which is only accessible to the researcher.

As participants were disclosing personal information during participation in the interviews, by recalling and disclosing information about their experience of therapy, it was important to have a risk plan (Appendix E). If a participant became distressed, tearful, or found it difficult to

speak or experienced a panic attack during or after participation in the interview, a distress protocol would have been followed. The researcher would have intervened and informed the participant that they can withdraw from the interview at any time and would then be debriefed immediately. The risk plan was not needed. Participants were provided with a list of services available to help support them. The list of services was provided in the debrief form (Appendix E).

Analysis

The analysis looked at what the participants said in their transcripts, and the researcher's interpretations of this. Four super-ordinate themes emerged. Table 1 below, shows a schematic representation of these four super-ordinate themes: 'Indian fathers and their family', 'east versus west', 'the therapist' and 'what is therapy'.

The super-ordinate theme 'Indian fathers and their family' looks at the close nature of the Indian family, and the fathers' significance and role within it. The next superordinate theme, 'east versus west' explores the differences within Indian and British cultures in relation to therapy. The following theme 'the therapist' discusses the role of the therapist and what Indian fathers expect of them. The forth superordinate theme 'what is therapy' looks at Indian fathers understanding of therapy. Each super-ordinate theme will be discussed in detail, with reference to the sub-themes that make up each theme.

Table 1: *Summary of Themes Formed Through the Analysis Process*

Super-ordinate Theme	Sub-themes	Quotes
Indian fathers and their family	Collective culture	Indian family ties are more stronger you know...It's more tied down, Indian relationships...The family ties are more stronger in Asian families and there's more to think about. (Participant 1)
	Expectation of masculine role	Father is most important in the family because he's the...in our Asian community the father is the head of the family. (Participant 3)
	Stuck in silence	It's a good time to get your emotions out, you know talk about things. (Participant 2)
East versus West	Stigma & shame	There's more things that you can't talk about, certain things you can. (Participant 1)
	Foreign concept	I know our thinking is like that because these things we never come across before in the life and we never need it either but in this country stress and other things are coming to you and err that causes the problem. (Participant 4)
The therapist	Technique	So just talking to somebody who could ideally give you ideas on how to make certain matters better...And what steps to take and that, and what steps not to take. (Participant 1)
	Mediator	With the therapy people they don't take no bodies side. Because we all think I'm right, I'm right, until you point it out that you are wrong, a third person would point out where you are wrong. (Participant 4)
	Match to therapist	It's not like your families there or anything else, it's like you, it's somebody else you can talk to, you know an Asian person to talk to. (Participant 2)
What is therapy?	Self-growth	Yeah err it gave me a clearer view of err how to take matters into my own hands and that, you know find the barrier between, you know what was going on, you know what was causing the argument. (Participant 1)
	Expectations	I thought erm I thought it's going to be a bit of a waste of time to be fair, it turned out to be quite helpful actually...Until I actually came and then I realised it was quite helpful. (Participant 1)
	Outcome	But when you go there and they're talking you think oh no there's nothing wrong with my brain or nothing wrong with my thinking, they're trying to work it out for both partners. (Participant 4)

| Disclosure | It's kinda strange because you're put in a box and someone's asking you questions, you don't always want to answer them, you try. I'm not saying you avoid the issue, you know err, I don't know, it's just things you don't want to say but then yeah admit to yourself. (Participant 2) |

Indian Fathers and Their Family

This super-ordinate theme explores the closeness of the Indian family and how the father is positioned within it. It also looks at how Indian fathers have little opportunity to disclose their negative feelings and keep personal difficulties to themselves. Three sub-themes are presented: collective culture; expectation of masculine role and stuck in silence.

Collective culture. A collective culture is one that places value on unity, strong connections and bonds within the family. There is a strong emphasis on a close knit community and culture within the Indian family, which was evident amongst all the

participants.

As a whole, the interviews suggested that as a father, there is an obligation to the family, one which inhibits them in discussing their difficulties outside the family. In the Indian family, fathers cannot just think about themselves, their responsibility lies with the entire family. There are repercussions to be considered, most notably that pursuing therapy might bring shame on the family. Discussion of mental health difficulties and problems within the family is not usual.

Participant four feels that within the Indian culture, the family must listen to the elder in the house, regardless of whether they agree with him. He further explains how in contrast, in the UK, Indian family members believe that because they are educated they know better than the father. Participant four believes that this is how conflicts started within his family because this rule was broken, and why support from therapy is needed:

Back home if you look into it, not just India. . . .if the elder person says something, wife listen to it, doesn't matter if it's good or bad and is same with the children, they have to just stop. . .stop mean stop. Over here they just think oh now we more clever than them, that's why the reason Asian families finding it more difficult to go to counselling. (Participant 4)

He seems to adopt a traditional view on how the family dynamic should function. Everyone has to follow him; if children listen to the mother, it goes against his beliefs and values. He also feels the mother needs to listen to the father in all matters. Clearly, he seems to not foresee a place where he and the mother might agree, as he views each family member as having a distinct role within the system. This seems to be quite a rigid view, and one that he has perhaps learned through his childhood and family.

Participant four's talk highlights the fathers' view of the importance of the family, and his right to supersede the individuals within the Indian family. His talk portrays the image of a powerful elder enforcing their beliefs and rules upon others. As a second generation Indian, there seems to be little recognition in his transcript of his or his family's possible struggles of being exposed to a more individualistic culture, living in the UK. Counselling has not previously been something to consider in his experience, as everything was functioning well until coming to the UK, where his family no longer listen to him. There is a feeling of being lost in translation as "stop" no longer means "stop", and now that his wife and children do not listen to him, he has had to go to therapy to be heard.

Further in participant four's transcript he emphasises the close nature of the Indian culture and the strong need to contain family politics within the family:

> Problems come in the family they don't want to come to this stage. . . .to a third party. . .third person come to know about what's happening in our family in our four walls. (Participant 4)

Taking family affairs to a stranger seems to be seen as more of a taboo than as support from an objective individual. Attending therapy "at this stage" is a last resort, when issues can no longer be resolved at home. It is as though the unity within the family has been broken because now a "third party" is involved, which to him is a strange dynamic. Participant one also expresses the close family culture within his transcript:

> Indian family ties are more stronger you know. . .it's more tied down, Indian relationships. . .The family ties are more stronger in Asian families and there's more to think about. (Participant 1)

The use of the word "tied" in participant one's dialogue portrays an image of being shackled to the family, which is their way of supporting him and keeping him safe, however for him there is no alternative coping mechanism. Things are 'tied' in everyday life to support them, (like splints on broken limbs) and keep them safe from the unknown (like chaining up a bicycle). It is as if he cannot confide elsewhere. He also repeats the word "ties" helping him to reiterate how close the relationships and family can be, and invites the image of him perhaps needing to break free. The researcher's interpretation here has been influenced by personal experience of Indian families, one can feel safe within the family but yet at the same time want to break free hence the use of the word "shackled" being used to portray this. Consequently, therapy has given him the opportunity to talk about certain things that are regarded as forbidden at home:

> They helped me, you know get the stuff on my chest off and I got to talk about things
> that I couldn't talk to anyone else about. (Participant 1)

Participant two had a slightly different family dynamic, as he described his family as a "Westernised family" who do not worry about being judged negatively by others. However, he states that even if his family is less archetypal and more modern in its thinking, family unity and influence continue to impact the individual:

> Well like I was saying if there's a home environment a lot, being the typical Asian
> family, I'm not in a typical Asian family but family influence comes a lot into it.
> (Participant 2)

He talks about having a strong sense of a "home environment", which suggests proximity and togetherness within the family, thus ingraining the importance of collective values and needs above individual ones. The family is the instrument to help solve family issues:

> We deal with it as a family so. . .I just love my family and that's all I want really, I
> want family unity, my family comes first. (Participant 2)

This emphasises the collective nature within the culture, regardless of whether it is described as "westernised". He suggests his role as a father is to think about the needs of the family first above anything else. This unity of his family is everything to him.

Expectation of masculine role. Participants talked about how the Indian culture places explicit expectations on fathers within the family. Traditionally fathers are seen as the breadwinner and therefore the head of the family as illustrated by participant three:

Father is most important in the family because he's the. . .in our Asian community the father is the head of the family. (Participant 3)

For participant three, being the head of the family is extremely significant and he mentioned this on more than one occasion. As the head of the family, he believes it is his responsibility to teach others in his family how to behave and interact with one another. If any mistakes are made in the family, he is responsible as the father, and if he is not aware of these mistakes, he cannot rectify them. Consequently, attending therapy has firstly highlighted mistakes that both him and his partner have been making, and secondly enabled him to learn new things to teach his family:

Because I am the head of the family, is very good for me if I learn, someone and I teach my kids, my family, if I don't know about myself where I do mistakes, where I did some mistakes, I can't do nothing for them, my kids and my family. (Participant 3)

This idea of teaching the family creates the image of them being unable to acquire new skills for themselves: instead, it is the father's role to guide them. His transcript implies that all "mistakes" within the family are his fault, and he needs to have the solutions for them. This is the responsibility he has put on himself as the father. It sounds as though this can be a quite a burden for him to carry alone. These role expectations are likely to have been taught to him

from a young age by his own family and father. Therapy has enabled him to recognise that he does not have to be alone and can seek solutions from an outsider.

Participant two discusses the concept of difference within the Indian family and culture with regard to gender. He states how fathers do not get the recognition they deserve within the family system; they are seen as the parent who is bad compared to mothers. He feels that women tend to use emotions to get their way, whereas men cannot express themselves in a similar manner because it is not accepted within society:

> Fathers seem to be like the ones that are supposed to be the bad ones or the bad parent, who don't do the cooking, cleaning or tidying all the house and then goes to work. . . .I think women tend to get emotional and start crying and the waterworks.
>
> Blokes are behind your back, won't cry. (Participant 2)

This gender generalisation seems to be a reflection of his own experience as a father in his family. He seems to feel that no matter what he does, he cannot match up to women, whom he places on a pedestal. He positions mothers as superior: they not only have jobs but engage in all the domestic chores, and one wonders if he is envious of his wife and the position she holds in society, and the permissions available to her. He will not allow himself to articulate his emotions in the same way as women by "start crying". Although fathers get emotional, he believes they will not communicate it and instead express it "behind your back".

 Stuck in silence. This sub-theme presents a sense of sadness amongst all participants that they lack the opportunity to express themselves. It appears that Indian fathers hold onto their personal difficulties and negative emotions, unable to communicate them to anyone around

them, despite being in families that emphasise the importance of closeness and unity. This seems to lead to loneliness and isolation. Participant one opens up on how therapy has given him the necessary support for him to understand himself and his difficulties better. For participant one, having someone other than a family member to talk to was extremely valuable, which went beyond any embarrassment that he initially felt:

> Just support I think, I guess a bit of support and that, a bit of help and support in understanding matters better init. . . you can't talk to your family, your mum or your wife, you know something that is really personal, you know that you don't like. (Participant 1)

He uses the word "support" repeatedly, emphasising the lack of support for him from within the family system. Participant one has been searching for containment that he could not receive until he came to therapy. It seems even if he could confide in his family members that this would be difficult for him because it means facing the ugly truth; the things that are too personal, that he does not like. For him, having a therapist, gave him the support he needed to undo his silence.

Participant two discusses the notion of evacuating his feelings in therapy, where, unlike in his family, he is able to talk about them. Consequently, therapy has given him the space to off load his negative emotions:

> It's a good time to get your emotions out, you know talk about things. (Participant 2)
>
> Similarly participant three feels a sense of relief after his course of therapy. He uses

the notion of breathing better now, which implies that before therapy, he was

suffocating as he did not have an appropriate outlet:

But after all the sessions I feel like that I am breathing very well now. (Participant 3)

His talk creates an image of his difficulties being heavy and weighed down on him (tied up),

leading to difficulty breathing. This could be a metaphor for him comparing therapy to a

medicine, perhaps like an asthma inhaler, which has helped loosen his tight chest. He could

also be physically breathing better; perhaps having the opportunity to express himself without

being judged negatively, helping relieve his anxiety, which he felt in his body.

Participant four talks about being trapped and unable to turn to the family for support. He uses

the word "clog" to describe how he feels, implying that there has been a build up of confusion

and problems over time. Therapy has helped set him free, and this in turn has enabled him to

establish better relationships by resolving family issues:

Sometimes we get stuck and. . . .this there's so much clog in your brain. . .it will help

your thinking, your brain and your stress and your family matters. (Participant 4)

As a father, there seems to be little space to discuss the stresses and difficulties of life within

the Indian family. Aspects such as stress or depression do not hold much weight in the culture,

and therefore are not taken seriously. There seems to be a consensus amongst all the participants

that therapy has provided them with a safe place to talk through their difficulties, rather than

keeping them locked away and tied up.

East versus West

In the interviews, the four Indian fathers described a constant struggle between their culture of origin and the culture of the country they have settled in. Their various discussions paint a picture of a tug-of-war between the divergent cultures and the values they place on the people within it. Two sub-themes were identified: stigma and shame, and foreign concept. The subtheme, stigma and shame, explores the difficulty Indian fathers face with regards to mental health and therapy. There is a lot of concern and anxiety as to what the community and other family members will think of them, if they disclose that they have mental health problems or that they need therapeutic support. The sub-theme, foreign concept, looks at how therapy is an unusual concept for them. Sharing family problems is not seen as the norm, especially with someone who is outside the family unit. The struggles of having a language barrier are also mentioned by some of the participants.

          Stigma and shame. This particular sub-theme has immense significance on participants and their help-seeking behaviour. There is a lot of stigma concerning mental health in general within British society; however, within the Indian culture, it is arguably worse. This is due to the sense of dishonour and disgrace on the family felt in relation to perceived negative judgment by others within the community. There is a degree of secrecy about issues such as mental health and family conflict, which is usually kept within the family:

There's more things that you can't talk about, certain things you can. (Participant 1)

Participant one highlights the difficulty of being able to talk freely; it is problematic because he feels restricted by ideas about what he can share and what he cannot. As a result he has had

to contain these issues, putting on a facade in front of family, as divulging would cause embarrassment.

Participant two indicates there is shame and embarrassment associated with seeking therapy. He divulges his concerns about the negative stereotype he has of the type of people who attend therapy, which has been shaped by the media:

> There's a stereotype for coming to therapy you know, you watch these comedy programmes, you watch TV, you know gotta be really sad to come into therapy. . .Sometimes you hear it's the shame factor if you come for therapy or we don't want so and so or x and y families to find out. (Participant 2)

For participant four, the idea of disclosing to a therapist is viewed as problematic, because he believes that both the therapist, and others who know that he is coming to therapy, will view him and his family negatively:

> You think a third party will come to know you and that's set at the back of your mind or people will think you're going counselling or what's wrong. . .what other people think about me, why do I need counselling, something wrong with my brain. . .something wrong with my brain or probably I'm behind or something like these sort of things come to mind. (Participant 4)

His perceptions about the thoughts of others has great value for participant four; therapy can affect his credibility within the extended family and culture. He fears being judged negatively

by others, which seems to be his primary concern. His anxieties of what others may think make him think he is defective as he makes reference to his brain malfunctioning.

Foreign concept. Therapy was described by participants as being an alien notion. Problems and difficulties that arise within the family are supposed to be kept within the family; therefore taking them to a non-family member was a difficult concept for participants to grasp, even when the family cannot always help eradicate problems, as illustrated by participant two:

> In Asian cultures it's like hidden underneath, families trying to deal with it and families can't always deal with it. (Participant 2)

Participant two suggests an image of a family gathered together around a table, desperately trying to solve difficulties to ensure non-family members do not get involved. It appears from his talk that, if there is an underlying problem, the family either tries ignoring it or resolving it themselves. When neither strategy works, it becomes necessary to seek support from someone who can "deal with it". However the unfamiliarity of therapy has led to uncertainty about what to expect from it, what to talk about, and what the boundaries are in sessions, as shown by participant one:

> The first few days were a bit awkward, cause I didn't know what to talk about. (Participant 1)

Participant one feels self-conscious because there have not been prior circumstances where he has had to open up to someone, especially a non-family member. The initial therapy sessions sound as if they were spent in silence due to the awkwardness. Over the course of therapy, he

has become more comfortable with the therapist and the process. Consequently this has enabled him to talk freely and recognise therapy as a space, where he can talk about things he wants to, as there is no rule as to what is appropriate and what is not appropriate. This is a contrast to what he knows in Indian culture, as usually difficulties would be concealed. Therapy is therefore seen by participants as a Western concept. This is because many services do not have the resources to deliver culturally sensitive counselling. These participants have been seen in a service by a therapist who speaks their native language, and, who better understand the norms, values and pressures within the Indian culture. A service that can provide culturally sensitive counselling may be more appealing to clients from that culture, which participant three and four illustrate, as therapy is less daunting:

> Because my English is no good that's why there is a little bit of a problem for me, it's very hard for me, but I will try my best (laughs) and that's why we came here. (Participant 3)

> Although I can speak English some of the hard words I wouldn't be able to pick it up and err probably not able to understand, be incomplete, I think err that was good. (Participant 4)

Both participant three and four indicate how important it was for them to be able to communicate in their native tongue. Without this they would have not been able to articulate themselves well. It also allowed them to feel safe and more comfortable with the process of therapy, although they were in unfamiliar territory. Participant three explains that he came to this particular therapy service because they were able to deliver therapy in other languages besides English. His laugh within the transcript implies he is possibly feeling nervous in the

interview about expressing himself in English; perhaps in the interview, he is realising how therapy in English would have felt. Participant four implies that when communicating just in English, some of the meaning gets lost, resulting in him feeling "incomplete". Talking in his own language makes him feel whole and complete.

For some of the participants, therapy has been a concept that they have never heard of until they were recommended it by other services. For first and second generation Indian fathers, therapy according to their knowledge does not exist in their country of origin, as exemplified by participants three and four, who were the two older participants:

> No, in our country they don't do it like that. In this country it's very good for us. (Participant 3)

> I know our thinking is like that because these things we never come across before in the life and we never need it either but in this country stress and other things are coming to you and err that causes the problem. (Participant 4)

Participant three indicates that in his country therapy is not readily available, in contrast to the UK where it is accessible for any individual experiencing problems in their life. It seems that services in his country reflect the dynamic and abide to the norm that family difficulties are not discussed outside the family. Thus therapy according to him is absent. He appreciates the existence of therapy in the UK as it has helped him.

Similarly participant four explains his ignorance to therapy; this is because in his country he never needed it. In the UK, he feels, the dynamic is different and individuals are more likely to

suffer from stress and family difficulties, thus it is recommended to go to therapy. He suggests that because therapy is a Western concept, it is needed in Western countries only. Participant four implies that his problems are caused by being in the UK, rather than having their origin in him, or in his culture, as he did not encounter issues prior to moving to the UK.

The Therapist

The therapist plays a significant part within the process of therapy. Three sub-themes were identified, which discuss the features of the therapist that Indian fathers valued: technique; mediator and match to therapist. The sub-theme, technique, explores participants' experience of the therapist being in an expert position, whose recommendations need to be followed. The subsequent sub-theme, mediator, explores Indian fathers' experience of the therapist being someone who is unbiased. The last sub-theme, match to therapist, focuses on how similarities between the therapist and the participants were important and helpful.

 Technique. The technique the therapist utilised has been an important factor for participants. Having the therapist support clients, by giving them advice on how to improve matters in their family, was of huge value to them. It is evident from participant one's talk that the techniques the therapist employs need to be solution focused, didactic and prescriptive. An approach that was less directive may have not been well tolerated by the participant, as he wanted ideas and techniques on how to move forward:

> So just talking to somebody who could ideally give you ideas on how to make certain
>
> matters better. . .and what steps to take and that, and what steps not to take. (Participant
>
> 1)

Similarly, for participant two, the therapist is seen as the expert and someone who knows best, therefore it is imperative for participants to follow the advice given to them:

> I think sometimes some people don't listen to the actual what the counsellor is saying to you. (Participant 2)

The way in which participant two talks about therapy creates the image of it being similar to school, which requires regular attendance and careful listening. The therapist is like the teacher who gives the pupils instructions and homework, which need to be followed and completed. Without this process, pupils cannot progress forward; similarly with therapy.

Participant four believes that the therapist has the ability to "cure" individuals because they have trained and worked for many years with different clients and difficulties. Consequently the advice they give is valued greatly:

> A lot of other things which you come to know from err the err the therapy people and they got more experience than us. They been trained like that and they take it out of your brain and err it helps quite a bit. (Participant 4)

He suggests that, before therapy, he lacked the knowledge on how to improve his family difficulties. With the support of the therapist, he has been able to increase his knowledge. However, as well as supplying knowledge, he feels that it eradicates issues, using a medical analogy to describe that he feels that the therapist extracted the bad parts from his brain.

 Mediator. The therapist is seen by Indian fathers as an arbitrator: someone they can open up to, who will not take sides. It also helps that the therapist is not related to them, which makes opening up easier. The therapist is seen as providing an impartial "truth", taking the responsibility in helping "sort" the difficulties encountered for everyone in the family, as illustrated by participant three:

> You tell us the truth and everything and then we sort everything on behalf of you and behalf of your wife as well and your family counselling here and we told erm everything and after this erm they sorted everything. (Participant 3)

Within the Indian culture the father is seen as the one with the most responsibility, therefore there is the possibility of a fight for control in the therapy. However, participant three seems very contained in therapy, he is able to articulate himself and let the therapist take charge and act as a buffer who does not judge or take sides. The participant has let the therapist take charge, suggesting therapy has been one place where he can let go and take on a different role: one where he is guided and told what to do rather than the other way round, perhaps as his father once did for him.

The idea of receiving impartial advice from the therapist is significant for Indian fathers. Participant four talks about how each person in the family, including himself, believes they are correct. He sees the therapist's role as helping individuals to explore alternatives and different perspectives:

> With the therapy people they don't take no-body's side. . .because we all think I'm right. . .I'm right, until you point it out that you are wrong, a third person would point out where you are wrong. (Participant 4)

Participant four acknowledges the problem of only being able to perceive a situation from one's own point of view. Like participant three, this participant positions the therapist as a better father, disregarding what others, including him, in the family say, and pointing out everyone's mistakes. The role of the therapist as a mediator is what draws the truth and honesty from the fathers, having an active therapist can be seen as a beneficial aspect of therapy.

Match to therapist. Having a therapist who reflects similar morals, values and cultural understanding was very important to Indian fathers, allowing the process of therapy to unravel with less difficulty. All four participants stated that attending therapy sessions with a therapist who was from an Asian background made it easier for them, as they felt their "Asianness" was understood:

> Actually having a Asian counsellor made it better cause they understand. (Participant 1)

Therapy itself is an unfamiliar process and for participant one, having a therapist who shared his cultural background helped increase familiarity and made therapy less daunting. Participant one is relieved that he does not have to educate the therapist on customs and traditions in his family because she already has awareness. He associates familiarity with trust and confidentiality, which enhances his experience of therapy. Participant one does not seem to feel that disclosing personal issues with a therapist who is from a similar background is detrimental, which is a common belief about culturally sensitive therapy. It would be difficult for him to open up to someone where there is a possibility of being judged negatively, and it appears from his talk that he did not feel that.

Participant two shares a similar experience to participant one, but goes further to explain that one's family is not always enough to talk to, and having an Asian non-family member is helpful to confide in:

> It's not like your families there or anything else, it's like you, it's somebody else you
>
> can talk to, you know an Asian person to talk to. (Participant 2)

Like participant one, he suggests that he can trust a therapist from a similar background. There seems to be less fear in talking about difficulties with an Asian therapist, strengthening the therapeutic relationship. Talking freely with the therapist also enables him to be honest.

This reflects participant two's honesty in the interview itself, where he reveals many personal difficulties in his family life to the interviewer. When he comments to the interviewer "you know, an Asian person" it is as if he assumes the interviewer understands what he means because of the similar background. While a client may automatically assume the therapist understands them without further explanation, it is important for the therapist to be vigilant to areas where difference might be usefully explored, rather than simply believing the experience between therapist and client to be the same, without question.

Participant two also talks about a feared lack of understanding from non-Asian organisations, with regard to his relationship and difficulties. He feels that a therapist with a similar cultural background to him helped him feel better understood:

> Well I think if I went to certain English organisations may be they couldn't, they
>
> probably wouldn't understand the culture differences, especially in my relationship.
>
> (Participant 2)

Here participant two firstly uses the word "couldn't" and then "wouldn't" suggesting that he believes other organisations which in his eyes have insufficient cultural understanding, might be unable, or more importantly unwilling to understand him.

Another aspect of familiarity is language. Having an Asian therapist who shares a similar language to the participants was an important part of therapy for the fathers:

> All the time they talk to me in English and err Hindi and Punjabi. (Participant 3)

Here participant three stresses the importance of having a bilingual therapist who can understand him in his native tongue. Being a first generation Indian father, language can be a barrier, which could have prevented him from receiving adequate support. Language seems to be a major factor preventing individuals from ethnic minorities from pursuing therapy.

Participant four found therapy helpful and easier because his therapist was Asian. This is because he cannot always express himself in English, and only knows how to do so in his language. He also makes the point that some Indian beliefs, ideas and concepts may not be easily translatable into English:

> Well easier with Indian circumstances. The reason is some of the words we probably can't explain in English or any other language that's why I felt more comfortable with an Indian counselling. (Participant 4)

He indicates a sense of being lost without a common language with the therapist. This in turn would increase his anxiety around expressing himself freely with no restriction. Both participants seem more at ease from being able to mix both their native tongue and English.

What is Therapy?

The super-ordinate theme, what is therapy, encompasses four sub-themes: self-growth; expectations; outcome; and disclosure. Indian fathers felt therapy enabled them to grow personally, which helped their family relationships, which is explored in the sub-theme 'selfgrowth'. The participants went into therapy having certain expectations, which were initially negative; this is explored within the sub-theme 'expectations'. The sub-theme 'outcome' explores participants' positive experience of therapy and the last sub-theme 'disclosure' discusses the difficulties Indian fathers had in opening up and talking about their personal

issues.

Self-growth. Self-growth is a concept used to describe change; in this instance, the change refers to relationships. The fathers found therapy to be an arena where they could allow themselves to reflect, explore and achieve their goal of improving their relationships.

For participant one, therapy gave him the platform to dissect and take control of his difficulties:

> Yeah err it gave me a clearer view of err how to take matters into my own hands and that, you know find the barrier between, you know what was going on, you know what was causing the argument. (Participant 1)

Before therapy, it is as though there was an obscure barrier preventing him from recognising what his problems were and how to move forward. His experience of therapy has enabled him to perceive his situation differently; his awareness is clearer. He talks about taking matters into his own hands, suggesting that he had felt out of control for a long period of time, not feeling like he knew what was happening. The lack of control and knowledge may have conflicted with his role as the father, therefore creating tension and the need to seek support from therapy.

Participant four highlights his lack of experience in solving domestic problems. Therapy has given him the opportunity to consider alternatives to help improve the difficulties in the family. Although this participant separated from his wife following therapy, he talks about therapy positively, as he has acquired a different way of thinking, demonstrating his development as an individual. The therapy may have helped him to split up with his wife which is another taboo in the culture, but was perhaps what they needed to do:

> She helped me there about what else we can do and what else we can't do, how things work, that was few things I came to know about it err which was without my experience before but as you say you live and learn every day, persons live and learn everyday so I was learning a few things from there and err a few things were working better. (Participant 4)

He talks about the therapist helping him, which evokes an image of a child who does not know the correct path, does not know how much power he has, or how to use it, and is turning to the parent for advice and guidance.

Expectations. This particular theme concerns participants' beliefs prior to therapy and its impact on their future. Some of the fathers entered therapy with preconceptions based on stereotypes or personal biases:

> Err I just thought, I thought erm I thought it's going to be a bit of a waste of time (laughs) to be fair, it turned out to be quite helpful actually. . .Until I actually came and then I realised it was quite helpful. (Participant 1)

Participant one repeats the word "thought", suggesting that his predictions of therapy were incorrect, which is illustrated by him laughing. The tone of his voice and his shock at the benefits of attending therapy, which was contrary to his beliefs, was evident. His use of "quite helpful", which he repeats throughout the interview, confirm his later statement that it was not until he attended therapy, that he realised how it could help him and his family. This highlights his determination, and perhaps his desperation, in wanting to reconcile the difficulties in his family despite having a negative view about therapy initially.

In contrast, participant three did not know what to expect of therapy, as it was a new concept for him to grasp:

> Yeah I said to you before it was very good for me and my family because when I came here first I don't know what was going on. . .Family therapy is err same like that when we came here we don't know about that. (Participant 3)

Participant three talks about uncertainty, due to his lack of knowledge on what therapy is. This is evident by the use of his language, creating a picture of a fish out of water. He is in a different environment that is unknown to him. This is possibly parallel to how he felt when he came to

the UK, and similarly how he felt coming to therapy and perhaps even coming to the interview. There seems to be similarity between the unknowns, however when coming to therapy he has someone (the therapist) with him in the unknown.

For participant three, time was also an important factor helping him and his family. Initially, the therapeutic experience was uncertain and daunting for him, however time played a role in developing the client therapist relationship, and in turn, helped him to understand what is expected in therapy:

> Slowly slowly slowly slowly in 6 err 7 weeks everything was finished, it's erm family services is very good for me and my family. (Participant 3)

He repeats the word "slowly" emphasising that therapy takes time and requires dedication. Therapy is about active engagement, and he feels it has helped his family tremendously, which has lead him to feel that therapy as a whole is positive but needs time to resolve issues.

Participant four talks freely about his emotions, and states some feelings of anxiety regarding therapy. His concerns were about what the therapist would expect from him. Therapy being a new experience for him has triggered concerns, which he attempts to minimise by saying "a little bit worried" however it is apparent that he has been ruminating and questioning what therapy is about. His thoughts about what he can and cannot say, what the other will say, what to do, and whether it will work, which may well reflect the problems that took him to therapy:

> Well I was a little bit worried first erm. . .what they will say, what not to say, how it works, how it wouldn't work. (Participant 4)

 Outcome. Over the course of therapy the fathers have been able to conjure a description of what therapy means to them; all of them found therapy to be a beneficial experience. For participant one, therapy made things "work" again and he felt "better":

> Well family therapy, I mean it picks up on the things, like if there's something wrong in a relationship it tells you how to kind of get matters working and you know better. (Participant 1)

It seems here that he is thinking of therapy in medical terms. The way he describes family therapy creates an image of someone having a broken bone that needs an x-ray. In the same way therapy is a diagnostic, able to see the unseen, and "pick up" the problems and issues causing distress in his life. Once the break has been identified, he has been guided on how to nurture the damaged relationships, and the end result has been that everything is working better. Thus therapy has the ability to mend broken relationships and rectify individual difficulties through self-exploration and awareness. Consequently after a period of time, he was able to move forward with his family and relationship:

> Actually it went all well because we talked about our differences, slowly over time we had a reconciliation and then it was quite good. . .it kinda picks up points where you know that you miss out in relationships and helps to repair, repair matters and that. (Participant 1)

Therapy is a process which takes time, where he had to be patient in order to achieve the results. He uses the word "repair" implying again that something is broken and needs fixing. He articulates that when an individual is involved in conflict with other family members, it can be

difficult to think rationally and be objective. Therapy has enabled him to step back and "pick up points", which he previously overlooked, and as a result he has been able to work through the problems slowly:

> So I think it does help, it helps a lot, it helps a lot. (Participant 1)

It feels as though he has not previously been able to sit and reflect on his experience of therapy, and the interview process has given him that opportunity. This is evident in his speech, he repeats himself, and it seems as though he is actually thinking aloud and has had a "light-bulb" moment, where he has stopped and acknowledged how his views about therapy have actually changed over time.

After the course of therapy, participant two explains that issues in his family were resolved. He feels very positive about therapy, which has given him the opportunity to discuss his feelings:

> No, after counselling the main issues gone, so very good. . .it's a good time to get your emotions out, you know talk about things. (Participant 2)

It seems he has not previously had the chance to open up to anyone, this experience has given him a positive view that disclosing your emotions is healing rather than keeping them to himself. Therapy can perhaps be viewed as being "a good time", his talk suggests there are perhaps right times and wrong times to let an outsider in. For him it was the right time to off load his emotions, like a heavy load being lifted off his shoulders or chest, allowing him to now breathe easier. Thus he says he would "recommend" therapy to others for family difficulties. It has been a "dual" process for participant two, where he has been able to practice active listening and

honest talking to a non-family member, and in turn with his wife. For him it has been about sharing personal things with his wife and the therapist and respecting what they say:

> I recommend it to anyone who's got a problem in their relationship, it's mutual, well erm it's not like err, it's not like your families there or anything else. It's like you, it's somebody else to can talk to. (Participant 2)

Through the interview, it seemed that participant two has a slightly naive impression of therapy being something that is able to solve all your difficulties all the time. This may reflect the fact that he achieved a positive outcome from therapy, therefore influencing his view and recommendation to others, and how happy he is to find someone who can tell him what to do and who he can listen to.

For participant three, therapy feels like a fairytale, where everyone lived happily ever after. He mentions towards the end of his sentence that it "hits" him that family therapy was useful for him, this almost seems like a shock to him, something that he did not consider:

> But the third time I understand everything and she understand everything as well and after this when we go back home we talked to each other err we don't shout, we talk nicely and do good conversation with each other and err then it hits me that family counselling is very good for me. (Participant 3)

Participant three is similarly a supporter of therapy. He explains that in the future if he encounters any difficulties in his family life he would consider attending therapy again:

> Er if I need it then I should come back. . .family services is very good for me and my
>
> because we need our kids back. . .if every couple came here for counselling then it's
>
> good for them. Every couple like me. (Participant 3)

His dialogue indicates that to him therapy is like a medicine; after the first course of therapy there is a possibility that he may need a further dosage. His talk indicates that he attended therapy to get his kids back, which is instrumental to him, consequently therapy is perceived as a tool that helps get children back.

In contrast to the other fathers, participant four was not able to reconcile with his wife and family, however he still believed in the benefits of therapy. He is able to appreciate that therapy can resolve personal matters and interpersonal difficulties. Within the transcript he talks about the helpful aspects of therapy and he feels comfortable having conversations about therapy with friends at the temple. In the quote below he is talking about a female friend, who went to therapy after having a "bad" time in her life, and therapy enabled her to change it:

> I have seen some people err talking with my friends and it did help them. I was talking
>
> to them at the temple one day and err she said she was quite bad and she says if you'd
>
> seen me two years ago I was not like this, she totally changed all together. (Participant
>
> 4)

Participant four's concerns are eliminated after attending therapy and he realises there is no malfunction on his part, helping him recognise that family issues and difficulties are quite normal and it is often useful to seek support. Thus he has a positive attitude towards it and realises that he made some mistakes:

> When you go there and they're talking you think oh no there's nothing wrong with my brain or nothing wrong with my thinking, they're trying to work it out for both partners. . .yeah I'm quite positive about the counselling because certain things which about me and my side as well err which I was thinking were right but it turned out I wasn't right about a few things and err I changed that. (Participant 4)

   Disclosure. This theme highlights the importance of building a good therapeutic relationship with the therapist, to enable personal disclosures to unravel. Within Indian culture, disclosure to a stranger about family difficulties can be stressful and anxietyprovoking for individuals. All four fathers stated the initial difficulty they had in therapy with regard to talking in depth about their private lives:

> After the first two sessions, the third one went quite well and I was speaking quite freely. (Participant 1)

Although participant one was unsure of what to discuss in therapy initially, he states it got easier to disclose. As this was the first time he had engaged in therapy, he was initially concerned about what was appropriate talk in therapy. However with his continued attendance and dedication to improve his family life the awkwardness eased, allowing him to talk more openly.

Participant two states that he often did not want to reveal delicate information to the therapist. He found it difficult to "answer" to someone else, which reflects his position in the family, where he is not used to opening up and answering to others. Therapy has provided an

opportunity to divulge personal difficulties whereas previously there seemed to be denial and avoidance about accepting difficulties:

> I mean it's kinda strange because you're put in a box and someone's asking you questions, you don't always want to answer them, you try. I'm not saying you avoid the issue, you know err, I don't know, it's just things you don't want to say but then yeah admit to yourself. (Participant 2)

He has some difficulty articulating himself here. It seems that he is placed in a "box" and the therapist's seeing and thinking is threatening, making him feel vulnerable rather than contained, as it was for other participants. This may be a reflection of his upbringing where his own fathers' authority was more difficult for him to accept. He expresses that he does not want to respond to the therapist's interrogation, which he does not further rationalise. It is possible that he feels therapy is a strange dynamic because he is not usually the one answering to others. As the father he does the questioning. This could also be a reflection of the difficulty he has trying to accept the problems in his family, which goes against the ideal of perfection. He may speculate that if you attend therapy that makes you imperfect, yet he knows too that avoidance is imperfect. It has in the past been easier for him to deny or "avoid issues" until therapy, where he is almost challenged to disclose.

Participant four felt similarly to participant two in that he does not want to disclose in therapy:

> I don't want to disclose my privacy to anyone. . .when there's a bitterness, problems come in the family they don't want to come to this stage to a third party, third person come to know about what's happening in our family in our four walls, behind the four

walls whatever they are doing they think they are doing it right but it's not right all the

time. (Participant 4)

The fear of having a "third party" involved in his private family life appears to be stressful for him. He explains that family difficulties should not get to a point where they have to be taken outside the family house to discuss with a stranger. This highlights his feelings of shame, where he has not been able to manage the family difficulties at home and needs additional support. The family can be seen as the four walls versus the outsider third party. The four walls are containing, yet they offer a false certainty in contrast to the third party that offers insight but with exposure.

Discussion

Summary of Results

The current study aimed to explore Indian fathers' experience of family therapy. The analysis identified four major themes: Indian fathers and their family; East versus West; the therapist; and what is therapy. There were two main findings. Firstly Indian fathers experienced family therapy as an unfamiliar, but helpful, concept. Secondly, Indian fathers placed great importance on being matched to the therapist, which improved their experience of therapy. This chapter explores these findings in relation to existing literature, and discusses the implications of this for clinical practice. It then examines the limitations of the current research and suggests directions for further research. The final section of this chapter provides a reflexive statement exploring the researcher's personal thoughts and reflections on the research.

Comparison with Existing Theory and Implications for Clinical Practice

This section will discuss the research findings with existing literature and the implications of the findings for clinical practice throughout. This study has contributed to existing knowledge on Indian people and therapy by exploring Indian fathers' experience of family therapy.

Prior to this, research has focused primarily on therapists' experience of working with Indian families. The current findings have helped gain some insight and understanding into Indian fathers' thoughts and feelings about the therapy they have received.

Existing literature illustrates that men in general seek help less from therapy compared to women (Good & Wood, 1995; Hammer, Vogel & Heimerdinger-Edwards, 2012). Based on referral figures from the Indian family therapy organisation that participants were recruited from, three quarters of the total number of clients engaging in therapy were women.

According to McKelley (2007), Freud believed that this is because therapy questions men's power and status. The male personality can be a significant aspect influencing men's willingness to engage in therapy. Within society there are masculine norms proposing certain beliefs on what it is to be a man, these include superiority over women, self-sufficiency and suppression of emotion (Mahalik et al, 2003). Literature has shown that men who adhere more to these masculine norms are more likely to perceive help-seeking negatively (O'Neil, 2008). Gender role socialisation also encourages men to display stoic and emotional restraint, and to deny any psychological difficulties (Berger, Addis, Green, Mackowiak & Goldberg, 2013). This can often lead to men suffering in silence (Addis, 2011). Good and Wood (1995) found that men are known to prefer to problem solve their difficulties rather than talk to someone intimately because this is something they have been socialised to do. Lalwani,

Sharma, Rautji and Millo (2004) report that there is unreported mental health problems in South Indian men because of their tendency to keep quiet about health issues, particularly mental health problems because it threatens their masculinity and the conventional gender standards of being strong and in control (Bhui, Chandran & Sathyamoorthy, 2002). This is in accord with the sub-theme of expectation of masculine role, in the present study. At the outset, Indian fathers found it difficult to communicate their family difficulties and feelings to the therapist. They were out of their comfort zone and within an unfamiliar environment. Gender and culture are interwoven however there is a possibility that being an Indian man can further hinder individuals from attending therapy. This is because the Indian culture places certain expectations on fathers within the family, for example being the leader and having particular responsibilities, this is supported by literature (Chadda & Deb, 2013) and by what some of the participants said in the current study.

Therapy as a "Western concept" (McGoldrick, Giordano & Garcia-Preto, 2005), was expressed by all the participants under the sub-theme of foreign concept. Therapy is entrenched within Western culture, meaning that a lot of the theories of therapy are traditionally rooted in central European and more currently North American culture (Lago, 2006). As a result, Lago argues, these theories are constrained, making it difficult to apply them to individuals from multicultural societies. The concept of therapy was not readily understood by the Indian fathers. The idea of sharing family and personal difficulties with a non-family member is not the norm within their culture, and it took time for the Indian fathers to adapt, learn to speak freely to the therapist, and disclose personal matters. This finding is supported by current literature, which positions the Indian family and culture as adopting a collectivist nature, which can be defined as having agreement amongst members, interdependence and precedence for others (Hue & Triandis, 1986). Thus the family is supposed to be the main emotional support network for individuals; consequently it is alien to have to go outside the family system and discuss difficulties in therapy (Johnson & Nadirshaw, 1993).

The sub-theme, disclosure, explored Indian fathers' difficultly to share their private lives with a third party. It gives the impression that the initial stage of therapy is not straightforward and simple. Over time this changed for the Indian fathers and they were able to disclose to the therapist. This has implications for practice, as terms such as disclosure need to be explained, and the importance of being patient with this client group who may take a few sessions to fully open up. Counselling psychologist need to be mindful that this may require them to support this client groups motivation and manage expectations.

Present literature focuses more overall on Indians as a whole and discusses reasons why they do not engage in therapy. For example Mukherji (1995) states individuals from Indian

backgrounds delay treatment and help due to social appeal and cultural sanctions. Youssef and Deane (2006) further added that individuals from Indian backgrounds are hindered from engaging in therapy because of the psychological burden and shame related to mental health and therapy. This was supported by the findings in the present study as expressed by the participants under the sub-theme of stigma and shame. This was a pertinent sub-theme within the study because all participants stated experiencing a degree of shame and stigma about seeking therapy. There seemed to be a lot of fear for Indian fathers around talking freely and honestly without negative judgment. This partly relates to the belief that family matters should be concealed from non-family members, and the concern of what others within the community will say if they were to find out they were attending therapy. Existing research highlights there being social anxiety within the Indian culture with regard to what others think (Seegobin, 1999). The current study helps explain why Indians in general engage less in therapy and it helps to understand that different cultures employ divergent help seeking behaviours. This is due to their particular cultural norms and values (Lago, 2006). The current study adds further to the literature that despite having these anxieties around shame and stigma, Indian fathers still attended therapy and in time become advocators of it. This could be because they were referred to the family therapy service by support workers or the courts, and one of the fathers was recommended to attend the service by someone he knew. This has implications for clinical practice; to help engage more Indian fathers within therapy. Indian fathers who have already experienced family therapy need to help promote the benefits. This would encourage other Indian fathers to consider it and hopefully engage in it. As mentioned earlier one of the fathers in the current study was recommended to go to therapy. It was not clear whether this was through another Indian father, but highlights that recommendation from others can help promote family therapy within this group. This is supported by literature; Guillebeaux et al (1986) found that one of the main considerations men viewed as influencing them to attend

therapy was recommendation from others. This study highlights how fathers with prior therapy experience can help advocate it to others. This could be done via expert patient seminars or workshops where Indian fathers talk about their experience of family therapy. Location would be important to consider as it would need to be within places where Indian fathers access, such as places of worship (gurdwaras, temples, mosques) and community groups.

It seems from the current study that therapy provided Indian fathers with the opportunity to express themselves. Within the Indian culture overt displays of emotional difficulties are viewed as a poor reflection of an individual which consequently reflects badly on the family. In the Indian culture psychological distress is often communicated by physical problems, commonly known as somatisation (Chadda & Deb, 2013) which is more accepted within the culture. Behavioural difficulties are sometimes viewed as religious or supernatural connotations (Steiner & Bansil, 1989). Participant four in particular talked about something being wrong with his brain, although he did not report any somatic symptoms, on numerous occasions expressed having a faulty brain. This relates to the mind-body debate, which questions whether "mental phenomena are physical phenomena, and if not, how they relate to physical phenomena" (McLaughlin, 1995, p. 597). Participant four seems to be talking about monism (Van Gelder, 1998), which adopts the view that the mind and brain is the same thing. He later talks about how therapists are trained to take problems out of your brain and as a result he felt better, which also supports the monism approach. This could have implications on clinical practice as Indian fathers may not accept that their physical symptoms are due to mental factors, making it difficult for therapist to work with them. Indian fathers' talk suggested that they found it helpful to receive advice and suggestions on how to improve their relationships. Within the Indian culture there is a restriction in vocabulary for mental health problems therefore the language they use to communicate their difficulties may well be different to their

white counterparts. It also raises concern on expectations Indian fathers have of psychologists, as participant four talks about therapists having the ability to extract the "clog" out of his brain. These expectations need to be explored with clients within the first session to avoid unrealistic beliefs they may have about it. These findings are significant because this could be another reason Indians do not engage in therapy, they may not understand that somatic symptoms can be a result of the body's attempt to cope with emotional and psychological distress.

The Indian fathers in the study had attended therapy for approximately seven sessions. For participant three in particular it felt like a long time. This has implications on current therapy providers, especially long-term therapy providers who may need to consider reducing sessions to accommodate some Indian father's needs. This is because if they are experiencing therapy as a slow, long process they may not stay engaged. This may be one reason that Indian clients drop out of therapy. This finding also suggests that a cognitive behavioural approach may be favoured in these particular cases as it can provide short-term support and strategies to apply to their difficulties. Other suggestions include utilising the two plus one model of therapy, which involves having two, one hour sessions a week apart and then having a third session three months later. Other options could be having therapy fortnightly or monthly, having single session consultations (Talmon, 1990) and incorporating more solution focused work. Solution focused family therapy work has illustrated better compliance with assigned tasks and quicker improvement (Adams, Piercy & Jurich, 1991).

Talmon's single session work involved follow up with clients who were viewed by therapists as "drop outs" and lacking motivation. He concluded that these clients were actually satisfied with their single session. This also raises concern on Indian fathers' expectations on the time frame of therapy, highlighting the importance of having pre-therapy groups, workshops and seminars to help socialise them to therapy and address any expectations. GPs, who are often

first consulted could provide Indian fathers with therapy leaflets and briefly talk them through what therapy is. These options should be presented to Indian fathers to choose from.

Participant two disclosed feeling unfairly treated as a father compared to women, with regards to receiving appreciation for his role within the family. This is mirrored in existing literature on family therapy, which found that father's attendance in therapy was not necessary for behaviour change at home in children (Firestone, Kelly & Fike, 1980). Although this study was done 34 years ago, it suggests that one parent is sufficient to affect positive change in the home behaviour of children (Firestone et al, 1980). Firestone also reports that fathers are not as important as the mothers since they do all the work with the child, which is supported by recent literature (Bagner, 2013). This creates a sense of hopelessness which is reflected in participant two's transcript. His experience and existing literature highlights how Indian fathers in general are marginalised within both the family system and therapy, yet within the Indian culture they possess a superior position. There is a danger in this as they are overlooked when it comes to receiving support, not just within services but within families too, it poses the question of where do Indian fathers go with their problems? The current study helped understanding reasons why they do not engage such as stigma etc. The inclusion of Indian fathers in family therapy can help them feel more valued and appreciated. Clinically, therapists need to involve fathers more within the process of family therapy and invite them to sessions directly rather than through the mother. It is often thought that fathers are not involved within family therapy because of work commitments (Bagner, 2013).

The current study illustrated how, despite their negative preconceptions of therapy, these Indian fathers had an overall positive experience of it. Over time they developed skills such as being able to self-reflect, considering others' perceptions and improving their ability to problem solve.

This finding is not evident in current literature because previous research has not considered Indian fathers' experience of family therapy, or therapy in general. Without knowing their experience of family therapy it is difficult for therapy services to improve. Although Guillebeaux et al (1986) explored the experience of men who attended marital and family therapy, they only report on factors that influenced their decision to attend therapy rather than what they learnt from it. This study also only surveyed men in their 30s who were predominately white, middle class and highly educated, therefore not factoring in cultural difference.

This research has highlighted that some Indian fathers might prefer to be matched to an Indian therapist with regards to sharing a common cultural background and language, therefore this is something services should offer. Having an Indian therapist enabled them to talk more freely and not worry about explaining cultural norms, customs, traditions and values because the therapist already knew them, enabling them to feel comfortable and safe. This is in contrast to previous literature that demonstrated that Indian people prefer white therapists, placing more trust in them because they felt Indian therapists would take the information they divulged back to the community (Virdee, 2004). There may be a cultural idea that non-Indians know better as they are separate from the community and possess more power, and this belief might help explain why Indians do not want therapy that is like this. It would be helpful to understand what it is they would like from therapy. Indian participants in Virdee's study may not have fully understood the concept of confidentiality, either because of language barriers or the therapist not explaining it properly. The participants in the current study had more awareness of confidentiality issues and understood if and when this would need to be breached. This may have been a reflection of the therapists skills in explaining the term efficiently, and it

emphasises the need for therapist to explore the difference between public and private and inside and outside the therapy room with these clients, to ensure they understand the term. Language also plays a significant role; having a therapist who speaks the same language again enabled Indian fathers to feel safe and to communicate themselves fully without being constrained to English only. Thus this highlights the need for services to employ therapists who are bilingual to be able to provide a culturally sensitive service to Indian fathers; this should be a choice rather than mandatory.

The technique of the therapist was of importance to the fathers. The participants valued having a therapist who was active in their approach and able to help provide guidance and advice. Behavioural work could be something they respond well to rather than cognitive aspects of cognitive behavioural therapy (CBT) because they view psychological difficulties manifesting physically. Contemporary literature indicates that CBT is both "versatile" and "universal" whilst working with Indian families (Dattilio & Bahadur, 2005). Literature indicates when working with Indian individuals it is best to include the entire family, for example after individual sessions to see the family too. This is suggested because of the close interpersonal relationship amongst family members and any change produced in one family member may not be accepted or tolerated by other members (Steiner & Bansil, 1989). Within the current study, this particular issue was rarely discussed, although participant one expressed finding it helpful to attend therapy alone initially and then with his partner and mother. This may be related to the particular issue he was seeking therapy for. Steiner and Bansil's (1989) recommendation seems naive, as every individual should be treated holistically and this particular suggestion may not work so well with every Indian individual and the difficulty they are presenting with. This also raises concern around the issue of confidentiality, which would need to be breached if involving other family members.

As mentioned earlier participants expressed that it was helpful to be told how to improve their relationships indicating the value placed on a more structured approach to therapy. The family therapist explained that she always adhered to a person centred approach whilst utilising different theoretical orientations such as CBT, solution focused work and transactional analysis, which was explained to the clients at the onset of therapy. Previous research indicates that CBT enables therapists who are working with individuals from different cultures to work collaboratively by allowing the family's cultural beliefs to help inform the treatment goals and process of therapy (Dattilio & Bahadur, 2005). It is further indicated that CBT is a culturally sensitive model because material is produced by individual family member's automatic thoughts and rational responses rather than predetermined principles (Dattilio & Bahadur, 2005). Researchers stress the importance of incorporating spiritual and/or religious beliefs and cultural norms in the utilisation of CBT interventions. Naeem, Gobbi, Ayub and Kingdon (2009) state that in order to adapt CBT to work cross culturally, it is important to explore how consistent concepts underpinning therapy relate with how individuals perceive themselves, the world and the people around them. Scorzelli and Reinke-Scorzelli (1994) found that 82% of psychology students in India found cognitive therapy approaches clashed with their ideals and beliefs, 46% stated that therapy in general conflicted with their cultural and family values and 40% reported that this conflicted with their religious values. This incongruity was due to religious beliefs that supernatural powers determine individuals' destiny and are influenced by their actions in a previous life. It seems that although these conflicts exist that they may not necessarily be unhelpful. The current study illustrated that regardless of any doubts or cultural conflicts prior to therapy Indian fathers had a positive experience. CBT upholds particular values such as assertiveness, personal independence, verbal ability, rationality, cognition and behavioural change. In contrast, within some cultures, value is placed on subtle communication,

interdependence, listening and observing, acceptance and on a spiritual view of the world (Jackson, Schmutzer, Wenzel & Tyler, 2006). Participants in the current study did not express any particular religious beliefs or the importance of addressing them within the therapy they had, therefore it may not be necessary to address unless it is specifically mentioned by clients.

Existing research indicates that therapy is not well utilised by the Indian community due to lack of awareness of services, lack of confidence in their efficacy and appropriateness, perception of cultural and language barriers and the fear that confidentiality will be breached (Beliappa, 1991). The current study highlights the need to create more awareness amongst the Indian population around what therapy is. In the current study participants indicated that they either had no prior knowledge on therapy or had cynical views of it. Often GPs are the first point of contact for many clients, therefore they need to have some provision of helping educate Indian people on what therapy involves. This could be through workshops and psychoeducation groups, which are delivered by community outreach and advocates such as elders from the community, religious figures and expert clients. This could be something that the NHS, private and charity services implement too, which would help raise awareness within the Indian community and help individuals who do not understand the concept of therapy to prepare for it. It is also helpful for therapists to consider using the first few sessions to socialise Indian fathers to the concept of therapy.

This study illustrates the difficulty Indian fathers have in gaining access to services as demonstrated by participant two, who explains that he feels other English organisations may not have understood the cultural differences in his relationship. Counselling psychologists working with Indian fathers need to be transparent if they do not understand cultural differences, allowing some space in sessions to help encourage Indian clients to discuss their

fears/prejudices and the therapist learning from the client about their cultural background. Counselling psychologists can help other therapists with their biases by holding seminars where past expert clients help educate them on how they can improve services to make them more alluring to other Indian fathers. Services could promote therapy to Indian fathers by advertising it in different Indian dialects, making posters and leaflets that include Indians, or employing a social marketing approach using media where a well known Indian figure discusses mental health and therapy.

It is difficult to refer Indian clients only to Indian therapists because of a lack of resources. In this instance it is important for non-Indian therapists to be aware of Indian cultural values. This highlights the need for training programmes and organisations to provide therapists with workshops and training on working cross-culturally. Although this is attempted in university doctorate programmes it is not delivered efficiently, as one lecture on working crossculturally is not sufficient preparation for trainees. Discussion with other counselling psychology trainees has indicated that this is evident in other doctorate programmes too. Counselling psychology training programmes need to allocate teaching on working with culture and diversity. This is an area that seems to be neglected and needs addressing.

Teaching programmes need to have lectures/seminars on the background of Indian society and their values/beliefs, the family structure and family roles, confidentiality, stigma and shame, reflection on trainees' personal biases/stereotypes and have expert clients visiting to provide information on their experience of therapy and generating question and answer with the trainees. This would help broaden their knowledge and better equip them to work with Indian clients, consequently increasing empathy and understanding on the cultural pressures, customs, traditions and values within the community. Although it is fair to appreciate that no one therapist can become an expert in all the different cultures they work with, having some

understanding and prior teaching can help improve their delivery of therapy and in turn improve the clients' experience, as illustrated in the current study.

This can also be mirrored in continuing professional development (CPD), helping non-Indian therapists to learn in more depth the dynamics involved within the Indian society and family. Currently on the division of counselling psychology website there is no CPD workshop, or training, on working cross-culturally. Furthermore email contact with the division of counselling psychology CPD lead, Ketan Patel, indicated that there is currently no representation of CPD workshops or seminars on working cross-culturally. He inquired whether the researcher was interested or knew someone who would be interested in contributing to such seminars/workshops. The BPS division of clinical psychology has a "race and culture faculty" website, which helps support psychologists to consider ethnicity and cultural diversity and disparities based on these differences, and encourages research and learning and sharing ideas. One of the faculty's aims is to encourage strategies to help increase the number of black and ethnic minority individuals to the profession of clinical psychology. This is not evident within the division of counselling psychology and there needs to be something similar on the counselling psychology website because at present it seems that this is not something of concern to the profession.

Limitations and Directions for Further Research

This section of the chapter discusses the limitations of the current study and possible recommendations for future research. The sample size consisted of four Indian fathers, which is a limitation of the current study, despite a small sample size being recommended for an IPA study (Smith et al, 2009). Within this IPA study the sample cannot be viewed as representative of Indian fathers, although it does present a comprehensive analysis of the accounts of a small number of participants therefore conclusions can only be applied to the group. IPA does not involve generalising findings to the wider population, however it would have been helpful to

gain more insight into Indian fathers' experience of family therapy with a few more participants adding more richness to the data.

Another limitation of this study is the fact that all four participants were recruited from the same family therapy organisation and were seen by the same therapist. This can be viewed as a drawback because the fathers' experience may reflect more on that particular service and that therapist, and perhaps not giving a broader experience of family therapy in general. The fact that this service particularly caters for Indian clients may have a bearing on why the fathers' experience was positive. It would be interesting for future research to investigate whether there is a consensuses amongst other Indian fathers experience of family therapy who have accessed non-Indian organisations, for example like the NHS and in another area in England to explore whether the findings can be generalised.

In the current study there were some factors that ensured some homogeneity amongst the sample group, for example all the Indian fathers had completed their therapy and had undergone therapy at the same family therapy service. However the sub-culture/religion of the four fathers differed, which included two Sikh fathers, one Muslim father, and one Hindu father. A more homogenous sample would have included participants who were all from the same sub-culture/religion. In the current study participants were initially going to be recruited from the researcher's placement however the family therapy service closed down and recruitment of Indian fathers was extremely difficult thereafter. Contact was made with the Indian family therapy organisation in an urban area in England; the manager explained that none of their clients wanted to be involved in taking part in an interview but to keep trying. Many private therapists said the same thing and added that their clients did not want to discuss their personal matters with a stranger. There was a challenge in gaining access within services to talk to clients.

This suggests that the concerns, anxiety and shame that Indian fathers have with entering therapy is also mirrored in them taking part in research. Similar to understanding the barriers that inhibit their engagement in therapy, it is important to address their engagement in research as services cannot develop and improve for ethnic minorities if they do not take part in research. It is difficult to determine whether Indian fathers within other services were actually approached to take part in the study, or whether organisations and therapists were being standoffish. The current study has highlighted that Indian fathers were willing to talk to a stranger and that, like therapy, although they initially had some apprehension, they took part.

With regards to recruitment, the researcher was signposted to the Indian family therapy organisation within England, where the family therapist was interested in helping, by directing her former clients to the researcher. This leads to concern that the participants in the current study only took part and said positive things within the interview to please their therapist (Orne, 1962). They may have had concerns about whether the information they shared would be taken back to their therapist, potentially impacting on confidentiality. The researcher did explain the term confidentiality to all participants and that their interviews would be used for the purpose of the study. The family therapist and administrator did ask the researcher how the interviews went and what was discussed, however the researcher explained that they could read the thesis on completion where the interview findings would be discussed.

There is a tendency within research studies to group divergent Indian sub-cultures together. This neglects to appreciate the distinctive features of each particular group. Durvasula and Mylvaganam (1994) suggest that conclusions about a certain Indian sub-culture cannot be generalised to others. Wang et al (2006) found that it is difficult to focus on a particular Indian sub-culture because research indicates a lack of engagement from Indian individuals in therapy.

The current study found that although the participants were from different subcultures that they all had similar experiences indicating that this is not necessarily true. Nevertheless participant two mentioned his religion on more than one occasion. He said that he is Sikh and his wife is Muslim and this difference has caused issues within their family, which he states may not have been understood by "English organisations". He also talked about there being a drinking culture within the Sikh community. Participant three also mentioned his cultural background being Pakistani and women not receiving "full respect" from the men. This difference in sub-culture and religion needs to be further explored. Future potential research could involve the exploration of Indian fathers' experience of therapy from one particular Indian sub-group/religion to help ensure homogeneity. Experience has shown this is a difficult task, which was known prior to the current study. To maybe help ensure more participant engagement, recruitment needs to be wider for example through GPs, NHS and private hospitals. Holding a group meeting would be a good forum for the researcher to talk directly through the study and interviews with potential participants rather than having the therapist do it. Thus this would help avoid demand characteristics, where participants may feel they have to say positive things about the therapy because their therapist has been involved with recruitment. Direct recruitment within community groups like places of worship and services which offer counselling specifically set up to serve the ethnic minority community may also be an option. Interviews could be done online or over the phone. If this proves to be more responsive then it could be something that is considered in therapy too. The location needs to be considered too. The participants in the current study were interviewed in the same therapy rooms at the Indian family therapy organisation that they had therapy sessions; again this may have influenced their positive responses. Future research may consider an alternative interview location, such as a room at the university.

The Indian fathers' responses given in the interviews may have been affected by the researcher's ethnicity, gender and age, being a young Indian female who could be seen as a daughter figure. This could have prevented them from talking freely about their experience. To determine whether this was an influential factor, other methods of interviewing would need to be considered for future research within this area, such as telephone interviewing by a male researcher or e-mailing the interviews. However it can also be viewed that having a female interviewer enabled them to disclose comfortably because it mirrored their therapy experience, which could have also prepared them to be more transparent about their experience in the interview. Another contributing factor which could have affected their responses is disclosing personal information to a stranger. As mentioned in the interviews it took the Indian fathers a few weeks to feel at ease and safe with the therapist in order to open up and talk about personal matters. They may have possibly felt exposed and judged in the interview process. This suggests it may have been helpful to explore other options for example have some time prior to the interview to build rapport with the participants, have repeated interviews, use non face-to-face interview methods such as over the phone or via email. These methods could also help minimise the interviewer being an influential factor to the fathers' responses.

The research findings from the current study indicated that these Indian fathers found it helpful to be matched to an Indian therapist. Having a common language and similar cultural background helped them feel better understood by their therapist. However the findings are based on one organisation where the therapist was Indian and spoke an Indian language. Recommendations for further research would involve investigating Indian fathers' experience of having therapy within other organisations where an Indian therapist does not speak Indian languages or with a non-Indian therapist. This would help give an in-depth understanding on

whether the ethnicity of the therapist and language has any bearing on the clients' experience of therapy.

Literature indicates that there are more male therapists working in marital and family therapy services compared to females, who work predominately in individual work (Walters, 2011). Male therapists are thought to better engage the whole family, where fathers feel they have an ally (Heubeck et al, 1986 as cited in Walters, 2011). They act as a positive role model for male clients as they model beliefs and values which are not constrained to the usual male stereotype (Dienhart, 2001). Research on Indian fathers' experience of having a male therapist and whether this has an effect on how they experience family therapy would help understand factors which impact their experience. This might involve conducting a discursive study, which explores how Indian men construct gender, maleness, fatherhood in therapy and therapists.

Conclusions

There are many factors that impact Indian fathers and their help seeking behaviour. Therapy has been constructed within a Western culture and therefore it is not readily accepted amongst the Indian community. Despite the hindrances such as being the head of the family, a stigma being attached to therapy, social anxiety about negative judgement from others, the norm being not to disclose to a non-family member and mental health often being expressed as somatic symptoms within the culture, Indian fathers were able to engage in therapy and reap the benefits of it.

It is encouraging to listen to Indian fathers' therapeutic experience, which in the past has been ignored. Previous literature has focused on therapists' experience of working with Indian clients, thus the current study has made an original contribution to the field of counselling psychology on the basis of exploring the experiences of Indian fathers utilising an IPA approach. It has been important to understand Indian fathers' experience to help improve services and increase the engagement of Indian men accessing services. The Indian community is marginalised in accessing therapy for mental health problems; a community psychology approach would help understand the underlying social issues that contribute to their lack of engagement. The aim of community psychology is to advocate social justice to marginalised populations and empower them. Community level prevention interventions could help tackle this issue of lack of engagement from Indian fathers by not just focusing on the individual but the environment in which they live in. Mental health cannot be treated solely by psychological and psychiatric services. Currently services have not moved forward in engaging Indian fathers within therapy, highlighting that it is a bigger problem, which requires addressing the community as a whole, by focusing on educating them on therapy and mental health. Counselling psychology might need to focus more on how organisations can work within the

Indian community to increase their engagement. This needs to be attempted through education on what therapy entails, workshops and psychoeducation talks to help elevate any anxiety, expert clients speaking about their experience within community groups, (temples etc) and within the doctorate programmes. This would enable social change rather than change on the individual level. If this is not addressed within counselling psychology then there is a danger that this population group will continue to go unnoticed with increase in suicide amongst young Indian women due to interpersonal difficulties, family violence and problems, unemployment and alcoholism, (Bhugra, 2002) and substance use amongst Indian men, which is used as a way to cope with difficulties within the culture (Pannu, Bhala, Zaman & Zaman, 2009).

The themes that emerged from the analysis help understand Indian fathers concerns that prevent them from asking for help and instead keeping problems hidden. All the fathers in the current study expressed how effective therapy had been for them, which is an encouraging finding indicating that some Indian fathers may have started off cynical about therapy, but later changed their minds. They have been socialised to conform to a collectivist culture involving family, which is the primary source of emotional support. Thus this study has created a new understanding to existing literature on Indians and family therapy, suggesting that their current beliefs and therapists' beliefs around therapy need to be challenged and highlights that everyone including Indian fathers need help and support sometimes.

The current study indicates the need for more research to be conducted in relation to Indians and therapy, as has been highlighted throughout the thesis. Through more research, there will be the opportunity to improve practice due to deeper knowledge of the Indian community. This would be adhering to the scientist/practitioner stance outlined in the counselling psychology professional guidelines. Furthermore, improved practice would empower and

enable professionals to educate this community group on therapy and its place within society, which would hopefully encourage better uptake of services and improved mental health metrics across the board for this community.

Reflexive Statement Part Two

Through the process of collecting date from participants I feel I have developed in my skills of interviewing. When interviewing participant one I felt boundaried and worried about influencing the participants' responses therefore I strictly stuck to the script and did not ask participants to elaborate or give more detail in their response. I did not want to influence participants with leading questions or cloud their mind with my own preconceptions, for example participant one mentioned needing support, in this instance I did not ask for clarification on what support meant to him, which would have given more depth in understanding his experience. This made it difficult to draw out more detailed discourse from participants. On reflection this could have also been due to participants feeling that they have answered the questions adequately. This could have affected the research findings by not having as detailed accounts of Indian fathers' experience. I found that when I got to interviewing participant four I felt confident and realised I relied less on the script and instead improvised acknowledging that it is okay to ask participants to clarify and expand on their responses. This potentially impacted the data collected as I feel that the first interview was shorter and this changed as the interviews went on, consequently interview four was the longest. This indicates that more information could have been drawn from the participants with appropriate prompting. This highlights a dynamic when working with this client group. Firstly participants had to be told to take part in the study, had to be told to come to therapy, they valued being told what to do in therapy sessions and I had to prompt them to talk about their experience rather than them talking freely. This dynamic possibly goes against the very thing

we are taught as counselling psychologist, which is to be client centred and relational and maybe these clients cannot make use of that. Maybe they will disengage if we do that because they will think that is of no use to me. It may be that they are better suited to CBT therapists and medics because they are more directive in their approach. It may or may not be useful to them but that is another debate, with regards to engagement it poses the question - are we requiring CoP to do the very opposite of what this client group need – what do we do as a profession? With this client group it may be that clinically to come alongside them it requires taking authority over them because that is what is needed. There possibly needs to be comprise on both sides, the clinicians need to think differently on how they approach this group and the clients need to have more awareness of therapy in general.

The process of finding participants for the study could have possibly affected the interview process because they were directly approached by their former therapist. This may have led to demand characteristics, where they only talked about the positive aspects of their therapy. There may have been concern about whether the information they divulged would be later shared with the therapist. The participants in the study may have also been apprehensive talking about their personal experience with an Indian female who could be seen as a daughter figure. Thus the dynamic could have been alien to them where they have to answer to a daughter. They may have therefore felt uncomfortable disclosing too much detail. This might explain why the interviews were short. It can also be viewed that participants saw this as a positive factor because they had an Indian female asking them questions, which matched their therapy experience and although the interviews were short it could be that that was all the participants had to say about the topic.

The room that the participants were interviewed in could have also affected the interview process. This is because it was the same room they had their therapy sessions. This is an issue

because it may have had an influence on the dynamic in the room, where they felt they were within a therapy session rather than being interviewed. They possibly may not have seen me as independent from the organisation and again felt they had to talk about positive experiences because that is what was expected of them. This could be because they felt a sense of respect for their former therapist and consequently towards me too. Within the Indian culture there is a huge sense of honour and respect, especially towards individuals who have helped them and are viewed as a professional.

On reflection coming to the end of the project, I have wondered why the therapist chose particular clients to participate in the study. There seems to be a few possible contributing factors such as pragmatics (clients who were easily accessible), those that completed treatment, those that engaged well and had been compliant therefore the therapist may have had a good inclination that they would say positive things

The research process has changed my opinions about Indian fathers and family therapy as many of them viewed it as positive. This went against my initial thoughts and beliefs, and I was honestly shocked at the findings. This highlights how other therapists who are working cross-culturally may hold certain beliefs about a particular ethnic group and they may go unchallenged as were mine until this study. I now feel less influenced by biases which were strongly present at the outset. I began the research with a negative attitude towards Indians and therapy and felt angry about the general discourse and beliefs that Indian people are a particular way e.g. Indian fathers are domineering, which was based on anecdotal literature.

The analysis process is the point of my research where I feel I adopted a more neutral position and respected what the participants in the current study had to say. Although I come from an Indian background, I do not have the right to assume that I understand my participants any

better because their life experiences have differed from my own. I can appreciate that we may have been exposed to similar social and cultural pressures but I cannot assume that I can identify with them because individuals construct meaning based on their experience.

The study has helped create insight for counselling psychologists on a phenomenon, which has highlighted that Indian individuals' engagement in therapy is something that requires addressing within the community. I also feel happy to know that the pessimistic view of Indians not liking therapy has been challenged.

The research process has highlighted the dynamic of concealment and ignorance possibly within the profession. Maybe CoP does not know what to do with Indian clients and are avoiding some of the issues discussed as they do not want to expose their ignorance. The CoP profession is meant to be about diversity however this is not reflected in doctorate training or CPD as discussed within the discussion chapter. This possibly exposes that they do not know anything about it and therefore they do not have teaching on it, highlighting the resistance in the profession.

Whilst writing up my thesis I have felt isolated from my family and friends as it consumed a huge part of my life. I constantly questioned myself, "what am I doing?" and "what is the purpose of this research?" which caused panic and confusion. The words spoken by Albert Einstein helped me realise the difficult and challenging process of research, "If we knew what it was we were doing, it would not be called research, would it?" this quote was used by Terry Hanley (2010, p. 3), who highlights that research is much like therapy in that it is a "process of discovery". Throughout the research process I found myself referring back to that quote for reassurance.

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Appendices

Appendix A: Recruitment poster

Appendix B: Participant information sheet

Appendix C: Informed consent form

 Appendix D: Interview schedule

Appendix E: Debriefing sheet

Appendix F: Recruitment questionnaire

Appendix G: Participant 1 theme table

Appendix K: Master table

Appendix A

Indian Fathers and Family Therapy

Are you an Indian father attending family therapy or have completed family therapy?

If yes, then please read on…

My name is Sukhi Virdee; I am a trainee Counselling Psychologist studying at London Metropolitan University. I am currently carrying out research on Indian father's experience of family therapy.

The university has ethically approved this study.

If you are interested in taking part in the study please contact me via email: sukhi20@hotmail.co.uk

Thank you for taking the time to read this poster

Appendix B

<u>Participation Information Sheet</u>

You are being asked to take part in a research study. Before deciding whether you would like to take part or not, it is important that you understand why the research is being carried out and what it will involve. Please take time to read the following information carefully.

What is the purpose of this study?
I am a trainee Counselling Psychologist at London Metropolitan University and am currently carrying out research on Indian fathers and family therapy. The aim of the study is to understand how Indian fathers experience family therapy interventions. At present there has been no research done on this topic area thus not much is known about their experience. This research hopes to broaden the range of knowledge on Indian fathers in the field of Counselling Psychology. The information acquired from this study will assist in building the foundations for future qualitative research exploring Indian families and family therapy, as at present no literature explores this.

Currently there is no qualitative research that explores Indian father's experience of family therapy. This study aims to fill this gap and provide insight on their experiences consequently advancing existing literature on fathers and family therapy therefore making an original contribution to the field of Counselling Psychology. This study also aims to help Counselling Psychologists/practitioners to better engage Indian fathers therefore helping the process of family therapy.

What do I have to do?
If you decide to take part in this research you will be asked to complete an interview which will last approximately an hour.

Do I have to take part?
Participation is entirely voluntary. If you decide to participate you will be asked to sign a consent from. You are free to withdraw at any point (up until two weeks after the interview date). The interviews will be recorded and will be strictly confidential. You will remain completely anonymous i.e. your name and identity will not at any point be revealed. All recordings will be kept in a secure place with a password lock and destroyed once the project is completed.

What about the findings of the study?
The data from the interviews will be used for my Doctoral level Counselling Psychology project. Your identity will remain anonymous.

If you wish to obtain a summary of the findings, please provide your contact details. Your details will be kept separate from the material that you provide during the interview.

Contact details:
Please take your time in deciding whether or not you wish to take part (Up to two weeks after receiving the participation information sheet). You will have the opportunity to ask any questions at the end of the interview. You will be given information on sources of support if you would like this.

Thank you so much for your time, if you have any further quires please do not hesitate to contact me via email: ▬▬▬▬▬▬▬▬▬ or my research supervisor, Dr Russel Ayling, ▬▬▬▬▬▬▬

Appendix C

<u>INFORMED CONSENT FORM</u>

Title of Research: How do Indian fathers experience Family Therapy? An Interpretative Phenomenological Analysis

<u>To be completed by participant:</u>

Please initial the boxes to indicate whether you agree with each statement:

1. I confirm that I have read and understand the information sheet
    for the above study

2. I have had the opportunity to ask any questions regarding the study

3. I understand that my participation is voluntary and that I am free to withdraw (up
    until two weeks after the interview date) without   giving any reason

4. I understand that participation in this study is anonymous

5. I agree for the researcher to audiotape the interview and also to allow her to use
    verbatim quotations from my speech in the write up

6. I agree to take part in the above study

_____   _____   _____

Name of Participant   Signature   Date

_____   _____   _____
Researcher   Signature   Date

Appendix D

Interview schedule

1. How would you describe family therapy?
   Possible prompts: Can you tell me a bit more about that?

2. Can you please tell me about how you came to enter family therapy?
   Possible prompts: What were your thoughts and feelings around family therapy?

3. Can you please tell me your experience of family therapy?
   Possible prompts: Can you please tell me what you think are the advantages and disadvantages of attending family therapy?
   How have you found family therapy sessions? Does anything make it better? Does anything make it worse?

4. Can you please tell me how suitable you think family therapy was for your family?
   Possible prompts: Where other options or therapies offered?

5. Can you please tell me whether you would opt for family therapy in the future?
   Possible prompts: What has made you feel that way? Can you please tell me whether this has changed from the onset?

6. Is there anything else you would like to share?

7. How have you experienced taking part in this interview today?

Appendix E

Debrief Form

Thank you for taking part in this research. The data from the interviews will be used for my Doctoral project.

This study aims to explore how Indian fathers experience family therapy. In order to explore this you took part in completing an interview.

Existing literature on family therapy with Indians has provided useful information to help practitioners modify/improve their therapeutic approach when working with them. However there has been no focus on exploring the subjective experience of Indian clients, experiencing family therapy, with particular focus on Indian fathers. This is important because research has demonstrated that it is important that fathers are directly involved in family therapy interventions (Carr, 1998).

The conclusions drawn from research on fathers and family therapy come from quantitative studies. It would be helpful to use qualitative methodology to explore how fathers experience family therapy with particular interest to Indian fathers. It would be helpful to understand Indian fathers experience as it would help unearth a phenomenon which has not yet been investigated. By carrying out this research I hope to understand Indian father's experiences consequently advancing existing literature on fathers and family therapy, therefore making an original contribution to the field of Counselling Psychology. This study also aims to help Counselling Psychologists/practitioners to better engage Indian fathers, therefore helping the process of family therapy.

Please contact the researcher on the following email address ███████████████ if you would either like a summary of the results or have any queries or questions about the study. Please remember if you would like to withdraw from the study it should be done within 2 weeks of the interview date.

If you have any queries or complaints regarding any aspect of the study please contact my research supervisor Dr Russel Ayling at London Metropolitan University on ███████████████.

I understand that it may have been difficult for you to discuss particular topics in the interview. I deeply appreciate you taking the time to take part in the study and if you feel you need any further support or if participation has raised any concerns please contact one of the following agencies for one to one counselling support or advice:

▪ Local GP

▪ Keyworker

▪ Mind: Infoline, 0300 123 3393, info@mind.org.uk

▪ Samaritans: 08457 90 90 90, jo@samaritans.org, www.samaritans.or

Appendix F

<u>Recruitment Questionnaire</u>

1. **Name:**

2. **Contact details:**

3. **Age:**

4. **Are you a father:**
   Yes ☐
   No ☐

5. **What is your religious background? (Please tick)** Hindu
   ☐
   Sikh ☐
        Muslim ☐
           Jain ☐
           Other ☐

   Please write below:

6. **Are you receiving family therapy?**
   Yes ☐
   No ☐

   If yes, have you completed family therapy? (Please tick)
   Yes ☐
   No ☐
7. **Please state what family therapy service you have been referred from.**

_____

Appendix G

	Family are priority	5/121	Indian family ties are more stronger
UNDESIRABLE FEELINGS	Anxiety	2/47-48	Erm the first few days were a bit awkward, cause I didn't know what to talk about
	Confusion	1/13	No, no I didn't know what it was all about
	Social anxiety	5/122	There's more things that you can't talk about, certain things you can
	Fear of disclosure	2/47-48	Erm the first few days were a bit awkward, cause I didn't know what to talk about
	Shame	5/122	There's more things that you can't talk about, certain things you can
	Negative judgement	1/18-19	I thought it's going to be a bit of a waste of time to be fair
THERAPIST ROLE	Techniques & interventions to help problems	3/62-63	So just talking to somebody who could ideally give you ideas on how to make certain matters better
	Didactic approach	5/137	And what steps to take and that, and what steps not to take
	Solution focused	6/143-144	Yeah err it gave me a clearer view of err how to take matters into my own hands
	Prescriptive	4/108-109	It gives a clearer view of how to you know fix my relationships
	Impartial advice	6/160-161	Just you know talking to somebody who's different, who's not related to you
	Guidance	3/61-62	Erm I mean the thing that made it better was just giving ideas you know on how to make matters better than before
	Problem solving	2/54-55	Helps you err gain ,ore knowledge of how to get your matters solved
	Advice giving	5/135	I was getting good advice off Meena and everything

	Curing relationships	4/108-109	It gives a clearer view of how to you know fix my relationships
MATCH TO THERAPIST	Asian counsellor	5/114-115	Actually having a Asian counsellor made it better cause they understand
	Feeling understood	5/114-115	Actually having a Asian counsellor made it better cause they understand

	Cultural similarity	2/48-50 5/114-115	The third one went quite well and I was speaking quite freely about how my relationship is...I think Meena was the person, who was my family counsellor, she was quite helpful Actually having a Asian counsellor made it better cause they understand
FATHERS NEED SUUPORT	Wounded self		
	Caring pain	4/85-86	Just support I think, I guess a bit of support and that, a bit of help and support in understanding matters better init
	Being helped	6/163-164	Then when you speak to somebody else they can give you a clearer view of where you're going wrong and what's going right
	Concealing true feelings	2/43	Erm no, just say it's been quite helpful going to family therapy
	Not being supported in family	6/162-163	You can't talk to your family, your mum or your wife, you know something that is really personal, you know that you don't like
	Difference in family roles	5/134-135	I think it was quite, quite suitable, it's quite you know, it has worked for me, you know I was getting good advice off Meena and everything
	Being heard/telling story	6/160-161	Erm just you know talking to somebody who's different, who's not related to you and then you can talk your intimate problems
	Masculine role	1/24	Err no, no fears really
	Loss of control	1/3-4	There was a bit of domestic violence in the family, so because of that I was referred to family counselling
	Being understood	5/114-115	Actually having a Asian counsellor made it better cause they understand
WESTERN CONCEPT	Easier for others	5/114	I think it is a bit different

	Difference of cultures	5/115	The family ties are more stronger in Asian families
	Awkward/strange dynamic	3/78	Err it wasn't too awkward
	Self-disclosure	2/47-48	The first few days were a bit awkward, cause I didn't know what to talk about
	Lack of awareness	1/18-19	I thought it's going to be a bit of a waste of time to be fair
	Universality	3/81	I think no, I think it's the same

OUT OF PLACE	Out of comfort zone	2/47	First few days were a bit awkward
	Uncomfortable with new environment	2/28 2/43	Erm I think it's quite helpful actually Erm no, just say it's been quite helpful going to family therapy
	Uncertainty	1/13	No, no I didn't know what it was all about
	No prior knowledge	1/15	Until I actually came and then I realised it was quite helpful
	Avoidance of detail	2/28-29	Erm I think it's quite helpful actually, you know, it kinda picks up points where you know that you miss
	Difficulty articulating experience	2/43	Quite helpful
CREATION OF NEW PERSPECTIVES	Objective view	6/164-165	Give you a clearer view of where you're going wrong what's going right
	Giving clarity	6/151-152	I think that was quite helpful when we both attended to get matters cleared up a bit
	Helpful	6/165	So I think it does help, it helps a lot, it helps a lot
	Support system	4/85	I guess a bit of support and that, a bit of help and support in understanding matters better init
	Sharing strategies	4/96-97	You know ideas of how to make the relationship work better between me and my wife

	Optimism	2/37-39	Well family therapy, I mean it picks up on the things, like if there's something wrong in a relationship it tells you how to kinda of get matters working and you know better
	The new self	4/101	You know misunderstandings were all cleared as well, yeah and everything
	New relationships	4/96-97	You know ideas of how to make the relationship work better between me and my wife
PERCEPTION OF THERAPY	Healing process	3/58-59	They helped me, you know get the stuff on my chest off and I got to talk about things that I couldn't talk to anyone else about
	Repairing relationships	2/28-30	It kinda picks up points where you know that you miss out in relationships and helps to repair, repair matters and that
	Client role to follow advice	5/137	And what steps take and that, and what steps not to take
	Openness to change	2/33-34	Err no I didn't have any clue what it was to start off with, because it's the first time I attended something like that

	Time period	3/67-68	Actually it went all well because we talked about our differences, slowly over time we had a reconciliation and then it was quite good
	Fixing what is broken	4/108-109	So you know it gives a clearer view of how to you know fix my relationship
EXPECTATIONS OF THERAPY	Negative preconception	1/18-19	Err I just thought, I thought erm I thought it's going to be a bit of a waste of time to be fair, it turned out to be quite helpful actually
	Surprise at the benefits	1/15	Until I actually came and then I realised it was quite helpful

Appendix H

Theme/cluster	Sub-theme	Participant	Line number	Quote/key word
Indian fathers & their family	**Collective culture**	P1	5/121-122 5/126 5/115-116	*Indian family ties are more stronger you know...It's more tied down, Indian relationships The family ties are more stronger in Asian families and there's more to think about*
		P2	5/133-134 8/246-247 2/54-55	*Well from my family, I, I just love my family and that's all I want really, I want family unity, my family comes first* *I know other families out there who can't turn around to cause of the shame thing. We deal with it as a family so* *Well like I was saying if there's a home environment a lot, being the typical Asian family, I'm not in a typical Asian family but family influence comes a lot into it*
		P3	3/69-71 6/160-161	*Yeah because you know if we live together as nicely like a nice couple then it's very good for me. If we shout at each other, we swear at each other then it's no good for any of the family I don't do mistakes in my life but if for my family we needed that I would come back again*
		P4	8/220-226 8/239-241	*Back home if you look into it not just India in many countries you know Jamaica, many countries, if the elder person says something wife listen to it, doesn't matter if it's good or bad and is same with the children, they have to just stop...stop mean stop. Over here they just think oh now we more clever than them, that's why the reason Asian families finding it more difficult to go to counselling, this is something that never ever came to their knowledge before and it was working alright even without counselling* *Problems come in the family they don't want to come to this stage...to a third party...third person come to know about what's happening in our family in our four walls*
	Stuck in Silence	P1	4/85-86 6/162-163 6/160-161	*Just support I think, I guess a bit of support and that, a bit of help and support in understanding matters better init* *You can't talk to your family, your mum or your wife, you know something that is really personal, you know that you don't like* *Erm just you know talking to somebody who's different, who's not related to you and then you can talk your intimate problems*

		P2	4/107-108	*And it's unfair for some fathers, it can mentally you know upset you, you know I had a bad time, you know I haven't seen the kids yet*
			2/44-45	*It's a good time to get your emotions out, you know talk about things*
			4/115-118	*Fathers seem to be like the ones that are supposed to be the bad ones or the bad parent, who don't do the cooking, cleaning or tidying all the house and then goes to work*
		P3	4/114-115	*But after all the sessions I feel like that I am breathing very well now*

			5/150-151	*If I don't do any other mistakes in my life then we live together nicely*
			6/176-178	*When I came here, I am err not feeling good on that time but after this slowly slowly err when I appreciate I did some of the mistakes*
		P4	1/17-18	*Sometimes we get stuck and...this there's so much clog in your brain*
			3/68	*It will help your thinking, your brain and your stress and your family matters*
	Expectation of masculine role	P2	4/115-118	*Fathers seem to be like the ones that are supposed to be the bad ones or the bad parent, who don't do the cooking, cleaning or tidying all the house and then goes to work*
			4/114-115	*I think women tend to get emotional and start crying and the waterworks. Blokes are behind your back, won't cry*
			4/102-105	*You know a women can say x, y and z to a judge even though the dad the father pays the maintenance, could be the perfect dad, they can err, seems to be about the kids and they're with their mum. That's the society we live in, that's the way the law works in this country*
		P3	4/100-103	*Because I am the head of the family, is very good for me if I learn, someone and I teach my kids, my family, if I don't know about myself where I do mistakes, where I did some mistakes, I can't do nothing for them, my kids and my family*
			3/88-89	*Father is the head of the family, if he did some of the mistakes, his children, his daughters, his sons, his wife should be doing a mistake as well*
			3/87-89	*Father is most important in the family because he's the...in our Asian community the father is the head of the family*
		P4	8/229-231	*I seen many families err so many problems with this sort of thing, just sick of children because mother takes children's side too much and err mother doesn't listen to father and err relation goes wrong and then the family get apart*
East Vs West	**Stigma & shame**	P1	5/122	*There's more things that you can't talk about, certain things you can*
		P2	8/243-244	*Sometimes you hear it's the shame factor if you come for therapy or we don't want so and so or x and y families to find out*
			8/233-234	*Yeah I think so. I was a bit wary before, you know there's s stereotype for coming to therapy you know*

		P3	5/126 7/191	*No in our country they don't do it like that. In this country it's very good for us But* *after this slowly slowly I feel better and relax as well*
		P4	4/97-98 4/100-101 6/161-164 7/206-207	*What other people think about me, why do I need counselling, something wrong with my brain* *Something wrong with my brain or probably I'm behind or something like these sort of things come to mind* *You think a third party will come to know you and that's set at the back of your mind or people will think you're going counselling or what's wrong. That's the thinking at the back of the brain Not many Asian people try to go to counselling because err they're feeling embarrassment of themselves*
	Foreign concept	P1	2/47-48	*The first few days were a bit awkward, cause I didn't know what to talk about*
		P2	8/240-241	*In Asian cultures it's like hidden underneath, families trying to deal with it and families can't always deal with it*
		P3	6/171-174 4/117-118 5/126	*Because my English is no good that's why there is a little bit of a problem for me, it's very hard for me, but I will try my best (laughs) and that's why we came here and all the time they talk to me in English and err Hindi and Punjabi* *Nah because you know in our Indian culture, Pakistani culture it's very different, we don't give full respect to our wife's but in the UK everybody's the same init* *No, in our country they don't do it like that. In this country it's very good for us*
		P4	5/141-143 7/208-210 8/225-227 3/84	*Although I can speak English some of the hard words I wouldn't be able to pick it up and err probably not able to understand, be incomplete, I think err that was good* *I know our thinking is like that because these things we never come across before in the life and we never need it either but in this country stress and other things are coming to you and err that causes the problem* *This is something that never ever came to their knowledge before and it was working alright even without counselling. Even if they have to tell the wife how to listen but in this country it's totally opposite* *Never heard of it before*
	Ambivalent/ Uncertainty	P1	1/13 2/33-34	*No, no I didn't know what it was all about* *Err no I didn't have any clue what it was to start off with, because it's the first time I attended something like that*
		P3	2/60-6 4/111-112	*Yeah...now after 6 sessions after 2 or 3 sessions I can't understand the first session and the second session, it is a little bit but the third time I understand everything* *Yeah I said to you before it was very good for me and my family because when I came here first I don't know what was going on*

		P4	2//31-32	*Well yeah I was a bit worried in case they will ask me some personal questions and things like that*
The therapist	**Technique**	P1	3/62-63 5/137 3/61-62	*So just talking to somebody who could ideally give you ideas on how to make certain matters better* *And what steps to take and that, and what steps not to take* *Erm I mean the thing that made it better was just giving ideas you know on how to make matters better than before*
		P2	3/65-66 2/45-46	*I think sometimes some people don't listen to the actual what the counsellor is saying to you* *Err you know it's obviously there, advice there, which you can work on*
		P4	1/18-21 3-4/90-91	*A lot of other things which you come to know from err the err the therapy people and they got more experience than us. They been trained like that and they take it out of your brain and err it helps quite a bit* *Telling us what one partner can do, what the other partner got duties to be done*

			2/39-40	*She helped me there about what else we can do and what else we can't do, how things can work*
	Mediator	P1	6/160-161	*Just you know talking to somebody who's different, who's not related to you*
		P2	6/170-171	*Good to have a counsellor understand kinda both points of view*
		P3	2/53-56	*You tell us the truth and everything and then we sort everything on behalf of you and behalf of your wife as well and your family counselling here and we told erm everything and after this erm they sorted everything*
		P4	5/128-131 5/131-132 9/260-261	*Your talking to a third party, who you don't know and they don't take anybodies side, they tell both parties what is best for them for you and that err probably in family matter nobody, no relations, anybody else can't do that because they would take a side With the therapy people they don't take no bodies side* *Because we all think I'm right...I'm right, until you point it out that you are wrong, a third person would point out where you are wrong*
	Match to therapist	P1	5/114-115 2/48-50	*Actually having a Asian counsellor made it better cause they understand* *The third one went quite well and I was speaking quite freely about how my relationship is...I think Meena was the person, who was my family counsellor, she was quite helpful*
		P2	2/35-36 6/162-164	*It's not like your families there or anything else, it's like you, it's somebody else you can talk to, you know an Asian person to talk to* *Well I think if I went to certain English organisations may be they couldn't, they probably wouldn't understand the culture differences, especially in my relationship*
		P3	6/172-174	*That's why we came here and all the time they talk to me in English and err Hindi and Punjabi*

		P4	5/139-141	*Well easier with Indian circumstances. The reason is some of the words we probably can't explain in English or any other language that's why I felt more comfortable with an Indian counselling*
What is therapy	**Self-growth**	P1	6/143-144 2/54-55 3/67-68	*Yeah err it gave me a clearer view of err how to take matters into my own hands and that, you know find the barrier between, you know what was going on, you know what was causing the argument* *Well the advantages are it helps you err gain more knowledge of how to get your matters solved* *Actually it went all well because we talked about our differences, slowly over time we had a reconciliation and then it was quite good*
		P2	1/28-30	*We had a lot of issues in our relationship, me and my wife, I've actually come off a prison sentence, had to do the family counselling to look at the underlying issues*
		P3	1/21-22	*Yeah family therapy is good because you, when somebody does a mistake and they don't know about that and we had too many problems*
		P4	2/40-43 9/253-254	*That was few things I came to know about it err which was without my experience before but as you say you live and learn every day, persons live and learn every day so I was learning a few things from there and err a few things were working better* *Well err they would err probably tell the rest of the family few things they were not aware about it*

				before
	Expectations	P1	1/18-19 1/15	*Err I just thought, I thought erm I thought it's going to be a bit of a waste of time to be fair, it turned out to be quite helpful actually* *Until I actually came and then I realised it was quite helpful*
		P2	8/233-235	*You know there's a stereotype for coming to therapy, you know you watch these comedy programmes, you watch TV, you gotta be really sad to come into therapy*
		P3	4/111-112 2/49-50	*Yeah I said to you before it was very good for me and my family because when I came here first I don't know what was going on* *Family therapy is err same like that when we came here we don't know about that*
		P4	1/24-25 2/34-35	*Well I was a little bit worried first erm..what they will say, what not to say, how it works, how it wouldn't work* *But there were no personal questions, only questions they would ask was related to it*
	Outcome	P1	6/151-152 2/37-39	*I think that was quite helpful when we both attended to get matters cleared up a bit Well family therapy, I mean it picks up on the things, like if there's something wrong in a relationship it tells you how to kinda of get matters working and you know better*
		P2	2/45-47 1/12	*You know it's obviously there, advice there, which you can work on, you know the points and certain areas that we should work on Erm I mean it kinda stopped my problems*

		P3	6/177-178 4/100-101 1/14-15 2/61-64	*But after this slowly slowly err when I appreciate I did some of the mistakes* *Yeah I told you before it's good for me first of all because I am the head of the family, is very good for me if I learn someone and I teach my kids, my family* *And then she started everything for us and now we're living like a nice person, nice family But the third time I understand everything and she understand everything as well and after this when we go back home we talked to each other err we don't shout, we talk nicely and do good conversation with each other and err then it hits me that family counselling is very good for me*
		P4	4/103-105	*But when you go there and they're talking you think oh no there's nothing wrong with my brain or nothing wrong with my thinking, they're trying to work it out for both partners*
	Disclosure	P1	2/47-48	*Erm the first few days were a bit awkward, cause I didn't know what to talk about*
		P2	1/18-21	*I mean it's kinda strange because your put in a box and someone's asking you questions, you don't always want to answer them, you try. I'm not saying you avoid the issue, you know err, I don't know, it's just things you don't want to say but then yeah admit to yourself*
		P3	2/38-39	*Erm they helped me all the time erm because after when we were here we tell them everything about our week*
		P4	1/25-26 2/31-32 8/239-242	*I don't want to disclose my privacy to anyone* *Well yeah I was a bit worried in case they will ask me some personal questions and things like that* *When there's a bitterness, problems come in the family they don't want to come to this stage to a*
				third party, third person come to know about what's happening in our family in our four walls, behind the four walls whatever they are doing they think they are doing it right but it's not right all the time